Summary Plan Description

of the

PLUMBERS AND PIPEFITTERS MEDICAL FUND

(Restated Effective September 1, 2014)

Summary Plan Description
of the
PLUMBERS AND PIPEFITTERS
MEDICAL PLAN

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Jay Schwab

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Legal Counsel

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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

July 1, 2014

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 September 1, 2014.

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 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

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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 42)..... $ 10,000
If death is accidental, benefit is doubled.

Weekly Accident & Sickness Benefit (non-occupational) (Page 43)
Per week up to 13 weeks..... $ 350

Accidental Dismemberment or Loss of Sight Benefits (Page 45)
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 45)
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 47)
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) (MD and VA only)
Offset by Dismemberment or Loss of Sight, Speech or
Hearing Benefit, $1,000 per month, up to ..... $ 100,000

FOR COVERED EMPLOYEES, RETIREES AND THEIR COVERED DEPENDENTS

BASIC BENEFITS:

Hospital Expense Benefits (Page 48)
Room and Board (Page 48), per day, up to 70 days in one period of confinement, per calendar year..... $ 450
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Inpatient Provider Visits (Page 49)
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% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Mothers and Newborns (Page 50)
50% of Hospital room and board charges for Mother while hospitalized due to childbirth, 100% of Hospital room and board charges if newborn remains hospitalized after mother is released, available for Covered Employees and their spouses only.
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Maximum Miscellaneous Hospital Charges (Page 50)
Per confinement ..... $ 1,700
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Medical Emergency Benefit (Page 51)
Per Illness or Injury ..... $ 200
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Surgical Benefits (Page 52)
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% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Diagnostic Laboratory and X-Ray Benefits (Page 55)
Per calendar year..... $ 500
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Outpatient Provider Visits (Page 55)
Per calendar year, $100 per visit, up to ..... $ 1,500
Excess paid at 80% up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Annual Physical Examination Benefit (Page 56)
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% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Laboratory tests and x-rays conducted in conjunction with the Physical Exam Benefit will be paid up to the annual benefit. Any excess lab and x-ray charges will be considered under Major Medical.

Preventive Services Benefit (Page 56**)**
Services required to be provided as preventive services by the Affordable Care Act,,
Provided with $0 coinsurance, covered at 100% up to UCR
See page 56 for list of covered services

Mental or Nervous Disorder Treatment Benefit (Page 59)
Inpatient treatment payable as Hospital Expense Benefit; excess of allowance paid at 80% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Outpatient treatment covered at 80% of Covered Expenses up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Substance Abuse Treatment Benefit (Page 60)
Inpatient detoxification covered at 80% of Covered Expenses up to the annual Major Medical maximum benefit currently in effect (including all

Covered Expenses). Outpatient detoxification covered at 100% of Covered Expenses for the first thirty (30) days per calendar year, and thereafter at 80% of Covered Expenses up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Inpatient rehabilitation treatment covered at 80% of Covered Expenses up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Aftercare treatment covered at 80% of Covered Expenses up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Prescription Drug Benefits (Page 60)
Per person per calendar year..... $ 45,000
Covered expenses in excess of $45,000 will be paid at 80% of the Pharmacy Benefit Manager's repriced claim up to the annual Major Medical maximum benefit currently in effect (which is combined with all other Covered Expenses).

Organ/Tissue Transplant Benefit (Page 66)
(prior authorization required)
Covered Expenses payable under Major Medical Benefit and subject to the annual Major Medical Benefit limitation.

MAJOR MEDICAL BENEFIT (Page 67)
The Major Medical Benefit will pay 80% of Covered Expenses subject to Major Medical Deductibles.

Effective January 1, 2013, annual Major Medical maximum for Essential Health Benefits per eligible person: .....$ 2,000,000

As required by federal law, effective January 1, 2014, there will be no annual limit on Essential Health Benefits (see Definitions section of this booklet).

Out-of-Pocket Expense Maximum Benefit (Page 67)
per person, per calendar year, subject to limitations ..... $ 5,000
per family, per calendar year, subject to limitations..... $ 12,700

OTHER BENEFITS (Page 70)
(Benefits with special limits or benefits where the excess is not covered as a Major Medical Benefit.)

Well Baby Care Benefit (Page 70)
Ten (10) routine physical examinations within the first 24 months of life

Hearing Aids (Page 70)
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.

Shingles Vaccination (Page 71)
100% of the cost of a one-time Shingles Vaccination for all eligible Participants and Dependents age 60 and over…….Covered in Full

Diabetes Self-Management Training (Page 71)
100% of the prescribed educational charges per eligible individual per calendar year..... $ 500

Skilled Nursing Facility Benefit (Page 71)
(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% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses), but not to exceed 100 day lifetime maximum

Hospice Care Benefit (Page 72)
(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% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses), but not in excess of 180 total days of coverage.

Rehabilitation Service Benefit (Page 72)
(prior authorization required)
Inpatient treatment as an alternative to hospitalization, per day, up to 6 weeks ..... $ 100

Covered Expenses in excess of the maximum daily allowance paid at 80% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses), but not to exceed 6 week maximum.

Non-Institutional Medical Care Benefit (Page 73)
(prior authorization required)
Paid under Major Medical Benefit 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; this benefit paid up to the Major Medical Benefit limit currently in effect (including all Covered Expenses).

Dental Benefit (Page 75)
100% of fee schedule negotiated under preferred provider arrangement; Covered Person is responsible for any excess fees from non-preferred provider.

Maximum Benefit, per person, per calendar year	$	2,000
Prior Authorization amount, per person	$	200

All Covered Expenses for *pediatric* dental services in excess of the schedule will paid at 80% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Temporomandibular Joint (TMJ) Dysfunction (Page 79)

Lifetime maximum	$	1,500

All Covered Expenses for *pediatric* TMJ services in excess of $1,500 will paid at 80% up to the annual Major Medical maximum benefit currently in effect (including all Covered Expenses).

Vision Benefit (Page 79)
Through a VSP Participating Provider in the Premier Network:

Exam (every 12 months)	$15 co-payment
Frames and lenses (every 24 months subject to limitations)	$20 co-payment

OR

Contact lenses (every 24 months)	
Necessary Contact Lenses	Covered in Full
Elective Contact Lenses	$ 120 co-payment
Lenses (every 12 months)	$ 20 co-payment

but only if at least one of the following criteria is met:

- new prescription differs from the original by at least a .50 diopter sphere or cylinder; or
- there has been an axis change of 15 degrees or more; or
- there has been a .5 prism diopter change in at least one eye.

UV Protection ..... Covered in Full
Anti-Reflective Coating..... Covered in Full
Progressive Lenses..... Covered in Full

Through a Non-VSP Participating Provider:

Exam (every 24 months)	$	35
Frames (every 24 months)	$	35
Lenses (every 24 month):		
Single vision	$	25
Bifocal	$	40
Trifocal	$	55
Lenticular.....	$	80
Necessary Contact Lenses	$	210
Elective Contact Lenses	$	75

UV Protection ..... Not Covered

All Covered Expenses for *pediatric* eye exam services in excess of $35 will be paid at 80% up to the annual Major Medical benefit limit currently in effect (including all Covered Expenses).

FOR COVERED EMPLOYEES, RETIREES AND SURVIVING SPOUSES ONLY

Medical Reimbursement Allowance (Page 81)
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

Pharmacy Benefit (30-Day Supply)	Co-pay
Non-Covered Non-Formulary*	$ Full Cost
Covered Non-Formulary	$ 30
Formulary	$ 15
Generic	$ 5

At participating pharmacy, up to 100% of actual charges.

At a non-participating pharmacy, reimbursement for covered charges up to amount that would have been charged at a participating pharmacy.

Mail Order/CVS Pharmacy Benefit (90-Day Supply)	Co-pay
Non-Covered Non-Formulary*	$ Full Cost
Non-Formulary	$ 60
Formulary	$ 30
Generic	$ 10

*See the description of the Prescription Drug Benefits on page 60 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

SELF-PAY AND COBRA RATES

	Monthly Amount
Self-Payment Rates (Page 35)	
Employees, full benefits	$ TBD[1]
	Monthly Amount
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]

[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 will now be 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[4]
Retirees, age 62 and over (or anyone eligible to receive 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 Coverage, benefits payable for Hospital, Diagnostic Laboratory and X-Ray, Providers Visits, Medical Emergency, Surgical, Mental or Nervous Disorder, Substance Abuse and Physical Examination Benefits are coordinated with Medicare Parts A&B.

[4] amount is equal to the current hourly contribution rate times 160, and will be adjusted as the contribution rate changes.

RATES FOR POST-JUNE 1, 1993
RETIREES AND SURVIVING SPOUSES[5]

	Monthly Amount
Retirees, age 55 through 61	$ TBD[6]
Retirees, age 62 or over (or anyone eligible to receive Medicare), per individual	$ 140[5]
up to a maximum of 2.5 times the rate	$ 350[5]
Surviving Spouse, No Dependents	$ 140[5]
Surviving Spouse, with Dependents, per individual l	$ 140[5]
up to a maximum of 2.5 times the rate	$ 350[5]
Surviving Minor Dependent(s) (no surviving spouse), per individual	$ 140[5]
up to a maximum of 2.5 times the rate	$ 350[5]

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.

Employer Contributions

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

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

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[5] All those age 62 and over who retire on or after June 1, 1993 will pay an amount to be based on 66% (or a lesser percentage) of the prior year's benefit cost for certain retiree categories, with a maximum of 2.5 times the individual rate for those with dependents. This amount will be adjusted annually as necessary.

[6] This amount is equal to the current hourly contribution rate times 160, and will be adjusted as the contribution rate changes.

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.

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 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.

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.

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, 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. Provider

Qualified Medical Child Support Order - In accordance with Section 609 of the Employee Retirement Income Security Act (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.

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.

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.

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, 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 months 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).

Any hours in your Reserve Account (also known as "Hours Bank") will be decreased by the number of hours normally required to continue coverage concurrent with the eight Work Quarters; however, your Reserve Account will not be decreased until the number of Work Quarters (full or partial) that you could "buy" with your Reserve Account is equal to the number left under this Disability provision. 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.

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

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.

In addition to the hours counted under the 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.

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 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.

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.

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 proofs 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.

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.

NEWLY ORGANIZED GROUPS

The Plan provides special eligibility rules for employees in newly organized groups. These special rules are set forth in the Summary Plan Description Supplement for Newly Organized Groups (Page 128).

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 Plumbers and Pipefitters National Pension Fund, 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 must pay a monthly charge, however, as determined periodically by the Trustees, in order 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 National Pension 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 must pay a monthly charge, however, as determined periodically by the Trustees, in order 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 Plumbers and Pipefitters 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.

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 Plumbers and Pipefitters National Pension Fund, 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.

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.

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 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 are 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 Carday Associates or 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

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 your or your Spouse's pregnancy, childbirth, miscarriage or therapeutic abortion,[7] but no maternity benefits are provided for non-spouse Dependents. 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.

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;
- blood plasma, plasma extenders, and blood transfusions;
- services of a licensed physiotherapist;

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

- 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;[8]
- 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.

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.

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

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

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 outpatient care that is provided for the treatment of an accidental Injury or a sudden or serious Illness that requires immediate treatment, as determined by the Board of Trustees based on competent medical evidence, including the opinion of a qualified Provider, within 72 hours of the onset of the Injury or Illness. 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 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 or family practitioner who you can see for routine care. If you insist on using the emergency room for such care, however, please be aware that the Plan will not pay any emergency room charges for such care, which will greatly increase the amount of out-of-pocket expenses you will be required to pay.

If you or your Dependents go to an emergency room for a non-emergency condition, all charges except the facility charges are payable as though such services were provided in a Provider's office and will be paid under the Major Medical Benefit.

Charges for Emergency Room services rendered by a Provider that is out of the CareFirst geographic region ("Out-of-Area Emergency Room Services") shall not be subject to an out-of-network deductible. Such charges shall be paid under the Major Medical Benefit using reasonable and customary rates (rather than the discounts available under the Care First PPO or other Blue Cross/Blue Shield networks).

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
- to be covered 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.

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.

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. 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

As required by the Affordable Care Act, the Plan pays 100% of the Usual, Customary, and Reasonable expenses for services identified as required Preventive Services. These services include:

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked (one time in men aged 65-75)
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50 until age 65
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - ❖ Hepatitis A
  - ❖ Hepatitis B
  - ❖ Herpes Zoster

    - ❖ Human Papillomavirus
    - ❖ Influenza
    - ❖ Measles, Mumps, Rubella
    - ❖ Meningococcal
    - ❖ Pneumococcal
    - ❖ Tetanus, Diphtheria, Pertussis
    - ❖ Varicella
- Obesity screening and counseling for all adults
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Annual well-woman physical examination
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention (risk-reducing medications such as tamoxifen or raloxifene) counseling for women at higher risk
- Breastfeeding interventions to support and promote breastfeeding, including breastfeeding supplies
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception
- Domestic and interpersonal violence screening and counseling
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- HPV DNA Test every three years for women with normal cytology results age 30 and older

- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users

Covered Preventive Services for Children

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Blood pressure screening for children of all ages
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents aged 12-18
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and Body Mass Index measurements for children
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella

    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella

- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

In order to be covered as a Preventive Service by this Plan, the Provider must correctly bill for the service. The Provide must either bill separately for the preventive service, or bill for a general office visit in a way that indicates that the primary purpose of the office visit is to provide a Preventive Service.

MENTAL OR NERVOUS DISORDER TREATMENT BENEFITS

A mental or nervous disorder is a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder that is not organic or chemically induced.

Inpatient charges made in connection with the mental and nervous disorders are covered as any other inpatient expense. In addition, charges for outpatient physician visits are covered as any other outpatient physician visit expense and medical emergency care is covered as any other medical emergency care expense.

Benefits are also payable for all other out-of-Hospital treatment for mental and nervous disorders, but are limited to 80% of the Covered Expenses.

When prescribed by a Provider who specializes in psychiatry and who diagnosed the disorder, the following expenses are also allowable charges, subject to the limitations described above:

- group therapy;
- collateral visits with members of the patient's immediate family; and
- services of a qualified psychiatric social worker, a licensed clinical psychologist or a psychiatric registered nurse (R.N.).

No other benefits are provided under the Plan for the treatment of mental and nervous disorders except as provided under this section.

SUBSTANCE ABUSE TREATMENT BENEFITS

If you or your Dependents are confined in a Hospital or other licensed treatment facility for treatment of alcohol or substance abuse, you may be eligible to receive Substance Abuse Treatment Benefits.

Inpatient hospital, inpatient physician visits and outpatient physician visit charges made in connection with the treatment of substance abuse are covered as any other expense. Medical emergency care is also covered as any other medical emergency care expense.

Inpatient detoxification is covered at 80% of Covered Expenses.

Outpatient detoxification covered at 100% of Covered Expenses for the first thirty (30) days per calendar year, and thereafter at 80% of Covered Expenses.

Inpatient rehabilitation is covered at 80% of Covered Expenses.

Benefits are also payable for out-of-Hospital aftercare treatment.

Aftercare treatment is covered at 80% of the Covered Expenses.

No Weekly Disability Benefits are payable for disabilities relating to substance abuse.

No other benefits are provided under the Plan for the treatment of alcohol or substance abuse except as provided in this section.

PRESCRIPTION DRUG BENEFITS

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. Each prescription or refill entitles you to no more than a 30 day supply. This Prescription Drug Benefit is administered by Caremark.

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. 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 the Plan (In-Network pharmacy), the Plan pays for the total cost of the prescription or refill (minus the co-payment). Caremark's National Network contains more than 60,000 retail pharmacies, including all major chains and most independent pharmacies.

If you or your Dependent has a prescription filled or refilled at a pharmacy that does not have an agreement with the Plan (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 the Plan, 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 the Mail Order Program. "Maintenance drugs" are drugs which are prescribed for a long period of time and are necessary to sustain good health. 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.

Mail Order/CVS Pharmacy Program for 90-Day Supply

You and your Dependent(s) may receive up to a 90-day supply of maintenance drugs through the Mail Order Program (for one co-pay) or from a CVS pharmacy. As noted above, the Mail Order/CVS Pharmacy Program 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.

The procedure for obtaining covered prescription drugs through the Mail Order Program is available through the Fund Administrator's office.

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 (however, prescribed compounding drugs are covered with a limit of $100 per prescription);
- 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, unless specified by the prescribing Provider in writing to the satisfaction of the Trustees;
- anorexiants, unless prescribed for the treatment of Attention Deficit Disorder for children up to age 19, or otherwise specified by the prescribing Provider in writing to the satisfaction of the Trustees;
- 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 Caremark 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; or
- 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.
- any benefits in excess of $45,000 (net cost) per person, per calendar year.

Annual Maximums

The maximum amount payable for Prescription Drug Benefits is set forth in the Schedule of Benefits. Prescription drug costs above the annual maximum will be covered under Major Medical.

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 Caremark has identified and included on its internal Formulary List. The Formulary is a list of preferred medications that are safe, effective and economical. The Caremark Formulary was developed by a committee of pharmacists and physicians. This committee meets regularly to discuss new drugs and trends in therapy. These medications are clinically effective and cost-effective to help mange 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.

A ***Covered Non-Formulary*** drug is a brand-name drug that does not appear on the Caremark 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.

A Non-Covered Non-Formulary drug is a brand-name drug that appears on a list of excluded medications provided by Caremark and subject to change from time to time. You may request a list of the currently excluded medications from the Fund Office or from Caremark. These medications are excluded because there are cost effective alternatives available. If you are currently using a medication that gets added to the excluded medications list, or your doctor prescribes a medication for you that is on the excluded list, you must request prior authorization from Caremark in order to request coverage for the prescription. If your doctor can show that an alternative medication already covered by Caremark will not be effective for your or will have undesirable side effects, Caremark will grant authorization for coverage of the medication at the Covered Non-Formulary rate. If you do not receive this authorization, you will be charged the full cost of the medication.

In addition to the above classifications, prescription drugs that are required to be covered as a Preventive Service will be provided at no co-pay. See the section titled "Preventive Services Benefit" for more information.

Medicare Part D

The Medicare, Prescription Drug Improvement and Modernization Act of 2003 ("MMA") added a new prescription benefit for Medicare-eligible participants called Medicare Part D. ***Retirees who are Medicare-eligible MAY NOT participate in the Plan's prescription drug program if they sign up for Medicare Part D.***

The Trustees have determined, with the assistance of an actuary, that the Fund's prescription drug program for Medicare-eligible participants is "actuarially equivalent" to Medicare Part D. This means that, on average, the Fund's benefits are equal to or better than the standard Medicare Part D drug plan. Accordingly, a Retiree who enrolls in Medicare Part D will be excluded from participation in the Fund's prescription drug program as of the effective date of his enrollment in Medicare Part D. If he enrolls, his Dependent(s) will also be excluded from participation in the Plan's prescription drug program. If a Retiree does not enroll, but his Medicare-eligible Dependent independently enrolls in Medicare Part D, the Dependent will be excluded from the Plan's prescription drug program. (Please note that, notwithstanding the above, and in accordance with Medicare's payment rules, individuals with End Stage Renal Disease will not be excluded from the Plan's prescription drug coverage if they enroll in Medicare Part D.) Participants who are excluded from participation in the fund's prescription drug benefit program, however, will still be entitled (along with their eligible Dependents) to participate in the *medical and other benefits (as applicable)* offered by the Plan for Retirees, regardless of their participation in any Medicare program.

Active Employees who are Medicare-eligible are not required to sign up for Medicare Part D, and may still obtain their prescription benefits through the Fund and enroll in Medicare Part D. The Fund will coordinate benefits, as applicable, with Medicare Part D.

As required by the MMA, each Medicare-eligible participant will periodically receive a notice, called a Notice of Creditable Coverage, advising whether the Fund's prescription plan continues to be actuarially equivalent to Medicare Part D. Such participants are also entitled to receive such Notices upon request to the Fund Administrator.

The Plan will permit Medicare – eligible participants who enroll in Medicare Part D a one-time opportunity to re-enroll in the Plan so long as such re-enrollment is made in writing to the Fund Office no later than 180 days of the date the participant enrolled in Medicare Part D.

ORGAN/TISSUE TRANSPLANT COVERAGE

Coverage is provided for certain organ/tissue transplants under the Major Medical Benefit subject to the annual Major Medical Benefit Limitations and Deductibles. Additionally, benefits under this provision shall not be provided for organ/tissue transplants unless 1) the Health Care Financing Administration and four (4) insurance companies are surveyed, and three out of five agree that the transplant is not experimental or investigational in nature; 2) you have been covered under the Plan for at least the previous twelve (12) months (except that this 12-month waiting period will be reduced in accordance with the requirements of the Health Insurance Portability Accountability Act for periods of creditable coverage under another plan upon presentation of a certificate of creditable coverage); 3) a patient screening confirms the appropriateness of the transplantation; and 4) you receive a pre-certification of the transplant from the health-care provider authorized by the Fund to make such a determination.

If the donor and recipient are both covered by the Plan, both the donor's and the recipient's expenses are payable up to the recipient's Annual Maximums set forth in the Schedule of Benefits. 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 subject to the recipient's Annual Maximums set forth in the Schedule of Benefits. 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.

MAJOR MEDICAL BENEFITS

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.

After the annual deductible is met, the Plan pays 80% of certain allowable charges. You are responsible for paying the remaining 20%. 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 the Schedule of Benefits. Major Medical benefits are included in this maximum amount, but Basic and Surgical Benefits are not.

Out-of-Pocket Expense Maximum Benefit

The maximum out-of-pocket benefit as shown in the Schedule of Benefits will benefit you and your family by assuring that a fixed amount of Major Medical out-of-pocket-expenses will be incurred by you each calendar year. After an individual has incurred $5,000 of expenses out-of-pocket for deductibles and other eligible items, the Fund will pay 100% of reasonable and customary charges for the remainder of the calendar year for those items. However, expenses in excess of any designated maximums will not be paid as part of the maximum out-of-pocket benefit.

In addition to the $5,000 individual Out-of-Pocket Expense Maximum, there is a $12,700 Out-of-Pocket Maximum for a family, which includes any Participants with one or more Dependents. After a family has incurred $12,700 of out-of-pocket expenses for deductibles and other eligible items, the Fund will pay 100% of reasonable and customary charges for the remainder of the calendar year for those items. As with the individual out-of-pocket expense maximum, expenses in excess of any designated maximums will not be paid as part of the maximum out-of-pocket benefit.

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, Substance Abuse 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 both home and office 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 physical, 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;

- 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;
- 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; or
- 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.

No benefits are payable under this section until you and your Dependents meet the Major Medical deductible for the year. However, allowable charges that exceed the maximum amounts listed in the Schedule of Benefits are not paid as a Major Medical Benefit unless noted.

OTHER BENEFITS

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.

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.

SHINGLES VACCINATION

A (one-time) Shingles Vaccine is covered for all eligible participants and Dependents **age 60 and over** as recommended by the Center for Disease Control. The vaccine will be covered under all delivery methods, meaning that you may obtain the vaccine using your Caremark 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.

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 of written prior authorization from the Fund Office; 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 approved in advance by the Board of Trustees**. 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 of prior authorization from the Board of Trustees**, participants in need of short-term (six 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 of written prior authorization from the Fund Office.

Coverage is limited to a maximum of 6 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 services are pre-authorized by the Fund, 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;

- speech therapy due to mental, psychoneurotic, or personality disorders;
- more than two visits by a licensed social worker, except for outpatient mental health services;
- treatment of mental Illness;
- 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 a initial medical evaluation; or
- services performed outside the covered person's residence.

DENTAL BENEFITS

After you and your Dependents meet the applicable Dental Deductible for a year as shown in the Schedule of Benefits, the Plan pays for certain dental services, supplies and treatments for you and your Dependents, up to the maximum amounts shown in the Schedule of Benefits. Expenses for preventive care, the treatment of dental abnormalities, Illnesses or Injuries, and the restoration and replacement of missing teeth are covered up to the maximum allowable charges as determined by the Trustees. The Dental Deductible applies to all dental expenses except examinations, X-rays, emergency treatments and charges for prophylaxis or fluoride treatments.

If you or your Dependents receive treatment or supplies from a dentist who has a preferred provider agreement with the Plan, the Plan pays for 100% of your covered expenses, up to the maximum amount shown in the Schedule of Benefits.

If you or your Dependents receive treatment or supplies from a dentist who does not have a preferred provider agreement with the Plan, the Plan pays for 80% of the expenses you would have had if you were covered under the preferred provider agreement, up to the yearly maximum as

shown in the Schedule of Benefits. Any expenses in excess of these maximum amounts must be paid by you or your Dependents.

A list of the dentists with preferred provider agreements with the Plan will be provided to you automatically in a separate document.

Pre-Authorization

If the charges for a written dental treatment plan recommended by your dentist are expected to be at least $200, the plan must be reported to the claims administrator before the treatment begins. Forms requesting this pre-authorization are available from the claims administrator. Once the request is made, the treatment plan and charges will be reviewed by the claims administrator, and your dentist will be advised of your eligibility and the amount that the Plan will pay. After the treatment program is completed, your dentist must submit a claim form to the claims administrator, showing the date that the service was performed.

If you choose not to follow this process, the Board of Trustees will determine the amount to be paid by taking into account alternate procedures or services, based on recognized standards of service.

Covered Dental Expenses

The Plan pays dental benefits for the following services and supplies when they are recommended and provided by a licensed dentist:

- Routine Oral Examinations - including prophylaxis, oral examinations (including dental X-rays); diagnosis, and preparation of a treatment plan.
- Dental Care - including all dental services and supplies that are not covered as routine oral examinations or bridgework and denture replacement, including, but not limited to, the following:
  - tooth extractions;
  - palliative services (care designed to alleviate the symptoms of a dental condition);
  - fillings;
  - crowns;
  - caps;
  - oral surgery not otherwise covered;
  - anesthetics;
  - treatment of gum diseases;
  - root canal therapy;

- tests and examinations other than routine oral examinations;
- preventive services;
- initial installation of fixed bridgework (including inlays and crowns to form abutments);
- initial installation of partial or complete denture (including adjustments for a six-month period following installation); and
- repair of bridgework or dentures (including the addition of teeth, clasps, facings and connectors);

- Bridgework and Denture Replacement - including replacement of an existing partial or complete denture or fixed bridgework, but only if a claim under the Plan has been paid toward the cost of the work being repaired or replaced, and satisfactory evidence is presented that:
  - The existing denture or bridgework was installed at least five years before its replacement and that the existing denture or bridgework cannot be made serviceable, or
  - The existing denture is an immediate temporary denture and replacement by a permanent denture is required within six months from the date of installation of the immediate temporary denture;
- Orthodontic Care is limited to preventive services such as insertion of space maintainers, or services or appliances needed as a result of the bony impaction of a permanent tooth. Dental benefits are not payable for comprehensive orthodontic treatment or any other services or appliances of an orthodontic nature that are not listed above.

Procedure for Obtaining Covered Dental Care

Through a Preferred Provider

Subject to the Dental Deductible, if a Covered Person receives Covered Dental Care or dental supplies from a Dentist who maintains a preferred provider agreement with the Plan, a Dental Benefit shall be payable for such Covered Dental Care or dental supplies as shown in the Schedule of Benefits.

Through a Non-Preferred Provider

Subject to the Dental Deductible, if a Covered Person receives Covered Dental Care or dental supplies from a Dentist who does not maintain a

preferred provider agreement with the Plan, a Dental Benefit shall be payable for Covered Dental Care or dental supplies as shown in the Schedule of Benefits. Any Covered Expenses incurred in excess of the maximum amount listed in the Schedule of Benefits shall be paid by the Covered Person.

Dental Exclusions

No Dental Benefits are payable for:

- Charges for dental procedures covered in whole or in part under any other portion of this Plan;
- Charges incurred in connection with occupational accidental bodily injuries or Illnesses;
- Charges for dentures, bridges, and crowns and the fitting thereof which were ordered before the date the individual last became eligible for benefits;
- Charges for dentures (including bridges and crowns) which were fitted and ordered while coverage was in force but are delivered to the family member more than 60 days after termination of coverage;
- Charges incurred for the repair or replacement of fixed bridgework, splints, partial removable dentures, or full dentures, unless a period of five years has elapsed from the installation of the replaced appliance;
- Charges for a duplicate denture, replacing the same teeth as in existing dentures, except where an immediate denture is replaced by a permanent denture within six months from the date of installation of the temporary denture;
- Charges for orthodontic treatment or correction of malocclusion except for certain preventive services as approved by the Board of Trustees;
- Charges for the replacement of lost or stolen dentures;
- Charges for services and supplies that are solely cosmetic in nature, unless they are needed because of an injury that occurred while you are covered under the Plan;
- Charges for orthodontic treatment or appliances that are required as the result of the bony impaction of a permanent tooth;
- Charges for more than one set of diagnostic X-rays per year for each person, unless the X-ray is required to diagnose a specific condition or treatment;

- Charges for a dental consultation, if dental services are provided by that dentist on the same day or at any time within the next three months;
- Charges for treatment by anyone other than a dentist, except that cleaning, scaling and polishing may be done by a licensed dental hygienist if supervised by a dentist;
- Charges for crowns or inlays installed as multiple abutments or splints, unless a period of five years has elapsed from the date the crown or inlay was originally installed if the Plan paid a claim toward the cost of the original;
- Charges for prosthetic devices that are replaced within a five-year period, unless the appliance replaces a missing tooth if the Plan paid a claim toward acquisition of the original prosthesis;
- Charges for drugs, medicines, equipment or supplies used for personal hygiene;
- Charges for treatment of temporomandibular joint (TMJ) dysfunction;
- Charges for a drug, medicine or supply intended for personal hygiene such as tooth paste and cleaning devices;
- Charges for treatment exceeding $200 for which preauthorization was not obtained from the Trustees, in excess of the least costly available alternate procedures and services which meet recognized standards of service; and
- Charges for completion of insurance forms or Claims Administrator forms.
- Charges for hospital, surgical, or related services provided in connection with dental services for which benefits are otherwise payable under the Plan.

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. Expenses in excess of this maximum amount are not payable under the Major Medical, Dental Benefits, or any other section of the Plan.

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.

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.

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 24 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 Costco, Visonworks, and HourEyes.

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.

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 anytime 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.

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.

GENERAL EXCLUSIONS AND LIMITATIONS

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;
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;
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 reverse voluntary, surgically-induced infertility;
22. Educational or experimental services or supplies;
23. Treatment of learning disabilities, autism, mental retardation, special education, behavioral problems, developmental delay, or psychological testing;
24. 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;
25. Occupational, myofunctional or pulmonary therapy;
26. Hypnotism, biofeedback, or stress management;
27. Radial keratotomy;
28. Transportation of family members, medical personnel, supplies or equipment;
29. Treatment of sexual dysfunction or transsexual surgery;
30. Acupuncture;
31. ;
32. Elective abortions (except therapeutic abortions), the pregnancy of, or childbirth, or miscarriage by a Dependent child;

33. Failure to appear for a scheduled appointment or to provide claim forms or documents;
34. Nonprescription drugs, vitamins, or dietary foods or supplements;
35. Hypodermic needles, syringes or nonmedical substances, except when used in conjunction with insulin injections;
36. Private duty nursing care by a member of the patient's household or family;
37. 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;
38. Medicare Part B premiums and Medicare catastrophic coverage surcharges or surcharges for Covered Employees over age 65 who are Medicare eligible;
39. Whole blood (if not replaced);
40. Treatment for chronic foot conditions, corn paring, or toenail trimming or removal (except for diabetic patients);
41. Wigs, except as related to chemotherapy;
42. Any services or supplies not shown as covered;
43. Care provided in a nursing home, or any other facility that is not a Hospital, except as specifically provided herein;
44. Any benefit not otherwise specifically provided herein; and
45. Charges that exceed the Usual, Customary, and Reasonable fee for such service, supply, etc.
46. Any hospital charges incurred by Medicare-covered participants for treatment of hospital-acquired conditions that Medicare has deemed reasonably preventable and thus non-reimbursable.

If you or your Dependents fail to comply with the pre-certification or concurrent review procedures established by the Board of Trustees to assure that the care being provided is appropriate and necessary, benefits payable under this Plan may be reduced.

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 becomes 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 or your spouse retires while you are covered under this Plan (even if you retire because of Disability), coverage under this Plan is coordinated with Medicare coverage when you reach age 65 and become eligible for Medicare, whether or not you or your Dependents are enrolled under Medicare. 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. As a covered pensioner, or Dependent of a pensioner, for

whom Medicare coverage is primary (pays first), you should submit all of your medical claims to Medicare first. This Plan will then consider a claim for any remaining expenses and pay any balances unpaid by Medicare for covered Plan expenses that are considered Usual, Customary, and Reasonable. The Plan will not pay any hospital charges incurred for treatment of hospital-acquired conditions that Medicare has deemed reasonably preventable and thus not reimbursable. Medicare regulations prevent hospitals from passing these charges on to participants.

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.

IF YOU ARE A RETIREE, YOUR PARTICIPATION IN THE PLAN'S PRESCRIPTION DRUG BENEFIT WILL TERMINATE IF YOU ENROLL IN MEDICARE PART D. (For more information, see the section of the Summary Plan Description entitled "Prescription Drug Benefits/Medicare Part D," above).

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.

PPO UTILIZATION REVIEW AND PRE-ADMISSION

CareFirst Preferred Provider Organization

As a Participant in the Plumbers and Pipefitters Medical Fund, the CareFirst Blue Cross/Blue Shield Preferred Provider Organization (PPO) is available for your use. 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 directories of providers in the CareFirst PPO network to you. You can also look up providers on the CareFirst site, (www.carefirst.com (on the Members and Visitors" tab, click on "Find a Doctor"). 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.carefirst.com. After you click on "Members and Visitors," then "Find a Doctor," click on the "Other Networks" heading at the bottom of the page, and then click on "PPO-National/International Blue Cross Blue Shield Directory" link.

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.

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 and substance abuse treatment. 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:

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

B. **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 be substantially reduced. The amount of the reduction in such cases shall be established and administered on a non-discriminatory basis by the Board of Trustees.**

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 AND APPEALS

Claim Forms

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

Plumbers and Pipefitters Medical Fund
c/o Carday Associates, 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 Carday Associates, 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 Statement of Claim Form	Used for both obtaining a pre-treatment estimate of charges and for filing any dental claim.
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 to the Fund Office 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 Caremark card. Most drug chains, as well as a majority of independent pharmacies, honor the Caremark card.

If you visit a participating pharmacy, your Caremark 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.

One Caremark 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 Caremark 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 upfront. However, you can submit a prescription drug claim form, along with your receipt for the prescription, to Caremark for reimbursement. Caremark 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

A Dental Statement of Claim Form should be obtained from the Fund Office before the first visit to a dentist. This special dental form is a dual-purpose form which may be used by the dentist for a pre-treatment estimate and for the actual billing of dental services upon completion of treatment.

If, after examination, it is found that dental treatment is required, the dentist should be consulted regarding the recommended treatment plan and the total amount of his fee, since charges of $200 or more require pre-authorization by the Fund Office. If the dentist's fee for services and/or supplies will not amount to $200 or more, the dental claim form may be completed by the dentist and submitted to the Fund Office upon completion of the work. If the dentist's fee for services and/or supplies will amount to $200 or more, the dentist must complete a pre-treatment estimate of services and charges on the dental claim form and submit it to the Fund Office for pre-authorization before the treatment is started. The treatment plan and charges will be reviewed by the Medical Fund's dental consultant and the attending dentist will be advised of eligibility and the amount paid by the Plan. After services are completed, the dentist should resubmit the dental claim form for his or her billing.

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.

CLAIMS AND APPEALS

For Group Health Benefits

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 One-Net in advance of obtaining medical care, One-Net, 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 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. For pre-service claims for which you are required to contact the Fund in advance of obtaining medical care, there is one level of appeal, and you should submit your appeal of a denied claim to the Board of Trustees within this 180-day period. For pre-service claims for which you are required to contact One-Net in advance of obtaining medical care, there are two levels of appeal. You may appeal an initial adverse benefit determination by One-Net by submitting a written appeal to One-Net within 180 days of receiving the denial notice. If One-Net denies your appeal of a pre-service claim, you have within 60 days of receiving the denial notice to file a second appeal to the Board of Trustees.

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 the decision of the Fund (or One-Net, in the case of a failure to file a timely second level appeal of a pre-service claim) will be final and binding.

Upon receipt of an adverse benefit determination, or an adverse determination on a first level pre-service claim, 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 neither the Fund nor One-Net 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 (or One-Net) 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 (or, in the case of certain first level appeals of pre-service claims, by One-Net) none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. For pre-service claims with two levels of appeal, the review of the

second level appeal shall be made by the Board or subcommittee thereof, neither of whom decided the first level of appeal nor is the subordinate of any individual who decided the first level of appeal. 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 (and for pre-service claims with two levels of appeal, One-Net will give no deference to the initial adverse determination in deciding 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.

For pre-service claims with two levels of appeal, One-Net will notify you of its decision of a pre-service claim first level appeal within a reasonable period of time, but not later than 15 days after it receives your request for review. The Fund will notify you of a pre-service claim second level appeal within a reasonable period of time, but not later than 15 days after receiving 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 ot review the appeal, or plan to relay on a new or additional rationale, the Fund will provide you 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.

b. Content of Notification

The Fund (or One-Net, if One-Net is deciding the first level appeal of a pre-service claim) 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, 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 Section 5 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 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 and 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 as described in Section Four, Filing a Claim for Benefits.

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 and Weekly Accident and Sickness Benefits

General

To file a claim for Supplemental Workers Compensation Benefits or Weekly Accident and Sickness Benefits ("Supplemental Benefits"), you must follow all of the procedures in the "Claim Forms" section of this booklet.

Notification of Initial Benefit Determination

The Fund will decide claims for Supplemental Benefits 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 application for Supplemental Benefits 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 a right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. 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. 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 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 Plain 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.

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 5 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, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. 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.

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.

Claims and Appeals for Supplemental Benefits

General

To file a claim for Supplemental Benefits, you must follow all of the procedures set forth in the "Claim Forms" section of this booklet.

Denial of Claim for Benefits

If you claim for benefits is denied, in whole or in part, the Fund claims payment 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 a right to bring a civil action under Section 502(a) of ERISA.

This notice will be given to you within a reasonable time but not more than 90 days after your claim is received by the Fund Office. This 90-day period may be extended for up to an additional 90 days if special circumstances require that additional time is needed to process your claim. If an extension is needed for the Fund to process your claim, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which the Fund expects to make a decision. 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 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 60 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 make "legal" arguments; however, you should state clearly why you believe you are

entitled to the benefit of your claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

Notification of Decision on Appeal

a. Timing of Decision on Appeal

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 5 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. The decision of the Board of Trustees on review shall be final and binding upon all parties including the claimant and any person claiming a benefit on behalf of the claimant.

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.

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.

THIRD PARTY LIABILITY CLAIMS (REIMBURSEMENT/SUBROGATION)

From time to time, a person who is eligible to receive benefits from this Plan 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 Plan 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 Plan for any and all expenses incurred by the Plan 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 Plan pays $1,000 in benefits due to injuries resulting from the accident, and you or your spouse is entitled to recover or recovers, due to a legal suit or settlement, any money from the other person, or the other person's insurance company, the Plan is entitled to receive up to $1,000 of such money as reimbursement for the benefits it provided to you or your spouse.

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

As noted above, before the Plan pays any benefits to you or your Dependents, you must sign a written agreement stating that the Plan 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 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 Plan and will be applied first to reimburse the Plan, in full, and without any reduction for attorneys' fees or costs. 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 Plan also provides that it 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 Plan's subrogation right is established by the Plan and not by the agreement. The Plan 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 the Plan pays benefits to you or your Dependents and you do not reimburse it after you recover from another party, or you fail to respond to the Fund's requests for information about the status of your claim, the Plan can withhold and offset any other benefits that may be payable to you or your Dependents, or may take legal action against you, in order to recover the amount paid, plus interest.

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 of Benefits

You may not assign your benefits under the Plan, except that 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 can be considered to be 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.

Erroneous Payments

Every effort will be made to insure 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 anytime. 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 or substance abuse 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 is 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.

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 is located at 10455 Mill Run Circle, Owings Mills, Maryland 21117. The Trustees have also contracted with Vision Services Plan, P.O. Box 2487,

Columbus, OH, 43216-2487, which provides a vision benefit for the Fund's participants through participating optometrists.

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. Caremark, Inc., 2211 Sanders Road, Northbrook, Illinois 60062 provides a prescription drug and mail order drug program for the Fund's participants. The Trustees have also contracted with Chubb Insurance Co., 1801 "K" Street, N.W., Suite 700, Washington, DC 20006 through an insured arrangement, to provide the Supplemental Insured Occupational Accident Benefits. The Trustees have also contracted with American Health Holding, Inc., 7400 West Campus Road, F-510, New Albany, Ohio 43054, to provide utilization management services to the Plan.

Address of the Administrator at the Fund Office

Fund Administrator
Carday Associates, 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

James E. Killeen, III, Chairman
c/o U.A. Local Union No. 5
5891 Allentown Road
Camp Springs, MD 20746

Jack Taylor
c/o U.A. Local Union No. 5
5891 Allentown Road
Camp Springs, MD 20746

Walter "Dick" Harrigan
c/o U.A. Local Union No. 5
5891 Allentown Road
Camp Springs, MD 20746

Employer Trustees

Lou Spencer
Pierce Associates, Inc.
4216 Wheeler Avenue
Alexandria, VA 22304

Michael Apperson
R. M. Thornton
120 West Hampton Avenue
Capitol Heights, MD 20743

Jay Schwab, VP
W.E. Bowers & Associates, Inc.
12401 Kiln Court, Suite A
Beltsville, MD 20705

Professional Advisors

Legal Counsel:	O'Donoghue and O'Donoghue LLP
Auditor:	Salter & Company, 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 Caremark. Vision benefits are administered through Mid-Atlantic Vision Service Plan, Inc. All benefits are processed under a third party administration agreement with Carday Associates, Inc.

(d) No payments provided for in this Plan are insured (except a supplement to workers' compensation) 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 and in accordance with Article XIII of the Plan 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 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.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect

- COBRA continuation coverage, when your COBRA continuation ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of a creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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:

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.

SUMMARY PLAN DESCRIPTION SUPPLEMENT FOR NEWLY ORGANIZED GROUPS

Which Employees Qualify for These Special Rules?

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 participants in the Plan and who currently have Employer-provided coverage. 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 in the Summary Plan Description. Employees must affirmatively make this election. The election will apply for one year and cannot be reversed.

To What Period Do These Special Rules Apply?

The Supplement 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. During this limited period, the Sections below should be substituted for the Sections of the Summary Plan Description with the same title. All other provisions of the Summary Plan Description apply to Employees in Newly Organized Groups during this limited period.

After an Employee in a Newly Organized Group has maintained eligibility for one year, all of the rules and benefits of the Plan apply as described in this Supplement and 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 Supplement, 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 in this booklet .

Initial Eligibility

If you are an Employee in a Newly Organized Group, you will become eligible for benefits on the first day of the month following thirty (30) days after the start of Covered Employment and following the completion of at least 125 hours of work in Covered Employment in the immediately preceding calendar month 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.

Examples of Initial Eligibility for Benefits

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 obligated to contribute to the Fund for any of his employees. Mike will become eligible for benefits from the Fund on May 1 (1st of month following 30 days after the start of Covered Employment) if Mike works at least 125 hours for which contributions are owed to the Fund during the month of April and the Fund receives those contributions (and all other contributions due from the effective date of the collective bargaining agreement) and a list of the Employees in this Newly Organized Group that includes Mike on or before May 15th.

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 <u>not</u> work at least 125 hours for which contributions were owed to the Fund in April. He did work 125 hours for which contributions were owed in May. Bob will become eligible for benefits from the Fund on June 1st provided the Fund receives contributions for May hours (and all contributions due for prior months) and

a list of Employees in this Newly Organized Group that includes Bob on or before June 15th.

Continuing Coverage

Once you have earned your initial eligibility, you will stay eligible under these special rules as long as you work at least 125 hours per month and the Fund receives contributions for those Hours.

If you fail to work at least 125 hours in a month, you will lose your eligibility on the first of the month following the month in which you fail to work at least 125 hours.

After one year following your initial eligibility, the special rules described in this Supplement are no longer applicable to you. For continued coverage, you must meet the "Continuing Coverage" rules of the Plan described in this booklet.

Termination of Coverage

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 Supplement, you can then become eligible for benefits only by meeting the regular Initial Eligibility rules of the Plan as described 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 Supplement, 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 Supplement, the coverage continuation rules described 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 Supplement, the coverage continuation rules for your Dependents described on page 38 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 Supplement, you are not entitled to a Reserve Account or an Unemployment Set-Aside Account or to obtain coverage for benefits through any such Account.

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 provide by the Plan, with the same co-payments and deductibles.

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

Accidental Death Benefit
Death Benefit
Accidental Dismemberment and Loss of Sight Benefit
Supplemental Occupational Accident Benefit
Weekly Accident & Sickness Benefit
Medical Reimbursement Allowance

You will become eligible for these benefits, as well as all other benefits offered by the Plan, after one year, so long as you meet the regular eligibility rules of the Plan.

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 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.

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

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.

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