PIPE FITTERS' WELFARE FUND, LOCAL 597

FOR

RESIDENTIAL AND LIGHT COMMERCIAL SERVICE PIPE FITTERS

SUMMARY PLAN DESCRIPTION

AND

PLAN DOCUMENT

2020 EDITION

PIPE FITTERS' WELFARE FUND, LOCAL 597
RESIDENTIAL AND LIGHT COMMERCIAL SERVICE PIPE FITTERS

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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 for Residential and Light Commercial Service Pipe Fitters (the "Plan"), effective January 1, 2020, unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your 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 (see Section 12 of this booklet). 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. IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT 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 BOARD OF TRUSTEES RESERVES 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 MATERIAL PLAN CHANGES.

PLAN VENDOR INFORMATION AS OF JANUARY 1, 2020

The **Fund Office** is responsible, under the oversight of the Board of Trustees (the "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 providing various reports and other services that the Plan requires. Please visit www.pf597.org 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 **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 **Preferred Provider Organization (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 Blue Shield of Illinois (BCBSIL) as its Preferred Provider Organization.*** 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. Please call the number provided on your ID card 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.*** Please call Express Scripts at (877) 567-5547 or visit www.express-scripts.com for more information.

The **Dental PPO** provides access to dental providers offering discounted fees. ***The Trustees selected Dental Network of America (DNOA) to provide the Plan's Dental PPO.*** Please call DNOA at (877) 522-6758 or visit www.dnoa.com for more information.

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 **Employee Assistance Program** 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 Employee Resource Systems, Inc. (ERS) as the Employee Assistance Program provider.*** EAP services are available 24 hours a day, 365 days a year by calling (800) 292-2780. Calls are answered directly by clinical professionals who provide immediate service even after standard business hours.

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SECTION 1: SCHEDULE OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Plan. 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.

Medical Benefit	
Plan Deductibles for Covered Medical Expenses	
Calendar Year Deductible (Does not apply to Preventive Services)	$600 per person $1,800 per family
Medical Benefit Out-of-Pocket Maximum	
Out-of-Pocket Maximum per Calendar Year The out-of-pocket maximum does not include Prescription Drug Co-Payments or Non-PPO expenses. 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.	$5,000 per person $10,000 per family
Covered Medical Expenses Subject to Visit Maximums	
Spinal Manipulation and Naprapathy (excluding laboratory tests)	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, subject to medical necessity review
Outpatient Occupational Therapy	40 visits per person per calendar year, subject to medical necessity review
Infertility Treatment (Participant and Dependent spouse only)	$20,000 per lifetime (for no more than two cycles to achieve conception)

Medical Benefit		
Covered Medical Expenses Paid by the Fund up to the UCR Charges	***PPO Charges***	***Non-PPO Charges***
Physician Office Visit	80%	60%
Specialist Office Visit	80%	60%
Preventive Services	100%	Not Covered
Emergency Room Services	80%	80%
Emergency Medical Transportation	80%	60%
Hospital/Facility	80%	60%
Mental and Nervous Disorders	80%	60%
Chemical Dependency/Substance Abuse	80%	60%
Spinal Manipulation and Naprapathy	80%	60%
Outpatient Physical/Speech Therapy	80% (40% after 40 visit limit)	60% (40% after 40 visit limit)
Outpatient Occupational Therapy	80% (40% after 40 visit limit)	60% (40% after 40 visit limit)
Skilled Nursing Care	80%	60%
Durable Medical Equipment	80%	60%
Infertility Treatment (Participant and Dependent spouse only)	80%	60%
All Other Covered Medical Expenses	80%	60%

Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year (excluding prescription narcotics (narcotic agonists)) *These maximums are adjusted annually so the combined out-of-pocket maximums for Prescription Drugs and Medical (PPO) equal the maximum permitted under the Affordable Care Act.	$3,150 per person* $6,300 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	40% ($5 minimum)	40% ($10 minimum)
Preferred Brand Drugs on the preferred brand list are considered good values, both clinically and financially.	40% ($15 minimum)	40% ($30 minimum)
Non-Preferred Brand Drugs on the non-preferred brand list are the most expensive drugs available on the market. Always ask if there is a generic or preferred brand that is available.	40% ($30 minimum)	40% ($60 minimum)
Specialty	40%	
Your Co-Payment for prescription narcotics (narcotic agonists) is always 40% and is not subject to any out-of-pocket maximum.		

Dental Benefit		
Covered Expenses Paid by the Fund up to the UCR Charges	***PPO Charges***	***Non-PPO Charges***
Maximum Benefit per Calendar Year	$2,000 per person (does not apply to Dependent children under age 19 for Diagnostic and Preventive services)	
Diagnostic and Preventive Services	100%	
All Other Covered Services	80%	
Orthodontia Services	Not Covered	
Employee Assistance Program (EAP)		
Counseling with EAP Staff Members	No charge for up to three sessions per problem, situation or issue	

SECTION 2: ELIGIBILITY

2.01 Eligibility for Benefits

A. Eligibility Hours and your Accumulation Account

You are eligible for benefits based on the number of Eligibility Hours in your Accumulation Account. Your Accumulation Account is a record of your Eligibility Hours used in determining eligibility for benefits. You can accumulate a maximum of 1,500 hours in your Accumulation Account once you meet the Initial Eligibility Requirements.

Eligibility Hours are hours that are credited to your Accumulation Account which are used in determining eligibility for benefits. 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. Benefit Quarters

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

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

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

C. Initial Eligibility Requirements

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

D. Continued Eligibility Requirements

Once you meet the Initial Eligibility 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 amount 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 below:

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

Your coverage under the Plan will end upon the earliest of the following events:

1. You fail to qualify for eligibility under any of the Plan's eligibility rules;
2. You become eligible for benefits under the Pipe Fitters' Welfare Fund, Local 597 Plan;
3. Your death; or
4. The Trustees terminate the Plan.

F. Reinstatement of Eligibility

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

G. 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.

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

Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION.**

Option 2: Suspend active coverage under the Plan for as long as the Plan's eligibility rules permit and then elect COBRA Continuation 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 Continuation 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. To reinstate your eligibility, you must provide the Fund Office with a copy of your discharge papers within the time periods provided under USERRA as described in the following chart.

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

Once you provide the Fund Office with your discharge papers, your Accumulation Account, which was suspended when you went into active military service, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund, for the balance of the current Benefit Quarter.

Your eligibility for subsequent Benefit Quarters will be determined as of the corresponding determination dates under the Plan's Continued Eligibility Requirements.

Option 2

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

To reinstate your 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 above.

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 Benefit Quarters will be determined under the Plan's Continued 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 Continuation Coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

You must provide the Fund Office with a copy of your discharge papers within the time periods provided under USERRA as described above.

If your 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 Continuation Coverage as of the date of discharge, or a later date as agreed to by the Fund. Upon discharge, you can pay for COBRA Continuation Coverage until the later of (1) the end of six months of payments, or (2) the end of the original 24-month period.

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

When you take leave 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 if you meet the following criteria:

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

2. You have worked at least 1,250 hours during the previous 12 months; and

3. You work at a location where at least 50 employees are employed by your Employer within a 75-mile radius.

The duration of leave available to you will depend on the reasons for which you are taking the leave.

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 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 period provided above.

2.02 Dependent Eligibility

A. Dependents' Initial Eligibility

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

1. You are eligible for coverage; or

2. He or she meets the definition of Dependent under the Plan.

B. When Dependent Eligibility Ends

Your Dependents' coverage will end on the date the earliest of the following events occurs:

1. Your eligibility ends for reasons other than your death;

2. He or she no longer meets the definition of a Dependent;

3. Your Dependent enters military service; or

4. The Trustees terminate the Plan.

C. Coverage for Surviving Dependents

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 31, June 30, September 30 or December 31, depending on the hours in your Accumulation Account).

D. 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 your 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 the Plan's coordination of benefits rules.

The Fund Office will notify you and any 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.

2.03 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, as amended (COBRA). Qualifying Events include death, a reduction of hours, loss of employment (except due to gross misconduct), entitlement to Medicare benefits, a Dependent losing his or her Dependent status under the Plan, and separation or divorce.

If you elect COBRA Continuation Coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA Continuation 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 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 and your eligible Dependents may elect up to 18 months of COBRA Continuation 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. Any child born to or placed for adoption with you during the period of COBRA Continuation Coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage based on when you no longer have sufficient hours in your Accumulation Account to meet the Continued Eligibility requirements under the Plan.

2. Disability Extension of 18-Month COBRA Continuation Coverage

If you or an eligible Dependent is determined by the Social Security Administration to be disabled, you and all family members previously covered under COBRA may be entitled to receive an additional 11 months of COBRA Continuation 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, Payments and Due Dates

The COBRA premium is determined by the Trustees in accordance with federal law and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan.

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.

E. 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 your Dependents' addresses.

F. Electing COBRA Continuation Coverage

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

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.

2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.

3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any minor children who were covered by the Plan on the date of the Qualifying Event.

4. The person electing 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.

G. When the COBRA Continuation 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 terminates under the Plan.

H. When COBRA Continuation 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 your Dependent has a health problem for which coverage is excluded or limited under the other group health plan;

2. The required premium is not timely paid;

3. The Trustees terminate the Plan;

4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA Continuation Coverage period;

5. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or

6. Your Dependents become entitled to Medicare, unless they are entitled to COBRA Continuation Coverage due to your death.

SECTION 3: MEDICAL BENEFIT

3.01 Eligibility for Medical Benefit

If you meet the eligibility requirements listed under Section 2, your coverage includes the Medical Benefit.

3.02 The Deductible

The deductible is the amount of Covered Medical Expenses that you and each of your eligible Dependents pay each calendar year before benefits are paid. The amounts of the individual and family Deductibles are listed in the Schedule of Benefits.

The family Deductible may be satisfied through any combinations of individual Deductibles. 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.

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 that Accident.

3.03 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, Customary and Reasonable (UCR) Charges up to any Plan maximums.

3.04 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 remainder 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.

3.05 Preferred Provider Organization (PPO)

The 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 the Fund's 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. Although you are not required to use PPO Hospitals and providers, 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 Fund will provide you with information on PPO providers upon your request.

If you visit an out-of-network provider, you will have larger out-of-pocket expenses, a lower percentage paid and may have to pay the difference between the UCR Charges and the total billed amount.

3.06 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.

You will be notified by the Fund Office if your claim is subject to case management.

3.07 Covered Medical Expenses and Exclusions

A. Covered Medical Expenses

The Plan covers the Usual, Customary and Reasonable (UCR) Charges 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 room rate; or

        ii. The Hospital's regular daily rate for a private room, when required.

    b. Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services while hospitalized.

    c. Outpatient Hospital services including fees incurred for:

        i. Outpatient surgical procedures; and

        ii. Emergency treatment for an injury or Sickness.

    Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours

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

2. Medical care and treatment (including surgery) provided by a legally qualified Physician or other 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 (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose related to the person's physical disorder, (c) generally is not useful in the absence of illness or injury and (d) 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 (a) equipment that serves as a comfort or convenience item or (b) 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 when:

a. Your confinement begins within 14 days after a Hospital admission of at least three days duration;

b. Your care and treatment are for the Sickness or Accident that caused the Hospital confinement immediately before admission to the Skilled Nursing Care Facility; and

c. You are under the regular care of a legally qualified Physician or Surgeon.

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

11. Treatment for Chemical Dependency/Substance Abuse.

12. Treatment for Mental and Nervous Disorders.

13. Surgical removal of tumors or cysts from the mouth.

14. Expenses incurred as a result of an accidental injury to sound natural teeth when the expense is incurred within 90 days of the Accident.

15. Spinal manipulation and naprapathic services 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 Schedule of Benefits when performed by a person licensed by the State to perform such procedures. No benefits are provided for covered persons 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 Schedule of Benefits. No benefits are provided for covered persons under age 16.

16. Non-experimental or non-investigative 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 provided for both you and the donor.

17. Medical and surgical benefits for mastectomies as required by federal law under the Women's Health and Cancer Rights Act of 1998 (WHCRA), including the following, when requested by the patient in consultation with her Physician:

    a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications of all stages of mastectomy including lymphedemas.

18. Medical care and treatment by a certified nurse anesthetist if such treatment would otherwise be covered under the Plan if provided by or under the supervision of a legally qualified Physician.

For purposes of this Section, certified nurse anesthetist shall mean a person who (a) has graduated from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor, (b) passed the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessor, (c) is licensed in the state or jurisdiction where the services are rendered to provide or administer anesthetics to patients and (d) is acting within the scope of his or her license.

19. Medical care and treatment by a surgical assistant or surgical technician who assists a Surgeon in performing surgical procedures.

20. Licensed ambulatory surgery center services.

21. Routine well newborn and child care.

22. Routine immunizations.

23. Operating and recovery room charges.

24. Allergy serums.

25. Provided there is an appropriate Medically Necessary reason for conducting the test, genetic testing is covered for determining the existence of inherited mutations which creates a susceptibility to (a) medullary carcinoma of the thyroid, (b) colon cancer and (c) breast or ovarian cancer (inherited BRCA1 or BRCA2 mutations).

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

a. For medullary carcinoma of the thyroid, genetic testing for RET proto-oncogene point mutations will be eligible for coverage in family members who are:

i. Symptomatic patients with defined RET gene mutations;

ii. Patients known to be affected by inherited medullary thyroid cancer or to multiple endocrine neoplasia type 2, but not previously evaluated for RET mutations; and

iii. Patients with medullary thyroid cancer with no family history of such cancer (sporadic incidence).

b. For colon cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

   i. Genetic testing to determine carrier status of the adenosis polyposis coli gene (APC) is eligible for coverage in:

      1. Patients with greater than 20 colonic polyps; or

      2. First-degree relatives (i.e., siblings, off-spring, or parents) of patients diagnosed with familial adenomatous polyposis (FAP).

   ii. Genetic testing is considered Investigative and is not eligible for coverage for the following:

      1. Identification specifically for I 1307K mutation; and

      2. Identifying which patients should undergo HNPCC genetic testing by using the replication error (RER) phenotype test, also referred to as the micro-satellite instability (MSI) test.

c. For breast or ovarian cancer, the determination of whether genetic testing is Medically Necessary is subject to the following requirements and restrictions:

   i. Genetic testing is available for:

      1. Individuals who have breast or ovarian cancer and are from families with a high risk of BRCA1 or BRCA2 mutations.

      2. Unaffected individuals (male or female) who come from families with a known BRCA1 or BRCA2 mutation.

   ii. Genetic testing is Investigative and not eligible for coverage for:

      1. Unaffected family members in the absence of a known BRCA1 or BRCA2 mutation in the family, unless the family history reveals at least four first and/or second-degree relatives with breast, ovarian or colon cancer and there is no affected family member available for testing;

      2. Unaffected individuals of potentially high-risk populations (e.g., Ashkenazi Jewish descent) with no significant family history; and

      3. Minors for BRCA1 or BRCA2 mutations.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. Elective medical and surgical sterilization procedures.

32. Applied behavior analysis (ABA) services for the treatment of autism by an early intervention specialist that is certified and licensed in the state in which the services are provided. Such services must be provided by a Physician, licensed psychologist, licensed clinical professional counselor in the appropriate field, licensed clinical social worker or other licensed professional as recognized by the Plan.

33. 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; and

    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.

34. 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.

35. 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 his or her 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.

    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.

36. 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

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

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

8. Dental x-rays and/or dental services performed on or to the teeth, wisdom teeth, nerves within the teeth, gingivae or alveolar process, except as specifically provided under Covered Expenses in Section 3.07(A). Coverage for inpatient and/or out-patient hospitalization in connection with a covered dental procedure is covered 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.

9. Dental services, including orthodontia and treatment of temporomandibular joint syndrome (TMJ) except as specifically provided in Section 3.07(A).

10. Prescription drugs, except those provided when the claimant is receiving care in a Hospital or Skilled Nursing Care 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 Illness; or

    c. For conditions resulting from Accident, Illness, or accidental injuries, 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.

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 except as required by federal law.

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 accidental injury), 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 (a) you are at least 100 pounds or more above your ideal weight, (b) you are considered morbidly obese and (c) 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 under federal law.

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.

26. Telephone consultations.

27. Special home construction or vehicle modification.

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

29. 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.

30. Inpatient or outpatient expenses resulting from behavioral problems, conduct disorders, learning disabilities and developmental delays that are not the result of a Mental Disorder.

31. Any expenses or charges for orthopedic shoes.

32. Hearing aids.

33. Genetic manipulation or genetic testing, except for the genetic testing provided in Section 3.07(A)(25).

34. Any expenses or charged related to genetic counseling.

35. 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 except as required by federal law.

36. Charges incurred for special education provided to any individual. This exclusion does not apply to diabetes education as provided in Section 3.07(A)(29).

37. Charges incurred for any Hospital confinement or other medical care or service which an eligible Employee or other eligible individual would not be legally required to pay.

38. 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 except as required by federal law.

39. 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 3.07(A).

40. Massage therapy.

41. Recreational therapy.

42. Hot and cold therapy of any nature.

43. Charges for any of the circumstances listed under the General Plan Exclusions in Section 8.

3.08 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 the 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 4: FAMILY WELLNESS CENTERS

4.01 Eligibility for Family Wellness Centers

If you meet the eligibility requirements set forth in Section 2, you may access services provided by the Family Wellness Centers.

4.02 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 and your Dependents. The Family Wellness Center also provides 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

Indiana Family Wellness Center
10090 Georgia Street, Suite 3
Crown Point, IN 46307

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

SECTION 5: PRESCRIPTION DRUG BENEFITS

5.01 Eligibility for Prescription Drug Benefits

If you meet the eligibility requirements of Section 2, 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.

5.02 General Provisions

The Prescription Drug Benefit is administered by a prescription benefit manager (PBM). Accordingly, 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.

5.03 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 card for use at any participating pharmacy. You can use your ID card at any participating pharmacy.

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

You will receive the quantity prescribed by your Physician, up to the maximum described above and 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 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 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.

5.04 The 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 from the Mail Order Program:

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

B. Complete all required information on the form;

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

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

If you do not receive your medication within the applicable timeframe, please call the Mail Order Program's customer service department at the number on the back on your ID card. This number is also on the mail order form or you may call the Fund Office for it.

5.05 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.

5.06 Prescription Drugs Not Covered

This Prescription Drug Benefit does not cover the following:

A. Fertility drugs or agents;

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

C. Investigational or Experimental drugs;

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

E. Medications for sexual dysfunction, inadequacies or enhancements, except as provided in Section 5.05(J);

F. Amphetamines and/or anorexiants for weight loss;

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

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

I. Any item classified as a device or supply through the prescription card program, unless specifically included in Section 5.05;

J. Drugs or medicines which are not prescribed to treat a mental or physical condition for which the U.S. Food and Drug Administration (FDA) has approved usage of such product, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage;

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

L. Allergy serums;

M. Products indicated for cosmetic use; or

N. Drugs for any of the circumstances listed under the General Plan Exclusions in Section 8.

5.07 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 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.

5.08 Specialty Drug Benefits

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 covered drugs 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 noninjectable drugs having one of more of several key characteristics, including:

A. Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;

B. Need for intensive patient training and compliance assistance to facilitate therapeutic goals;

C. Limited or exclusive product availability and distribution;

D. Specialized product handling and/or administrative requirements; and

E. Costs in excess of $500 for a 30-day supply.

5.09 Prescription Drug Cost Savings Incentive Programs

From time to time the Fund may adopt programs offered by its 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.

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

5.10 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/her individual out-of-pocket maximum.

SECTION 6: DENTAL BENEFIT

6.01 Eligibility for Dental Benefit

If you meet the eligibility requirements of Section 2, your coverage includes the Dental Benefit. The benefit amounts are shown in the Schedule of Benefits.

6.02 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 encourages you to submit a predetermination of benefits claim form that includes:

A. A description of the proposed dental treatment; and

B. The Dentist's estimated charges.

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

6.03 Alternate Course of Dental Treatment

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

A. Customarily used nationwide in the treatment of the condition; and

B. Recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice.

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

6.04 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.

6.05 Dental Preferred Provider Organization (PPO)

The Fund has contracted with a Dental PPO as an additional option with no change in benefits. If you use a provider who is in the Blue Cross network, the charges may be lower and, as a result, both you and the Fund pay less.

6.06 Covered Dental Expenses

Covered Dental Expenses include the following dental services provided by a Dentist or provided under a Dentist's supervision:

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 one 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 this 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).

6.07 Exclusions and Limitations

The Dental Benefit does not cover the following services and supplies:

A. Dental services or supplies which are covered under the Medical Benefit;

B. Orthodontia expenses;

C. Treatments solely for cosmetic reasons;

D. Treatments for the repair of congenital oral defects or primarily for the restoration of the vertical dimension of the face;

E. Veneers; or

F. Any of the items listed under the General Plan Exclusions in Section 8.

6.08 Extension of Dental Benefit

Coverage for Dental Expenses ends when your eligibility 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 7: THE EMPLOYEE ASSISTANCE PROGRAM

7.01 Eligibility for Employee Assistance Program

You and your Dependents are eligible for the Employee Assistance Program Benefit if you meet the eligibility requirements set forth in Section 2.

7.02 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 alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and educational and career-related problems. 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 work. Persons eligible to use the EAP have access to up to three **FREE** 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 assistance program. Confidentiality is compromised only when a threat to life exists (i.e., suicidal or homicidal risk, stalking or child abuse).

SECTION 8: GENERAL PLAN EXCLUSIONS

8.01 Exclusions from Coverage

The following list of types of services is not an all-inclusive listing of the Plan's limitations and excluded procedures, services, supplies or treatments. It is only representative of the types of services and supplies for which charges may be incurred which are not payable by 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.

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. Illness or injury resulting from the commission of a felony or involvement in a criminal act, except for injuries arising 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. However, the Plan will cover expenses as required under 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, unless such services or supplies are provided under the supervision of a Physician 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 expense or charge for Experimental or Investigative Treatments and Procedures.

L. Any expenses or charges for services and supplies that exceed the UCR Charges.

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 for (1) failure to keep scheduled visits, (2) completion of claim forms or (3) reports or medical requests not requested by the Fund.

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

SECTION 9: COORDINATION OF BENEFITS

9.01 Benefits Are Coordinated

Under the 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.

9.02 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.

9.03 How Benefits are Paid

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

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

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 to this Plan, the order of benefit payment will be determined according to the Plan's coordination of benefits rules.

9.04 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 age of majority will be primary.

    3. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:

        a. The plan of the parent with custody is primary and pays benefits first;

        b. The plan of the step-parent with custody pays benefits second;

        c. The plan of the parent without custody pays benefits third; and

        d. The plan of the step-parent without custody, if any, pays benefits fourth.

E. A plan that covers you as an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

F. A plan that covers you as a current full-time employee or as a Dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.

G. A plan that covers you as a Dependent spouse will pay first and a plan that covers you as a Dependent child will pay second.

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.

H. 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.

9.05 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.

9.06 Coordination of Benefits with Medicare

A. When You are an Employee

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

B. End Stage Renal Disease (ESRD)

There are special rules that apply to the first 30 months of an ESRD (the initial 30-month period). If you are eligible for benefits because of your 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 will pay second. After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

SECTION 10: SUBROGATION AND REIMBURSEMENT

10.01 Reimbursement to the Plan

The Plan's right of subrogation and reimbursement arises when benefits are paid on behalf of an eligible individual as a result of an Accident or Sickness for which another party may be responsible. By accepting benefits under the Plan, you agreeing 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.

10.02 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.

10.03 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 the Fund paid benefits on your and/or your Dependent's behalf.

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, including contact information of an attorney representing you in your claim against a third party.

C. 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.

D. You and/or your Dependent agree to reimburse the Fund in full for the benefits expended on your and/or your Dependent's behalf related to the claim against a Third Party.

If you fail to meet your responsibilities, the Fund may withhold future benefit payments until you comply with these requirements. In addition, the Fund may deny or reduce any future benefits covered under the Plan.

10.04 If You Are Reimbursed by a Third Party

If you and/or your Dependent receive payment from a Third Party for benefits paid by the Fund, you or the Third Party must reimburse the Fund.

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.

If you and/or your Dependent receive payment from or on behalf of a Third Party for benefits 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 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 (if applicable) 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 or reducing 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 recover 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.

10.05 Attorney Common Fund Doctrine Claims against the Fund

If you and/or your Dependents retain your own attorney, you are wholly responsible for all attorneys' fees or other expenses incurred to obtain the Third Party recovery. If the attorney(s) that you and/or your Dependents retain in relation to an Accident or Sickness brings a separate claim or lawsuit against the Fund to recover his/her attorneys' fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependents are required to reimburse the Fund from the money you and/or your Dependents 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 attorneys' fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your Dependents 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 Dependents to enforce its reimbursement rights, you and/or your Dependents shall also be responsible for the Fund's attorneys' fees and costs incurred. To the extent the expenses, including but not limited to attorneys' fees and costs, incurred by the Fund exceed the amount you and/or your Dependents recover from any Third Party or you and/or your Dependents 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 Dependents until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

10.06 Lien on Third Party Recoveries

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

SECTION 11: CLAIMS AND APPEALS PROCEDURES

11.01 General Information

A. Exhaustion of Remedies

You must exhaust all of the claims and appeals procedures under the Plan before you file any action in court or administrative action for benefits. If you are dissatisfied with the written decision of the Board of Trustees on review after you have exhausted all of the procedures set forth in this Section, 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 four months** of the date of such denial. Further, no lawsuit may be filed unless you have first filed a claim and exhausted the internal appeal procedures.

B. Discretionary Decision Making Authority of the Trustees

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties hereto and beneficiaries of this Plan.

No 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. However, this provision will not affect the rights and liabilities of any of the parties under any of such Collective Bargaining Agreements.

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

11.02 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. Additionally, if you request prior approval for a benefit that does not require prior approval by the Plan, 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 offered under this Plan, you must submit a completed claim form. You may obtain a 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

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

a. Employee's name;

b. Patient's name;

c. Patient's date of birth;

d. Social Security number of Employee;

e. Date of service;

f. CPT Plus 2020 Edition (the code for Physician services and other health care services found in the *Current Procedural Terminology* as maintained 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. 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.

3. Dental Claims

All dental claims should be filed with the Fund Office.

C. Where to File a Claim

1. Hospital, Physician, and Medical Claims

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

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680

For services performed outside of Illinois, all Hospital, Physician and medical claims, should be filed with the local Blue Cross Blue Shield 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 claims should be filed with the Fund Office at the following address:

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

11.03 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 11.02(C), 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.

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.

11.04 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 you with the following information:

A. Sufficient information to identify the claim involved, including the date of service, the health care 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; and

H. If your health claim was denied on the basis of Medical Necessity, Experimental or Investigative Treatment or Procedure or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request.

11.05 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 your 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 Process

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 (the Appeals Committee composed of Trustees) 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 an Experimental or Investigative Treatment or Procedure), 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

Ordinarily, decisions on appeals 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.

11.06 Notice of Decision on Internal Appeal

The Fund will provide you with a written decision, in a culturally and linguistically appropriate manner, on any internal appeal of an Adverse Benefit Determination. The notice of a denial of a claim on appeal will include the following:

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

B. The specific reason(s) for the determination;

C. Reference to the specific Plan provision(s) on which the determination is based, including the denial code and its corresponding meaning;

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;

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.; and

H. If the determination was based on Medical Necessity or because the treatment was an Experimental or Investigative Treatment or Procedure or other similar exclusion, the Fund will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

11.07 External Review Procedures

A. External Review Filing Deadline

If your 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, 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. Determination of Eligibility for 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.

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.

2. 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.

3. 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 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.

11.08 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.

11.09 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 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 of the first surviving class of beneficiaries 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.

11.10 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.

11.11 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. 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.

11.12 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 of part of the benefits that might otherwise be due.

11.13 Prohibition on Rescission

The Fund 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 that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Fund must provide 30 calendar days advance notice to a covered person before coverage may be rescinded.

11.14 Workers' Compensation

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

SECTION 12: DEFINITIONS

12.01 Definition of Plan Terms

This Section 12 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. **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.

C. **Board of Trustees and/or Trustees** means the individuals designated as Trustees in the Trust Agreement for the Pipe Fitters' Welfare Fund, Local 597, together with their successors designated and appointed in accordance with the terms of such Trust Agreement. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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

E. **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.

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

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

H. **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.

I. **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.

J. **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.

K. **Dependent** means any one of the following:

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 calendar 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 retardation or physical handicap, provided:

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

   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.

L. **Employee** means (1) all Employees of Employers for which the 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 the Pipe Fitters' Welfare Fund, Local 597, Pipe Fitters' Retirement Fund, Local 597, and Pipe Fitters' Training Fund, Local 597, and (5) other Employees of an Employer covered by a participation agreement with the Fund that provides for Employer contributions on their behalf.

M. **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.

N. **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 (a) the subject of ongoing phase I or phase II clinical trials, (b) the subject of on-going phase III clinical trials or (c) 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 an Experimental or Investigative Treatment or Procedure. 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.

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

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

Q. **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.

R. **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.

S. **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.

T. **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.

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

V. **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.

W. **Plan and/or Welfare Plan** means the Pipe Fitters' Welfare Fund, Local 597 for Residential and Light Commercial Service Pipe Fitters, as set forth in this document as adopted by the Trustees and as thereafter amended by the Trustees.

X. **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.

Y. **Prescription Drugs** mean 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.

Z. **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 in (4) 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 in paragraph (1) above, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

BB. **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, Surgeon or a registered nurse (RN).

CC. **Usual, Customary and Reasonable (UCR) 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 amount the Fund would have paid if the item had been covered under any such Plan PPO contract as represented to the Fund by the network administrator.

   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 service; (b) the amount the Plan generally uses to determine payments

for Non-PPO services but applying only PPO provider cost-sharing; or (c) the Medicare rate, excluding any PPO provider cost-sharing.

3. For service or supply where the fee cannot be determined under (1) or (2) above, the fee shall be based on 125% of the amount that would be allowed by Medicare, except as described in (4) below.

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

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under the subsections listed 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 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 90th 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 the subsections listed above.

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

EE. **Other Terms**

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

Terms	**Section**
1. Accumulation Account	2.01
2. Benefit Quarters	2.01
3. COBRA Continuation Coverage	2.03
4. Deductible	3.02
5. Durable Medical Equipment	3.07
6. Eligibility Hours	2.01
7. Family and Medical Leave Act (FMLA)	2.01
8. Qualified Medical Child Support Order	2.02

SECTION 13: ADDITIONAL PLAN INFORMATION

13.01 Plan Name

Pipe Fitters' Welfare Fund, Local 597 for Residential and Light Commercial Service Pipe Fitters.

13.02 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 are as follows:

Union Trustees	Employer Trustees
Mr. Chris Hernandez Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. John D. Curran Meccon Industries, Inc. 2703 Bernice Road Lansing, Illinois 60438
Mr. Thomas J. Kotel Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Ms. Jill McCall Mechanical Contractors Association 7065 Veterans Boulevard Burr Ridge, Illinois 60527
Mr. Michael Maloney Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Ms. Kathy McCauley McCauley Mechanical Construction, Inc. 8787 S. 78th Street Bridgeview, Illinois 60455
Mr. Kevin Morrissey Pipe Fitters' Welfare Fund, Local 597 45 North Ogden Avenue Chicago, Illinois 60607	Mr. Marc A. Pittas Hill Mechanical Corporation 11045 Gage Avenue Franklin Park, Illinois 60131

13.03 Plan Sponsor and Administrator

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

13.04 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.

13.05 Agent for Service of Legal Process

Nichole M. 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 addresses.

13.06 Source of Contributions

The benefits described in this Welfare Fund booklet are provided through Employer contributions and self-payments made under COBRA. 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.

13.07 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.

13.08 Trust Fund

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

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

13.09 Discretionary Authority of Fund Administrator

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

13.10 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.

13.11 Type of Plan

This Plan is maintained for the purpose of providing medical, prescription drug, dental and employee assistance benefits to participants in the event of Sickness or Accident. The Plan benefits are shown in the applicable Schedule of Benefits.

13.12 Gender

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

13.13 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 Welfare Fund or benefits of this Welfare Plan. Neither the Welfare Fund nor any of the assets thereof, shall be liable for the debts of any participant, Dependent or beneficiary entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceedings.

Notwithstanding the above, the Fund shall pay benefits to the service provider on behalf of a participant and/or a Dependent upon authorization of such payment by the execution of a claim form assignment statement and if the Physician or supplier agrees to accept the UCR 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.

13.14 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.

13.15 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 question and will not apply to any other provisions of the Trust Agreement or the Plan.

13.16 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.

13.17 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 Office.

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.

13.18 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 (a) that the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.504(f)(1)(ii) or (iii)) or (b) that qualifies as Summary Health Information and that the Fund receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan or (ii) 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.

13.19 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.

13.20 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, as amended (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 the summary annual report.

B. Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself 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 people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. Enforce Your Rights

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

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

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

E. Receive Assistance with Your Questions

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

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration

U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

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

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

13.21 Affordable Care Act

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Co-Payments, exclusions, limitations, definitions, eligibility and the like. The Trustees have made a good faith effort to comply with the Affordable Care Act and a reasonable interpretation of the term ''Essential Health Benefits.'' The Trustees' intent was and is to make only those changes that are minimally necessary to comply with the Affordable Care Act. In the event that those changes or other provisions of the Plan are no longer required by the Affordable Care Act, the Employee Retirement Income Security Act of 1974, as amended (ERISA) or the Internal Revenue Code, the Trustees reserve the unilateral right to return the Plan to its pre-Affordable Care Act terms or other terms that meet the minimum requirements of the Affordable Care Act, ERISA or the Internal Revenue Code.

APPENDIX A: 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.