Summary Plan Description

of the

PLUMBERS AND PIPEFITTERS MEDICAL PLAN

This summary has been prepared for your use as a convenient reference. It is not a contract.

(Restated Effective January 1, 2025)

Summary Plan Description
of the
PLUMBERS AND PIPEFITTERS
MEDICAL PLAN

For information regarding eligibility,
medical claims or claim forms, call or write:

Plumbers and Pipefitters Medical Plan
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

(800) 741-9249

To All Covered Employees:

We are proud to present you with this new Summary Plan Description booklet describing the comprehensive benefits provided to eligible Employees and their Dependents under the Plumbers and Pipefitters Medical Plan. This booklet incorporates all of the provisions of the Plumbers and Pipefitters Medical Plan and will serve as the Summary Plan Description and the official Plan document as of January 1, 2025.

The Plan's basic benefits are designed to cover a considerable portion of your hospital, surgical and medical bills. Major Medical coverage provides additional benefits for most expenses in excess of, or not covered by, the basic benefits. Your Plan also pays benefits for dental, vision care, and prescription drug expenses. In addition, death benefits and disability income benefits are provided for Employees as specified in this booklet.

It should be noted that if you are injured while at your place of work or require medical care as a result of your employment, you should obtain care through the arrangements provided by your Employer under workers' compensation laws. The Medical Plan does not provide benefits for care needed if you are hurt on the job. However, certain income replacement and death and dismemberment benefits are available under the circumstances described in the section of the booklet on "Supplemental Insured Occupational Accident Benefits."

The Plan has been designed to provide the protection that you need. We urge you to take full advantage of the benefits provided but, at the same time, to be a smart consumer of health care. Make sure that the claims you submit are for expenses actually incurred and that such expenses are reasonable. In recent years, the cost of health care has risen dramatically. As a result, it is important that all of us take an active part in controlling health care costs. If we work together to spend our benefit dollars wisely, the Plan will continue to prosper and provide important protection for many years to come.

The Medical Plan is maintained exclusively for the benefit of you and your Dependents, and it is intended to continue for an indefinite period of time. However, this does not prevent the Trustees from amending or terminating the Plan if economic conditions make such action necessary. Although this booklet is a detailed summary of the Medical Plan provisions, it is not a contract. It does not contain the detailed Agreement and Declaration of Trust, or the related Collective Bargaining Agreement. These documents also govern the operation of this Plan. The Medical Plan must be interpreted in accordance with these documents, which are available for your inspection at the Fund Office.

We urge you to read your Plan booklet carefully so that you will be familiar with the benefits to which you are entitled and the Plan's eligibility requirements. We hope that you will share our pride in your Plan and the measure of security it provides to those who work in our industry.

Sincerely,
BOARD OF TRUSTEES

DISCRIMINATION IS AGAINST THE LAW

The Plumbers and Pipefitters Medical Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plumbers and Pipefitters Medical Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Medical Benefits provided under this Plan are afforded without regard to an individual's sex assigned at birth, gender identity, or gender.

The Plumbers and Pipefitters Medical Fund provides free aids and services to people with disabilities when needed for such individual to communicate effectively with the Fund. Those may include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, etc.). The Plumbers and Pipefitters Medical Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Fund Office.

If you believe that the Plumbers and Pipefitters Medical Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Fund's civil rights coordinator, c/o BeneSys, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, Telephone 1-800-741-9249, Fax 410-872-1275. You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Fund's civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Esta descripción resumida del plan está disponible en español por solicitud.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-410-872-9500.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-410-872-9500 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-410-872-9500.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-410-872-9500

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-410-872-9500

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-410-872-9500

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-410-872-9500-- (رقم هاتف الصم والبكم:

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-410-872-9500

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-410-872-9500

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-410-872-9500

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-410-872-9500 पर कॉल करें।

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-410-872-9500 .

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. تماس بگیرید. 1-410-872-9500با

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-410-872-9500

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-410-872-9500

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-410-872-9500

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Do not rely on this chart alone - it merely summarizes the benefits payable. Read the entire booklet to find what benefits are payable for each specific kind of expense and what expenses are not covered. All benefits are subject to the definitions, limitations, and exclusions set forth in this booklet.

FOR COVERED EMPLOYEES ONLY

	Maximum Benefits
SUPPLEMENTAL BENEFITS	
Basic Death Benefit (Page 56) If death is accidental, benefit is doubled.	$ 10,000
Weekly Accident & Sickness Benefit (non-occupational) (Page 57) Per week up to 13 weeks	$ 500
Accidental Dismemberment or Loss of Sight Benefits (Page 58)	
Loss of one hand, foot or eye	$ 5,000
Loss of two or more hands, feet or eyes	$ 10,000
Maximum for losses resulting from one accident	$ 10,000
Supplemental Workers' Compensation Benefit (Page 59) Offset by Workers' Compensation Disability Benefit, 66 2/3% of basic weekly wage, up to the maximum amount payable under the Workers' Compensation law of the District of Columbia, up to 104 weeks, per week (MD and VA only)	$ 150
Supplemental Insured Occupational Accident Benefits (Page 60) These benefits are governed by an outside insurance policy.	
Accidental Death	$ 100,000
Loss of two or more: hands, feet, eyes, speech, Hearing	$ 100,000
Loss of one: hand, foot, eye, speech, hearing	$ 50,000
Loss of thumb and index finger of same hand	$ 25,000
Maximum for all losses to one person	$ 100,000
Maximum for all losses to multiple Employees resulting from one accident, prorated among all Employees	$ 2,500,000
Total Disability, (payable after one year) Offset by Dismemberment or Loss of Sight, Speech or Hearing Benefit, $1,000 per month, up to	$ 100,000

FOR RETIREES ONLY

Death Benefit (Page 56)..... $ 3,000
(If death is accidental, benefit is doubled)

Accidental Dismemberment and Loss of Sight Benefit (Page 58)
Loss of two or more of hands, feet or eyes.....$ 3,000
Loss of one hand, foot or eye.....$ 1,500
Maximum for all losses resulting from one accident.....$ 3,000

FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS ONLY

Medicare-eligible retirees and dependents will receive medical and prescription drug benefit coverage under Humana Medicare Advantage Medical and Prescription Drug Plan (MAPD Plan). The Basic Benefits, Major Medical Benefits, Other Benefits, and Prescription Drug Benefits described in this Schedule of Benefits and in this SPD do not apply to Medicare-eligible participants. For more information the benefits of the MAPD Plan, please consult the Humana Summary of Benefits.

Medicare-eligible retirees remain eligible for the Plan's Dental and Vision benefits, the Death Benefit, and the Medical Reimbursement Allowance, and may utilize the UA Plumbers Local 5 Medical Fund Health and Wellness Center with no out-of-pocket costs.

FOR COVERED EMPLOYEES, NON-MEDICARE ELIGIBLE RETIREES AND THEIR COVERED DEPENDENTS

BASIC BENEFITS:

Hospital Expense Benefits (Page 62)
(prior authorization required for hospital admissions (page 87) unless the admission is for Emergency Services)

Room and Board (Page 63), per day, up to 70 days in one period of confinement, per calendar year.....$ 450
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Inpatient Provider Visits (Page 64)
In Hospital, per calendar year, one visit per day,
up to 2 Providers per Hospital, $100 per visit, up to .....$ 1,500
Excess paid at 80% for in-network care, 60% for out-of-network care, or the Out-of-Network Rate for either out-of-network care at an Emergency Department in connection with Emergency Services or care for a non-Emergency Services by an out-of-network provider at an in-network facility, as a Major Medical Benefit (including all Covered Expenses).

Mothers and Newborns (Page 64)
For Participants, Spouses, and Dependents: 50% of Hospital room and board charges for mother while hospitalized due to childbirth.

Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses). For newborn children of Covered Employees and their spouses only: 100% of Hospital room and board charges if newborn remains hospitalized after mother is released. (This coverage is not available to newborn children of dependents of Covered Employees. The Plan generally does not cover grandchildren of Covered Employees).

Maximum Miscellaneous Hospital Charges (Page 65)
Per confinement .....$ 2,500
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Medical Emergency Benefit (Page 65)
Per Illness or Injury .....$ 500
Excess paid at 80% (in-network and out-of-network care) as a Major Medical Benefit (including all Covered Expenses). In the case of expenses incurred for care by an out-of-network provider at an in-network facility, in connection with out-of-network care at an Emergency Department for Emergency Services, or for air ambulance services by an out-of-network provider, excess paid at the Out-of-Network Rate as a Major Medical Benefit (including all Covered Expenses).

Surgical Benefits (Page 66)
Charges for primary surgeon up to 100% of UCR;
Charges for assistant surgeon up to 20% of UCR;
Oral surgery excluded except as a result of an Injury;
Cosmetic surgery excluded unless within two years of Injury;
Outpatient Surgical Facility Charges, per incident .....$ 1,250
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Diagnostic Laboratory and X-Ray Benefits (Page 70)
Per calendar year.....$ 800
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Outpatient Physician Visit Benefits (Page 70)
Per calendar year, $100 per visit, up to .....$ 1,500
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Visits to providers at UA Plumbers Local 5 Health and Wellness Center (including visits for annual physical examinations) will be covered at 100% with no coinsurance regardless of whether you have met your deductible. The cost of such visits will not be included in determining if you have exhausted your Basic Benefit.

Annual Physical Examination Benefit (Page 70)
One exam per calendar year, for routine examinations or administrative examinations
for routine examinations, up to.....$ 200
for administrative examinations, up to .....$ 75
Excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Preventive Services Benefit (Page 71)
Services required to be provided as preventive services by the Affordable Care Act, provided with $0 coinsurance, covered at 100% up to UCR.

Shingles Vaccination (Page 73)
100% of the cost of a one-time, one-dose Zostavax Shingles Vaccination for all eligible Participants and Dependents age 60 and over, **or** 100% of the cost of a one time, two-dose Shingrix Shingles Vaccination for all eligible Participants and Dependents age 50 and over .....Covered in Full

Participants and Dependents who received a Zostavax vaccine prior to September 11, 2018 may thereafter receive a one-time, two-dose Shingrix Shingles Vaccination, which will be covered in full.

UA Plumbers Local 5 Medical Fund Health and Wellness Center Benefits (Page 74)
All services received and prescriptions filled at the Health and Wellness Center are provided with no coinsurance and no copay for Covered Employees, Retirees, and their covered Dependents. Covered Expenses incurred at the Health and Wellness Center for provider visits or prescriptions will not be included in determining if you have exhausted your Basic Benefit.

Mental or Nervous Disorder Treatment Benefit (Page 75)
Inpatient treatment payable as Hospital Expense Benefit; excess of allowance paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

Outpatient treatment covered at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit (including all Covered Expenses).

MAJOR MEDICAL BENEFIT (Page 77)
The Major Medical Benefit will pay 80% of Covered Expenses for in-network care and 60% of Covered Expenses for out-of-network care, subject to Major Medical Deductibles where applicable. If a Covered Expense is incurred for care by an out-of-network provider at an in-network facility, out-of-network care at an Emergency Department for Emergency Services, or out-of-network air ambulance services, the Major Medical Benefit will pay the Out-of-Network Rate for the Covered Expenses for the care provided by the out-of-network provider.

Medical Out-of-Pocket Expense Maximum (Page 77)
In-Network:
per person, per calendar year, subject to limitations ..... $ 5,000
per family, per calendar year, subject to limitations ..... $ 10,000
Covered Expenses for care from in-network providers in excess of the in-network out-of-pocket maximum will be paid at 100% of the in-network discounted amount. Your deductible and any co-payments and other eligible items paid for covered medical expenses for care from in-network providers count towards this out-of-pocket maximum.

Out-Of-Network:
per person, per calendar year, subject to limitations ..... $ 10,000
per family, per calendar year, subject to limitations ..... $ 20,000
Covered Expenses for care from out-of-network providers in excess of the out-of-pocket maximum will be paid at 100% of the usual, customary and reasonable (UCR) charge. Your deductible and any co-payments and other eligible items paid for covered medical expenses for care from out-of-network providers count towards this out-of-pocket maximum.

Expenses paid for out-of-network care cannot be applied to the in-network out-of-pocket expense maximum except for expenses paid for care by an out-of-network provider at an in-network facility, out-of-network care at an Emergency Department for Emergency Services, or out-of-network air ambulance services.

Organ/Tissue Transplant Benefit (Page 80)
(prior authorization required)
Covered Expenses payable under Major Medical Benefit.

OTHER BENEFITS (Page 82)
(Benefits with special limits or benefits where the excess is not covered as a Major Medical Benefit.)

Well Baby Care Benefit (Page 82)
Ten (10) routine physical examinations within the first 24 months of life

Hearing Aids (Page 82)
Including batteries, fittings, repairs and replacements,
up to a maximum benefit (every three years) ..... $ 2,000
This is a Basic Benefit only; the balance of charges in excess of the maximum are **not** paid under Major Medical.

Diabetes Self-Management Training (Page 82)
100% of the prescribed educational charges per eligible individual per calendar year..... $ 500

Skilled Nursing Facility Benefit (Page 83)
(prior authorization required)
Inpatient treatment as an alternative to hospitalization, per day, up to 100 days lifetime maximum..... $ 100
Covered Expenses in excess of the maximum daily allowance paid at 80% for in-network care, 60% for out-of-network care as a Major Medical

Benefit (including all Covered Expenses), but not to exceed 100-day lifetime maximum.

Hospice Care Benefit (Page 84)
(prior authorization required)
Up to 180 days per lifetime and a maximum of 100% of Covered Expenses up to ..... $ 30,000
Excess paid at 80% for in-network care, 60% for out-of-network care as a Major Medical Benefit (including all Covered Expenses), but not in excess of 180 total days of coverage.

Rehabilitation Service Benefit (Page 84)
(prior authorization required)
Inpatient treatment as an alternative to hospitalization,
per day, up to 10 weeks ..... $ 100
Covered Expenses in excess of the maximum daily allowance paid at 80% for in-network care, 60% for out-of-network care as a Major Medical Benefit (including all Covered Expenses), but not to exceed 6 week maximum.

Non-Institutional Medical Care Benefit (Page 85
(prior authorization required)
Paid under Major Medical Benefit (including all Covered Expenses) not to exceed 30 days per year unless authorized for one additional 30-day period upon submission and approval of treatment plan indicating necessity of additional days.

Prescription Drug Benefits (Page 88)

Prescription Drug Out-of-Pocket Expense Maximum
per person, per calendar year, subject to limitations ..... $ 1,600
per family, per calendar year, subject to limitations ..... $ 3,200

Covered expenses in excess of the out-of-pocket maximum will be paid at 100% of the Pharmacy Benefit Manager's repriced claim. Only co-payments paid for covered prescription drugs count towards this out-of-pocket maximum.

Prescription drugs received at the UA Plumbers Local 5 Medical Fund Health and Wellness Center shall be covered at 100% with no co-payment or co-insurance.

FOR COVERED EMPLOYEES, NON-MEDICARE ELIGIBLE RETIREES AND THEIR COVERED DEPENDENTS

Dental Benefit (Page 94)
Subject to the Dental Benefit Deductible, Covered Dental Services received at Participating dentists in the United Concordia network are covered in full, up to the annual program maximum.

Subject to the Dental Benefit Deductible, Covered Dental Services received at Non-Participating Dentists are reimbursed at 80% of the Dental Fee Schedule, up to the annual program maximum. Non-Participating dentists may bill you or your Dependents for any difference between their charge and the amount reimbursed by the Plan.

Annual Program Maximum Excluding TMJ (per person age 19 & over) per calendar year.....$3,500
Annual Program Maximum (per person under age 19)
per calendar year .....Unlimited

Temporomandibular Joint (TMJ) Dysfunction (Page 100)
Lifetime maximum (per person age 19 and over) .....$ 1,500
No lifetime maximum for TMJ benefits for participants under age 19.

Vision Benefit (Page 100)
(Co-payments are what you pay, the Fund pays the remainder.
Allowance Amounts are what the Fund pays, you pay the remainder.)
Through a VSP Participating Provider in the Premier Network:
Exam (every 12 months) ……$ 15 co-payment
Safety glasses (Employees only)
(every 24 months subject to limitations).....$ 20 co-payment

Frames and lenses (every 12 months)
Lenses (every 12 months).....$ 20 co-payment
Frames .....$ 150 allowance
UV Protection .....Covered in Full
Anti-Reflective Coating.....Covered in Full
Progressive Lenses.....Covered in Full

OR

Contact lenses (every 12 months)
Necessary Contact Lenses ..... $20 co-payment
Contact Lens Exam and Elective Contact Lenses ..... $120 allowance

Through a Non-VSP Participating Provider (allowance amounts):
Exam (every 12 months) ..... $ 35
Frames (every 12 months) ..... $ 35
Lenses (every 12 months):
Single vision ..... $ 25
Bifocal ..... $ 40
Trifocal ..... $ 55
Lenticular ..... $ 80
UV Protection ..... Not Covered

Necessary Contact Lenses (every 12 months) ..... $ 210
Elective Contact Lenses (every 12 months) ..... $ 75

All Covered Expenses for pediatric eye exam services (through age 18) in excess of $35 paid at 60% for out of network care.

FOR COVERED EMPLOYEES, RETIREES AND SURVIVING SPOUSES ONLY

Medical Reimbursement Allowance (Page 103)
Eligible expenses for you or your Covered Dependents can be submitted up to a per calendar year amount determined by the Trustees on an annual basis.

DEDUCTIBLES/CO-PAYMENTS

Provider	PPO Provider	Non-PPO Provider
Major Medical Deductible		
Per individual, per calendar year	$ 200	$ 500
Per Family, per calendar year	$ 400	$ 1,000

Retail Pharmacy Benefit (up to 34-day supply)	Co-pay
Excluded*	Full Cost
Non-Formulary Brand	$ 30
Formulary Brand	$ 15
Generic	$ 5

At a participating pharmacy, after co-payment, 100% of remaining actual charge for prescription will be covered in most cases.

At a non-participating pharmacy, individual will be reimbursed for covered charges up to the amount that would have been charged at a participating pharmacy less co-payment.

Express Scripts Home Delivery (up to 90-day supply)	Co-pay
Excluded*	Full Cost
Non-Formulary Brand	$ 60
Formulary	$ 30
Generic	$ 10

*See the description of the Prescription Drug Benefits on page 88 for information on receiving coverage for prescriptions that are currently listed as excluded medications.

Dental Benefit Deductible	
Per individual, per calendar year	$ 50
Per family, per calendar year	$ 150

Deductible does not apply to certain services, including Preventive Services. See the Dental Benefit section (page 94) for a full list of Covered Services not subject to the Dental Benefit Deductible.

SELF-PAY AND COBRA RATES

	Monthly Amount
Self-Payment Rates (Page 48)	
Employees, full benefits	$ TBD[1]
Employees, alternate coverage, Medical Benefits only	$ TBD[2]
Employees, alternate coverage, Medical Benefits and Prescription Drugs	$ TBD[2]
Totally Disabled Ex-Employees, including eligible individuals who are not receiving pension benefits (who are not covered by Medicare as primary payer)	$ TBD[3]

Contact the Fund Office at 1-800-741-9249 for currently applicable self-pay rates.

[1] Self-Pay Employees desiring full benefits, all non-bargaining unit covered employees, and all retirees between the ages of 55 and 61 (inclusive), and certain Totally Disabled ex-employees receiving workers' compensation pay the current hourly contribution rate times 160. This amount will be adjusted as the contribution rate changes.

[2] This amount is based on 85% of projected annual expense, to be adjusted annually as necessary.

[3] This amount is based on 85% of the current hourly contribution rate times 160 and will be adjusted as the contribution rate changes.

RATES FOR INDIVIDUALS WHO RETIRE PRIOR TO JUNE 1, 1993 AND THEIR SURVIVING SPOUSES

	Monthly Amount
Retirees, age 55 through 61	$ TBD
Retirees, age 62 and over (or anyone eligible for Medicare) per individual	$ 80
up to a maximum of 2.5 times the rate	$ 200
Surviving Spouse, under age 65, No Dependents	$ 100
Surviving Spouse, under age 65, with Dependents, per individual	$ 100
up to a maximum of 2.5 times the rate	$ 250
Surviving Spouse, age 65 and over, with Dependents, per individual	$ 80
up to a maximum of 2.5 times the rate	$ 200
Surviving Minor Dependent(s) (no surviving spouse), per individual	$ 100
up to a maximum of 2.5 times the rate	$ 250

* * * * * *

NOTE: For those Covered Persons eligible for Medicare, benefits payable for Hospital, Diagnostic Laboratory and X-Ray, Providers Visits, Medical Emergency, Surgical, Mental or Nervous Disorder and Physical Examination Benefits are coordinated with Medicare Parts A & B.

RATES FOR POST-JUNE 1, 1993
RETIREES AND SURVIVING SPOUSES

		Monthly Amount
Retiree age 55 through 59		$1,392.00*
(Single rate covers retiree and dependents)		
Retiree age 60 (Single)		$ 522.00
With one dependent (Single Plus 1)		$ 1,044.00 **
Maximum family rate	(Family)	$1,305.00
Retiree age 61 (Single)		$ 348.00
With one dependent (Single Plus 1)		$ 696.00 ***
Maximum family rate	(Family)	$ 870.00
Retiree age 62 or over (or disabled, under 62)	(Single)	$ 139.00
With one dependent	(Single Plus 1)	$ 278.00 ****
Maximum family rate	(Family)	$ 348.00

*This amount is equal to the Plumbers Local 5/MCAMW Basic Construction Agreement's ("CBA") current hourly contribution rate times 160 and will be adjusted as the contribution rate changes.
** This amount is 75% of the CBA's current hourly contribution rate times 160 and will be adjusted as the contribution rate changes.
*** This amount is 50% of the CBA's current hourly contribution rate times 160 and will be adjusted as the contribution rate changes.
**** This amount is 20% of the CBA's current hourly contribution rate times 160 and will be adjusted as the contribution rate changes.

For all Retirees age 60 and older, the rate for Single coverage is ½ the rate for Single Plus 1, and the rate for Family coverage is 2 ½ times the Single rate.

Contact the Fund Office at 1-800-741-9249 for currently applicable self-pay rates.

NOTE: For those Covered Persons eligible for Medicare, benefits payable for Hospital, Diagnostic Laboratory and X-Ray, Providers Visits, Medical Emergency, Surgical, Mental or Nervous Disorder, and Physical Examination Benefits are coordinated with Medicare Parts A & B.

COBRA Rates

As of January 1, 1990, and subject to revision at 12-month intervals at approximately 102% of the cost of providing such coverage.

Contact the Fund Office at 1-800-741-9249 for currently applicable COBRA rates.

Employer Contributions

Bargaining Unit Covered Employees, based on the hourly rate in effect under the current Collective Bargaining Agreement.

DEFINITIONS

While reading through this booklet you may encounter terms with which you may not be familiar, or which may have a specific definition. The following definitions are provided to help you understand what these terms mean and how they are applied.

Agreement and Declaration of Trust - the Plumbers and Pipefitters Medical Fund Restated Agreement and Declaration of Trust as amended or restated from time to time.

Allowable Expenses - any Usual, Customary, and Reasonable charges for benefits and services covered in full or in part under this Plan and any other plan in which the person making the claim participates.

Attending Provider - the Provider who assumes responsibility for the care and treatment of a Covered Person.

Collective Bargaining Agreement - the contract(s) or labor agreement(s), as amended, between Plumbers Local Union No. 5 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO (Local 5) and any Employer, or between Local 5 and the Mechanical Contractors Association of the Metropolitan Washington, Inc. concerning the terms and conditions of employment and contributions to the Fund.

Confinement - an admission (or a series of admissions) to a Hospital for any one Illness or Injury.

Covered Employment - work for which an Employer is required to make contributions to the Fund under a Collective Bargaining Agreement or other signed stipulation.

Solely for the purposes of determining an Employee's Initial Eligibility (page 25) and eligibility to use the Wellness Center (page 74), "Covered Employment" also includes documented attendance and participation in classes sponsored by the Plumbers and Pipefitters Apprenticeship Fund that an Employee attends between the hours of 6:30 a.m. and 3.p.m., and which accordingly preclude the Employee from working for a contributing Employer during those hours

Covered Expense - any charge that is allowable under this Plan for a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation, or cure of an Illness or Injury to a structure or function of the mind or body.

Covered Person - an Employee or Retiree or a Dependent of an Employee or Retiree who meets the requirements for coverage as set forth in this booklet.

Deductible - the out-of-pocket expense that must be paid each calendar year before a benefit is payable.

Dentist - a person who is duly licensed and acting within the scope of his or her license to practice dentistry, and includes a Provider furnishing dental care that he or she is licensed to provide.

Dependent - your lawful spouse and any biological, step, lawfully-placed foster or legally adopted (eligibility begins at the time of placement) child(ren):

- from birth up to the last day of the month of the month in which they turn age 26; or

- from age 26 or older if the child lives with you, receives most of his or her financial support from you and is unable to engage in any substantial gainful activity by reason of any permanent medically determinable physical or mental impairment that began before age 26 while the child was covered under this Plan. For children age 26 or older, proof of a child's physical or mental impairment must be provided to the Fund Office within 31 days after the child's coverage would otherwise end.

Disability - your inability to perform substantially all of the duties of your occupation in Covered Employment because of a physical or mental Injury or Illness. For your Dependents, the term means the inability to perform substantially all of the normal functions and activities of a person of the same sex and age who is in good health.

Eligibility Quarter - a period of three consecutive calendar months beginning on the first day of any May, August, November or February during which an Employee has Eligibility in the Plan as a result of having worked the required number of hours in Covered Employment during the preceding Work Quarter.

Emergency Department - means the emergency department of a hospital; a hospital outpatient department that provides Emergency Services; or a health care facility that provides Emergency Services and that is geographically separate, distinct, and licensed separately from a hospital.

Emergency Medical Condition - In general, the term "Emergency Medical Condition" means an illness, injury, symptom, or condition severe enough that you reasonably believe it will risk serious danger to your health if you do not get medical attention right away. More specifically, the term "**Emergency Medical Condition**" means medical condition, including a mental health condition or a condition caused by a substance use disorder, manifesting itself by acute symptoms of sufficient severity (including but not limited to severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Whether a medical condition is an Emergency Medical Condition will not be determined based on diagnostic codes used by the provider or facility.

Emergency Services – In general, the term "Emergency Services" means services received in an emergency room or appropriately licensed urgent care facility to check for an Emergency Medical Condition and treat you to keep such a condition from getting worse. **Services are considered "Emergency Services"** only if they involve an **Emergency Medical Condition**. If an Emergency Medical Condition exists, emergency services include a medical screening examination and further treatment, within the capabilities of the emergency department of a hospital, or an independent freestanding emergency department appropriately licensed under state law (including ancillary services routinely available to the emergency department or independent freestanding emergency department) required to stabilize the patient with respect to the condition. Emergency Services also include services you may receive after you are in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law. Emergency services will be covered without prior authorization, without regard to whether the health care provider furnishing the emergency services is a participating network provider, and not impose any administrative requirement or limitation on coverage that is more restrictive for out-of-network services. The plan will comply with special cost-sharing rules for out-of-network services, and without regard to other terms or conditions of the coverage other than exclusions of benefits, coordination of benefits, permissible waiting periods on coverage permitted under federal law.

Employee - someone who:

- works within the jurisdiction of Local 5 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada and works in a job category covered by a Collective Bargaining Agreement and on whose behalf an Employer makes the required contributions to the Fund; or

- works as a full-time officer or employee of Plumbers Local 5 or the Plumbers and Pipefitters Apprenticeship Fund; or

- satisfies the requirements established by the Board of Trustees for participation.

An unincorporated sole proprietor or partner is not treated as an Employee under this Plan.

Employer - The Union, Apprenticeship Fund, or any Employer that is obligated under a Collective Bargaining Agreement or a signed stipulation to make contributions to the Fund on behalf of its Covered Employees.

Essential Health Benefit - as defined in The Affordable Care Act of 2010 (and as amended by applicable law). Essential Health Benefits include the following categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services including oral and vision care.

The fact that each of these general categories is included within the Affordable Care Act's list of Essential Health Benefits shall not be construed to mean that all items and services falling within these categories are covered under the Plan.

Extended Care Facility/Skilled Nursing Facility - a Medicare-certified institution (or a distinct part of an institution) which:

- is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled or sick persons, and

- is duly licensed and regularly provides 24-hour skilled nursing care by and under the direction of licensed, qualified registered nurses (R.N.), and which also provides therapeutic services by licensed, qualified therapists, acting within the scope of their licenses.

Extended Care Services - services in a Skilled Nursing Facility provided for a limited duration after a Hospital stay, and for the same condition as the Hospital stay.

Fund - the Plumbers and Pipefitters Medical Fund.

Fund Office - the place designated by the Board of Trustees where the administrative activities of the Plan are carried out.

Hospital - an institution that is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the primary function of which is to provide inpatient services, both diagnostic and therapeutic, surgical and non-surgical, for a variety of medical conditions.

Illness - a disease or disorder resulting in an unsound condition of the mind or body.

Incurred - having become legally responsible for payment of a Covered Expense and refers to the date a service or supply is furnished.

Injury - a wound or damage to the body sustained accidentally and by external force.

Medical Fund or Plan - the Plumbers and Pipefitters Medical Fund or Plan, as amended from time to time.

Medically Necessary - services or supplies furnished or prescribed by a Provider or other licensed provider to identify or treat a diagnosed or reasonably suspected Illness or Injury, the furnishing of which is:

- Consistent with the diagnosis and treatment of the patient's condition; and

- In accordance with standards of good medical practice; and

- Required for reasons other than the convenience of the patient, Provider, or other licensed provider; and

- The most appropriate level of service or supply that can be provided safely for the patient.

When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Provider or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

Medicare - the health insurance benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Other Health Plans - individual or group benefit plans (insured or self-insured) such as benefits available from your spouse's employer, Medicare, and no-fault automobile insurance.

Out-of-Network Rate – means, to the extent required under federal law with respect to care at an Emergency Department in connection with Emergency Services, services rendered by an out-of-network provider at an in-network facility, and out-of-network air ambulance services, either (i) the amount agreed to as full payment by the Fund and the provider or (ii) the amount determined by the independent dispute resolution process provided for under federal law (sections 9816(c) or 9817(b) of the Internal Revenue Code), in each case reduced by the amount owed by the participant as cost-sharing.

Outpatient Facility - a clinic or other establishment that maintains and operates facilities for surgery, diagnosis, and treatment on an outpatient basis, and which has an attending medical staff consisting of at least one Provider and Anesthesiologist (or a nurse anesthesiologist under the supervision of a Provider).

Plan - the Plumbers and Pipefitters Medical Plan, as amended from time to time.

Plan Year - the period beginning January 1st through December 31st.

Preventive Service - as defined in The Affordable Care Act of 2010 (and as amended by applicable law). Preventive services include, but are not limited to:

- 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 ("Task Force") with respect to the individual involved;

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("Advisory Committee") with respect to the individual involved;

- With respect to infants, children, and adolescents (up to age 21), evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and

- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

If a recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of the preventive service, the Plan can use reasonable medical management techniques to determine any coverage limitations.

Preventive services will be covered by the Plan as of the Plan year that begins on or after the one-year anniversary of the adoption of a recommendation or guideline. For example, if a recommendation is adopted April 2, 2014, it will be covered by the Plan as a preventive service as of January 1, 2016, the Plan Year that begins after the April 2, 2015 anniversary of the adopted guideline.

Provider - a medical professional who is licensed by his or her jurisdiction and practicing within the scope of his or her license to provide a service covered by the Plan.

Qualified Medical Child Support Order - In accordance with Section 609 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), any duly entered judgment, decree or order (including approval

of a property settlement) made pursuant to a state domestic relations law (including a community property law) which relates to the provisions of child support, alimony payments or marital property rights to an Alternate Recipient, as that term is defined in Section 609(a)(2)(c) of ERISA.

Qualifying Payment Amount - means an amount determined in accordance with regulations issued by the Departments of Treasury, Health and Human Services, and Labor. Generally, the Qualifying Payment Amount equals the median contracted rate for an item or service as of January 31, 2019 and adjusted annually thereafter according to guidance from the Department of Treasury and Internal Revenue Service.

Recognized Amount - the lesser of the Qualifying Payment Amount and the amount actually billed by the Provider.

Retiree - a person who meets the eligibility requirements to be a Retiree as set forth in this booklet.

Schedule of Benefits - the Schedule of Benefits and Deductibles set forth in this booklet.

Surgical Procedure - cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electro cauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

Total Disability and Totally Disabled - your complete inability to engage in substantial, gainful activity because of a physical or mental Injury or Illness that is expected to last permanently and indefinitely.

Trustees - those persons, and their successors, who are appointed pursuant to the Plumbers and Pipefitters Medical Fund Restated Agreement and Declaration of Trust to administer the Fund.

Union - Plumbers Local Union No. 5 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

Usual, Customary, and Reasonable (UCR) - a level of covered charges to the extent that they are not more than the level generally charged by providers in the same geographic area for the same or similar services. Whether a charge for a service or supply is Usual, Customary, and Reasonable is determined by the Trustees through various means, including, but not limited to, comparison with charges generally incurred

by persons in like circumstances for similar services and supplies in cases of comparable nature and severity in the particular geographical area concerned. Where it cannot be determined that a charge for a particular service or supply is Usual, Customary, and Reasonable using the method described in the preceding sentence, UCR means the lesser of: a) the provider's actual charge, or b) an amount that shall not exceed 150% of the analogous reimbursement rate under Medicare.

Work Quarter - a period of three consecutive calendar months beginning on the first day of any January, April, July, or October during which an Employee must accrue the required number of hours of Covered Employment to remain a Covered Employee under the Plan during the following Eligibility Quarter.

ELIGIBILITY AND COVERAGE

EMPLOYEES

To participate in this Plan, you must (1) work within the jurisdiction of Local 5 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, (2) be a full-time officer or Employee of Local 5 or of the Plumbers and Pipefitters Apprenticeship Fund, or (3) otherwise satisfy the requirements established by the Trustees. If you work within the jurisdiction of Local 5, this work must be with an Employer who is obligated by a Collective Bargaining Agreement to make contributions to the Medical Fund on your behalf. This is referred to as Covered Employment. No medical examination is required in order for you to participate in this Plan. The eligibility rules first listed below are the rules for regular eligibility. They are followed by special eligibility rules for employees of Newly Organized Groups, which is a temporary status for certain new participants.

Initial Eligibility

You are eligible for Plan benefits on the first day of the second month after you have worked 750 hours in Covered Employment. These hours must be worked within no more than a nine (9) consecutive-month period. You are then eligible for at least three months before you must satisfy additional employment requirements for continued coverage.

If you become Disabled during this initial eligibility period, you may freeze any hours you worked toward the 750-hour requirement for up to 24 months. After 24 months of Disability, you may not freeze any hours worked.

Continuing Coverage

After you become eligible under the Plan's regular rules for eligibility, your continued coverage depends upon your working for a minimum number of hours in each Work (calendar year) Quarter. Your eligibility for benefits will continue during the periods shown below, which are referred to as Eligibility Quarters, if you worked in Covered Employment for at least 300 hours in the corresponding Work Quarter.

Work Quarter	Eligibility Quarter
If you worked at least 300 hours during the month of:	You are eligible for benefits during the months of:
January, February, March	May, June, July
April , May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

In order to ensure that there is sufficient time for employment reports to be received and processed by the Fund Office, a "lag month" is used in determining your quarterly eligibility. The lag month is the month between the end of a Work Quarter and the beginning of the next Eligibility Quarter as shown above.

Extended Coverage During Temporary Disability

If you become Disabled but not Totally Disabled, you and your Dependents continue to be covered under this Plan while you remain Disabled for up to eight Work Quarters after your coverage would normally end. If you want to continue your coverage after that date, you must make monthly self-payments, as described later in this booklet. No benefits are continued for Disability for more than eight Work Quarters during any five-year period unless you are making monthly self-payments to continue your coverage.

For each Work Quarter that you are Disabled, you are credited with 300 hours. If you are not Disabled for an entire Work Quarter, you are credited with up to eight hours for each day that you are absent from work because of your Disability (up to a maximum of 300 hours).

Your Reserve Account hours may be used up to "pay for" coverage during this period of temporary disability, but those Reserve Account hours will only begin to be decreased under this section when the number of Work Quarters (full or partial) that you could "buy" with your Reserve Account (up to three Work Quarters) is equal to the number of Work Quarters left under this Disability provision.

For example, if J.C. became temporarily disabled in January 2019, and remained disabled for eight Work Quarters, and he had three Work Quarters in his Reserve Account, then, starting in April 2020, J.C.'s Reserve Account hours will be used to pay for the remaining three Work

Quarters of his Disability coverage. After that, J.C. will not have any more hours in his Reserve Account, and he will need to self-pay to continue coverage.

The Trustees may require proof of Disability as many times as determined to be reasonably necessary. A Disability shall be deemed to end on the date you are released for employment, unless such return to Covered Employment is for purposes of rehabilitation, is required by statute or an agency decision, or is compatible with a determination of the covered employee's Disability.

Coverage During Total Disability

If you became Totally Disabled, and you are awarded Social Security Disability or workers' compensation benefits, you will continue to be covered under this Plan, without the need to make self-payments, for up to two (2) months from the date of the award letter. Thereafter, you may continue your coverage by making appropriate self-payments. In order to receive coverage under this section, you must have been eligible to receive benefits under the Plan for four (4) out of five (5) years or twelve (12) out of fifteen (15) years (excluding any period of COBRA Continuation Coverage) immediately before the date your disability began. You must also continue to receive Social Security Disability or workers' compensation benefits.

The Trustees may require proof of your continued receipt of Social Security Disability benefits or workers' compensation benefits. In so doing, you may be asked to provide a copy of your most recent check for either benefit.

After you begin receiving a pension (including a disability pension) from the United Association National Pension Fund, you will be considered a Retiree under this Plan.

In addition to the eligibility rules above, if you have been eligible for benefits under the plan for at least ten (10) years, periods of unemployment from covered employment will be counted toward meeting the plan's eligibility requirements for continued coverage for a Retiree or a Totally Disabled Employee if, during the unemployment period he or she had:

1. remained available for work in Covered Employment on a daily basis;

2. remained in the geographical area covered by the Union

3. signed the referral book on a monthly basis;

4. not refused any jobs in Covered Employment;

5. not worked at the trade for employers not signed to the Collective Bargaining Agreement; and

6. not worked for an Employer in a position not covered by this Plan.

If you have been eligible for benefits under the Plan for at least ten (10) years, hours that you worked under a collective bargaining agreement in the geographical jurisdiction of another U.A. local union for which no reciprocal agreement was in effect will also be counted toward meeting the Plan's eligibility requirements for continued coverage as a Totally Disabled Employee.

Coverage Under a Reserve Account

If you work more than 350 hours during a Work Quarter, all of your hours over 350 are credited to a "Reserve Account" established in your name, up to a maximum of 900 hours. Reserve Account hours are used during periods of unemployment or low employment in determining your eligibility under this Plan. Under this provision, you can accumulate up to three quarters of paid-up eligibility to be used during periods of low or no employment.

In order to qualify to use the Reserve Account, you must:

1. remain available for work in Covered Employment on a daily basis;

2. remain in the geographical jurisdiction covered by the Union unless you are working under a United Association or U.A. local collective bargaining agreement outside the Union's geographical jurisdiction;

3. sign the referral book on a monthly basis;

4. not refuse more than two jobs in Covered Employment;

5. not work at the trade for employers not signed to the Collective Bargaining Agreement or to any United Association or U.A. local union collective bargaining agreement; and

6. not work for an Employer in a position not covered by this Plan.

Note: Use of the Reserve Account is not available to Employees in Newly Organized Groups.

Coverage Using Unemployment Set Aside Account

For Covered Employees whose eligibility for coverage under this Plan's basic eligibility provisions has terminated due to insufficient work hours and who have exhausted any coverage available to them through the application of all hours in their Reserve Account, coverage may be extended through the end of the next Eligibility Quarter by using hours from the Unemployment Set Aside Account for the current Work Quarter. The Account will be debited with an amount equal to the number of hours used, multiplied by the current contribution rate.

Rules for Use of Unemployment Set Aside Account

The use of the Unemployment Set Aside Account is limited to Covered Employees whose loss of coverage is due to a layoff due to lack of work, a directive from the Union, or firing without just cause.
Note: Use of the Unemployment Set Aside Account is not available to Employees in Newly Organized Groups.

During the period that the Covered Employee is off work, he or she must remain available for work on a daily basis and remain in the geographic area covered by the Union. The Unemployment Set Aside Account will not be made available to anyone who has refused any jobs in Covered Employment during the period of unemployment, or to a Covered Employee who is unemployed and has not signed the referral book at the Union during each of the six months prior to the beginning of the Eligibility Quarter for which assistance is requested, or to a Covered Employee who leaves the unionized pipefitting industry.

The use of hours from the Unemployment Set Aside Account is limited to the first two Work Quarters following a loss of work, during which the Covered Employee does not work 300 hours or does not have sufficient hours in his or her Reserve Account to retain eligibility for coverage. Thereafter, the Covered Employee may not use it again until his or her eligibility for a subsequent Eligibility Period is established based on hours actually worked in Covered Employment.

Priority of Coverage Under the Unemployment Set Aside Account

Covered Employees claiming assistance under the Unemployment Set Aside program will be given coverage on a "first-come, first served" basis as registered by the Fund Office through receipt of an appropriate application on a form which you must request from the Fund Office. A separate application must be submitted for each Work Quarter for which assistance under this program is desired. Once the funds allocated for this Account have been exhausted by Covered Employees, it will not be available to others until and unless sufficient subsequent contributions are received and allocated for this purpose.

Coverage Under a Reciprocal Agreement

If you work in another U.A. Local Union jurisdiction that is covered by a reciprocal agreement, your hours are treated as hours worked in Covered Employment for eligibility purposes if the reciprocal plan contributions are forwarded to the Fund Office. For hours worked on or after August 1, 2003, if the rate of contributions received from the visited Local Union's medical fund ("Visited Fund") is greater than the rate of contributions that would have been made had you worked for an Employer under this Plan, your hours of work under the Visited Fund's plan will be proportionately increased. This increase will be based upon the ratio that the received reciprocal contribution rate bears to the rate of contributions that would have been made had you been working under this Plan. The resulting increased hours will be treated as hours worked in Covered Employment under this Plan. If, however, the rate of contributions received from the Visited Fund is less that the rate of contributions that would have been made had you worked for an Employer under this Plan, your hours of work will not be proportionately decreased; instead, you will receive full credit for these hours of work.

For example, if you travel to a Local that reciprocates contributions to this Fund and work 160 hours, and the medical fund contribution rate in that local is $8.00 and the contribution rate to this Fund is $4.00, your hours credited to this Plan will be increased proportionately by 100% to 320 hours. If, on the other hand, the contribution rate in the Visited Fund is less than the Fund's contribution rate of $4.00, you will still be credited with the full 160 hours you worked and will not face a proportionate decrease in your hours for crediting purposes.

If you work in another U.A. Local Union jurisdiction that is not covered by a reciprocal agreement, your hours are not taken into account for eligibility purposes. As a result, your benefits coverage ends when you fail to meet the requirements for continued eligibility. If this happens, you should

contact the other Local Union's plan to find out when you will be covered under that plan.

If you become Totally Disabled after you have been eligible for benefits under this Plan for at least ten (10) years but, at the time you become Totally Disabled you are working in another U.A. Local Union jurisdiction that is not covered by a reciprocal agreement, your hours that you work without the reciprocal agreement being in effect are included for eligibility purposes.

Coverage During Military Service

If you are on active military duty for thirty (30) or fewer days, and you meet the other requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you (and your eligible family members) will continue to receive health coverage for up to thirty (30) days, in accordance with USERRA, at no expense to you. On or after January 1, 2006, the amount of employer contributions that would otherwise be owed for such periods of qualified military service will be considered an administrative expense of the Fund, and no individual Employer will be liable to make such contributions.

If you are on active duty for more than thirty (30) days, USERRA permits you to continue medical, vision, and dental coverage for you and your Dependent(s) at your expense for up to 24 months if your service lasts 24 months or longer. If your service lasts fewer than 24 months, your continuation coverage will last for the length of your period of service. This continuation right operates in the same way as COBRA Continuation Coverage. In addition, you and your Dependent(s) may be eligible for health coverage under the military's health coverage plan, TRICARE (formerly CHAMPUS). The Plan will coordinate benefits with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from "service in the uniformed services," as defined in USERRA, your eligibility will be fully reinstated on the day you return to work with a Participating Employer, provided that you report back to work with your pre-service Employer or report back to your Union for work with a Participating Employer within:

a. ninety (90) days from the date of discharge, if the period of service was more than one hundred eighty (180) days; or

b. fourteen (14) days from the date of discharge, if the period of service was thirty one (31) days or more but less than one hundred eighty (180) days: or

c. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus, travel time and an additional eight hours), if the period of service was less than thirty one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended to the time period of your recovery, not to exceed two years.

Using Hours Bank Eligibility

If you elect USERRA continuation coverage and you have sufficient hours in your Reserve Account to provide eligibility for the period of your service (after the first 30 days, during which coverage is provided without depleting your eligibility), you may elect to either use your Reserve Account hours (if applicable) or self-pay for USERRA continuation coverage. If you elect to use your existing eligibility and if your existing eligibility runs out during your service, you may then commence self-payment if you are still permitted to continue your coverage under the rules discussed above. Upon your return to employment from the uniformed service, the Plan will allow you to be immediately eligible to resume coverage, but you must pay for such coverage at the applicable COBRA rates until you regain eligibility as a result of hours reported. *Note: Use of the Reserve Account is not available to Employees in Newly Organized Groups.*

Alternatively, if you elect to pay for USERRA continuation coverage (after the first 30 days of service during which coverage is continued at no cost to you), your existing eligibility will be frozen until you return to Covered Employment from the qualified military service so that it may be used to establish your continuing eligibility for coverage at that time at no cost to you.

Notice and Election of Coverage

You are required by USERRA to give advance notice to your Employer that you are leaving for a period of military service, unless giving such notice is impossible or unreasonable or barred by the military. Upon giving such notice to your employer, you should also notify the Plan in writing that

you are leaving to perform military service and that you elect to continue your medical coverage. Within 60 days after receipt of that notice, the Fund Office will provide you with specific information regarding the cost of USERRA continuation coverage.

If you do not give advance notice of your leave for military service to your Employer, your coverage will be terminated as of the date you leave employment for military service. If your failure to give advance notice of your military service is excused, because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Plan will reinstate your health coverage retroactive to the date of departure from employment if you contact the Plan to request continuation coverage within 30 days of your departure and return the USERRA continuation coverage election form the Fund Office with your initial payment within 30 days of receiving that form.

If you give advance notice of your leave for military service to your employer but fail to notify the Plan that you desire to elect continuation coverage, your coverage will be terminated as of the date you leave employment for military service. The Fund Office will reinstate your health coverage retroactive to the date of departure from employment, however, if you contact the Plan to request continuation coverage within 30 days of your departure and return the USERRA continuation coverage to the Fund Office with your initial payment within 30 days of receiving that form.

Contact the Fund Office at 1-800-741-9249 for information if you are called to active military service.

Coverage During Leave Under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) allows an Employee to take up to 12 weeks of unpaid leave during any 12-month period due to:

1. the birth of a child of the Employee and in order to care for such child;

2. the placement of a child with the Employee for adoption or foster care;

3. the need to care for a spouse, child, or parent with a serious health condition;

4. the Employee's own serious health condition; or

5. a “qualifying exigency” arising out of the fact that a covered family member is on covered active duty or called to covered active duty status in the Armed Forces (including the National Guard or Reserves).

Additionally, an eligible Employee who is a family member of a covered military service member undergoing medical treatment, recuperation or therapy is able to take up to 26 workweeks of leave in a single 12 month period to care for the covered service member with a serious illness or injury incurred in the line of duty or a serious illness or injury that was aggravated by service in the line of duty on active duty. Covered service members include veterans who were members of the Armed Forces (including the National Guard or Reserves) at any time during the 5 years preceding the date on which the medical treatment, recuperation or therapy began.

During his or her leave, the Employee can continue all of his medical coverage and other benefits offered through the Fund. The Employee is generally eligible for a leave under the FMLA if the Employee:

1. has worked for a covered Employer for at least 12 months;

2. has worked at least 1,250 hours over the previous 12 months; and

3. has worked at a location where at least 50 employees are employed by the Employer within 75 miles.

The Fund will maintain the Employee’s eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under the FMLA and the contributing Employer makes the required notification and payment to the Fund. If you need to take leave for an FMLA-qualifying event you should immediately notify your Employer.

Reinstatement of Coverage

If your eligibility is discontinued for more than four (4) quarters and you then work for at least 750 hours in Covered Employment in the next nine-consecutive month period, you again become eligible for coverage under this Plan on the first day of the second month following the month in which you reach 750 hours.

However, if your eligibility is discontinued because of unemployment or Disability and if you continuously and actively seek work in employment covered by the Plan, you can again become eligible for coverage after you have worked at least 300 hours in Covered Employment within a six-month

period. Coverage under this provision will be reinstated on the first day of the second month after you work the 300 hours. Of course, if you are Disabled, you must actively seek work at the time of your recovery for the above reinstatement provisions to apply. If you are ineligible for coverage under this Plan for four consecutive Work Quarters, you must re-qualify under the initial eligibility requirements of this Plan.

Termination of Coverage

If you do not work for at least 300 hours in Covered Employment during a Work Quarter, coverage for you and your Dependents under this Plan automatically terminates at the end of the current Eligibility Quarter.

For example, if you worked in Covered Employment for only 200 hours during the months of January, February and March, your coverage ends on April 30. If you are making self-payments to continue your coverage as described in this booklet and you do not make a payment on time, your coverage automatically terminates at the end of the period for which you last made a timely payment.

Of course, your coverage can terminate earlier if the Plan itself is terminated or if you do not submit any information requested by the Fund Office.

If you are covered under this Plan but are not covered under a Collective Bargaining Agreement, your coverage can also terminate if your Employer does not make the required payments on your behalf. Termination for these Employees shall be effective as of the end of the month for which payment was due. In these circumstances, such Employees cannot use their Reserve Accounts.

If you leave Covered Employment in the unionized plumbing and pipefitting industry, you cannot use your Reserve Account, and coverage for you and your Dependents under this Plan terminates at the end of the month following the month in which you leave. However, you and your Dependents automatically lose eligibility for certain benefits on the date you leave Covered Employment. These benefits are:

- Prescription Drug Expenses
- Dental Expenses
- Vision Care Expenses
- Weekly Accident and Sickness Benefit
- Benefits for non-emergency (elective) surgery

If you stop working for an Employer who participates in this Plan you will not receive credit under this Plan for the hours you work unless you are still working in the unionized pipefitting industry in a jurisdiction which has a reciprocal agreement with this Plan. Once your coverage is terminated, you must re-qualify for benefits under this Plan by meeting the eligibility requirements explained earlier in this booklet.

SPECIAL RULES FOR EMPLOYEES IN NEWLY ORGANIZED GROUPS

The Fund has established special eligibility rules for "Employees in Newly Organized Groups." Employees who qualify for these special rules are individuals who are not already participants in the Plan. They may be current employees of a newly organized company that signs a collective bargaining agreement with the Local Union or newly organized employees represented by the Local Union who are then employed by an Employer already contributing to the Fund. The purpose of these special eligibility rules is to encourage the addition of new participants to the Plan. These special eligibility rules are not available for current employees represented by the Local Union, newly indentured apprentices or other regular applicants for representation by the Local Union. Employees who qualify for these special rules may choose to participate in the Plan through these special rules or through the Plan's regular rules as described above. Employees must affirmatively make this election. The election will apply until you have worked 750 hours in Covered Employment in a period of not more than twelve months, and the election cannot be reversed.

To What Period Do These Special Rules Apply?

This Section describes the eligibility requirements and benefits that are applicable to Employees in Newly Organized Groups for a limited period before an Employee establishes eligibility under the regular Initial Eligibility rules of the Plan.

After an Employee in a Newly Organized Group has worked 750 hours in covered employment in a period of not more than twelve months, these special rules are no longer applicable. In addition, if an Employee in a Newly Organized Group loses eligibility under the special Continuing Eligibility Rules described in this Section, these special rules are no longer applicable. In this circumstance, the Employee can then become eligible for benefits only by meeting the regular Initial Eligibility rules of the Plan as described earlier in this booklet.

Initial Eligibility – Employees in Newly Organized Groups

If you are an Employee in a Newly Organized Group, you will become eligible for benefits effective on the first day of the month following the completion of at least 125 hours of work in Covered Employment for which the Fund receives contributions. The names of the new Employees covered under this provision must be received in the Fund Office prior to the first day of the first month of coverage. Employees are encouraged to notify Local 5 when they have worked 125 hours in Covered Employment.

Examples

Assume Mike's employer signed a collective bargaining agreement with Local 5 on March 10. Mike has been employed by this employer for several years, but the employer was not previously obligated to contribute to the Fund for any of his employees. If Mike works 125 hours for which contributions are owed to the Fund during the month of March, and the Fund receives a list of the Employees in this Newly Organized Group that includes Mike before April 1, and the Fund receives the contributions due from the employer for work in March (and all other contributions due from the effective date of the collective bargaining agreement) on or before April 15th, then Mike will become eligible for benefits from the Fund effective April 1 (1st of month following completion of 125 hours of work in Covered Employment) and remain eligible through at least May 31.

Assume Bob is part of a new group of employees represented by Local 5 hired by an Employer under a collective bargaining agreement covering this new group of employees. He started working for the Employer under the collective bargaining agreement on March 10. Although he remained employed by the employer, he did not work at least 125 hours for which contributions were owed to the Fund in March. He did work 125 hours for which contributions were owed to the Fund between March 10 and April 9. If the Fund receives a list of the Employees in this Newly Organized Group that includes Bob before May 1, and the Fund receives the contributions due from the employer for work in April (and all other contributions due from the effective date of the collective bargaining agreement) on or before May 15th, then Bob will become eligible for benefits from the Fund effective May 1 (1st of month following completion of 125 hours of work in Covered Employment) and remain eligible through at least June 30.

Continuing Coverage - Employees in Newly Organized Groups

Once you have earned your initial eligibility, you will stay eligible under these special rules as long as you work at least 750 hours in a period of

not more than 12 months and the Fund receives contributions for those Hours.

If you fail to work at least 125 hours in two consecutive months, you will lose your eligibility on the first day of the month following the second month in which you fail to work at least 125 hours, unless you make self payments to the Fund as described in the section titled "What Happens if You Don't Have Enough Hours (Self-Payments)."

After you have worked 750 hours in a period of not more than 12 months, the special rules described in this section are no longer applicable to you. For continued coverage, you must meet the "Continuing Coverage" rules of the Plan described earlier in this booklet.

Termination of Coverage for Employees in Newly Organized Groups

This Plan is designed to provide needed benefits for all eligible Employees and their covered Dependents. However, you should be aware of the circumstances that could result in a loss of eligibility. It is possible for you and your Dependents to lose eligibility if:

- Fewer than 125 hours of Employer contributions are received by the Fund for a month on your behalf.

- You work for a non-participating employer in the Plumbing and Pipefitting Industry within the geographic jurisdiction of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO (in this case, your eligibility will terminate immediately) unless such work is pursuant to a written agreement which is provided to the Fund.

- You are inducted into the Armed Forces.

- There is a Plan amendment that affects eligibility.

Reinstatement of Coverage if You Lose Your Eligibility

If, for any reason, you lose your eligibility for benefits during the limited period covered by the special rules described in this Section, you can then become eligible for benefits only by meeting the regular Initial Eligibility rules of the Plan as described earlier in this booklet.

What Happens if You Don't Have Enough Hours (Self-Payments)

If you lose your eligibility for benefits during the limited period covered by the special rules described in this Section, you may make self-payments to the Fund if you have worked at least some hours in Covered Employment during the preceding month. If coverage for you and your Dependents ends because you work less than 125 hours in Covered Employment during a month, you can continue this coverage by making monthly self-payments to the Fund Office. For each month, the payment is based on the current hourly contribution rate charged to your Employer, multiplied by the difference between 125 hours and the number of hours that you worked.

If you have worked no hours in Covered Employment during the preceding month, you may continue your eligibility only by making payments for COBRA Continuation Coverage as provided in this booklet.

Continuing Your Eligibility While Totally or Temporarily Disabled

If you become Totally Disabled or Temporarily Disabled during the limited period covered by the special rules described in this Section, the coverage continuation rules described earlier in this booklet do not apply. However, you may continue your eligibility by making payments for COBRA Continuation Coverage as provided in this booklet.

Continuing Eligibility for Your Dependents After Your Death

If you should die while you are an Eligible Employee during the limited period covered by the special rules described in this Section, the coverage continuation rules for your Dependents described on page 53 of the Summary Plan Description do not apply. However, your dependents may continue eligibility by making payments for COBRA Continuation Coverage as described in this booklet.

No Coverage Under Reserve Account or Unemployment Set-Aside Account

During the limited period covered by the special rules described in this Section, you are not entitled to a Reserve Account or an Unemployment Set-Aside Account or to obtain coverage for benefits through any such Account.

Coverage Under a Reciprocal Agreement

During the limited period covered by the special rules described in this Section, the same rules will apply for coverage under a reciprocal agreement as apply to employees who are not Employees in Newly Organized Groups. See the paragraph on this topic on page 30 in the section relating to regular eligibility.

Coverage for Qualified Periods of Military Service or Family and Medical Leave

During the limited period covered by the special rules described in this Section, the Fund will continue eligibility for Employees in Newly Organized Groups during periods of qualified military service or for qualified Family and Medical Leave to the extent required by federal law. See discussion of these requirements earlier in this booklet in the section relating to regular eligibility.

Scope of Benefits for Employees In Newly Organized Groups and Their Dependents

As an Employee covered by the Plumbers and Pipefitters Medical Plan through the special eligibility rules for “Employees in Newly Organized Groups,” you and your eligible dependents are entitled to all medical benefits provided by the Plan, with the same co-payments and deductibles.

You are not, however, entitled to the following benefits during the limited period covered by the special eligibility rules described in this Section:

Medical Reimbursement Allowance
Reserve Account
Unemployment Set-Aside Account

You will become eligible for these benefits, as well as all other benefits offered by the Plan, after you have worked 750 hours within a period of not more than 12 months, so long as you meet the regular eligibility rules of the Plan.

DEPENDENTS

Coverage under this Plan for your Dependents begins on the date you become eligible for coverage or, if later, the date he or she meets the Plan's definition of "Dependent."

In order to determine whether your dependents meet the Plan's definition of "Dependent," the Trustees may require you to provide proof of marriage, parentage, or disability.

If your Dependent is found to be Disabled, the Trustees may require that you periodically provide proof that the Disability is continuing and may, at the Plan's expense, require your Dependent to undergo a medical examination to verify the continued Disability. If you do not provide the proof requested, or do not agree to have your Dependent undergo a medical examination, the coverage for your Dependent may be refused or terminated.

Coverage for your Dependents automatically ends on the date your coverage ends or on the date the coverage for all Dependents in the entire Plan terminates. However, coverage for your Dependents also ends when they fail to meet the Plan's definition of "Dependent," they become covered under this Plan as Employees, or when your surviving spouse remarries.

Coverage for your Dependent child(ren) will also end on the last day of the calendar month in which, in accordance with procedures established by the Trustees, you request to terminate your minor child's coverage as a Dependent under the Plan because you determine that more favorable alternative coverage from another plan, group health insurance, or public program is available for the child only if that child is not covered under this Plan. If your child is under 18 and/or disabled, and unless you have sole legal custody of your child, both you and your child's other parent with legal custody must consent to terminate the child's coverage as a Dependent under the Plan on this basis. If your child is age 18 or over and not disabled, both you and your child must consent to terminate the child's coverage as a Dependent under the Plan on this basis. The Plan will not be responsible for any loss you or your child experiences as a result of the decision to terminate your child's coverage under the Plan. A child whose coverage is terminated as provided in this paragraph may again obtain coverage as a Dependent under the Plan, if otherwise eligible, on the first day of the calendar month after the calendar month the Fund Office receives notice of his or her reenrollment in writing in a form acceptable to the Trustees.

If your Dependents are making self-payments to this Plan in order to continue their coverage as described in this booklet, their coverage ends on the last day of the month for which they made a timely payment.

No payments are made under this Plan for expenses incurred by you or by your Dependents after coverage ends, even if the expenses are in

connection with a medical condition that existed before the coverage ended.

Qualified Medical Child Support Orders

The law provides that an Alternate Recipient, as defined below, under a Qualified Medical Child Support Order (QMCSO), also defined below, must continue to receive medical coverage in compliance with a court order. A QMCSO is a judgment or court decree that requires a group health plan to provide coverage to the children of a plan participant, under a state domestic relations law. The term "Alternate Recipient" means any child of an employee who is recognized under a medical child support order as having a right to enrollment under a group health plan. You may obtain, upon request to the Plan Administrator and without charge, a copy of the Plan's procedures for processing QMCSOs.

Adopted Children

Coverage for an adopted child of an Active Employee will begin when the child is "placed," determined in accordance with the law, not when the adoption becomes final. Limitations on pre-existing conditions of your adopted child are not permitted.

Dependents of Retirees

Retiree must notify the Fund Office of new Dependents within sixty (60) days of the occurrence of any of the following events: (a) the Retirees' marriage or remarriage; (b) the birth of Retiree's Dependent Child; or (c) the placement of a Retiree's Dependent child with the Retiree for adoption. Failure to provide the notice shall preclude all coverage under the Plan for the Retiree's Spouse; and failure to provide the notice shall preclude all covered under the Plan for the Retiree's Dependent child(ren) until such notice has been provided.

RETIREES

If you retire before you reach age 55, you and your Dependents are not eligible for Retiree coverage under this Plan.

If you retire after you reach age 55, are receiving a non-suspended pension from the United Association National Pension Fund (UANPF), and have been covered under this Plan for four (4) out of the five (5) years or twelve (12) out of the fifteen (15) years immediately preceding your retirement (excluding any period of COBRA Continuation Coverage), you and your Dependents are eligible for Retiree coverage under this Plan.

You will continue to be covered under this Plan, without the need to pay a monthly charge, for the month in which your pension takes effect. After that month, however, you must make a monthly self-payment, in an amount determined periodically by the Trustees, to continue your coverage under the Plan.

Alternatively, if you retire after you reach age 55, you are receiving a Social Security pension, you are not performing any work that would be considered disqualifying employment under the terms of the UANPF Plan, and you have been covered under this Plan for at least the twenty (20) years immediately preceding your retirement, you and your Dependents are eligible for Retiree coverage under this Plan. You will continue to be covered under this Plan, without the need to pay a monthly charge, for the month in which your Social Security pension takes effect. After that month, however, you must make a monthly self-payment, in an amount determined periodically by the Trustees, to continue your coverage under the Plan

If you are Totally Disabled and otherwise meet the requirements shown in this section, you are considered to be a “Retiree” and are eligible for Retiree coverage under this Plan. If you become Totally Disabled under this provision, your coverage will continue as long as you make self-payments at the rate for Retirees age 62 and older and as long as you continue to receive your pension from the United Association National Pension Fund.

Once you are eligible for Retiree coverage under this Plan, your coverage will continue until you no longer qualify as a “Retiree” under the Plan or you fail to make a timely self-payment, as described in this booklet. Your coverage may also terminate if you do not provide any information requested by the Fund Office. Of course, your coverage may terminate if the Plan itself, or the portion of the Plan that provides Retiree coverage, is terminated. Any portions that are payable to you as a Retiree under this Plan are reduced by any amounts you obtain or are eligible to obtain from Medicare.

Retirees who return to work in Covered Employment will continue in “Retiree” status if the Retiree continues to draw a pension while working. The Retiree will pay monthly premiums for coverage, and his Employer will pay contributions to the Fund at the hourly rate in effect until such time as he ceases working in Covered Employment. Retirees will not participate in the Active Hour Bank if they draw a pension.

You must elect Retiree coverage under the Plan within thirty (30) days of your Pension Effective Date (or the date of your first pension benefit

payment, if because of retroactive application, it is later than your Pension Effective Date).

If, at any time after you last worked in Covered Employment, before or after your retirement, you are employed (or self-employed) in any capacity or position (including supervisory) in the plumbing and pipefitting industry by an employer that is not signatory to an agreement with the Union, your eligibility for Retiree coverage (and that of your Dependents) will terminate immediately and you will no longer be eligible for Retiree coverage under the Plan. You must notify the Fund immediately if you engage in such work.

Coverage of Retirees

In addition to the hours counted under the rules above, if you have been eligible for benefits under the plan for at least 10 years, periods of unemployment from covered employment will be counted toward meeting the Plan's eligibility requirements for continued coverage for a Retiree or a Totally Disabled Employee if, during the unemployment period he or she had:

1. remained available for work in Covered Employment on a daily basis,

2. remained in the geographical area covered by the Union,

3. signed the referral book on a monthly basis,

4. not refused any jobs in Covered Employment,

5. not worked at the trade for employers not signed to the Collective Bargaining Agreement, and

6. not worked for an Employer in a position not covered by this Plan. If you have been eligible for benefits under this Plan for at least ten (10) years, hours that you worked under a collective bargaining agreement in the geographical jurisdiction of another U.A. local union for which no reciprocal agreement was in effect will also be counted toward meeting the Plan's eligibility requirements for continued coverage for a Retiree.

SPOUSES AND DEPENDENTS OF DECEASED EMPLOYEES OR RETIREES

If you die while you are covered under this Plan, the coverage for your Surviving Spouse and Dependents continues for up to two months (not including month of death) free of charge, unless your Spouse remarries within that two month period. This does not apply if you die while on COBRA Continuation Coverage. After the initial two month period, your Spouse can continue to receive benefits by making timely monthly self-payments to the Fund Office. Coverage for your Surviving Spouse and Dependents automatically ends on the date your Spouse remarries.

If you die while you are eligible for Retiree coverage under this Plan, the coverage for your Surviving Spouse and Dependents continues for up to two months without charge or, if earlier, until the date your Spouse remarries. After this two month period, your Spouse can continue coverage for himself or herself and your Dependents by making monthly payments to the Fund.

Coverage for your Surviving Spouse and Dependents automatically ends on the date your Surviving Spouse remarries, the date your Surviving Spouse or Dependents fail to provide any information requested by the Fund Office, or the last day of the month for which a timely self-payment was made. Of course, the coverage for your Surviving Spouse and Dependents may end earlier if the Plan itself, or the part relating to this coverage, is terminated.

Any benefits that are payable to your Surviving Spouse and Dependents under this Plan are reduced by any amounts they obtain or are eligible to obtain from Medicare.

COVERAGE OF NON-BARGAINING UNIT COVERED EMPLOYEES

Notwithstanding any other provisions of this Plan, the coverage pursuant to a signed stipulation of Covered Employees who are not part of the bargaining unit, and coverage of their Dependents, is based upon the payment by the Employer of monthly contributions to the Plan at an hourly rate, as set forth in the Collective Bargaining Agreement, multiplied by one hundred sixty (160). The failure of the Employer to make such payments by the 20th day of the month following the month for which the payment is due shall result in the termination of coverage for such Employees as of the end of the month for which the payment was due.

TOTALLY DISABLED EX-EMPLOYEES

If you become Totally Disabled while covered under this Plan and you are awarded Social Security Disability or workers' compensation benefits, you will continue to be covered under this Plan, without the need to make self-payments, for up to two (2) months from the date of the award letter. Thereafter, you may continue coverage for yourself and your Dependents for up to 24 months by making monthly self-payments as described in this booklet.

If you become Totally Disabled while you are covered under this Plan, have been awarded Social Security Disability Benefits or workers' compensation benefits, and, at the time you become Totally Disabled, you were eligible to receive benefits under this Plan for four (4) out of the five (5) previous years or twelve (12) out of the fifteen (15) previous years (excluding periods of COBRA Continuation Coverage), you may continue coverage for you and your Dependents by making monthly self-payments to the Fund Office as described in this booklet.

Your coverage automatically ends on the date you stop being Totally Disabled, the date you fail to provide any information requested by the Fund Office, or the last day of the month for which you make a timely self-payment. In addition, your coverage can end earlier if the Plan itself is terminated.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

In general, when an Employee's medical and dental coverage ends, the Employee, the Employee's covered Spouse and/or Dependent child(ren) are entitled to by law, and will be provided with, a Certificate of Coverage that indicates the period of time that the Employee and/or such individuals were covered under the Plan. Such a certificate will be provided to them shortly after the Plan knows or has reason to know that coverage for such Employee, Spouse, and or Dependent child(ren) has ended. In addition, such a certificate will be provided upon receipt of a request for such a certificate that is received by the Fund Administrator at the address provided in this booklet within two years after the date coverage ended. If you request a Certificate, the Fund will send it within a reasonable and prompt period of time.

VERIFICATION OF ELIGIBILITY

You or a doctor or Hospital may call the Fund Office at 1-800-741-9249 to verify your eligibility or the eligibility of a Dependent. A verification of eligibility means only that you or your Dependents are covered by the Plan

and may receive benefits in accordance with the Plan. You or your Dependents are also subject to the limitations and exclusions contained in the Plan. The verification of eligibility does not mean that you or your Dependents are covered for the treatment provided if the terms of the Plan are not met. You should become familiar with the provisions of this Plan so that you can determine whether services provided to you or your Dependent will be covered.

SELF-PAYMENTS

This Plan allows you to make self-payments on behalf of yourself and your Dependents in order to maintain your coverage if you become ineligible during periods of unemployment or Disability. If you leave the geographic area covered by the Local 5 Agreement or leave the unionized plumbing and or pipefitting industry, you are not permitted to make self-payments except under COBRA Continuation Coverage. However, Retirees, Disabled Employees, Totally Disabled Employees and Surviving Spouses and Dependents of deceased Employees or Retirees may (subject to limitations) make monthly payments to continue eligibility. The Trustees reserve the right to change the monthly self-pay rates at any time.

EMPLOYEES

Employees Working in Covered Employment

If coverage for you and your Dependents ends because you work less than 300 hours in Covered Employment during a Work Quarter, you can continue this coverage by making monthly self-payments to the Fund Office. For each Work Quarter, the monthly payment is based on the current hourly contribution rate charged to your Employer, multiplied by the difference between 300 hours and the number of hours that you worked.

You may not make self-payments under this provision if you did not work in Covered Employment during the Work Quarter.

Your monthly contribution for a Work Quarter must be received no later than 45 days after the end of that Work Quarter. If your contribution is not received by the Fund Office by that date, you must meet the initial eligibility requirements described earlier in this booklet in order to reestablish your coverage.

Employees Not Working in Covered Employment

If your coverage is still in effect, but you do not meet the requirements for continuing coverage as described earlier in this booklet, and you did not work in Covered Employment during the previous Work Quarter, you may continue your coverage for up to 12 months by making monthly self-payments to the Fund Office. This coverage may be continued for more than 12 months only if you have been continuing to make self-payments since September 20, 1977. The amount of the monthly payment is based on the current hourly contribution rate charged to Employers for 160 hours per month.

If your coverage terminates while you are not working in Covered Employment, but you are available for and actively looking for work in Covered Employment, you can elect alternate coverage for a reduced package of benefits for yourself and your Dependents for up to 24 months by making self-payments to the Fund Office. The election of alternate coverage may be made instead of continued coverage under COBRA as discussed in this booklet. The amount of your monthly self-payment is established by the Board of Trustees and may be changed at any time. Once you elect this alternate coverage, you cannot later change your mind. This coverage automatically ends if you do not return to work when it is available.

Your monthly contribution must be received by the first day of each month. If your contribution is not received by the Fund Office on or before the last day of that month, your coverage is considered to have ended on the last day of the preceding month, and you must meet the initial eligibility requirements described earlier in this booklet in order to reestablish your coverage.

Totally Disabled Employees

If you are Totally Disabled and are not eligible for benefits under any other provisions of the Plan because of your Total Disability, you may continue coverage for yourself and your Dependents for up to 24 months by making monthly self-payments to the Fund Office. You may only make these self-payments if: (1) you are unable to work at your job in Covered Employment and (2) you have applied for or are appealing your denial of workers' compensation or Social Security Disability benefits. You cannot make self-payments under this section if you are able to resume your job in Covered Employment or if there is a final determination denying your Social Security Disability or workers' compensation appeal.

You must notify the Fund Office within 10 days after you receive your first Social Security Disability or workers' compensation benefit payment. The Trustees may require you to provide any information necessary to determine whether or not these benefits have actually been received. Your coverage may be terminated if you do not furnish the requested information or if you do not provide notice of your receipt of benefits. If you or your Dependents receive benefits from the Plan because you failed to provide this notice or information, the Trustees may take any action necessary to recover those benefits.

The amount of the monthly payment is based on the current hourly contribution rate charged to Employers for 160 hours per month.

Your monthly contribution must be received by the first day of each month. If your contribution is not received by the Fund Office on or before the last day of that month, your coverage is considered to have ended on the last day of the preceding month, and you must meet the initial eligibility requirements described earlier in this booklet in order to re-establish your coverage.

If you are Totally Disabled, you have been awarded Social Security Disability or workers' compensation benefits, and you were eligible for benefits under this Plan for four out of the five years (or 12 out of the 15 years) immediately preceding the date you become Totally Disabled, you may continue your coverage for up to two months without cost. After this two-month period, you can continue your coverage by making monthly self-payments to the Fund Office. If you have been awarded Social Security Disability, you are required to pay the monthly self-pay rate for Totally Disabled Ex-Employees found in the Schedule of Benefits.

If you have not been awarded Social Security Disability but you are receiving workers' compensation benefits, the amount of the monthly payment is based on the current hourly contribution rate charged to Employers for 160 hours per month. If settlement of your workers' compensation claim is reached, or your benefits are otherwise terminated, you will be allowed one month after the workers' compensation settlement to apply for Social Security Disability Benefits before your benefits under the Plan are terminated.

The amount of your monthly self-payment is established by the Board of Trustees and may be changed at any time. Your monthly contribution must be received by the first day of each month. If your contribution is not received by the Fund Office on or before the last day of that month, your coverage is considered to have ended on the last day of the preceding month, and you must meet the initial eligibility requirements described earlier in this booklet in order to re-establish your coverage.

DEPENDENTS

If coverage for your Dependents ends because your coverage terminates, your Dependents may choose to continue their coverage under the COBRA Continuation Coverage benefits described later in this booklet. However, the maximum period for which COBRA benefits are payable to your Dependents is reduced by any periods of time that you make self-payments on their behalf.

Your Dependent's monthly contribution must be received by the first day of each month. If the contribution is not received by the Fund Office on or before the last day of that month, your Dependents' coverage is considered to have ended on the last day of the preceding month. The Trustees may request that your surviving spouse provide proof of his or her marital status. If this proof is not provided, the coverage for your Dependents may be terminated.

RETIREES

If you retire before reaching age 55, you may not make self-payments to continue your coverage under this Plan.

If you retire after you reach age 55, are receiving a non-suspended pension from the United Association National Pension Fund (UANPF), and have been covered under this Plan for four (4) out of the five (5) years or twelve (12) out of the fifteen (15) years (excluding periods of COBRA Continuation Coverage) immediately preceding your retirement, you may continue your coverage until the month you reach age 62 by making monthly self-payments to the Fund Office.

Once you reach age 62, you can receive Death, Accidental Death, Basic Medical, Major Medical, Vision Care, Prescription Drug and Dental Benefits under this Plan by paying the monthly charge shown in the Schedule of Benefits. Any benefits payable to you under this section are reduced by the amounts you receive, or are eligible to receive, from Medicare.

If you are eligible for a pension benefit from the UANPF and have applied for a pension benefit but have not yet received your first pension benefit payment, your first monthly self-payment must be received by the Fund Office no later than the first day of the month after you receive your first pension benefit payment. At that time, you must make monthly self-payments for all prior months for which you received coverage as a Retiree, other than the first month for which you received coverage as a Retiree. Going forward after your pension benefits commence, your monthly self-payment must be received by the Fund Office by the first day of each month. If your self-payment is not received by the Fund Office on or before the last day of the month that it is due, your coverage will be considered to have ended on the last day of the preceding month. Once your coverage is terminated due to non-payment, it cannot be reinstated.

For your convenience, if you are receiving a pension benefit from the UANPF, you may authorize the UANPF to deduct your monthly self-

payment for Retiree coverage from your pension benefit and remit it directly to the Fund. Contact the Fund Office for an authorization form.

SURVIVING SPOUSES AND DEPENDENTS OF DECEASED EMPLOYEES OR RETIREES

If you are the surviving spouse or Dependent of an Employee or Retiree who died while covered under this Plan, you can continue your coverage for up to two months (not including the month of death) without cost. If you are a surviving spouse of an Employee or Retiree, you can continue your coverage after this two-month period by making monthly self-payments to the Fund Office.

If you were a Dependent of an Employee or Retiree and become an orphan while you are covered under this Plan, you may continue your coverage for up to two months without cost. After this two-month period, your coverage may be continued until you no longer meet the Plan's definition of Dependent, as long as monthly payments are made on your behalf by your guardian. The amount of this monthly self-payment shall be determined periodically by the Board of Trustees and is shown in the Schedule of Benefits.

Benefits for Surviving Spouses and Dependents automatically end on the date the Surviving Spouse remarries. Any benefits payable under this section are reduced by amounts entitled to or received from Medicare.

Your monthly contribution must be received by the first day of each month. If your contribution is not received by the Fund Office on or before the last day of that month, your coverage is considered to have ended on the last day of the preceding month.

COBRA CONTINUATION COVERAGE

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end due to a life event known as a "qualifying event." The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA"). Under certain circumstances where your coverage under the Plan would otherwise end, you and your Dependents may choose to temporarily continue your coverage at group rates. This extended coverage is called "COBRA Continuation Coverage" and is available to you and your Dependents. If you do not elect COBRA continuation coverage for your Dependents when it is available, they can elect it for themselves. Once COBRA continuation coverage ends, no further self-payment coverage is available. As an employee, you will become a "qualified beneficiary" entitled to COBRA continuation coverage if your hours of work are reduced or your employment is terminated for any reason other than your gross misconduct. In that case, you and/or your Dependents have the right to elect COBRA continuation coverage for up to 18 months. This maximum 18-month period is offset by any self-payments you make under the Plan's self-payment provisions.

If you and/or your Dependent is determined by the Social Security Administration to have been totally disabled at the time you left service, or to have become totally disabled during the first 60 days of COBRA continuation coverage, then you and your Dependents who were entitled to the initial 18 months of COBRA coverage are entitled to keep COBRA coverage for an additional 11 months. To qualify for this special extended COBRA eligibility, you must send a copy of the Social Security Administration's Disability determination to the Fund Office within 60 days of the determination.

If coverage for your Dependents would otherwise end because of your death, your divorce or legal separation, your becoming entitled to Medicare benefits or, in the case of a dependent child, the child's ceasing to meet the qualifications of a "Dependent" under the Plan, he or she can elect to continue existing health coverage for up to 36 months. The maximum period of COBRA Continuation Coverage available to your Dependents is 36 months, even if two or more of the events qualifying them for coverage occur, and is reduced by any periods of time that self-payments were made on their behalf.

- You or your Dependent must notify the Fund Office of any of the following events:
- If you die,

- If you are divorced or legally separated,
- If a beneficiary ceases to meet the definition of a Dependent,
- If a second COBRA-qualifying event (such as your death, divorce or Medicare eligibility or if a beneficiary ceases to meet the definition of Dependent) occurs after a qualified beneficiary has already become eligible for COBRA coverage of 18 months (or 29 months in the case of disability), or
- If the Social Security Administration determines that a qualified beneficiary is disabled or is no longer disabled.

You must give notice to the Fund Office in writing within 60 days from the later of the date the event occurs or the date you will lose coverage as a result of the event. Your notice must identify the Plan, the covered employee and eligible beneficiaries (including full names, social security numbers, addresses and telephone numbers), the event listed above and the date on which it occurred. If applicable, you should also provide a copy of the relevant underlying documents, *e.g.,* the death certificate, divorce decree or disability determination.

In order to protect your family's rights to COBRA continuation coverage, you should also generally notify the Fund Office as soon as practicable of any changes in the addresses of family members.

Your Employer will notify the Fund Office of your death, termination of employment or reduction in your work hours within 60 days from the later of the date the event occurs or the date you will lose coverage as a result of the event. After the notification of the COBRA-qualifying event is received in the Fund Office from you or your employer, you and your Dependents will receive information regarding your rights and the procedures to be used to elect COBRA continuation coverage. The Fund Office will provide you with an election form that must be completed and returned within 60 days of the date your coverage would have been lost or, if later, 60 days after you receive notice of your COBRA rights.

The cost of your COBRA premium is determined according to the cost of providing you coverage at a group rate plus 2% for administration. This amount differs from other self-payment rates which are subsidized by the Fund, and which are tied to multiples of the contribution rates. The COBRA premium is due by the seventh day of each month, with a 30-day grace period.

There are two types of COBRA continuation coverage. The first is called "core coverage" and includes the medical benefits available under the Plan, but does not include Vision Care or Dental Benefits. The second type is called "non-core coverage" and includes Vision Care and Dental Benefits.

You may always elect core coverage, and, if your existing coverage includes both core and non-core coverage, you may elect to continue both. You are responsible for paying the entire cost of COBRA continuation coverage. The Fund Office will notify you of the charge for both the "core" and the "non-core" coverage when you become entitled to COBRA continuation coverage.

Although your COBRA continuation coverage may continue in effect for up to the maximum period described previously in this booklet, it will terminate earlier if:

1. the health care offered by the Plan to all active Employees and their Dependents terminates;

2. you or your Dependents do not pay the premium on time;

3. you or any of your Dependents become covered under another Health Plan unless the plan contains a limitation or exclusion pertaining to any pre-existing condition of that person; or

4. you or any of your Dependents becomes entitled to Medicare.

(**Note:** If you become entitled to Medicare while on continuation coverage and thereby lose your continuation coverage, your Dependents with Plan continuation coverage will not lose their coverage until 36 months after the date of your original qualifying event.)

ALTERNATE COVERAGE

If you do not choose to receive COBRA Continuation Coverage, you may instead elect to continue your medical benefits for up to 24 months by making monthly self-payments to the Fund Office. However, once you elect this alternate coverage, you may not change your mind at a later date and decide to receive COBRA Continuation Coverage.

Alternate coverage is available only if you are unemployed and actively seeking employment in the part of the industry covered by the Plan. If you decline to return to work when work is available, your right to further self-payments for alternate coverage will end.

SUPPLEMENTAL BENEFITS

BASIC DEATH BENEFIT

Employees and Retirees who die for any reason while covered under this Plan are entitled to a Death Benefit as shown in the Schedule of Benefits. If the death is accidental, the amount of the benefit is doubled.

There is an additional Death Benefit for on the job accidents which applies only when an Employee is working in Covered Employment within the geographical jurisdiction of Plumbers Local Union No. 5. For details of this benefit, see the section titled, "Supplemental Insured Occupational Accident Benefits."

Payment will be made to your Beneficiary, upon a submission of a written request (application) for that benefit to the Fund Office accompanied by a copy of your death certificate. Such a request must be made within one year of your death for payment to be made.

You may name anyone you wish as your Beneficiary and you may change your Beneficiary at any time by filling out the proper form. If you do not name a Beneficiary, or if the person named does not survive you, the Plan provides that your Beneficiary will be the surviving person or persons in the first of the following classes:

1. your surviving spouse;
2 your surviving children, (including legally adopted children);
3. your parents;
4. your brothers and sisters; and
5. your estate.

If two or more persons are entitled to benefits, they will be paid equal shares unless you specify otherwise. Your Beneficiary designation does not automatically change because of your divorce, marriage, legal separation or the birth of your child; it can only be changed if your Beneficiary dies before you or if you file a new Beneficiary designation form with the Fund Office. It is your responsibility to review your current Beneficiary designation form and make sure that it accurately reflects your wishes.

If the Death Benefit is payable to a minor, payment will be made to the minor’s legally appointed guardian, or the adult assuming the physical custody and principal support of the child.

Limitation:

No benefits are payable unless a certified copy of the death certificate and written request for benefits is received by the Fund Administrator within one (1) year from the date of the Covered Employee's or Covered Retiree's death.

WEEKLY ACCIDENT AND SICKNESS BENEFIT

The Plan pays you a weekly benefit as shown in the Schedule of Benefits for up to 13 weeks while you have a Disability and are prevented from working on account of a non-occupational accident, Illness, pregnancy or pregnancy-related condition. If the Disability is the result of an Injury, the weekly benefit begins on the first day of Disability. If your Disability results from an Illness that lasts more than seven days, the weekly benefit begins on the eighth day of your Disability. However, if the Illness continues for at least 14 days from the date you become Disabled, the weekly benefit is paid retroactively from the date your Disability began.

Upon receipt of the required claim form and medical evidence, including medical records, benefits are payable for a maximum of 13 weeks for any one Disability. Successive periods of Disability are considered one continuous period of Disability, unless they are due to different and unrelated causes, or unless you return to full-time work for at least two full work weeks. It is not necessary for you to be confined to your home to collect benefits, but you must be under the care of a legally qualified Provider and medical evidence of your Injury or Illness must be provided. No Disability is considered to begin more than one day before your first visit to a Provider. A benefit is not payable if you die before you receive that payment. Also, benefits are not payable for a Disability that results from alcohol or substance abuse. Further, you are not eligible to receive a Weekly Accident and Sickness Benefit while you are an organ transplant donor.

You are not eligible to receive a Weekly Accident and Sickness Benefit if:

- you have not completed 300 or more hours of Covered Employment in the three-month period immediately preceding the month in which the Disability occurs (unless, at the time the disability occurs, you are currently employed, you were actively seeking employment in the industry during the preceding three-month period, and you worked at least 3,400 hours during the preceding three years), or

- are not working in Covered Employment when your Disability begins, or

- you are receiving workers' compensation benefits, or

- you are required to make self-payments to continue your coverage as described elsewhere in this booklet (unless you have completed 300 hours or more of Covered Employment during the three month period immediately preceding the month in which the disability occurs, or at the time the disability occurs you (1) were currently employed; and (2) were actively seeking employment in the industry during the preceding three months; and (3) worked at least 3,400 hours during the preceding 36 months).

A Weekly Accident and Sickness Benefit is payable only during your period of Disability. Once you recover from a Disability, you must notify the Fund Office of your recovery. If you receive disability payments after your recovery, those payments must be returned to the Fund. If an overpayment is made for a period when you are not Disabled, and you do not return these payments to the Fund, that amount plus any interest charge that the Fund may impose will be deducted from your next claim for benefits.

In determining whether you are Disabled or if a Disability is continuing, the Fund reserves the right to request that you submit to a periodic physical examination at the Fund's expense by a Provider selected by the Fund. Your benefit may be terminated if you refuse to undergo a physical examination requested by the Fund.

ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT BENEFITS

The Plan pays you a benefit, as shown in the Schedule of Benefits, if you lose one or more of your hands or feet, or if you permanently lose your sight.

Benefits are paid only if your Injury results in a loss of sight, or one or more limbs within 180 days of the date of the accident. The maximum amount payable for all losses resulting from one Injury is shown in the Schedule of Benefits.

No benefits are paid for losses that result from an Illness, a medical or surgical treatment, bacterial infection (except when it results from an accidental cut or wound), or Injuries that occur while you are working for compensation in non-unionized employment or self-employment in the plumbing and pipefitting industry.

As shown in the Schedule of Benefits, there is also a Supplemental Insured Occupational Accident Benefit for dismemberment or loss of sight as a result of an on-the-job accident. For details of this benefit, see the section titled, "Supplemental Insured Occupational Accident Benefits."

SUPPLEMENTAL WORKERS' COMPENSATION BENEFIT

If you are Disabled because of a work-related injury and are receiving workers' compensation benefits in connection with that injury, you also may be eligible to receive a weekly benefit from the Plan depending on the jurisdiction which is providing the workers' compensation benefits. Benefit levels are generally lower under the Maryland or Virginia workers' compensation laws, as compared to the District of Columbia benefit levels. The Plan provides a supplementary benefit designed to bolster benefit levels if your benefits are payable from Virginia or Maryland, so that your benefits will be approximately equal to the benefits which would have been payable by the District of Columbia.

In order to be eligible for this weekly benefit, you must become Disabled while you are working in Covered Employment within the geographic jurisdiction of Plumbers Local Union No. 5, and you must be working under a Collective Bargaining Agreement between Plumbers Local Union No. 5 and an Employer that requires the payment by the Employer of a supplemental hourly contribution designed to cover the cost of such coverage. Most importantly, your disability must be job related and must result in the actual payment of weekly workers' compensation benefits under the Virginia or Maryland statute. Your Disability must begin within 90 days after your injury and must prevent you from performing all of the duties of your regular occupation in order to make you eligible for these weekly benefits. Your benefits begin on the fourth day of your Disability or, if later, the date you become eligible for workers' compensation benefits as a result of your injury. Once you stop receiving weekly workers' compensation benefits, your weekly benefits under this section automatically end.

If, after one year of receiving the supplemental benefit, you are considered Totally Disabled, the weekly supplemental benefit will end. At that time, you will be eligible for the "Total Disability" benefit described in the section titled, "Supplemental Insured Occupational Accident Benefits."

If you get a lump-sum workers' compensation award or settlement for your work-related injury, your weekly Supplemental Workers' Compensation Benefit stops immediately.

If there is a question about where you should be receiving workers' compensation benefits (in Maryland, Virginia or the District of Columbia) that will make a difference in the amount you receive, the Plan will pay the Supplemental Workers' Compensation Benefit after you sign a written statement agreeing to repay any benefits that are more than the amount you are entitled to once the workers' compensation award to you is actually made.

SUPPLEMENTAL INSURED OCCUPATIONAL ACCIDENT BENEFITS

If you are injured on the job while working in Covered Employment within the geographical jurisdiction of Plumbers Local Union No. 5, you may be eligible to receive supplemental benefits provided through an outside insurance policy provided through Chubb Insurance Company ("Chubb policy"). This section briefly describes the benefits of that policy; for more details of these benefits, contact the Fund Office if you are injured on the job.

All benefits provided as part of the Supplemental Insured Occupational Accident Benefits are subject to the limitations of and governed by the provisions of the Chubb policy.

If any portion of this "Supplemental Insured Occupational Accident Benefits" section is inconsistent with the provisions of the Chubb policy executed to provide such benefits, the provisions of the Chubb policy shall govern.

Supplemental Insured Occupational Accident Benefits, as shown in the Schedule of Benefits, are paid if you die, or lose your sight, speech, hearing or one or more limbs as a result of your work-related injury within one year. These benefits are paid through the Chubb policy.

If you are totally disabled for a year, you will then be eligible for a monthly benefit until your recovery or until a total of $100,000 has been paid, less any amounts paid for dismemberment or loss of sight, speech, or hearing. This monthly payment is paid through the Chubb policy and is subject to all of the terms of the policy.

The Supplemental Insured Occupational Accident Benefits do not cover losses that result from:

- commuting to and from work;
- intentionally self-inflicted injuries or suicide, committed while sane or insane;
- war or act of war;

- illness, pregnancy, childbirth, miscarriage or bacterial infection (except when resulting from an accidental cut or wound); or
- Injuries that you do not file a claim for within one year.

The Chubb policy may also pay you additional benefits related to an on-the-job injury. Contact the Fund Office immediately if you are injured on the job for more information about Supplemental Insured Occupational Accident Benefits.

BASIC BENEFITS

The following section describes the Basic Benefits available to Covered Employees, Non-Medicare Eligible Retirees, and their Dependents. If you are a Medicare-Eligible Retiree, please consult the Humana Summary of Benefits for a description of the medical benefits available to you.

HOSPITAL EXPENSE BENEFITS

Hospital Expense Benefits are paid under this Plan for you and your Dependents, up to the maximum amounts shown in the Schedule of Benefits. Benefits are also paid in connection with pregnancy, childbirth, miscarriage or therapeutic abortion.[4] Separate limits apply to Room and Board Charges, Inpatient Provider Visit Charges, Medical Emergency Charges and Miscellaneous Hospital Charges. No Hospital Benefit shall be payable for medical care that is covered as a benefit under any other provision of this Plan. Prior Authorization, as described on Page 87, is required for all hospital stays except those for Emergency Services.

Covered Hospital Care

Covered Hospital Care includes the following services or supplies furnished in a Hospital or Birthing Center:

- room and board;
- Providers visits;
- operating room fees;
- diagnostic laboratory and pathology tests;
- x-ray examinations;
- kidney dialysis;
- radiotherapy including use of x-ray and other high-energy modalities, radon, radium, cobalt, and other radioactive substances;
- bandages, surgical dressings, casts, splints, trusses, braces, and crutches;
- prescription drugs taken or administered during hospitalization;
- anesthesia and its administration;
- oxygen and its administration;

[4] An abortion is considered therapeutic if the life of the mother would be endangered if the fetus were carried to full term.

- blood plasma, plasma extenders, and blood transfusions;
- services of a licensed physiotherapist;
- services of a dentist for treatment of fractures or dislocations of the jaw including oral surgery and replacement of permanent teeth within 12 months after the date of the Injury that led directly to such condition;
- services of a nurse-midwife;[5]
- ambulance service for emergency transportation of the patient to or from the nearest Hospital or Birthing Center equipped to provide the required medical care; and
- air ambulance service for emergency transportation of the patient to or from the nearest Hospital or Birthing Center equipped to provide the required Medical care.

Ambulance service and air ambulance service as described above shall be covered as a Medical Emergency Benefit and shall be paid as described in the "Medical Emergency Benefit" portion of the Schedule of Benefits. Notwithstanding the preceding sentence, the Plan will cover air ambulance services at 100% of the billed amount in cases where American Health Holding, Inc. (AHH) has determined that the transportation is medically necessary and has negotiated an agreement with an air ambulance service provider to provide the transportation.

Room and Board Benefit

The Plan pays a basic benefit not to exceed actual charges for each Hospital Confinement up to the maximum daily benefit shown in the Schedule of Benefits for semi-private room and board charges. Hospital room and board benefits are limited to a maximum of 70 days of Hospital Confinement for each Injury or Illness in a calendar year.

Charges in excess of the basic benefit for covered Hospital Confinements including intensive care or quarantined private care are paid under the Major Medical Benefit. The amount payable for newborn children is 50% of the room and board charges for the mother while she is confined in the Hospital as a result of the childbirth.

[5] A nurse-midwife is a member of the American College of Nurse-Midwifery who is duly certified to practice midwifery.

Inpatient Provider Visits

The Plan pays for up to one visit per day by no more than two Providers per Hospital, up to the maximum amount shown in the Schedule of Benefits. Benefits are not paid for visits by your surgeon in connection with a Surgical Procedure or post-operative care. Services provided by a nurse-midwife are covered, as long as the nurse-midwife is supervised by a Provider. No benefits will be paid for charges by a Provider in conjunction with the services rendered by a nurse-midwife unless the Provider's services are rendered as a result of a complication of pregnancy. Where a complication of pregnancy occurs, the benefit payable for the combined services of the nurse-midwife and the Provider shall not exceed the maximum listed in the Schedule of Benefits for services of a Provider performing the services. In such cases, priority of payment shall be based on the date that the bill is received by the Plan's claims administrator.

A complication of pregnancy for purposes of this coverage is any of the following:

- surgical operations for extra-uterine pregnancy;
- intra-abdominal surgery after termination of pregnancy;
- confinement in a Hospital for pernicious vomiting of pregnancy;
- confinement in a Hospital for toxemia;
- delivery by cesarean section;
- threatened miscarriage; and
- severe postpartum hemorrhage.

Mothers and Newborns

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 the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child 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 plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Miscellaneous Hospital Charges

The Plan pays a basic benefit for other Hospital charges incurred while you are confined in the Hospital up to the maximum amount per Confinement shown for Miscellaneous Hospital Benefits in the Schedule of Benefits.

Certain Allowable Expenses that are not covered in full by the basic benefit as Hospital Expense Benefits may be paid under the Major Medical Benefit. Coverage includes charges by a Hospital for services and supplies such as the use of an operating room, X-rays, laboratory tests, drugs and medicines, charges for the administration of anesthesia, and professional ambulance service to and from the Hospital.

Periods of Confinement

If you or your Dependents are confined to a Hospital more than once, each Confinement is considered separate if:

- it is due to an entirely different, unrelated cause;
- it is separated from the last Confinement by at least 30 days; or
- you completely recover from the Injury or Illness that resulted in the earlier Confinement.

MEDICAL EMERGENCY BENEFIT

The Plan pays a basic medical emergency benefit, not to exceed actual charges, up to the amount shown in the Schedule of Benefits, for Emergency Services provided to treat Emergency Medical Conditions. Charges that exceed the maximum basic benefit shown in the Schedule of Benefits are payable as Major Medical Benefits.

Coverage for outpatient care under this benefit includes:

- Providers' services;
- Emergency Room charges;
- X-ray, diagnostic and laboratory services; and
- Miscellaneous charges.

Due to the high cost of receiving medical services at a Hospital emergency room, you are encouraged to develop an ongoing relationship with a general practitioner, family practitioner, or a practitioner at the UA Plumbers Local 5 Medical Fund Health and Wellness Center, whom you can see for routine care. If you use the emergency room for routine care, or care for a condition that is not an Emergency Medical Condition (as

defined above to include conditions that a prudent layperson would reasonably believe would risk serious danger to their health), the Plan will not pay any emergency room charges for such care and will only pay other charges to the extent of what the cost would have been if you had received such care in a Provider's office, both of which will greatly increase the amount of out-of-pocket expenses you will be required to pay.

Charges for Emergency Services rendered by a Provider that is out of the CareFirst geographic region ("Out-of-Area Emergency Services") shall not be subject to an out-of-network deductible. Such charges shall be paid first under the Medical Emergency Benefit using the Out-of-Network Rate (rather than the discounts available under the Care First PPO or other Blue Cross/Blue Shield networks). Excess shall be paid at the Out-of-Network Rate as a Major Medical Benefit (including all Covered Expenses).

SURGICAL BENEFITS

You and your Dependents are reimbursed by the Plan for expenses that you pay for a primary surgeon in connection with a Surgical Procedure that is performed in a Hospital, a Provider's office or some other outpatient facility. The maximum amount payable, including benefits for assistant surgeons, is shown in the Schedule of Benefits. Benefits are also payable for Surgical Procedures performed in connection with you or your spouse's pregnancy. For outpatient surgeries, the Surgical Benefit will include coverage of the facility fees up to the Usual, Customary, and Reasonable level and subject to the maximum listed in the Schedule of Benefits.

Surgical services consist of surgeon's fees for all surgeries performed in or out of a Hospital as well as endoscopic procedures (inserting a tube to examine internal organs) including cystoscopy, proctoscopy and sigmoidoscopy. Surgical claims will be paid up to the Usual, Customary, and Reasonable level for the given procedure. Amounts in excess of the allowable amount are covered under the Major Medical provisions of the Plan.

Single Surgeries

The maximum amount payable for any one Surgical Procedure is shown in the Schedule of Benefits and shall not exceed the actual cost incurred for the Surgical Procedure.

Multiple Surgeries

If you or your Dependents have more than one Surgical Procedure done at the same time, the maximum benefit payable depends on the operations performed.

If the Surgical Procedures are done by the same Provider in the same area, the maximum amount you receive is 100% of the Usual, Customary, and Reasonable charges for the first surgery and 50% of the Usual, Customary, and Reasonable charges for each additional surgery.

If the Surgical Procedures are done at the same time but are in different areas of your body or make the surgery more difficult, you are reimbursed for up to 100% of the Usual, Customary, and Reasonable charges for each surgery.

Successive Surgeries

Successive operations are considered a single surgery unless:

- you are completely recovered from the first surgery;
- the surgeries are separated by at least one month;
- the causes of surgeries are entirely unrelated; or
- each surgery is performed on a different part of your body through different incisions.

Second Surgical Opinions

In order to encourage you or your Dependent to seek a second surgical opinion before undergoing elective, non-emergency surgery, the Plan pays the full amount of the fee charged by the second Provider. If a third opinion is required because the second surgical opinion does not confirm the need for the proposed surgery, the Plan also covers those costs in full, up to the maximum amount shown in the Schedule of Benefits. The benefit payable shall not exceed the actual charges incurred, subject to the payment limitations listed elsewhere in this Plan.

No more than two second surgical opinions are covered, and benefits are not paid if:

- the Provider is not certified as a specialist in the field of the surgery;
- the proposed surgery is not covered under this Plan;
- the opinion is provided by someone who can benefit financially depending on the opinion given;

- the Provider does not personally examine you;
- the consultation is in connection with a Surgical Benefit that would not be payable under the Plan; or
- the opinion is provided after the surgery.

Second opinions are not suggested for emergency surgery that must be performed immediately in order to protect the patient's health or life. A second opinion is only necessary for elective, non-emergency Surgical Procedures. The choice to go ahead with the operation is entirely up to you.

Breast Reconstruction

Benefits for breast reconstructive surgery in connection with a mastectomy shall, at a minimum, provide for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage under the major medical prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Oral Surgery

When oral surgery is required as a result of an accidental bodily Injury, the Plan pays up to 100% of the Usual, Customary, and Reasonable charges for the surgical services of a dentist or oral surgeon, up to the maximum amount shown in the Schedule of Benefits.

In addition, up to 100% of the Usual, Customary, and Reasonable charges for surgical benefits, up to the maximum amount shown in the Schedule of Benefits, is payable for oral and maxillofacial surgery, but only when it does not involve a tooth structure, alveolar process, periodontal disease or disease of gingival tissue.

The Plan pays for surgical benefits on behalf of a dentist or oral surgeon if they provide treatment required as a result of an accidental bodily Injury. Surgical benefits are also provided for the following oral surgery procedures:

- the excision of partially or completely unerupted impacted teeth;

- the excision of a tooth root without the extraction of the entire tooth; or
- other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

Surgical and related benefits (e.g., for hospitalization, out-patient services, anesthesia services) are not payable for any other expenses for dental services or oral surgery. The dental benefits provided by the Plan are described later in this booklet.

Cosmetic Surgery

Cosmetic surgery is any operation performed to improve appearance rather than for therapeutic reasons. Generally speaking, cosmetic surgery is not a covered benefit. If, however, such surgery is necessary to correct damage resulting from accidental Injury, mastectomy, or for the correction of a congenital defect, up to 100% of the Usual, Customary, and Reasonable charges, up to the maximum amount shown in the Schedule of Benefits, for such surgery and related Hospital and other medical expenses are covered. In addition, the surgery must be completed within two years after the accident. No other expenses for cosmetic surgery are covered.

Bariatric Surgery

Bariatric surgery is covered under the surgical benefit if the procedure is medically necessary as pre-certified prior to the surgery. Your request for approval of bariatric surgery will be reviewed by American Health Holding, Inc. (AHH) in order to determine whether the planned surgery is medically necessary. AHH's determination will be made on the basis of care guidelines developed in the healthcare industry, which may be changed over time. You may contact AHH if you have questions concerning those care guidelines (see page 116).

Once you or your provider notify the Fund of your intention to undergo bariatric surgery, you may be enrolled in AHH's Bariatric Care Management program, which includes pre- and post-surgery case management. This program will include education and support concerning the surgery, weight loss, and overall health.

The costs arising from pre-surgery medical and psychological screenings, as well as pre-surgery counseling, are covered under the Plan. Post-surgical care costs, including post-surgery case management related to the surgery, are also covered.

DIAGNOSTIC LABORATORY AND X-RAY EXAM BENEFITS

The Plan pays a benefit, up to the maximum amount shown in the Schedule of Benefits, for actual expenses incurred in connection with laboratory or X-ray services that are performed for diagnostic purposes.

Diagnostic Laboratory and Pathology Test and X-Ray Examination Benefits are not payable for:

- dental X-rays, except in the case of an accidental bodily injury to your natural teeth;
- examinations or tests that are not recommended or approved by a legally qualified Provider or surgeon, other than X-ray examinations ordered by a chiropractor; or
- eye examinations.

OUTPATIENT PHYSICIAN VISIT BENEFITS

The Plan pays a basic benefit for each visit made by your Provider in your home or in the Provider's office as a result of an Injury or Illness. The maximum amount payable for Outpatient Provider Visit Benefits each year is shown in the Schedule of Benefits. After you and your Dependents meet the Major Medical deductible for a year, any charges in excess of this maximum amount are paid as a Major Medical Benefit.

Telehealth and other remote care outpatient physician visits shall be covered in the same manner as outpatient physician visits made in your home or in the Provider's office.

No benefits are payable under this section for dental services or treatment, eye examinations, eyeglass fittings, diagnostic X-rays, or visits by a surgeon on or after the date of the surgery.

ANNUAL PHYSICAL EXAMINATION BENEFIT

The Plan pays for the Usual, Customary, and Reasonable expenses that you have in connection with one routine medical examination for yourself or your Dependents in any calendar year, for preventive or administrative purposes up to the maximum amounts shown in the Schedule of Benefits. (Certain annual physical examinations are covered up to 100% of UCR under the Preventive Services Benefit. See below.) An administrative examination is covered if it is done for purposes such as student exams, sports exams, summer camp exams, school exams, driver’s license exams. Any related diagnostic laboratory tests and X-rays are also

covered under this benefit. An examination is covered if it is not connected to a specific Injury or Illness, or if it is not work-related. Physical examinations in a Hospital are not covered under this benefit. An examination of a Dependent within the first 24 months of his or her life is also not covered under this benefit. Examinations during your Dependent's first 24 months of life are covered under the Plan's Well-Baby benefits as described in this booklet.

PREVENTIVE SERVICES BENEFIT

(a) In General

The Plan covers preventive services and supplies in the form of periodic physical exams, routine screening tests, immunizations, and other benefits to the extent required by applicable law. These services are not subject to the Plan's Deductible and are paid in full by the Plan (**100% Coverage**) when provided in-network or up to 100% of the Usual, Customary and Reasonable charge when provided out-of-network**.**

The Plan adheres to certain federal guidelines in determining the preventive services or treatments it will cover. To the extent not already set forth in the guidelines, the Plan may impose reasonable, recognized rules or other limits with respect to the number of visits or treatments it will cover in any given period of time for any one particular preventive service. To the extent any such limits or other rules are inconsistent with applicable law or the guidelines, applicable law or the guidelines will control.

The types of preventive services the Plan covers are described as follows:

(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 (Task Force) with respect to the individual involved.

(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears 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 the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

(4) With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), which will be commonly known as HRSA's Women's Preventive Services: Required Health Care Plan Coverage Guidelines.

A comprehensive list of available preventive services may be found at the following website: www.healthcare.gov/preventive-care-benefits/

The preventive services for which coverage is required by law is updated from time to time and will be deemed to have been incorporated in the Plan by reference. Any change or update to the types of preventive services required by law will take effect with respect to the benefits provided under the Plan on the first day of the Plan Year beginning on or after one year following the date the change or update occurs.

Important Note: To the extent the comprehensive list referenced above is inconsistent with applicable law or the preventive service guidelines, such applicable law or guidelines will control.

(b) Preventive Service Billing Practices

The following rules apply with respect to charging for Physician office visits that include covered preventive services:

(1) If a preventive service is billed separately (or is tracked separately) from an office visit, then this Plan will impose the applicable cost-sharing provisions with respect to the office visit but not for the preventive service;

(2) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then the Plan will not impose the applicable cost-sharing provisions with respect to the office visit; and

(3) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive service, then the

Plan will impose the applicable cost-sharing provisions with respect to the office visit.

(c) Additional Information Regarding Preventive Services

You should also take note of the following restrictions and other conditions related to preventive services:

(1) Preventive services must be billed correctly under the appropriate services codes.

(2) Preventive services may be subject to reasonable medical cost management techniques and standards (e.g., treatment, setting, frequency, and medical management standards) as imposed and altered by the Trustees from time to time.

(3) Preventive services may not be covered depending on the service at issue and the presence of various risk factors.

(4) Preventive services incurred for non-medical reasons (e.g., to maintain a license or employment, as part of judicial or administrative proceedings, a prerequisite for traveling or education purposes) are not covered under the Plan.

(5) A service that is provided to monitor or treat an existing condition and not as a preventive service will be covered to the extent otherwise covered by the Plan and will be subject to the Plan's applicable cost-sharing provisions.

SHINGLES (HERPES ZOSTER) VACCINATION

A (one-time, two dose) Shingrix Shingles Vaccine is covered for all eligible Participants and Dependents age 50 and over as recommended by the Center for Disease Control. A (one-time, one dose) Zostavax Shingles Vaccine is covered for all eligible Participants and Dependents age 60 and over as recommended by the Center for Disease Control. Generally, only one shingles vaccination (either Zostavax or Shingrix) will be covered for each eligible Participant or Dependent; however, if an eligible participant or Dependent received a Zostavax shingles vaccination prior to September 11, 2018, he or she may thereafter receive a (one-time, two dose) Shingrix Shingles Vaccine. The vaccine will be covered under all delivery methods, meaning that you may obtain the vaccine using your prescription drug card and have it administered by your physician or you

may obtain the vaccine at your physician's office, clinic, or other facility providing this vaccine.

HEALTH AND WELLNESS CENTER BENEFIT

The Plan pays 100% of the medical and prescription drug expenses you incur while utilizing the UA Plumbers Local 5 Medical Fund Health and Wellness Centers. The Wellness Centers provide primary care, preventive care, chronic condition management, and limited prescription drug benefits at no cost to Covered Employees, Retirees and their Covered Dependents.

The UA Plumbers Local 5 Medical Fund Health and Wellness Centers are located at:

4755 Walden Lane
Lanham, MD 20706
(240) 436-2840

4475 Regency Place, Suite 206
White Plains, MD 20695
(301) 476-0181

All Employees become eligible to use the Wellness Centers on the first day of the month following the completion of at least 125 hours of work in Covered Employment for which the Fund receives contributions. The names of new Employees covered under this provision must be received in the Fund Office prior to the first day of the first month of eligibility to use the Wellness Centers. Employees are encouraged to notify the Fund when they have worked 125 hours in Covered Employment. When an Employee becomes eligible to use the Wellness Centers, his or her Covered Dependents also become eligible.

Employees will continue to be eligible to use the Wellness Centers for as long as they remain eligible for coverage under the Plan either as an Employee of a Newly Organized Group or under the rules for regular eligibility. If an Employee is not an Employee of a Newly Organized Group and has not qualified for eligibility generally under the regular eligibility rules, he will cease to be eligible to use the services of the Wellness Centers according to the rules for Continuing Coverage set forth on page 25.

An individual will be eligible to receive limited services at the Wellness Centers prior to the completion of at least 125 hours of work in Covered Employment if such individual has been conditionally accepted into the Plumbers & Gasfitters Local 5 Apprenticeship Program with such acceptance conditioned on successful completion of a drug test and a physical exam. Such an individual will be eligible to receive i) one physical

examination, ii) one drug test, and iii) one flu shot at or through the Wellness Centers at no cost to the individual.

For information about the Wellness Center such as operating hours, see https://local5plumbers.org/wellness-center.aspx or call (240) 436-2840 (Lanham) or (301) 476-0181 (White Plains).

MENTAL OR NERVOUS DISORDER TREATMENT BENEFITS

A Mental or Nervous Disorder is a mental, emotional, or behavioral disease or disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders but does not include a substance use disorder otherwise excluded from coverage under the Plan. The Plan covers the treatment of Mental and Nervous Disorders, including, but not limited to the following Medically Necessary professional mental health services:

Outpatient Services:

- Therapy
- Medication management
- Intensive outpatient services and day treatment
- Partial hospitalization services in a licensed hospital

Inpatient Services:

- Hospitalization
- Psychiatric residential treatment and residential treatment for eating disorders

Generally speaking, treatment of Mental and Nervous Disorders is covered by the Plan in the same manner as treatment of other medical conditions covered by the Plan. More specifically, inpatient treatment for a Mental or Nervous Disorder is covered under the Hospital Expense Benefit, with costs in excess of the allowance covered as a Major Medical Benefit (including all Covered Expenses) and paid at 80% for in-network care and 60% for out-of-network care (after the deductible is met).

Outpatient office visits for the treatment of Mental Health and Nervous Disorders are covered in the same manner as outpatient physician visits and are paid at 100% for the first $100 per visit, up to $1,500 per year, with the excess paid at 80% for in-network care, 60% for out-of-network care, as a Major Medical Benefit. Other outpatient treatment for Mental or Nervous Disorders is covered as a Major Medical Benefit (including all Covered Expenses) and paid at 80% for in-network care and 60% for out-of-network care (after the deductible is met).

Emergency care for a Mental or Nervous Disorder is covered under the Medical Emergency Benefit, with costs in excess of the allowance covered as a Major Medical Benefit (including all Covered Expenses) and paid at 80% for in-network or out-of-network care (after the in-network deductible is met).

As otherwise set forth in this Plan, this Plan does not cover treatment of Substance Use Disorders, except for certain preventive services without cost sharing, which includes alcohol misuse screening and counseling, depression screening, and tobacco use screening. In addition, the Plan covers treatment of Mental or Nervous Disorders where the need for such treatment was caused or worsened by a Substance Use Disorder.

MAJOR MEDICAL BENEFITS

The following section describes the Major Medical Benefits available to Covered Employees, Non-Medicare Eligible Retirees, and their Dependents. If you are a Medicare-Eligible Retiree, please consult the Humana Summary of Benefits for a description of the medical benefits available to you.

A Major Medical Benefit is payable only for those Hospital, Diagnostic Laboratory and X-Ray, Outpatient Provider Visit, or Physical Examination expenses that exceed the maximum amounts payable under the basic benefit provisions contained in any other sections of this Plan. No benefits are payable for amounts which exceed the Plan's maximum allowable charge, or Usual, Customary, and Reasonable charge for a given service.

With respect to care received from in-network providers, after the annual deductible is met, the Plan pays 80% of Covered Expenses. You are responsible for paying the remaining 20%. With respect to care received from out-of-network providers, after the annual deductible is met, the Plan pays 60% of Covered Expenses. You are responsible for paying the remaining 40%. However, if you received care from an out-of-network provider at an in-network facility, Emergency Services from an out-of-network provider, or out-of-network air ambulance services, the Plan pays the Out-of-Network Rate, and you are responsible for paying 20% of the Recognized Amount. You will also only be responsible for paying 20% of the Recognized Amount if the Fund's provider database mistakenly states that an out-of-network provider is an in-network provider. In some circumstances, however, a provider may charge you an additional amount for the out-of-network services described above if you have given the provider written consent.

This deductible applies separately to each person in your family who is covered under this Plan. However, the maximum deductible amount that can be applied to your entire family in a calendar year is shown in the Schedule of Benefits. Major Medical benefits are included in this maximum deductible amount, but Basic and Surgical Benefits are not.

Medical Out-of-Pocket Expense Maximum

Once your co-pays and other eligible charges that you have paid for covered medical expenses in a calendar year equal the medical out-of-pocket expense maximum shown in the Schedule of Benefits, your covered medical claims will be paid at 100% of the usual, customary and reasonable (UCR) charge for the remainder of the calendar year. This medical out-of-pocket expense maximum is separate from the prescription

drug out-of-pocket expense maximum, and only your co-payments and other eligible charges paid for covered medical expenses will be counted toward the medical out-of-pocket expense maximum.

In addition to the individual out-of-pocket expense maximum, there is a family out-of-pocket expense maximum which applies in the case of an Employee with one or more eligible Dependents.

As shown in the Schedule of Benefits, the Plan has two separate out-of-pocket expense maximums, one for expenses incurred with respect to in-network care and one for expenses incurred with respect to out-of-network care. Expenses paid for out-of-network care cannot be applied to the in-network out-of-pocket expense maximum. Likewise, expenses paid for in network care cannot be applied to the out-of-network out-of-pocket expense maximum. The only exception to these rules is that Covered Expenses for Emergency Services provided by an out-of-network provider or facility, care provided by an out-of-network provider at an in-network facility, and out-of-network air ambulance services will be applied to the in-network out-of-pocket expense maximum.
The following will be combined for purposes of the Out-of-Pocket Maximum: Major Medical Benefits, Surgical Benefits (outpatient surgical facility only), Mental or Nervous Treatment, In-patient Rehabilitation Service Benefit, Non-Institutional Medical Care Benefit, Skilled Nursing Facility Benefit, Organ Tissue Transplant Benefit.

Covered Major Medical Care

Covered Major Medical Care includes the Usual, Customary, and Reasonable charges for the following necessary medical services, supplies and treatments:

- Hospital room and board, medical emergency and miscellaneous charges that exceed the maximum amounts payable under any other section of this Plan. If private accommodations are used, amounts that exceed the Hospital's daily rate for a semi-private room are disregarded unless the room is ordered by your Provider for valid medical reasons;
- The Usual, Customary, and Reasonable fees of a Provider, including fees for home visits, office visits, and telehealth and other remote care visits;
- The services of a registered graduate nurse other than a nurse who ordinarily resides in your home or who is a member of your or your spouse's family;
- Organ Transplant expenses as defined in this booklet;
- Diagnostic services (such as laboratory and X-ray examinations);

- X-ray, radium, or radioactive isotope therapy and chemotherapy;
- Blood transfusions (not including blood plasma) and renal dialysis;
- Injections and immunizations;
- Anesthetics and oxygen, and their administration;
- Casts, splints, trusses, crutches and leg, arm, neck and back braces, but no replacement, adjustment or repair of braces unless replacement is necessary due to the growth of a child;
- The first internal (implant) breast prosthesis or the first external breast prosthesis and first bra for use with external prosthesis following a mastectomy. Additional internal breast prostheses, bras, injections of silicone or other substances or any expenses in connection with the same are not payable. Replacements of external breast prostheses are Covered Expenses but no more frequently than once every three (3) years.
- Rental (or purchase, if purchase is less expensive than rental) of a wheelchair, iron lung, hospital bed or other durable medical or surgical equipment (for all such equipment the Fund pays only the value of the least expensive alternative); and within a reasonable period of time, for the maintenance and replacement of covered durable medical equipment.
- Up to 26 sessions each of visual or speech therapy in a calendar year, as determined to be medically necessary to achieve maximum restorative potential if authorized by a Provider and performed by a licensed, qualified therapist;
- Up to 52 sessions of physical therapy in a calendar year per injury, condition, diagnosis or procedure, as determined to be medically necessary to achieve maximum restorative potential if authorized by a Provider and performed by a licensed, qualified therapist;
- Professional ambulance service but only when used for emergency transportation of the patient to or from the nearest Hospital equipped to provide the required medical care;
- Artificial limbs, eyes and larynx, contact lenses required because of cataract surgery;
- Routine nursery care of a newborn child;
- One physical examination in each calendar year (after payment has been made pursuant to the Physical Examination Benefit described later in this booklet);
- Up to 12 visits per year with a Provider licensed to provide chiropractic services;
- Charges for outpatient Provider visits that exceed the maximum amount payable under the basic benefit provisions as an Outpatient Provider Visit Benefit;
- Wigs in the case of hair loss due to chemotherapy, not to exceed a maximum of $200; and

- Orthopedic shoes or supportive devices for the feet when prescribed for a child for a medical condition.

Expenses Not Covered Under Major Medical

Major Medical Benefits are not payable for:

- services of a dentist in connection with dental care;
- dental prosthetic appliances and fittings (unless required because of an Injury to your natural teeth);
- eye refraction, eyeglasses, or contact lenses (unless medically required as the result of an Injury);
- orthopedic shoes or supplemental devices except when prescribed for a child by a medical condition;
- prescription drugs, unless a person has reached his or her annual Prescription Drug Maximum Benefit;
- treatment for temporomandibular joint (TMJ) dysfunction in adults age 19 or over;
- hospice care;
- physical, speech or vision therapy provided after maximum restorative functioning has been achieved;
- dental or vision care;
- nursing services or other medical care performed by an individual who ordinarily resides in the home or is a related individual;
- inpatient care outside of a Hospital;
- home health care;
- surgical services;
- Death Benefits;
- Accidental Dismemberment or Loss of Sight Benefits;
- Weekly Accident and Sickness Benefits;
- Supplemental Occupational Accident Benefits;
- Medical Reimbursement Allowance;
- Replacement, adjustment or repair of brace, orthopedic shoes, or other supportive device for the feet, except for replacement due to the growth of a Dependent child;
- Spinraza.

No benefits are payable under this section until you and your Dependents meet the Major Medical deductible for the year.

ORGAN/TISSUE TRANSPLANT COVERAGE

Coverage is provided for certain organ/tissue transplants under the Major Medical Benefit subject to the Major Medical Benefit Co-payments and

Deductibles. **Upon receipt by the Fund Office of written prior authorization (page 87),** you may receive coverage of medical expenses related to organ/tissue transplant if the transplant is determined by American Health Holdings (AHH) to be medically necessary and not to be experimental or investigational in nature.

If the donor and recipient are both covered by the Plan, both the donor's and the recipient's expenses are payable. If the donor is not covered by the Plan, but the recipient is, and if the donor has no other coverage for the transplant, both the donor's and the recipient's expenses are payable. If the donor is not covered by the Plan but has alternative coverage for the transplant, and the recipient is covered, the donor's expenses are not payable under this Plan. If the recipient is not covered by the Plan, neither the donor's nor the recipient's expenses will be payable under this Plan.

OTHER BENEFITS

The following section describes Other Benefits available to Covered Employees, Non-Medicare Eligible Retirees, and their Dependents. If you are a Medicare Eligible Retiree, please consult the Humana Summary of Benefits for a description of the medical benefits available to you.

WELL BABY CARE BENEFIT

Benefits are payable for up to ten (10) well-baby routine visits during the first 24 months of life. These ten (10) visits will be covered at 100% of the Usual, Customary and Reasonable charge. A Well Baby Exam consists of a routine (non-diagnostic) medical check-up of a Dependent, performed by a Provider, and related diagnostic laboratory tests and X-rays. Please note once the child has reached age 2, the Physical Exam Benefit will provide coverage for one routine medical exam per calendar year up to the maximums shown in the Schedule of Benefits.

Limitations:

No Well-Baby Examination Benefits shall be payable for:

- More than ten (10) physical examinations during the first 24 months of life for any reason;
- An examination in connection with any Illness or Injury; or
- A physical examination in a Hospital.

Such examinations may be covered otherwise under the Plan, such as under Major Medical, however.

HEARING AIDS

The Fund provides coverage for any claims and charges for hearing aids, limited to a maximum per person for all Covered Services *every three years* of $2,000. If you have not used the maximum amount, the balance may be used for repairs and batteries.

Through a partnership with VSP and Tru Hearing, Participants who purchase hearing aids from a provider who participates with Tru Hearing will receive a discount on their purchase of hearing aid equipment.

DIABETES SELF-MANAGEMENT TRAINING

The Fund provides coverage for **Diabetes Self-Management Training** from a certified diabetes self-management education program pursuant to

a prescription written by your health care provider. An individual will be eligible for such coverage, if, within the last twelve months:

- the patient was first diagnosed as having diabetes; OR
- the patient's treatment changed from taking no diabetes medication to taking diabetes medication, or from taking oral diabetes medication to taking injectable insulin; OR
- the patient has been hospitalized or treated in an emergency room for complications related to diabetes; OR
- the patient has developed or has been determined to be at risk of developing one or more of the following conditions as a complication of diabetes: problems controlling blood sugar, foot problems, eye problems or kidney problems.

The patient should receive 10 hours of education over a 12-month period and an additional 2 hours of training in each subsequent year. Each year of training requires a prescription from a health care provider.

SKILLED NURSING FACILITY COVERAGE

A Skilled Nursing Facility is a Medicare certified institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled or sick persons, is duly licensed and providing 24-hour skilled nursing care by licensed, qualified registered nurses (R.N.) or licensed, qualified therapists, acting within the scope of their licenses.

No services provided in a Skilled Nursing Facility will be covered under this Plan except:

- as an alternate to hospitalization in an acute care facility;
- as part of a continuation of the care for treatment of the Illness, Injury or conditions which required the prior Hospital stay;
- upon receipt by the Fund Office of written prior authorization (see page 87); or
- services provided to a Covered Person prior to his or her achieving the maximum restorative potential.

Coverage is limited to a lifetime maximum of 100 days of post-Hospital Skilled Nursing Facility care in a Skilled Nursing Facility, as defined above, with a daily allowance provided up to the amount indicated in the Schedule of Benefits. Covered charges in excess of the daily allowance are paid under the Major Medical Benefit.

HOSPICE BENEFITS

Hospice benefits are provided to eligible participants who have been diagnosed as reaching the end stages (last six months) of a terminal Illness, as a more humane alternative to traditional treatment approaches. **Hospice benefits are covered if provided pursuant to a written treatment program established by a certified, licensed hospice care facility and upon receipt by the Fund Office of written prior authorization (page 87)**. The Plan provides for comprehensive hospice benefits including home health services, physical and respiratory therapies, services of a Provider licensed to provide home health or nursing services, nutritional counseling, counseling services (up to six visits) by a certified social worker, and up to 5 days of respite care. Once a hospice treatment plan is adopted, only services provided pursuant to that plan shall be considered for payment by the Plan. The benefit payable shall not exceed the actual charges or, if less, the Usual, Customary, and Reasonable charge for the Covered Expenses, up to the maximum listed in the Schedule of Benefits.

The period of hospice benefits shall be 180 days, but may be extended by the Trustees subject to medical review.

No Hospice Benefits are payable for care that you or your Dependents receive from a volunteer, anyone who normally does not charge for their services, for services which could have been performed by a member of your household, or for care that is not authorized in advance by the Fund.

REHABILITATION SERVICE BENEFIT

Rehabilitation benefits are covered for Plan participants who no longer require the level of services provided in an acute care (Hospital) facility, but who still require intensive physical therapy. Upon receipt by the Fund Office of written prior authorization (page 87), participants in need of short-term (ten weeks or less) rehabilitative services may receive them from a licensed, certified physical therapist in a licensed rehabilitation facility, extended care, or Skilled Nursing Facility, as an alternative to Confinement in a Hospital.

No benefits are provided under this section of the Plan for:

- therapy services provided by anyone other than a Provider licensed to provide physiatric or physical therapy services; or
- services provided after the patient has achieved his or her maximum restorative potential.

In addition, no rehabilitative services will be covered under this Plan except:

1. as an alternate to hospitalization in an acute care facility;

2. as part of a continuation of the care for treatment of the Illness, Injury or conditions which required the prior Hospital stay; and

3. upon receipt by the Fund Office of written prior authorization (page 87).

Coverage is limited to a maximum of 10 weeks of post-Hospital rehabilitative care per Illness, Injury or condition with a daily allowance provided up to the amount indicated in the Schedule of Benefits. Covered charges in excess of the daily allowance are paid under the Major Medical Benefit.

NON-INSTITUTIONAL MEDICAL CARE BENEFIT

In addition to the benefits previously described, the Plan also provides coverage for non-institutional medical benefits designed to encourage participants to utilize less expensive alternatives to hospitalization. The maximum amount payable is shown in the Schedule of Benefits, subject to the Major Medical Deductible.

Non-Institutional Medical Care Benefits include:

- skilled medical services;
- continuous, active and skilled nursing care, such as dressing changes, injections and monitoring of vital signs;
- physical, respiratory, or inhalation therapy;
- visits by a licensed social worker;
- prescription drugs;
- medical supplies and other charges that would have been paid if you or your Dependents were hospitalized, up to the maximum number of days and the amount shown in the Schedule of Benefits.

Nursing care services and therapy are only covered if they are provided by a Provider licensed to provide such services.

In order to receive this benefit, your Provider must certify in writing that you or your Dependent is under his or her continued care and, without the

non-institutional care, you must be hospitalized or placed in a skilled nursing facility. The agency that you are to receive the services from must submit a detailed written plan of treatment indicating the need for such services.

This benefit may be extended up to an additional 30 calendar days if an updated, detailed, written plan of treatment indicating the necessity of the additional days is submitted by your Provider and approved prior to the services being rendered. As with all non-institutional medical care benefits under the Plan, no benefits will be paid for expenses that are incurred prior to authorization being given by the Plan.

Non-Institutional Medical Care Benefits are not payable unless the Fund Office receives written prior authorization, and the care begins within 30 days after the authorization is received. Further, the services must be performed in your home, by someone who is not related to you and who does not normally reside in your home, and in accordance with a written plan submitted by a Medicare certified home health agency. In addition, benefits are not payable for:

- non-institutional care services if pre-authorization for such services is not obtained from the Plan;
- nursing services or services of a home health aide in excess of 12 hours per day;
- skilled nursing care in excess of 8 hours per day;
- more than two visits by a licensed social worker, except for outpatient mental health services;
- services provided by someone who normally lives in your home, or a member of your family;
- routine maternity care;
- housekeeping services (such as meal preparation, babysitting, and acting as a companion);
- visits by your Provider;
- intermittent care of a stable condition, or an initial medical evaluation used to establish the feasibility of a non-institutional medical care plan;
- custodial care;
- routine monitoring of a medical condition or an initial medical evaluation; or
- services performed outside the covered person’s residence.

Prior Authorization Required for Certain Benefits

The Plan requires you to obtain prior authorization before obtaining certain benefits, including, but not limited to, organ/tissue transplant benefits, skilled nursing facility benefits, hospice care benefits, rehabilitation service benefits, non-institutional medical care benefits, bariatric surgery benefits, and inpatient care for medical or mental health treatment. American Health Holding, Inc., (AHH) reviews all medical and mental health claims that require prior authorization. When prior authorization is required, you or your provider must contact AHH at (800) 641-5566. Prior authorization is not required in connection with Emergency Services.

If you or your Dependents fail to comply with the pre-certification or prior authorization requirements established by the Board of Trustees to assure that the care being provided is appropriate and necessary, benefits payable under this Plan may not be paid.

PRESCRIPTION DRUG BENEFITS

The following section describes the prescription drug benefits available to Covered Employees, Non-Medicare Eligible Retirees, and their Dependents. If you are a Medicare-Eligible Retiree, please consult the Humana Summary of Benefits for a description of the Prescription Drug Benefits available to you.

Pharmacy

The Plan pays for certain drugs that are prescribed by your Attending Provider, after you pay the co-payment shown in the Schedule of Benefits and described more fully below. This co-payment must be paid for each prescription or refill that you receive. This Prescription Drug Benefit is administered by Express Scripts, Inc.

Generally, each prescription or refill filled at a retail pharmacy entitles you a 30-day supply, but in no case more than a 34-day supply. However, you can fill up to a 90-day supply through Express Scripts' Home Delivery Pharmacy or through a participating CVS Pharmacy.

Covered prescription drugs are medically necessary drugs that cannot be legally dispensed without a prescription ("legend drugs"), including injectable insulin, or other state-controlled drugs that, by law, must be prescribed by a Provider. The Plan covers the cost of drugs prescribed for Mental or Nervous Disorders as any other prescription drug (other than drugs prescribed for the treatment of Substance Use Disorder, which are excluded under this Plan).

Covered prescription drugs also include compound medications, of which at least one ingredient is a legend drug in a therapeutic amount requiring a prescription, provided that the legend drug is otherwise covered under this benefit.

If you or your Dependent has a prescription filled or refilled at a pharmacy that has an agreement with Express Scripts (In-Network pharmacy), the Plan pays for the total cost of the prescription or refill (minus the co-payment). Express Scripts' National Network contains more than 64,000 retail pharmacies, including national chains and independent pharmacies.

If you or your Dependent has a prescription filled or refilled at a pharmacy that does not have an agreement with Express Scripts (Out-of-Network pharmacy), you must pay the entire cost of the prescription or refill. The Plan will reimburse you for the excess over the co-payment amount up to the amount that would have been incurred if you had obtained the

prescription from a pharmacy that does have an agreement with Express Scripts, if you submit a form to the Fund Office requesting the reimbursement.

Participants taking maintenance medications will be permitted three (3) "fills" of the prescription at the retail level. All further "fills" must be obtained through Express Scripts' Home Delivery Pharmacy or through a CVS pharmacy. "Maintenance drugs" are drugs which are prescribed for an extended period of time for a long-term condition. Examples are drugs used to treat high blood pressure, diabetes and arthritis.

If you fill your prescription through a federal agency pharmacy (such as the Veterans Affairs or Department of Defense dispensing facility) that requires you to obtain a supply in excess of the limit permitted for retail fills (e.g., a 90-day supply) as a condition of filling your prescription, you will be charged the applicable co-payment for the drug for each 30-day supply. Thus, for example, if you fill your prescription at the VA pharmacy and are required to obtain a 90-day supply, you will not pay more than three retail co-payments.

Prior Authorization

Coverage for certain prescription drugs will only be provided by the Fund if a prior authorization is obtained from Express Scripts by the prescribing provider. To determine whether prior authorization is needed for a particular drug or to initiate the prior authorization process, your provider should contact Express Scripts at 1-800-753-2851.

Home Delivery Pharmacy/CVS Pharmacy for 90-Day Supply

You and your Dependent(s) may receive up to a 90-day supply of maintenance drugs through Express Scripts' Home Delivery Pharmacy (for one co-pay) or from a CVS pharmacy. As noted above, Express Scripts' Home Delivery Pharmacy or CVS pharmacy must be used after three "fills" of a maintenance drug at the retail level. The co-payments are set forth in the Schedule of Benefits and are described more fully below. To learn more about how to fill your prescription through the Home Delivery Pharmacy, visit express-scripts.com or contact Express Scripts Member Services at 800-817-8082.

Express Scripts Exclusive Specialty Program/Accredo

Specialty medications are drugs, including infused or injectable medications, that usually require close monitoring and special storage.

Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

The Express Scripts Exclusive Specialty Program is designed to provide personalized care, education and support needed to obtain the full benefit of your treatment with specialty medications. If you are taking certain medicines, you can use Express Scripts' specialty pharmacy, Accredo, to get your medicine. All "fills" of non-urgent specialty medications must be obtained through Accredo. For medications that may require an immediate start, you may obtain the first "fill" at a retail pharmacy, and all subsequent "fills" through Accredo.

If you are taking a specialty medication, you will receive more specific information about this benefit.

Express Scripts' Compound Management Program

Compound drugs are medications made by combining, mixing or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available. Certain ingredients used in compound drugs are excluded from coverage. If you are prescribed a compound drug containing an ingredient that is excluded from coverage, you may be responsible for paying the cost of the entire prescription. To determine whether a particular compound drug ingredient is covered by the Plan, visit express-scripts.com or call Express Scripts Member Services at 800-817-8082.

Prescription Drug Out-of-Pocket Expense Maximum

Once your co-pays for covered prescription drugs in a calendar year equals the prescription drug out-of-pocket maximum shown in the Schedule of Benefits, your covered prescription drug claims will be paid at 100% of the Pharmacy Benefit Manager's repriced claim amount for covered prescription drugs for the remainder of the calendar year. This out-of-pocket limit is separate from the medical out-of-pocket expense maximum, and only your co-payments for covered prescription drugs will be counted toward the prescription drug out-of-pocket expense maximum.

In addition to the individual out-of-pocket expense maximum, there is a family out-of-pocket expense maximum which applies in the case of an Employee with one or more eligible Dependents.

Exclusions and Limitations

Prescription Drug Benefits are not paid for:

- a non-legend patent or proprietary drug, medicine or medication not requiring a prescription, except for the influenza vaccine Tamiflu (in any form available) and insulin. Prescribed compound drugs may be covered; however, any compound prescription containing an excluded from coverage will not be covered;
- a therapeutic appliance, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of the intended use, except paraphernalia necessary for the administration of insulin or the monitoring of blood sugar;
- blood or blood plasma, biologicals or immunization agents;
- an experimental drug or drug limited by federal law to investigational use;
- the administration of injectable insulin;
- a medication, legend or non-legend, that is consumed or administered at the place where it is dispensed;
- a medication that is to be taken or administered, in whole or in part, while the Covered Person is in a Hospital, rest home, sanatorium, extended care facility, convalescent or nursing home or similar institution;
- a refill that exceeds the number of refills specified by the Provider;
- a refill dispensed after one (1) year from the date of the order of the Provider;
- a prescription in excess of a thirty-four (34) day supply, except if provided through Mail Order;
- a prescription drug that may be properly received without charge under local, state or federal programs, including a workers' compensation law;
- vitamins, mineral or dietary supplement, except hematinics (including vitamin B-12 injections), prenatal vitamins, pediatric vitamins, and vitamin D products;
- tretinoin drugs, except for children up to age 19 (or, for individuals age 20 or older, if prior authorization on the basis of medical necessity is obtained);
- anorexiants, unless prescribed for the treatment of a mental health condition covered by the Plan;
- allergy extracts;
- injections except for insulin, bee sting kits, imitrex, glucagon, lupron, and interferons;

- drugs for sexual dysfunction or inadequacy, except for up to 6 pills/month for erectile dysfunction after a certification from Express Scripts that such drugs are medically necessary;
- devices for birth control or drugs for infertility;
- any prescription in excess of $1,000 without authorization;
- drugs that are dispensed from a Provider's office or from a location other than an outpatient pharmacy or a licensed pharmacy;
- cosmetics or beauty aids;
- all Non-Sedating Antihistamines ("NSAs") available over-the-counter; all other NSAs are subject to the highest tier copayment under the Plan;
- certain topical analgesics and patches (for a complete list of excluded analgesics, contact ESI at 800-817-8082);
- medication prescribed to treat substance use disorder as defined under the current Diagnostic and Statistical Manual of Mental Health Disorders. (However, the Plan will cover medications prescribed for medical and mental health conditions even if the need for such treatment was caused or worsened by substance use disorder).

Co-Payments

The co-payments vary, depending on whether you choose to obtain a generic, formulary, or non-formulary prescription. Categories of co-payments are explained below. Co-payment amounts for each category are set forth in the Schedule of Benefits.

A ***Generic*** drug is one that is chemically similar to the brand name drug and becomes available once the patent for the brand-name drug has expired. It is typically less expensive.

A ***Formulary*** drug is a brand-name drug that Express Scripts has identified and included on its internal Formulary list. The Formulary is a list of preferred medications that are safe, effective and economical. The Express Scripts Formulary was developed by an expert panel of pharmacists and physicians. These medications are clinically effective and cost-effective to help manage prescription costs without affecting the quality of care. If your doctor prescribes a Formulary drug for which there is a generic equivalent, you will be required to pay the Formulary co-payment, as well as the difference in the ingredient cost between the Formulary drug and the generic drug. To determine the status of any particular drug on the Plan's formulary, log onto express-scripts.com or contact Express Scripts Member Services.

A ***Non-Formulary*** drug is a brand-name drug that does not appear on the Express Scripts formulary List. If your doctor prescribes a Non-Formulary drug for which there is a generic equivalent, you will be required to pay the Non-Formulary co-payment, as well as the difference in the ingredient cost between the Non-Formulary drug and the generic drug.

An ***Excluded*** drug is a brand-name drug that appears on a list of excluded medications provided by Express Scripts and subject to change from time to time. Excluded drugs are not covered and will not be reimbursed by the Plan.

Your provider may request an exception to the formulary exclusion. In this case, Express Scripts will contact your provider for information to determine if the conditions of coverage are met for an exception to the formulary exclusion.

Medicare Part D

The Medicare Prescription Drug Improvement and Modernization Act of 2003 added a prescription benefit for Medicare-eligible participants called Medicare Part D. The Plan provides Medicare-eligible participants with a Medicare Part D Prescription Drug Plan through the Humana Medicare Advantage Medical and Prescription Drug Plan (MAPD Plan).

Medicare-eligible participants are automatically enrolled in the Medicare Part D Prescription Drug Plan. Participants may opt-out of this coverage; however, those who opt out of this coverage will not be eligible for prescription drug benefits from the Plan.

To learn more about the Plan's Medicare Part D Prescription Drug Plan, please consult the Summary of Benefits and Evidence of Coverage you received from Humana or call Humana at 800-733-9064.

DENTAL BENEFITS

United Concordia Dental Network

The United Concordia network of Participating Dentists is available for your use.

Choice of Dentist

You may choose any licensed dentist for services to be covered by the Plan. However, you will limit your out-of-pocket cost if you choose a United Concordia Participating Dentist ("Participating Dentist"). Participating Dentists accept their negotiated allowance as payment in full for Covered Dental Services. If you use a United Concordia Participating Dentist, your out-of-pocket cost will be limited to deductibles and amounts exceeding the program maximum. Participating Dentists will also complete and send claims directly to United Concordia.

If you go to a dentist who does not participate in United Concordia's network (a "Non-Participating Dentist"), you may have to pay the Non-Participating Dentist at the time of service. You will also have to pay the difference between the Non-Participating Dentist's charge and the amount that the Plan allows, in addition to any applicable deductible. You may have to submit the claim and wait for United Concordia to reimburse you.

To find a Participating Dentist, go to "Find a Dentist" on United Concordia's website at www.UnitedConcordia.com/ep or telephone United Concordia at 1-866-851-7568.

When you visit the dental office, let your dentist know that you are covered under a United Concordia dental program. If your dentist has questions about your eligibility or benefits, instruct the office to call United Concordia's Interactive Voice Response System at 1-866-851-7568 or visit Dental Inquiry at www.UnitedConcordia.com/dental-insurance/dentist.

Payment for Dental Services

After you and your Dependents meet the applicable Dental Deductible for a year as shown in the Schedule of Benefits, the Plan pays for Covered Dental Services for you and your Dependents, up to the maximum amounts shown in the Schedule of Benefits. The Dental Deductible

applies to all Covered Dental Services except examinations, X-rays, emergency treatments, charges for prophylaxis or fluoride treatments, sealants, and space maintainers.

Under the Plan's dental benefit, the Plan covers only those items and services that are listed in the Dental Fee Schedule. These are referred to as "Covered Dental Services." Dental benefits are not payable for any item or service that is not listed on the Dental Fee Schedule. A copy of the Dental Fee Schedule is available from the Fund Office. The Fee Schedule is subject to change upon the approval of the Trustees. The per person annual maximum does not apply to Covered Dental Services received by Participants and Dependents under age 19.

In network: Subject to the Dental Deductible, if you or your Dependents receive Covered Dental Services from a Participating Dentist, the Plan pays for the services in full up to the annual per person maximum amount shown in the Schedule of Benefits.

Out of Network: Subject to the Dental Deductible, if you or your Dependents receive Covered Dental Services from a Non-Participating dentist, the Plan pays 80% of the fee shown on the Dental Fee Schedule, up to the annual per person maximum amount shown in the Schedule of Benefits. Non-Participating dentists may bill you or your Dependents for any difference between their charge and the amount paid by the Plan. If the dentist's charge is less than 80% of the dental fee schedule, the Plan pays the charge amount.

Predetermination

A predetermination confirms that dental services you are about to receive are covered under the Plan. It helps you estimate any out-of-pocket expenses you may incur by calculating the total amount you owe and what the Plan will cover. It also notifies you of alternate treatment options covered by the Plan. We encourage you to ask your dentist to submit a predetermination to United Concordia for any procedure that exceeds $300. A predetermination is not a guarantee of payment-it is only an estimate of what you can expect to owe.

Covered Dental Expenses

The Plan pays for dental items and services that are Covered Dental Services when they are recommended and provided by a licensed dentist. Covered Dental Services include:

- Oral evaluations, including exams, x-rays, cleanings and fluoride treatments, sealants, palliative treatment (in emergency), and space maintainers
- Basic restorative services (e.g., fillings)
- Endodontics
- Non-surgical periodontics
- Repairs of crowns, inlays, and onlays
- Repair of bridges
- Denture repair
- Simple extractions
- Surgical periodontics
- Complex oral surgery
- General anesthesia, nitrous oxide, and IV sedation
- Inlays, onlays, and crowns
- Prosthetics (e.g., bridges, dentures)

For a full list of Covered Dental Services, see the Dental Fee Schedule. **Dental services and supplies that are not listed on the Dental Fee Schedule are not covered by the Plan.**

Limitations

The following limitations apply to Covered Dental Services:

- Full mouth x-rays - one (1) every 5 year(s).
- Bitewing x-rays- one (1) set(s) per 12 months.
- Oral Evaluations:
    - Comprehensive and periodic- one (1) of these services per 120 days. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations- one (1) of these services per dentist per patient per 120 days.
    - Detailed problem focused - one (1) per dentist per patient per 120 days.
- Prophylaxis - one (1) per 120 days.
- Fluoride treatment- one (1) per 120 days.
- Space maintainers - one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

- Sealants - one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
- Prefabricated stainless steel crowns - one (1) per tooth per lifetime for Members under age fourteen (14).
- Periodontal Services:
    - Full mouth debridement - one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy -two (2) per 12 months in addition to routine prophylaxis.
    - Periodontal scaling and root planing- one (1) per 36 months per area of the mouth.
    - Surgical periodontal procedures - one (1) per 36 months per area of the mouth.
    - Guided tissue regeneration - one (I) per tooth per lifetime.
- Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations - not within 24 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch- not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
- Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (I) every 3 year(s) thereafter.
- Pulpal therapy - one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
- Root canal retreatment - one (1) per tooth per lifetime.
- Recementation - one (1) per 36 months. Recementation during the first 12 months following insertion of any preventive, restorative or prosthodontics service by the same dentist is included in the preventive, restorative or prosthodontics service benefit.
- An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment

recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

- Intraoral Films:
    - Periapical - four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal - two (2) per 24 months under age eight (8).
- General anesthesia and IV sedation: a total of sixty (60) minutes per session.

Dental Exclusions

Dental items and services not listed in the Dental Fee Schedule are not covered by the Fund. Below is a non-exhaustive list of items and services that are not covered by the Fund under the dental benefit (though in some instances below the excluded items are covered by the Fund as medical benefits):

- Orthodontic care, except for preventive services such as insertion of space maintainers, or services and appliances needed as a result of the bony impacting of a permanent tooth.
- Dental benefits are not payable for comprehensive orthodontic treatment or any other services or appliances of an orthodontic nature.
- Dental services started prior to the Participant's Effective Date or after the Termination Date of coverage under the Plan (for example, but not limited to, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
- House or hospital calls for dental services and for hospitalization costs (facility-use fees).
- Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Participant is entitled to payment under an automobile insurance policy. The Plan's benefits would be in excess to the third-party benefits and therefore, the Plan would have right of recovery for any benefits paid in excess.
- Prescription and non-prescription drugs, vitamins or dietary supplements which are Cosmetic in nature as determined by the Plan Administrator (for example, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

- Elective procedures (for example, but not limited to, the prophylactic extraction of third molars).
- Treatment for congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
- Dental implants and any related surgery, placement, restoration, and prosthetics (except single implant crowns).
- Maintenance and removal of implants unless specifically covered.
- Diagnostic services and treatment of jaw joint problems by any method other than those specific TMJ services listed on the fee schedule as covered services.
- Treatment of fractures and dislocations of the jaw.
- Treatment of malignancies or neoplasms.
- Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- Preventive restorations.
- Periodontal splinting of teeth by any method.
- Duplicate dentures, prosthetic devices or any other duplicative device.
- Services for which in the absence of dental benefits under a plan the Member would incur no charge.
- Plaque control programs, tobacco counseling, and oral hygiene instructions.
- Treatment for any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
- Any claims submitted to the Plan Administrator by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
- Incomplete treatment (for example, but not limited to, patient does not return to complete treatment) and temporary services.
- Procedures that are:
    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.

- Specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
- Fees for broken appointments.
- Treatments that are not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan Administrator will apply.

TEMPOROMANDIBULAR JOINT DYSFUNCTION BENEFITS

Temporomandibular Joint (TMJ) Dysfunction Benefits are payable for you or your Dependents, up to a lifetime maximum as shown in the Schedule of Benefits and subject to the dental deductible. Expenses in excess of this maximum amount are not payable under the Major Medical, Dental Benefits, or any other section of the Plan. The lifetime maximum does not apply to pediatric TMJ Dysfunction Benefits.

VISION BENEFIT

The Plan pays for examinations by optometrists or ophthalmologists, and prescription eyeglass lenses and frames for you and your Dependents, up to the maximum amounts shown in the Schedule of Benefits. Charges for contact lenses that are needed because of cataract surgery are paid under the Major Medical Benefit. Vision screenings for children required to be covered as a Preventive Service shall be paid at 100%.

If you or your Dependents receive care from an optometrist who has a preferred provider agreement with the Plan through its participation with VSP's Premier Network, the Plan will pay for eye examinations, frames and lenses in accordance with the Schedule of Benefits.

Anti-reflective coating and progressive eyeglass lenses are included at no additional charge in the lens allowance shown in the Schedule of Benefits.

The vision plan of benefits through Vision Service Plan (VSP) covers the cost of one pair of prescription safety glasses every 24 months (subject to the co-payment shown in the Schedule of Benefits). This coverage is for Employees only and is not available to Dependents. Benefits include a covered-in-full safety frame from the ProTec Eyewear® collection, along with prescription lenses that meet current ANSI (American National Standards Institute) impact-protection standards. If you wish to take advantage of this benefit, call VSP at 1-800-877-7195 or access the VSP

website at www.vsp.com to find a provider who offers safety eyewear and carries the ProTec Eyewear® collection.

Participating providers in VSP's Premier Network also offer a discount to the Plan's participants toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames). Additionally, the Plan's participants are entitled to receive discounted professional fees for elective contact lens evaluations and fittings from VSP Participating Providers. Discounts are applied to the Participating Provider's usual and customary fees for such services and are available within twelve (1) months of the covered eye examination from the participating provider who provided the covered eye examination. Contact your VSP Participating Provider to learn more about these additional discounts. Discounts do not apply to vision care benefits obtained from non-VSP Participating Providers.

If you or your Dependents receive care from a non-VSP Participating Provider (one who does not have a preferred provider agreement with the Plan), the Plan pays for one eye exam and set of lenses, if needed, every 12 months, up to the specific amounts shown in the Schedule of Benefits.

The Fund also offers a Low Vision Benefit. This provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If you fall within this category, you will be entitled to professional services as well as ophthalmic materials, including but not limited to supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids. Supplemental testing, which includes evaluation, diagnosis and prescription of vision aids where indicated, is covered in full when you receive care from a VSP Participating Provider, and covered up to $125 when you receive care from a non-VSP Participating Provider. Supplemental aids are covered up to 75% of cost. Your maximum Low Vision Benefit is $1,000 every two (2) years. There are certain limitations on Low Vision Care. Check with your Provider.

A list of those optometrists and ophthalmologists who have preferred provider agreements with the Plan as part of the VSP Premier Network is available from the Fund Office, or by calling VSP at 1-800-877-7195 or accessing the VSP website at *www.vsp.com.* The Premier Network includes providers such as Visionworks, Costco, and Walmart/Sam's Club.

Vision Exclusions

No Vision Benefits are payable for:

- Optional cosmetic processes;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Sunglasses;
- Lenses or frames that are not prescribed;
- Post-cataract lenses;
- Photo chromic lenses, tinted lenses except Pink #1 and #2;
- Orthoptics or vision training; any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Prescriptions that are filled after 90 days;
- Costs of services and/or materials above Plan Benefit allowances provided in this Summary Plan Description;
- Services/materials not indicated as covered Plan Benefits in this Summary Plan Description

MEDICAL REIMBURSEMENT ALLOWANCE

Each active or retired participant, including surviving spouses, disabled employees, and self-pay participants, will receive an allowance for the purpose of reimbursing the participant for expenses incurred during the calendar year which are not covered by the Plan or any Other Health Plan. This allowance is called a Medical Reimbursement Allowance (MRA). Although there are not separate allowances provided for your Spouse and Dependent children covered by the Plan, their expenses will also be reimbursable through your MRA, given that they meet the requirements for eligibility. *The Medical Reimbursement Allowance is not available to Employees in Newly Organized Groups.*

Each year the Trustees will determine whether or not an MRA will be available for the following year, and if so, the amount of the allowance. This benefit can be terminated by the Trustees at the end of any calendar year. If a Medical Reimbursement Allowance is to be offered in a given year, the Trustees will provide an announcement to all Participants prior to the start of that year. This notice to the participants will contain all details regarding the amount of the allowance, eligible participants, expenses eligible for reimbursement, and claim filing procedures.

You may use your MRA to be reimbursed for eligible health care expenses which are now only partially reimbursed or are not covered under the Plan. Such expenses, as defined under Section 213 of the Internal Revenue Code, include deductibles, co-payments, charges over the Usual, Customary, and Reasonable amount, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services.

To be eligible for reimbursement, the expenses must be:

- incurred between January 1 and December 31 of the MRA calendar year;
- incurred while you are a Participant in the Plan;
- submitted while you are a Participant in the Plan;
- submitted for reimbursement on or before March 31st of the calendar year following the year the expenses were incurred; and
- properly submitted to the Fund Office with a copy of the Explanation of Benefits, the bill from the provider, and other acceptable proof that you paid the expenses and that they were not reimbursed by this or any other plan. The Eligible Employee or Retiree shall also provide a written statement that the expense has not been reimbursed or is not reimbursable under any other Health Plan coverage and if reimbursed from the Medical

Reimbursement Allowance such amount will not be claimed as a tax deduction.

You may submit a claim to the MRA at any time during the calendar year after you have accumulated the full amount of the MRA in claims eligible for reimbursement from the MRA. Any amounts under the full amount may be submitted only after the end of the year.

If an Eligible Employee or Retiree dies prior to submitting a claim to the Fund Office for eligible health care expenses that would be Eligible Medical Expenses except for the death of the Employee or Retiree, the expenses will be considered Eligible Medical Expenses and payment will be made to his or her estate. In such cases, the reimbursement claim must be completed and submitted to the Fund Office by either the surviving spouse or dependent of the Eligible Employee or Retiree, or by a representative of his or her estate.

Remember, all claims for a given calendar year must be submitted by March 31st of the following year or any remaining balance will be forfeited.

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions apply to benefits available to Covered Employees, Non-Medicare Eligible Retirees, and their Dependents. If you are a Medicare-Eligible Retiree, please consult the Humana Summary of Benefits for a description of exclusions and limitations under the MAPD Plan.

The following are not Covered Expenses and cannot be considered for any purpose under this Plan (except as allowed for reimbursement through the Medical Reimbursement Allowance, if available):

1. Expenses incurred while you or your Dependents are not covered by this Plan;
2. An Injury or Illness for which benefits are covered under a workers' compensation or similar law except to the extent benefits may be payable under the Plan's Supplemental Occupational Accident Benefit;
3. An Injury or Illness that arises out of or in the course of any occupation or employment for wage or profit;
4. Cosmetic, plastic or reconstructive surgery and any other surgical procedures not covered under the Plan, except to repair or alleviate damage resulting from or caused by:
   a. Accidental injury
   b. Congenital defect
   c. Mastectomy or lumpectomy resulting in breast deformity, in accordance with the Women's Cancer Rights Act of 1998, in which case coverage is provided for reconstruction of a breast on which a mastectomy has been performed, and for surgery and reconstruction of the other breast to produce symmetrical appearance;
5. Charges that would not have been made if no coverage existed, or charges that neither you nor your Dependents are required to pay;
6. Charges for services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government except as otherwise required by law;
7. Charges for services or supplies that are furnished, paid for, or otherwise provided for by any local, state or federal government agency, program or institution except community general Hospitals;

8. Charges for services and supplies that are not necessary for treatment of the Injury or disease, except routine physical or administrative examinations;
9. Charges for services and supplies not recommended and approved by the attending Provider as medically necessary or charges to the extent that they are unreasonable or unnecessary;
10. Charges for intermediate or custodial care by nursing homes, rest homes, places for the aged, or convalescent homes;
11. Charges for services or supplies related to weight control and treatment of obesity including gastric by-pass, bubble, stapling, or other such procedure to treat exogenous obesity or a program for treatment of obesity or weight reduction or physical fitness unless such program, service or treatment is a required Preventive Service (page 71); or unless such services meet the conditions set forth in the section titled “Bariatric Surgery Benefit” (page 69). This exclusion shall not apply when such services or supplies are prescribed for the treatment of a mental health condition covered by the Plan.
12. Personal comfort services not essential for treatment of an Illness or Injury, such as telephones, radio and television, air conditioners, humidifiers, beauty and barber services, admission kits, cosmetics, etc.;
13. Orthopedic shoes (except when joined to braces), orthotic devices, arch supports, heel lifts, or elastic stockings except when prescribed for a child’s medical condition;
14. Air purifiers, whirlpool bathing equipment, sun and heat lamps, heating pads, water beds, health club fees and exercise devices;
15. Travel and lodging, even when prescribed by a Provider;
16. Intermediate, Custodial or domiciliary nursing care;
17. Injuries or Illnesses that result while committing a crime or participation in a riot or public disturbance; however, this exclusion shall not apply when such Injuries or Illnesses result from a medical or mental health condition or domestic violence;
18. Third party liability claims, except as shown later in this booklet;
19. Injuries that occur in connection with the operation of, or in the course of falling or in any other manner descending from, an aircraft (including ultra-light craft, hang gliders, etc.), unless you are a fare-paying passenger on a regularly scheduled commercial flight;
20. Organ transplants except as permitted in this booklet;

21. Treatment to correct infertility (including in vitro fertilization) or to reverse voluntary, surgically-induced infertility;
22. Educational or experimental services or supplies;
23. Replacement or repair of internal (implant) breast prostheses and bras for use with external breast prostheses; replacement of external breast prostheses within a three-year period; and replacement or repair of other prosthetic devices within a three-year period, except when needed because of the growth of a dependent child;
24. Occupational, myofunctional or pulmonary therapy;
25. Hypnotism, biofeedback, or stress management, unless prescribed for the treatment of a mental health condition covered by the Plan;
26. Radial keratotomy;
27. Transportation of family members, medical personnel, supplies or equipment;
28. Treatment of sexual dysfunction;
29. Acupuncture;
30. Failure to appear for a scheduled appointment or to provide claim forms or documents;
31. Nonprescription drugs, vitamins, or dietary foods or supplements;
32. Hypodermic needles, syringes or nonmedical substances, except when used in conjunction with insulin injections;
33. Private duty nursing care by a member of the patient's household or family;
34. Stand-by charges for anesthesia, Hospital benefits, or physician's services provided as part of a surgical or maternity procedure for which no services are actually provided to the patient;
35. Medicare Part B premiums and Medicare catastrophic coverage surcharges or surcharges for Covered Employees over age 65 who are Medicare eligible;
36. Whole blood (if not replaced);
37. Treatment for chronic foot conditions, corn paring, or toenail trimming or removal (except for diabetic patients);
38. Wigs, except as related to chemotherapy;
39. Any services or supplies not shown as covered;
40. Care provided in a nursing home, or any other facility that is not a Hospital, except as specifically provided herein;
41. Any benefit not otherwise specifically provided herein;
42. Charges that exceed the Usual, Customary, and Reasonable fee for such service, supply, etc.;

43. Any hospital charges incurred by Medicare-covered participants for treatment of hospital-acquired conditions that Medicare has deemed reasonably preventable and thus non-reimbursable.
44. Care and treatment of grandchildren of Employees.
45. Charges for cloning, gene therapy, and gene therapy drugs (including, but not limited to, Zolgensma and Luxturna).
46. Surgery for the implantation of devices for the treatment of obstructive sleep apnea, including but not limited to Inspire, and other costs associated with the purchase and use of such implanted devices.
47. Treatment of substance use disorder.

SUBSTANCE USE DISORDER EXCLUSION

The treatment of substance use disorder is not covered by the Plan. "Treatment of substance use disorder" is defined as a service or set of services that may include medication, counseling or other supportive services designed to treat substance use disorder as defined under the current Diagnostic and Statistical Manual of Mental Health Disorders. As required by the Affordable Care Act, the Plan will cover Preventive Services related to substance use disorder (page 71). The Plan will also cover treatment of medical and mental health conditions as otherwise provided in this Plan even if the need for such treatment was caused or worsened by substance use disorder.

ROUTINE MEDICAL CARE AS PART OF CLINICAL TRIAL

Although educational or experimental services and supplies are generally excluded from coverage under the Plan, as required by the Affordable Care Act, the Plan will cover routine patient costs for items or services furnished in connection with participation in a clinical trial if those costs would otherwise be covered under the Plan.

"Routine patient costs" has the same meaning as that term is defined in the Public Health Services Act Section 2709 and includes items or services that are otherwise covered under the Plan and are used for the direct clinical management of the patient, but does not include items or services used solely to satisfy the data collection and analysis needs of the clinical trial.

COORDINATION OF BENEFITS

The benefits payable to you under this Plan are "coordinated" with any benefits payable to or on behalf of you or your Dependents for the same expenses from Other Health Plans or Medicare.

Benefits payable for Covered Expenses incurred by a Covered Person who is also eligible for Medicare or entitled to benefits from another Health Plan shall be coordinated so that the total amount payable shall not exceed 100% of expenses incurred. A Covered Person who is eligible for coverage under Medicare with Medicare acting as the primary payer shall be considered covered under Medicare.

In coordinating benefits, the Plan will offset the deductible for spouses who have primary coverage through other sources when a claim is submitted for coordination of benefits. This means that any deductible applied by a primary payer will count toward the deductible for this Plan if coordination of benefits applies and the other plan is the Primary Plan.

COORDINATION WITH OTHER HEALTH PLANS

Benefits are coordinated in the following order:

- A plan covering someone as an employee pays benefits before a plan covering that person as a dependent.
- The plan of a parent covered as an employee whose birthday (month and day only) falls earlier in the calendar year covers dependent children first. This is known as coordinating payments under the "birthday rule" and is applied when the other Plan also recognizes this order of payment.
- If a priority still cannot be established, the Plan pays benefits in the order determined by the length of time coverage has been in effect, starting with the longest period of coverage.
- This Plan always pays after a plan that does not have a coordination of benefits provision.
- A plan covering a person as a laid-off or retired employee, or a dependent of such person, pays benefits after any other plan covering the person as an employee.
- A plan covering someone as a dependent pays benefits after a plan covering that person in any other capacity.
- Special rules for coverage of dependent children (who are otherwise eligible for benefits under this Plan) in cases of legal separation and divorce (or if the parents have never married) apply as follows:
    - If there is a court decree which establishes financial responsibility for medical, dental or other health care

expenses for a child, benefits are determined in agreement with the court decree.

- If the parent with custody has not remarried, the benefit plan covering the parent with custody shall have primary responsibility for the child's benefit, and the plan covering the parent without custody shall have secondary responsibility.
- If the parent with custody has remarried, the benefit plan covering the parent with custody is primary, the stepparent's plan is secondary, and the plan of the parent without custody pays third.
- If two plans are both secondary, the rules shown above are repeated until one plan is shown to be primary.
- Benefits are paid under a secondary plan only to the extent that they are not payable under any other plan.

- Regardless of whether this Plan is primary or secondary, if you or your Dependents are covered under a prepaid program under another Health Plan, and you or your Dependents receive services which would normally be covered under the prepaid program, this Plan will only reimburse the copayment amounts you are, or would have been, required to pay under the prepaid program. A prepaid program includes a health maintenance organization (HMO), an individual practice association (IPA), and any other such programs deemed similar by the Board of Trustees.
- The maximum amount payable under this Plan is the amount that would have been payable if this Plan was the primary plan.

COORDINATION WITH MEDICARE

If you or your Dependent become eligible for Social Security at age 65 while you are still working, coverage by Medicare is possible even if you don't retire. Medicare includes hospital insurance benefits (called "Part A") as well as supplementary medical insurance (called "Part B"). Medicare also includes Part D (prescription drug benefits).

When you or your Dependents reach age 65 while you are still working, or if you are covered under this Plan as a Disabled Employee not receiving any form of pension benefits, benefits are paid under this Plan before they are paid under Medicare, unless you notify the Fund Office in writing that you want to waive your right to receive these benefits.

If you are a retired employee or an inactive disabled employee and become eligible for Medicare, Medicare will be your primary coverage. If you are a retired employee or an inactive or disabled employee not yet

eligible for Medicare, but your Dependent is eligible for Medicare, Medicare will be the primary coverage of your Medicare-eligible Dependent. **It is important that you or your Dependents enroll for Medicare at age 65, or if disabled prior to age 65, when you are eligible for Medicare coverage**, since your failure to do so results in lower medical protection.

It is important that you or your Dependents visit an office of the Social Security Administration during the three-month period before your 65th birthday to learn all about Medicare. If you have any questions on the coverage provided by this Plan, or need help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

(a) Benefits payable for Covered Expenses incurred by Covered Person who is also eligible for Medicare or entitled to benefits from another Health Plan shall be coordinated so that the total amount payable shall not exceed 100% of expenses incurred. A Covered Person who is eligible for coverage under Medicare with Medicare acting as the primary payer shall be considered covered under Medicare.

(b) In coordinating benefits, the deductible under this Plan shall be applied when the Plan is secondary to another plan except when the coordination of benefits is with Medicare.

BE SURE TO ENROLL IN BOTH PART "A" AND PART "B" OF MEDICARE. THE FUND WILL PAY BENEFITS AS IF YOU HAVE BOTH MEDICARE PART "A" AND PART "B" BENEFITS – WHETHER YOU SIGNED UP FOR THEM OR NOT.

Use of an Approved Facility

If Medicare or another Health Plan, as applicable, is the Primary Plan and requires that you use an approved Hospital or facility for treatment, payment for Covered Expenses will be made only when you use such approved Hospital or facility.

IMPORTANT RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

If you are a Retiree or become Totally Disabled while covered under this Plan, or are the dependent of a Retiree or a person who becomes Totally Disabled and you become eligible for Medicare, Medicare will be your primary coverage as soon as permitted under applicable law, and you will be automatically enrolled in a comprehensive fully insured Medicare Advantage Prescription Drug (MAPD) Plan as described below. If you are not eligible for Medicare when you retire and you are eligible for Retiree

coverage, the Fund will provide you with primary coverage until you become eligible for Medicare, after which you will be automatically enrolled in the MAPD Plan. However, if your dependent is eligible for Medicare when you retire, even if you are not eligible for Medicare at that time, Medicare will be your dependent's primary coverage, and your dependent will be automatically enrolled in the MAPD Plan.

In general, the MAPD Plan is a Medicare replacement for Medicare-eligible retirees and dependents only. The MAPD Plan also provides a comprehensive program of supplemental medical benefits and prescription drug coverage. Participants in the MAPD Plan are still covered by the Plumbers & Pipefitters Medical Fund. However, Humana, not the Fund Office, is primarily responsible for administering the MAPD Plan. Under this arrangement: (1) Medicare will be primarily responsible for paying your healthcare providers; (2) the MAPD Plan, in lieu of Medicare or the Plan, will be responsible for your medical charges as well as your medications; and (3) the Fund Office will remain available to assist you as necessary on other matters. For example, the Fund Office will continue to handle inquiries regarding eligibility, retiree premiums, dental and vision benefits, and all other benefits outside the scope of the MAPD plan. Participants on the MAPD Plan will continue to pay Retiree rates to the Fund.

The following paragraphs summarize the benefits of the MAPD Plan and what to expect if you are a Medicare-eligible participant.

(a) The MAPD Plan provides comprehensive benefits designed to help Medicare-eligible participants achieve better health outcomes, including wellness and chronic disease management programs.

(b) Enrolled individuals will receive a new ID card for medical and prescription drug coverage.

(c) Enrolled individuals will not have to change their current providers so long as the providers are eligible to receive payment from Medicare and are willing to bill the MAPD Plan. If your provider does not meet these criteria, you may have to find a different provider or pay for your services out-of-pocket.

(d) Medicare-eligible participants must be enrolled in Medicare Parts A and B and continue to pay their Medicare Part B monthly premium to the Social Security Administration,

including any income-related surcharges, to be eligible for coverage under the MAPD Plan.

(e) While the MAPD Plan is intended to replicate (and, in some cases, enhance) the medical and prescription drug benefits currently offered by the Plan, there will be some differences in benefits, as determined by both the insurance carrier for the MAPD Plan and the Centers for Medicare and Medicaid Services (CMS) guidelines.

(f) Please refer to the Humana Summary of Benefits for more information on the benefits available under the MAPD Plan.

PPO UTILIZATION REVIEW AND PRE-ADMISSION

CareFirst Preferred Provider Organization

Non-Medicare eligible Participants in the Plumbers and Pipefitters Medical Fund, may utilize the CareFirst Blue Cross/Blue Shield Preferred Provider Organization (PPO). A preferred provider organization is a group of select physicians, specialists, hospitals, and other treatment centers that have agreed to provide their services for a discount. The Fund Office furnishes at no charge a directory of providers in the CareFirst PPO network, which is provided automatically to newly-eligible participants and upon request to others. You can also look up providers on the CareFirst site, (www.carefirst.com). If you live in D.C., Maryland or Northern Virginia, you may also call CareFirst's member services department at 800-235-5160 to determine if your provider is in the network.

If you do not live in D.C., Maryland or Northern Virginia (considered "FlexLink" out of Local Area), you should call 888-444-8115 for assistance in locating a doctor or to verify if your provider is in the BlueCross/Blue Shield network. You may also access this information on-line at www.bcbs.com and clicking the "Find a Doctor" link at the top of the screen.

CareFirst has special arrangements with physicians, hospitals, and other settings where medical services are provided to discount substantially their normal fees. Because you usually pay a percentage of the billed charges, this will result in your paying a percentage of a smaller amount. **The benefit in using a preferred Provider or Hospital for medical or mental health benefits is a direct cost savings to you.** In addition, the Fund's costs are also reduced when you use a CareFirst provider, hospital or facility, which means that your contribution dollars are used more efficiently.

When you go to a participating Provider or Hospital, simply identify yourself as a CareFirst PPO participant by presenting your health identification card. The Provider or Hospital will submit your claim directly to CareFirst PPO who will discount the bill and forward it to the claims administrator for payment. You do not have to file any claim forms.

If your current CareFirst Provider is not already participating in the PPO, you should inform him or her that the Plumbers and Pipefitters Medical Plan is now participating in the CareFirst PPO Network. He or she may want to investigate becoming a participating physician.

You May Pay More if You Use a Non-PPO Provider / Risk of Balance Billing. If you use a non-PPO provider, the Fund will pay for the covered services in accordance with the Plan, but you may incur significantly higher out-of-pocket expenses, including a higher coinsurance percentage except in limited circumstances discussed in the Plan. In certain instances, the non-PPO provider also may charge you for the remainder (or "balance") of the provider's bill after applying payment from the Fund—this practice is often referred to as *balance billing*. This is true whether you use a Non-PPO Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a provider. **However, you should be aware that certain states prohibit balance billing, in which case you should not be responsible for amounts balance billed. Recent federal law also prohibits balance billing for Emergency Services received at an out-of-network facility, medical care from an out-of-network provider at an in-network facility, and air ambulance services.** In some circumstances, however, a provider may balance bill you for these services, if you provided written consent to be balance billed.

Continuing Care

Continuing Care patients, as defined below, may, for a limited period of time, continue to receive coverage at in-network rates for care from a provider or facility whose contract with CareFirst is terminated. If a participant elects to have this continuing care, the Fund is required to cover the course of treatment administered by the provider or facility on the same terms and conditions as would have applied if the provider were still in-network. The Fund will cover continuing care for the lesser of ninety days after a participant is notified of his or her right to continuing care or until the date when the participant is no longer a Continuing Care patient with respect to the particular provider or facility.

Continuing Care patients are patients who, with respect to a provider or facility:

- are undergoing treatment for a complex and serious condition;
- are undergoing a course of institutional or inpatient care;
- are scheduled to undergo nonelective surgery (including postoperative care);
- are pregnant and undergoing treatment for pregnancy; or
- are terminally ill and undergoing treatment for such illness.

Hospital Pre-Admission Certification

American Health Holding, Inc. (AHH) provides Utilization Management services to the Plan. AHH administers the Fund's hospital pre-admission certification program for all hospital admissions and psychiatric treatment except those for certain admissions in connection with Emergency Services. The purpose of this program is to protect your health and the financial integrity of the Fund by avoiding unnecessary treatment. AHH will evaluate the appropriateness, medical necessity and quality of care provided during your inpatient hospital admissions and for specific outpatient procedures.

Procedures

When you need to be admitted to the Hospital for:

- Scheduled Admission – You (or your Provider) must call AHH before your admission.

- Emergency Admission – You or a family member must call AHH within 48 hours of your admission.

Contact AHH at **1-800-641-5566. If you fail to contact American Health Holding within these time periods, benefits payable under this Plan may not be paid.**

AHH will determine whether a Hospital stay is Medically Necessary. AHH does NOT certify that you are eligible for benefits, that the procedures or Hospital stay is a covered service under this Plan, or the amount of coverage provided by this Plan. You and your Provider must verify eligibility and coverage with the Fund Office.

CLAIM FILING PROCEDURES

Claim Forms

All claims for covered supplemental, non-Retiree medical, or vision benefits should be sent to the Fund's claim administrator as follows:

Plumbers and Pipefitters Medical Fund
c/o BeneSys, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
1-800-741-9249

Claim Forms can be picked up from the Fund Office, the Local Union Office or will be mailed to you upon request from BeneSys, Inc. The following forms are frequently needed:

Group Hospital Claim Form	**Used only for confinement in a Hospital, not outpatient care.**
Statement of Claim Form	**Used for all out-of-Hospital medical charges including:** • **Hospital outpatient care;** • **Provider bills while confined;** • **Medical, supplementary accident;** • **X-ray and physical or laboratory benefits;** • **Vision care expenses (out of network)**
Dental Benefit Administered by United Concordia	**Claim forms for Non-Participating dentists are available from the Fund Office or at the following link, under Online Services: https://www.unitedconcordia.com/benefits/clients-corner/Plumbers-and-Pipefitters-Client-Corner-Dental-Benefits**

VSP Benefit	**Contact the participating VSP provider. For a list of providers use the following web site address: www.vsp.com or call 1-800-877-7195**
Weekly Disability Income Benefit Claim Form	**Used for filing non-occupational weekly disability income claims (available from the Fund Office). Send claims for Weekly Disability Income Benefits directly to the Fund Office.**
Occupational Group Proof of Claim Form	**Used to obtain Supplemental Workers Compensation Benefits**
Prescription Reimbursement Form	**May be used to file claims incurred in obtaining prescription benefits from pharmacies which do not have an agreement with this plan.**

Instructions For Completing Forms

- Each form has instructions printed on the form. Please follow the instructions carefully. Claim forms with missing information will delay processing and payment.

- Claims for Basic, Major Medical and other benefits should be submitted within one year after the date of service. In the event a claim is not filed within one year from the date a covered treatment or service is rendered, that claim will not be considered for benefit payment purposes.

- The Trustees have the right and opportunity to have the person who is eligible for benefits examined when and as often as they may reasonably require during the pendency of the claim. An autopsy may be performed if not forbidden by law or court order.

- If additional information or proof is needed to determine whether you or your Dependents are entitled to a benefit under this Plan, you must provide that information along with your written

permission for the Trustees to contact other individuals for information and obtain medical records.

For Vision Care Benefits

- When you are ready to obtain services, call your VSP participating doctor. If you need to locate a VSP doctor, call Vision Service Plan at (800) 877-7195 or visit the World Wide Web site at www.vsp.com.

- When making an appointment, identify yourself as a VSP member. The participating doctor will also need the covered member's identification number (your social security number), and the covered member's group name (Plumbers & Pipefitters Medical Fund). The participating doctor will contact VSP to verify your eligibility and plan coverage. He will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.

- If you or your Dependents visit a non-participating doctor, a regular medical claim form must be completed and submitted. Please mail the itemized bill and claim form to:

VISION SERVICE PLAN
P.O. Box 2487
Columbus, OH 43216-2487
Phone (800) 877-7195

Please note that all claims for reimbursement must be filed within 6 months of the date services were completed.

For Prescription Drug Benefits

Periodically you will be sent a plastic prescription drug identification card that is valid for the period indicated on the card.

When you or your Dependents need to have a prescription filled, you should consider using a pharmacy that honors the Express Scripts card. Most drug chains, as well as a majority of independent pharmacies, honor the Express Scripts card.

If you visit a participating pharmacy, your Express Scripts card must be presented to the pharmacist along with the prescription to be filled. The pharmacist will have all the necessary forms to be completed and will ask for the age and relationship of the patient to you and ask that the person picking up the prescription sign the claim form. Regardless of the total cost of the prescription, you pay only $5.00 for each generic original prescription or refill and $15.00 for each Formulary original prescription or refill and $30.00 for each Non-Formulary brand name prescription or refill. Your Plan pays all additional costs. Prescriptions obtained from the Health and Wellness Center are available free of charge.

One Express Scripts card covers all eligible members of a family and may only be used by persons covered under the program. Unauthorized or fraudulent use of your Express Scripts card to obtain prescription drugs results in the immediate cancellation of your prescription drug benefit.

If you use a non-network pharmacy or do not use your prescription drug card at a network pharmacy, you will have to pay the full cost of the medication up front. However, you can submit a prescription drug claim form, along with your receipt for the prescription, to Express Scripts for reimbursement. Express Scripts will reimburse you the amount of the discounted network price, less your applicable co-payment. Please remember that the discounted network price is often less than the full retail price, therefore your out-of-pocket cost will be higher at non-network pharmacies (or when you do not use your prescription drug card).

For Dental Benefits

Claims for dental benefits should be sent to United Concordia. Participating dentists are required to submit claims forms to United Concordia on your behalf. You may submit dental claim forms from Non-Participating dentists to:

United Concordia Dental Companies, Inc.
P.O. Box 69421
Harrisburg, PA 17106-9421

For Death and Accidental Death Benefits

In the event of death, a Photostatted copy of the death certificate must be submitted. In the case of accidental death, evidence concerning the cause of death must be submitted.

For Supplemental Insured Occupational Accident Benefits

An Occupational Group Proof of Claim and Provider's Statement must be obtained from the Fund Office. The claim form must be completed by the Covered Employee and the Provider as indicated on the form and must then be forwarded to the Fund Office. The Fund Office will then forward the completed claim form to the insurance company for processing. These benefits are paid at least once a month and any amounts unpaid at the end of the maximum payment period, as shown in the Schedule of Benefits, will be paid at that time in a single sum.

Generally, benefits under this Plan are paid directly to you or your spouse. However, you can request that payments be made to the person who provided the services or to your Dependents under certain circumstances.

Medicare Advantage Medical and Prescription Drug Claims

If you are a Medicare-eligible Participant covered under the MAPD Plan, claims should be submitted to the MAPD Plan for processing. If the MAPD Plan denies any claim in whole or in part, you have the right to seek review of that decision in accordance with the terms of the MAPD Plan. Please call Humana Group Medicare Customer Care at 800-733-9064 for more information and assistance.

CLAIMS AND APPEALS PROCEDURES

For Group Health Benefits for Covered Employees, Non-Medicare Eligible Retirees, and their Dependents

To file a claim for major medical, dental, vision or other group health benefits, you must follow all of the procedures set forth in the "Claim Forms" section of this Summary Plan Description. In addition, the following procedures apply.

Applicable Definitions

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves "urgent care," is a "pre-service claim," or is a "post-service claim." These and other important terms are defined in this subsection.

a. Urgent Care Claim

This is a claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2), in the opinion of a Provider with knowledge of your medical condition, would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim.

b. Pre-Service Claim

This is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

c. Post-Service Claim

This is any claim for a benefit that is not a pre-service claim. With this type of claim, you request reimbursement after medical care has already been rendered.

d. Concurrent Care Claim

This is any claim to extend the course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can either be an urgent care claim, a pre-service claim, or a post-service claim.

e. Incomplete Claims

A claim will be deemed incomplete if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Fund your name, your specific medical conditions or symptoms, and the specific treatment or service for which you request payment of benefits.

Notification of Initial Benefit Determination

a. Urgent Care Claims

The Fund will notify you whether your claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim, unless your claim is incomplete. The Fund may notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Fund may notify you orally unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

b. Pre-service claim

For pre-service claims for which you are required to contact the Fund in advance of obtaining medical care, the Fund will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Fund require that additional time is needed to process your claim. If an extension is needed, the Fund will notify you prior to the expiration of the initial 15-day period of

the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund needs an extension because you have submitted an incomplete claim, the Fund will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Fund may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination will be suspended from the date on which the Fund sends you notification of the extension until the date you respond to the request for additional information.

For pre-service claims for which you are required to contact American Health Holdings, Inc. (AHH) in advance of obtaining medical care, AHH, instead of the Fund, will notify you whether your claim is approved or denied, in accordance with the above time limits applicable to pre-service claims.

c. Post-service claims

The Fund will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if special circumstances beyond the control of the Fund require that additional time is needed to process your claim. If an extension is needed, the Fund will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Fund to decide a claim, the period for making a benefit determination will be suspended from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

d. Concurrent care

If the Fund has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund will

notify you of its determination within 24 hours after receiving your claim, provided that the Fund receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it's a pre-service or post-service claim.

e. Rescission

A rescission is a retroactive cancellation or termination of your coverage for reason other than fraud, intentional misrepresentation of material fact, or failure to pay a required premium. Termination of coverage for failure to pay a required premium is not a rescission. Additionally, termination of coverage retroactive to the date of divorce is not a rescission, when the Fund Office was not notified of a divorce and COBRA is not elected and/or the full COBRA premium is not paid by you or your ex-spouse. A rescission is a benefit claims decision which you have the right to appeal. If your coverage was rescinded for a reason other than fraud, intentional misrepresentation of material fact or failure to pay a premium, your coverage under the Plan will continue during the appeal period. You have the right to external review of decisions regarding the retroactive rescission of your coverage.

Denial of a Claim for Benefits

If any claim for benefits described above is denied, in whole or in part, the Fund (or an individual or entity acting on behalf of the Fund) will provide you with a written or electronic notice that states the following:

Information to identify the claim involved, including (where applicable):

- The date of service of the denied benefits;
- The health care provider;
- The claim amount;
- Notice of the right to receive the diagnosis code, treatment code and an explanation of their meaning upon request;

The specific reasons for the determination, including:

- If applicable, the denial code and its meaning;
- The specific plan provision on which the determination is based;

- A description of any standards used to deny the claim;
- A copy of any internal rule or guideline other than a plan provision used to make the determination, or a statement that you may receive a free copy of such rule or guideline upon request;
- If the denial is based on medical necessity, experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment leading to the denial or a statement that you may receive a copy of this explanation upon request;
- A statement that you are entitled to receive free, reasonable access to and copies of any documents, records, and other information relevant to your claim upon request;
- A description of your right to appeal the decision, including your right to make an internal appeal to the Trustees, your right to an external review, and the right to bring a civil legal action under ERISA Section 502;
- The contact information for any applicable office providing health insurance consumer assistance or ombudsman services;
- In the case of an adverse benefit determination concerning an urgent care claim, the notice will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.
- A statement about the availability of the notice in a language other than English, if it is determined that such a statement is required by the Affordable Care Act because there are 10% or more non-English speakers located in a county that is served by the Plan.

APPEALS

Internal Appeal

If your claim for major medical, dental, vision, or other group health benefits is denied, in whole or in part, you may request the Board of Trustees to review your benefit denial. Your written appeal must be submitted within 180 days of receiving the denial notice.

In the case of an adverse benefit determination of a dental claim, you are entitled to a review of that determination by the United Concordia Customer Service Department. If you do not agree with the decision made by the United Concordia Customer Service Department, you may request the Board of Trustees to review your benefit denial as described below.

In the case of a concurrent care claim only, the Fund will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated. Failure to file a timely appeal will result in a complete waiver of your right to appeal, and l the decision of the Fund will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund had this information in making the initial determination (or, where applicable, the first level of appeal). This does not mean that you are required to cite all of the Plan provisions that apply or to make “legal” arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal shall be made by the Board of Trustees or a subcommittee thereof, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Board or Subcommittee deciding the appeal shall give no deference to the initial denial or adverse determination or, where applicable, the first level of appeal. In the case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who has not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained in connection with the adverse determination will be identified upon request.

Also, in the case of an urgent care claim, you may request review orally or in writing, and communications between you and the Fund may be made by telephone, facsimile, or other similar means.

Notification of Decision on Appeal

a. Timing of Notification

1. Urgent Care Claim

The Fund will notify you of its decision of an urgent care claim as soon as possible, but not later than 72 hours after it receives your request for review.

2. Pre-Service Claim

The Fund will notify you of its decision on a pre-service claim within a reasonable period of time, but not later than 30 days after it receives your request for review.

3. Post-Service Claim

In the case of a post-service claim, the Trustees or a designated Committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review by the Trustees, a decision will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

4. New Information or New Basis for Decision

In advance of issuing the Fund's appeal decision, if the Trustees have relied upon or created any new or additional evidence to review the

appeal, or plan to rely on a new or additional rationale, the Fund will provide you, free of charge, with the new evidence or rationale before issuing their appeal decision so that you may have the opportunity to respond to the new evidence and/or rationale before the Trustees issue a final internal decision to you. In such cases, if the Plan receives new or additional information so late that you would have less than 15 days to respond before the Trustees issue their appeal decision, the period for deciding your appeal will be tolled by 15 days, or in the case of appeals of Post-Service Claims, until the next quarterly Trustees meeting. Upon request, this tolling period may be extended for a reasonable time at the discretion of the Trustees.

5. Content of Notification

The Fund will provide you with written or electronic notice of its determination on review. If the benefit is denied on review, the notice will include the following:

- Information to identify the claim involved, including (where applicable):
  - The date of service of the denied benefits
  - The health care provider
  - The claim amount
  - Notice of the right to receive the diagnosis code, treatment code and an explanation of their meaning upon request
- The specific reasons for the determination, including:
  - The specific plan provision on which the determination is based
  - A description of any standards used to deny a claim
  - A copy of any internal rule or guideline other than a plan provision used to make the determination, or a statement that you may receive a free copy of such rule or guideline upon request
  - An identification of any expert whose advice was obtained in order to make the determination, even if that advice was not relied upon
  - If the denial is based on medical necessity, experimental treatment or similar exclusion, either an explanation of the scientific or clinical judgment leading to the denial or a statement that you may receive a copy of this explanation upon request
  - A discussion of the Trustees' decision to approve or deny the appeal.

- A statement of your right to request an external review for determinations involving medical judgment or rescissions, or to bring a civil action under 502(a) of ERISA.

- Contact information for any applicable office of health insurance consumer assistance or ombudsman services available.

- A statement about the availability of the notice in a language other than English, if it is determined that such a statement is required by the Affordable Care Act because there are 10% or more non-English speakers located in a county that is served by the Plan.

External Review

In General

For appeals that involve medical judgment or the rescission of coverage, and appeals involving consideration of whether the Fund is complying with the balance billing and cost-sharing protections set forth in the No Surprises Act, you have the right to request an external review of the Trustees' final appeal decision. A request for external review must be made no later than four months after the date you receive your final adverse decision on your appeal, or, if there is no corresponding date that is four months after that date, then the first day of the fifth month following your receipt. If the last filing date falls on a weekend or Federal holiday, then the last filing date is extended to the next business day.

Within five business days of receiving your request for external review, the Fund will complete a preliminary review to determine:

- Whether you are or were covered by the Fund during the relevant time relating to the adverse benefit determination;
- Whether the adverse benefit determination relates to whether you are eligible for coverage by the Fund; and
- Whether you have exhausted the internal appeal process, or are not required to exhaust the internal appeal process (see below);
- Whether you have provided the necessary information for the Fund to process an external review.

Within one business day of completing this review, the Fund will provide you a written notice of whether your appeal is eligible for external review. If you are not eligible, the notice will explain the reasons why and provide you with information to contact the Employee Benefits Security Administration at 1-866-444-3272 (EBSA). If your request was not complete, the notice will describe what additional information or materials are needed to make the request complete. You will have the longer of the remainder of the four-month filing period or 48 hours to provide the necessary information.

If your claim is eligible for external review, the Fund will assign your claim to an accredited Independent Review Organization (IRO) in a manner that ensures the review is independent and unbiased.

You will receive a notification from the IRO when your claim has been assigned and will have ten business days to provide any additional written information to the IRO to consider with your claim. Any information you provide will be forwarded to the Fund within one business day.

The Fund will provide any necessary information to the IRO within five business days of your claim being assigned.

While your claim is being reviewed by the IRO, the Fund may independently decide to reverse the adverse benefit determination. In that case, the Fund will terminate the external review within one business day of its reversal decision.

In reviewing your claim, the IRO will review all available information and documents without being bound by any prior decisions by the Fund. The IRO may consider, where appropriate and available:

- Your medical records;
- Your attending health care provider's recommendation;
- Reports from other health care professionals and documents provided by the Fund, by you, or by your health care provider;
- The terms of the Summary Plan Description (SPD) and other governing documents of the Fund;
- Appropriate practice guidelines developed by the government or other professional associations;
- Any clinical review criteria developed by the Fund unless they are inconsistent with the SPD or applicable law;

- The opinion of the IRO's clinical reviewers

The IRO must provide a written notice of its final decision within 45 days of receiving the request for external review both to you and to the Fund. The notice will include:

- A description of the reason for the external review request, including information to identify the claim such as the date of service, health care provider, amount, and the reason for the previous denial;
- The date the IRO received the assignment and the date of its decision;
- References to the evidence or documentation the IRO considered to make its decision;
- A discussion of the principal reason(s) for the decision including its rationale and any evidence-based standards upon which it relied;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law;
- A statement that you may be entitled to judicial review; and
- Current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The IRO will maintain records of your claim for six years, which you may examine upon request.

If the IRO makes a decision in your favor, the Fund will immediately provide the coverage or payment requested in the claim.

Expedited External Review

If your claim involves a medical condition for which the normal timeline for an appeal or external review would either seriously jeopardize your life, health, or your ability to regain maximum function, you may request an expedited external review.

If the timeline for receiving an expedited internal appeal and then an external review would jeopardize your health as described above, you may

request an expedited external review immediately after an initial adverse benefit determination.

If the timeline for receiving a regular external appeal after a final internal appeal would jeopardize your health as described above, you may request an expedited external review after a final adverse benefit determination.

An expedited external review will follow the same process outlined for regular external reviews, but on an expedited timeline as follows:

- The Fund will immediately conduct a preliminary review of your claim and immediately provide you the notice about your eligibility.
- If eligible for external review, the Fund will, as quickly as possible, assign an IRO and provide it with all necessary documentation, either electronically, over the phone, by fax, or by any other method, as quickly as possible.
- The IRO must reach its decision as quickly as possible, but in no event more than 72 hours after receiving the review. The initial notice may be provided orally rather than in writing, in which case the IRO must provide a written notice within 48 hours of providing its initial notice.

Deemed Exhaustion of Appeals

If the Fund fails to follow any of the claims and appeals procedures outlined here, such as failing to provide notice within the time frames described, you will be considered to have exhausted the internal appeals process for purposes of seeking external review or pursuing a legal case.

However, if the Fund's failure is minor, does not adversely affect your claim, is attributable to a good cause or issues beyond the Fund's control, happens in the context of an ongoing good-faith exchange of information, and is not reflective of a pattern or practice of non-compliance with appeal requirements by the Fund, you will not be deemed to have exhausted the internal process. Within 10 days of your written request for an immediate external review due to the Fund's failure to follow its appeal procedures, you will receive a written notice from the Fund if the Fund determines that its actions fall under this exception that explains why the exception applies. If your request for immediate external review is rejected under this exception, the Fund will provide you with a notice of your opportunity to resubmit your claim and pursue the regular internal appeals process.

Right to Name Authorized Representative for Appeals

You may designate an authorized representative to pursue your appeal with the Fund.

Trustees' Decision on Appeal is Final and Binding

The decision of the Board of Trustees on review shall be final and binding upon all parties including any person claiming a benefit on your behalf, except in the case of an external review as provided above. The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

In the event of an external review, where the reviewer confirms a denial of coverage, the Trustees may still decide to provide the coverage at their discretion.

CLAIMS AND APPEALS FOR SUPPLEMENTAL WORKERS COMPENSATION BENEFITS, WEEKLY ACCIDENT AND SICKNESS BENEFITS, AND BENEFITS DUE TO DISABILITY

General

The following section applies to claims for benefits (and appeals of same) that involve a determination of eligibility based on temporary or total disability including Supplemental Workers Compensation Benefits or Weekly Accident and Sickness Benefits ("Supplemental Benefits"), extended coverage for ex-employees who are Totally or Temporarily Disabled or coverage for Dependents beyond age 26 on the basis of Disability. All of these types of claims are referred to in this section as Disability-related Claims.

Notification of Initial Benefit Determination

To file a claim for benefits, you must follow all of the procedures in the "Claim Forms" section of this booklet. The Fund will decide Disability-related Claims within a reasonable time but not later than 45 days from the

date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund if the Fund Office notifies you of the extensions prior to the expirations of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination will be suspended from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

Denial of a Claim for Benefits

If your Disability-related Claim is denied, in whole or in part, the Fund Office will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including your right to bring a civil action under Section 502(a) of ERISA in the event of a denial of benefits. In addition, the Fund Office will provide you with a copy of an internal rule, guideline, protocol or similar criterion if one was relied on in making the adverse determination, or alternatively, with a statement that such rule, guideline, protocol or similar criterion does not exist. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. The notice will also state that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information that is relevant to your claim. If applicable, the Fund Office will also provide you with the Plan's basis for disagreeing with or not following (i) views presented by your treating health care professionals and/or vocational professionals who evaluated you; (ii) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the

advice was relied upon in making the benefit determination; or (iii) a disability determination made by the Social Security Administration. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

Appeals

General

If your Disability-related Claim is denied, you may request the Board of Trustees to review your benefit denial by submitting a written appeal to the Trustees. Your written appeal must be submitted within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Plan Administrator will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Fund policy, determination or action. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The review on appeal shall be made by the Board of Trustees or subcommittee thereof, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Board or subcommittee deciding the appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who has not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in

connection with the adverse determination will be identified upon request. In addition, you will be provided, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, the Fund, the Trustees or a subcommittee thereof, or any other person reviewing your appeal. Such information will be provided to you as soon as possible and with sufficient time to give you a reasonable opportunity to respond to such new or additional information. In addition, you will be provided the same opportunity before an adverse benefit determination on appeal may be rendered based on a new or additional rationale.

Notification of Decision on Appeal

a. Timing of Decision and Notification

The Trustees or a designated Committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be received at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive a written or electronic notice of the decision of the Trustees after review by the Trustees, within five days of their decision.

b. Content of Notification

If the benefit is denied on review, this notice will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination and a statement of your right to bring a civil action under Section 502(a) of ERISA. In addition, the Fund Office will provide you with a copy of an internal rule, guideline, protocol or similar criterion if one was relied on in making the adverse determination, or alternatively, with a statement that

such rule, guideline, protocol or similar criterion does not exist. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. The decision of the Board of Trustees on review shall be final and binding upon all parties including any person claiming a benefit on your behalf. If applicable, the notice will also contain the Fund's basis for disagreeing with or not following (i) views presented by your treating health care professionals and/or vocational professionals who evaluated you; (ii) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (iii) a disability determination made by the Social Security Administration.

Notices involving an initial claim denial or appeal will include a statement of your entitlement to obtain the relevant notices in a culturally and linguistically appropriate manner.

Trustees' Decision on Appeal is Final and Binding

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

APPEALS FOR INDIVIDUALS ENROLLED IN THE MAPD PLAN

If you are a Medicare-eligible Participant covered under the MAPD Plan, claims should be submitted to the MAPD Plan for processing. If the MAPD Plan denies any claim in whole or in part, you have the right to seek review of that decision in accordance with the terms of the MAPD Plan. Please consult your Humana Evidence of Coverage or call Humana Group Medicare Customer Care at 800-733-9064 for more information and assistance.

Other Fund Policies, Determinations, or Actions

If you disagree with a policy, determination, or action of the Fund, you may request the Board of Trustees to review the Fund policy, determination or action with which you disagree by submitting a written appeal to the Trustees. Your written appeal must be submitted within 60 days after you learn of a Fund policy, determination or action with which you disagree and which is not a benefits denial.

Your written appeal should state the reasons for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you disagree with a Fund policy, determination, or action. The Trustees can best consider your position if they understand your claims, reasons, and/or objections.

The Trustees or a designated Committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review for the Trustees or Committee, you will be notified in writing.

The Trustees have full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits.

If the Trustees deny your appeal of a claim or challenged policy, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

Limited Judicial Review and Limitations Period for All Appeals

You may not commence a judicial proceeding against any person, including the Fund, the Plan, a fiduciary of the Fund or Plan, the Administrative Manager, the Trustees, or any other person, with respect to a claim for benefits, Plan policy change, or other determinations or

actions, without first exhausting the claims and appeals procedures set forth in this section.

If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Trustees' decision on appeal, but only if the action is commenced within a period of one year from the date of the Trustees' final decision on appeal, or, if applicable, one year from date of a decision made as a result of an external review of a claim for benefits. Any such action must be brought exclusively in the federal courts located within the State of Maryland. If you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

THIRD PARTY LIABILITY CLAIMS (REIMBURSEMENT/SUBROGATION)

From time to time, a person who is eligible to receive benefits from this Fund is injured as a result of another party's wrongdoing or negligence. Since it may take months or even years to obtain recovery in such a case, the Fund provides that payment may be made for services otherwise covered under the Plan upon receipt of a signed statement from the Participant agreeing to repay the Fund for any and all expenses incurred by the Fund from any recovery received from any source.

An example of this would be if you and your spouse are injured in an automobile accident which was another person's fault. If the Fund pays $1,000 in benefits due to injuries resulting from the accident, and, as a result of a lawsuit, settlement or insurance claim, you or your spouse recovers any money from the other person or the other person's insurance company, the Fund is entitled to receive up to $1,000 of such money as reimbursement for the benefits it provided to you or your spouse.

The Fund has a right to first reimbursement out of any recovery from another party. By accepting benefits from the Fund, the injured party agrees that any amounts recovered by the injured person by judgment, settlement, compromise or otherwise will be applied first to reimburse the Fund even if the injured party is not made whole. The Fund has an equitable interest in any amounts that you recover, or will recover, for the entire amount paid by the Fund for your claim and any amounts you recover must be segregated and held in trust on behalf of the Fund until the Fund's reimbursement rights are satisfied.

As noted above, before the Fund pays any benefits to you or your Dependent, you must sign a written agreement stating that the Fund will be reimbursed for any amounts that it paid in connection with the injury if you later receive payment from another party for that injury. You also must notify the Fund if you or your Dependent retains an attorney in connection with the injury. If you or your Dependent retains an attorney, the agreement must also be signed by the attorney.

You and your attorney must also provide proof, satisfactory to the Trustees, that no right, claim, interest or cause of action against a third party has been, or will be, discharged or released without written consent of the Board of Trustees. In addition, any claims that you make against a

third party must first be approved by the Trustees. Any settlement that you make against the other party must also be approved by the Trustees. You must agree to help the Fund in pursuing your claims against the other party, or to allow the Fund to pursue the claims on your behalf before any benefits are paid under this Plan.

By accepting these benefits, you also agree that any amounts recovered, and regardless of how the recovery is characterized, are assets of the Fund and will be applied first to reimburse the Fund, in full, and without any reduction for attorneys' fees or costs. You also agree that you, your Dependent, or anyone acting on your behalf or on behalf of your Dependent, will be considered a fiduciary under Section 3(21) of ERISA with respect to such recovered Fund assets. If the person who was injured is a minor, the parent or legal guardian must fulfill the above requirements on the child's behalf.

You should note that the Fund can seek recovery of any amounts you receive from another party even if you fail to inform the Fund of your claim or you fail to sign an agreement with the Fund. The Fund's subrogation right is established by the terms of the Plan and not by the agreement.

The Fund has a right to first reimbursement out of any recovery that the injured party receives from another party, whether or not you are made whole. This includes, but is not limited to, amounts that you may receive from a personal homeowners' insurance policy, an automobile insurance policy or a group insurance arrangement of any kind.

If you refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid on your or your Dependent's behalf related to the accident by other means. These may include, but are not necessarily limited to, bringing suit against you and/or your Dependent, insurers and any recipients of the Fund assets improperly distributed without consent of the Fund; and offsetting the amounts paid to you and/or your Dependent against future benefit payments until the Fund's lien is recovered. "Non-cooperation" includes the failure to execute a written agreement and the failure of you or your attorney to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation. In the event you and/or your attorney fail to respond to an inquiry by the Fund within thirty (30) days, the Fund will automatically offset amounts paid to you and/or your Dependent against future benefit

payments until you and/or your attorney provide the information requested by the Fund.

If it becomes necessary for the Fund to institute legal action against you for failure to reimburse it, in full, or to honor the equitable interest in the amount recovered by you from a third party, you will be liable for all costs of collection, including attorneys' fees and pre-judgment interest at a rate of 10% or at a rate determined by the Trustees to be assessed on the collection of delinquent contributions from employers, whichever is higher.

The Fund's right to reimbursement also includes the right to reimbursement from any payment made to you from any source to which you assign any claim against, or otherwise agree to reimburse any recovery from, the person who caused your injury.

The Trustees have absolute discretion to settle subrogation claims on any basis they deem warranted and appropriate under the circumstances.

MISCELLANEOUS

Action of Trustees

The Trustees have full discretion and authority over the standard and type of proof required in any case and over the application and interpretation of the Plan. No legal proceeding shall be filed in any court or before an administrative agency against the Plan unless all review procedures with the Trustees have been exhausted. Except as provided in the Trust Agreement or as determined by the Trustees, all actions taken by the Trustees that are fiduciary or would otherwise be considered settlor actions shall be considered fiduciary actions within the meaning of ERISA.

No Assignment or Attachment of Benefits

You may not assign any benefits, rights or claims for benefits to any third party including, but not limited to, a provider or facility, without the express written consent of the Fund Administrator. "Benefits, rights or claims for benefits" includes, but is not limited to, a claim for payment of a benefit under the terms of the Plan or other Plan document or communication, a claim for benefits under Section 502(a) of ERISA, a claim under ERISA for breach of fiduciary duty, or a claim for penalties assessable under law or regulation.

You may direct that benefits payable to you be paid to an institution or providers of medical care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider shall be considered an assignment of the benefit, a contract to pay benefits, or a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so.

All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings.

Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered, however, and it is determined that the Fund has paid you benefits that you are not entitled to, the Trustees have the right to seek recovery from you, including the right to reduce future

benefit payments by the amount of the erroneous payment. The Trustees also have the right to seek from you all costs of collection of an erroneous payment, including attorneys' fees and pre-judgment interest at a rate of 10% or at a rate determined by the Trustees to be assessed on the collection of delinquent contributions from employers, whichever is higher. The Trustees also have the right to recover such overpayments, to the extent of the error or excess, from any insurance company or other organization.

Misrepresentation or Fraud

If you receive benefits as a result of false information or a misleading or fraudulent representation, you will be required to repay all amounts and you will be liable for all costs of collection including attorney fees and pre-judgment interest at a rate of 10% or at a rate determined by the Trustees to be assess against delinquent contributions by employers, whichever is higher. The Trustees reserve the right to reduce future payments by the amount of the payments made because of fraud or misrepresentation.

No Fund Liability

The use of the services of any hospital, clinic, physician or other provider of health care, whether designated by the Fund or otherwise, is your voluntary act. Even if some benefits may be obtained only from providers designated by the Fund, that is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees of the Plan. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by a Workers' Compensation law or similar legislation.

Exclusive Rights

No individual shall have a right to benefits provided under the Plan, except as specified herein; and in no event shall any right to benefits under the Plan be vested. No party shall be bound to or shall be able to rely on any oral representations about the content of this Plan that are inconsistent with the terms of the Plan.

Right to Amend or Reduce Benefits

The Board of Trustees, in accordance with the Plan Document and Trust Agreement, has the right to amend the Plan at any time. This includes, but is not limited to, eliminating the existence of, or change in the duration of coverage for all employees, dependents and retirees, changing eligibility and requirements for coverage, changing the availability nature and extent of benefit, and the conditions for and methods of payment of benefits. The Trustees also have the right, at any time to reduce benefits. The benefits under the Plan, including retiree benefits, are not guaranteed and are provided only from assets of the Fund collected and available for such purposes. The right of the Board of Trustees to terminate or amend the Plan is described more fully below.

No Liability for Practice of Medicine

The Plan, the Board of Trustees or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over diagnosis, treatment, care or lack thereof, of any health care services provided or delivered to a Covered Person by any health care provider. Neither the Plan, the Board of Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to any Covered Person by any health care provider by reason of negligence, by failure to provide care or treatment or otherwise.

Confidentiality and Protection of Your Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA Rules). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, employers, the Union, your family members, service providers and other

third parties. Protected health information will be disclosed (1) only to the extent authorized by the patient; (2) as necessary for the administration of the plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. The Plan has adopted certain written rules and policies to ensure that with regard to its use, disclosure and maintenance of protected health information, it complies with applicable law.

You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Plan by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Plan has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of protected health information or your rights with regard to this information, you may request a copy of the Notice from the Fund Office.

Women's Health and Cancer Rights Act of 1998

As explained elsewhere in this booklet, the Plan will provide coverage for you or your eligible Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction surgery in connection with the mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998. Such coverage includes: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications for all stages of the mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act of 1996

As also explained elsewhere in this booklet, under federal (or state) law, group health plans and health insurers may generally not restrict benefits for length of hospitalization in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section.

Mental Health Parity and Addiction Equity Act of 2008

Notwithstanding anything in this Plan document to the contrary and in conformity with Section 712 of ERISA, with respect to benefits for services furnished after December 31, 2010 and to the extent the Mental Health Parity and Addiction Equity Act of 2008 supersedes, modifies or amends the Mental Health Parity Act of 1996, any aggregate and annual lifetime caps on mental health benefits under the Plan shall be the same as for medical/surgical benefits and shall be included in such limits, and any predominant quantitative or non-quantitative financial requirements or treatment limitations on mental health benefits shall be the same as for medical/surgical benefits, unless this Plan should qualify for the small employer or increased cost exemption.

Agreement and Declaration of Trust

The Plan is subject to and controlled by the provisions of the Restated Agreement and Declaration of Trust. In the event of a conflict between the provisions of the Plan and the provisions of the Restated Agreement and Declaration of Trust, the provisions of the Restated Agreement and Declaration of Trust will prevail.

Savings Clause

If any provisions of this Plan are held to be unlawful, or unlawful as to a particular person or circumstances, such finding shall not adversely affect the application of the other provisions of the Plan as they are described in this booklet, unless the illegality makes the continued operation of this Plan impossible.

Preservation of Plan Provisions

This document supersedes and replaces any previous literature furnished regarding the Plan's benefits and is intended to serve as both the Summary Plan Description and the Plan Document under ERISA.

In the event of inconsistency between or omission from the provisions of this Plan and mandatory provisions of applicable law or regulation or their interpretation by any court or regulatory agency with authority over the Plan, such provisions and their interpretation will control. When the provisions of this Plan are different from those mandated by applicable law

or regulation, but are nonetheless permitted by such law or regulation as interpreted by courts or agencies, the provisions of this Plan will control.

In the event of inconsistency between the English version of the Plan's Summary Plan Description and the Spanish translation of the Summary Plan Description, the provisions of this Plan as stated in English will control.

Forum Selection

Any legal action under Title I of ERISA brought against the Plan, the Fund, the Board of Trustees, the Administrative Manager, and/or any employee or agent thereof must be brought exclusively in the federal courts located within the State of Maryland, in which case the parties consent and submit to the personal jurisdiction of the federal courts located within the State of Maryland. Any other legal action brought against the Plan, the Fund, the Board of Trustees, the Administrative Manager, and/or any employee or agent thereof must be brought exclusively in the state or federal courts located within Maryland in which case the parties consent and submit to the personal jurisdiction of the state or federal courts located within Maryland.

Governing Law

The terms of the Plan are governed by and construed in accordance with federal law to the extent federal law applies. To the extent federal law does not apply, the terms of the Plan will be governed by and construed in accordance with the laws of the State of Maryland. The Trustees have the exclusive discretionary authority to interpret the Plan and render all decisions with respect to the Plan.

GENERAL INFORMATION AND ERISA RIGHTS

The following information is provided as required by ERISA:

Official Name of Plan: Plumbers and Pipefitters Medical Plan.

Type of Administration: The Plan is administered and maintained by a joint Board of Trustees, consisting of three Union representatives and three Employer representatives. The Trustees contract with a third-party administrator for administration and claims payment services.

Type of Plan: Employee Welfare Benefit Plan including hospitalization, medical, disability, dental, vision, and prescription drugs.

Governing Law: This Plan was created and accepted in the State of Maryland and all questions pertaining to the validity and construction of the Plan shall be determined in accordance with ERISA and other federal law.

Limitation of Action: No action shall be filed in court or before an agency for the payment of benefits under the Plan unless all review procedures are exhausted.

Gender: Whenever a masculine pronoun is used in this Plan, it includes the feminine unless the context clearly indicates otherwise, and vice versa. Words used in singular form also include the plural form in all situations where they would also apply, and vice versa.

Preferred Providers: The Board of Trustees has contracted with CareFirst Blue Cross/Blue Shield to provide the Plan's participants with access to a Preferred Provider Organization that provides medical services.

CareFirst
10455 Mill Run Circle,
Owings Mills, Maryland 21117
800-235-5160
www.carefirst.com

The Trustees have also contracted with Vision Services Plan, which provides a vision benefit for the Fund's participants through participating optometrists.

Vision Services Plan
P.O. Box 2487
Columbus, OH, 43216-2487
www.vsp.com

The Trustees have selected United Concordia Dental to administer dental benefits for the Fund.

United Concordia Dental
1800 Center St
Camp Hill PA 17011
www.unitedconcordia.com

The Trustees have also contracted with Humana Medicare Advantage PPO plan, which provides the Plan's Medicare-eligible participants with access to a Preferred Provider Organization that provides medical services and prescription drug benefits.

Humana
P.O. Box 669
Louisville, KY 40201-0669
www.humana.com

The Board of Trustees may, from time to time, in its sole discretion, enter into written agreements with other Preferred Provider Organizations. The use of any Preferred Providers is wholly at the participant's option. The existence of any Preferred Provider shall not imply in any manner an endorsement of any specific provider, nor shall it constitute any guarantee of the services rendered.

Other Providers

The Board of Trustees has contracted with certain organizations to provide certain other benefits under, or services to, this Plan:

Prescription and mail order drug program:
Express Scripts, Inc.
1 Express Way
St. Louis, MO 63120

Supplemental insured occupational accident benefits:
Chubb Insurance Co.
1801 K Street, N.W., Suite 700
Washington, DC 20006

Utilization management services:
American Health Holding, Inc.
7400 West Campus Road, F-510
New Albany, OH 43054
For precertification, call the number on your ID card.

Wellness Center Provider:
Marathon Health
10 West Market Street, Suite 2900
Indianapolis, IN 46204

Wellness Center addresses:

4755 Walden Lane
Lanham, MD 20706
(240) 436-2840

4475 Regency Place, Suite 206
White Plains, MD 20695
(301) 476-0181

Address of the Administrator at the Fund Office

Fund Administrator
BeneSys, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
1-800-741-9249

Plan Administrator

The official Plan Administrator is the Board of Trustees who has been designated as Agent for the Service of Legal Process. The Names, Titles and Addresses of the Trustees are:

Union Trustees
Terriea Smalls, Chairman
c/o U.A. Local Union No. 5
4755 Walden Lane
Lanham, MD 20706

Michael Canales
c/o U.A. Local Union No. 5
4755 Walden Lane
Lanham, MD 20706

Walter "Dick" Harrigan
c/o U.A. Local Union No. 5
4755 Walden Lane
Lanham, MD 20706

Employer Trustees
Reuben Ford, Co-Chairman
CRW Mechanical, Inc.
5807 Ellerbie Street
Lanham, MD 20706

Anne Finerfrock
W.E. Bowers
12401 Kiln Court
Beltsville, MD 20705

Andrew Tomlinson
G&M Services LLC
7526 Connelley Drive, Suite T&U
Hanover, MD 21076

Professional Advisors

Legal Counsel:	O'Donoghue and O'Donoghue LLP
Auditor:	Calibre CPA Group, PLLC
Consultant and Actuary:	The Segal Company

Source of Financing of the Plan and Identity of any Organization through which Benefits are provided:

(a) Payments are made to the Trust by individual Employers under the provisions of any of the Collective Bargaining Agreements, by some Employees through self-payments, and from any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible Employees or their Dependents, and the paying of all expenses incurred with respect to the operation of the Plan. The Trustees annually review the funding status of the Plan. The assets of the Fund are held in Trust in accordance with an agreement and Declaration of Trust.

(b) If you make a written request, the Fund Office will tell you whether an Employer is contributing to this Fund on behalf of Employees working under a Collective Bargaining Agreement.

(c) Prescription drug benefits are administered through a contract with Express Scripts. Vision benefits are administered through Vision Services Plan. All benefits are processed under a third-party administration agreement with BeneSys, Inc.

(d) No payments provided for in this Plan are insured (except a supplement to workers' compensation and the Humana MAPD Plan) by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund collected and available for such purpose. The Trustees have the right to terminate, suspend, withdraw, amend or modify the Plan, in whole or in part, at any time, including changes to all eligibility rules.

Date of the End of the Plan Year: December 31

Internal Revenue Service Plan Identification Number: 53-0190932

Plan Number: 501

Plan Termination

The Board of Trustees may terminate the Fund, and accordingly the plan of benefits provided by the Fund, in accordance with Article XII of the Fund's Restated Agreement and Declaration of Trust as described briefly below.

The Fund may be terminated by a written instrument executed by the Trustees. The Fund may be terminated if, in the opinion of the Trustees, it is not adequate to carry out the intent and purpose of the Fund as stated in its Trust Agreement or is not adequate to meet the payments due or which may become due under the Plan. The Fund may also be terminated if there are no individuals living who can qualify as Participants or Beneficiaries under the Plan. Finally, the Fund may be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of the termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan,

including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Participants and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any Contributing Employer, any Employer association, or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, Employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Fund.

YOUR ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT!

This booklet contains important information about your rights under the Plumbers and Pipefitters Medical Plan. Please read the information contained in this booklet very carefully. If you have any questions regarding your eligibility or coverage under any of the provisions of this Plan please contact the Fund Office at the following address:

Plumbers and Pipefitters Medical Plan
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
or call: (800) 741-9249

Please note that interpretations regarding participation in the Plan and eligibility for benefits, status of Employers and Employees, or any other matter relating to the Medical Plan, should only be obtained through the full Board of Trustees or the Fund Administrator. The Trustees are not obligated by, responsible for, or bound by opinions, information or representations from any other sources.