PIPE FITTERS LOCAL UNION NO. 211
WELFARE TRUST FUND

PLAN AND SUMMARY PLAN DESCRIPTION

As Amended and Restated Effective January 1, 2020

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ABOUT THE PLAN

PIPE FITTERS LOCAL UNION NO. 211
WELFARE TRUST FUND

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This plan document and summary plan description describes the benefits medical, life, and accident, death and disability (AD&D) benefits available under the Pipe Fitters Local Union No. 211 Welfare Trust Fund (the "Plan" or "Fund") to eligible individuals. The Plan is sponsored by a Joint Board of Trustees of the Pipe Fitters Local No. 211 Welfare Trust Fund (the "Board of Trustees").

All medical benefits provided under the Plan are funded directly from the assets of the Plan and are administered by Zenith American Solutions (the "Fund Administrator") and Blue Cross Blue Shield (the "Claims Administrator"). All life and AD&D benefits provided under the Plan are administered by and insured through a group policy with the Union Labor Life Insurance Company ("Union Labor Life").

Provisions Applicable to All Benefits

Any representations or statements made to the Employee or Provider by the Fund Administrator, the Claims Administrator, your Employer, your Union, their representatives or agents about eligibility or benefits under this Plan which disagree with the provisions of the Plan will not:

1. Be considered as representations or statements made by or on behalf of the Plan.

2. Bind the Plan for any benefits under the Plan.

The Board of Trustees reserves the right to terminate, suspend, withdraw, amend or modify the Plan at any time. Any change or termination of benefits will be based solely on the decision of the Board of Trustees and may, in the sole discretion of the Board of Trustees, apply to all covered individuals and their beneficiaries either as separate groups or as one group.

ELIGIBILITY DEFINITIONS

To better understand the benefits provided by the Plan and your potential eligibility for such benefits, you should know the following terms:

1. **Active Employee** - An Employee who has earned eligibility by completing sufficient hours during the relevant Qualifying Period, or by a combination of completing hours and applying hours credited to an Employee's hour bank.

2. **Active Work and Actively-at-Work** - An Employee's status as legally employed by and actively working for a Contributing Employer. A day of absence after employment begins which is excused by the Contributing Employer for illness, vacation or other approved leave of absence such that coverage is still effective as provided for elsewhere herein shall be considered a day of Active Work.

3. **Benefit Period** - The Calendar Month immediately following the Lag Month.

4. **Calendar Month** - Any of the 12 named months of the year commencing with the first day of the month.

5. **Contributing Employer** - Any of the following Employers which make contributions to the Plan on behalf of its Employees:
   a. The Fund;
   b. The Union;
   c. Any Employer which is required to make contributions to the Fund for benefits for the Employer's Employees, subject to the terms of a collective bargaining agreement between the Employer and the Union;
   d. Any Employer which has an agreement in force with the Fund under the terms of which the Employer is obligated to contribute to the Fund to provide health and welfare benefits for the Employer's Employees who are members of the Union; or
   e. Any Employer which has an agreement in force with the Fund under the terms of which the Employer is obligated to contribute to the Fund to provide health and welfare benefits for the Employer's Employees who are Non-Bargaining Employees.

6. **Covered Dependent** – Any Dependent that has been enrolled in and approved for coverage by the Plan.

7. **Dependent** – See definition below in "Coverage for Your Dependents".

8. **Eligible Employee** – Any Employee meeting the eligibility requirements listed below in "Coverage for You".

9. **Employee** - Any individual performing the regular duties for a Contributing Employer.

10. **Fund** - Pipe Fitters Local No. 211 Welfare Trust Fund (also called the "Plan" throughout this document).

11. **Hour Bank** - An account of hours established for each eligible Employee including all hours credited to the account less all hours deducted from the Hour Bank account balance as provided below:

    a. All hours worked by you during any Qualifying Period which are in excess of 140 hours and for which contributions are made by a Contributing Employer will be credited to your Hour Bank account; provided however, 140 hours will be deducted from your Hour Bank each Qualifying Period to provide you with coverage under this Plan. In no event will the number of hours in your Hour Bank account exceed 420 hours, except to the extent that you have maintained a higher balance from prior to January 31, 2017 or any other exception applies. To become initially eligible for benefits, you MUST work at least 360 hours during any 6 consecutive month period; after which you will receive coverage on the first day of the second calendar month following the month in which the 360th hour is worked;

    b. If, during any Qualifying Period, you work fewer than 140 hours for which contributions are made by a Contributing Employer, the number of hours needed to make up the difference will be deducted from your Hour Bank account, if any;

    c. If, during any Qualifying Period, you work fewer than 100 hours for which contributions are made by a Contributing Employer, those hours will not be credited to your Hour Bank but will instead be forfeited to the Fund;

    d. If your coverage would otherwise terminate because the balance in your Hour Bank falls below 140 hours, you will be able to pay the difference in the contributions if you have a minimum of 100 hours between your Hour Bank and your worked hours.

    e. If your coverage is terminated and remains terminated for twelve months, any remaining hours in your Hour Bank will be forfeited; and

    f. If, during any Qualifying Period, the total of the hours you work for which contributions are made by a Contributing Employer plus the balance in your Hour Bank is below 100, you will no longer be considered a self-pay Employee and your coverage will terminate. You will be eligible to apply for conversion coverage under the life and AD&D insurance benefits, and continuation of comprehensive medical benefits coverage under the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA). The complete COBRA provisions are outlined elsewhere in this document.

12. **Hours of Credited Employment** - The hours of employment for which a Contributing Employer is obligated to make contributions to the Plan and for which an Hour Bank account is maintained for each Employee by the Plan.

13. **Lag Month** - The one-month period immediately following the one-month Qualifying Period. The purpose of the Lag Month is to allow the Fund Administrator sufficient time to process the Employers' reporting forms.

14. **Newly Organized Employer** - An employer who was not signatory to a collective bargaining agreement with Pipe Fitters Local Union No. 211 during the term of the last negotiated collective bargaining.

15. **Non-Bargaining Employee** - Any individual performing the regular duties for a Contributing Employer, who does not belong to the Union and who is covered by a Participation Agreement that is submitted and approved by the Trustees. Non-Bargaining Employees include office, clerical, executive, supervisory, and estimators.

16. **Plan** - Pipe Fitters Local No. 211 Welfare Trust Fund (also called the "Fund" throughout this document).

17. **Qualifying Period** - The Calendar Month during which an Employee, by accumulating at least the number of Hours of Credited Employment specified above, will qualify for coverage during the applicable Benefit Period beginning on the first day of the second month after the Qualifying Period ends:

Qualifying Period	Benefit Period
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

18. **Retired Employee** - An Employee who is a Self-Pay Employee and is receiving a Pension from the Plumbers and Pipe Fitters National Pension Fund (also called the "Pension Fund"), who retired on or prior to January 1, 2019 and is eligible under the special rules for retired employees described below. A Retired Employee shall also be called a "Retiree" in this SPD. Effective April 1, 2019, the contribution rate for a Retired Employee will be equal to the rate in effect for COBRA coverage under the Plan.

19. **Self-Pay Employee** - An Employee who is paying the difference in contributions between 100 or more hours worked and the 140 hours of work required to be eligible for coverage. All Self-Pay contributions are based on the current Employer contribution rate. When the hourly contribution rate is increased, the Self-Pay contribution rates will automatically increase accordingly.

    Note: An Employee who does not have 100 total hours between worked hours and hours in his Hour Bank is not eligible to self-pay the remaining contribution and will be required to pay COBRA premiums in order to continue coverage.

20. **Union** - Pipe Fitters Local Union No. 211 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe fitting Industry of the United States and Canada, AFL-CIO.

ELIGIBILITY

Coverage for You

You are in the eligible class if an Hour Bank has been established on your behalf and you are an Employee of:

1. A Contributing Employer in a job classification which is covered by a collective bargaining agreement which is in effect between a Contributing Employer and the Union;
2. A Contributing Employer in a job classification which is not covered by a collective bargaining agreement, but which has entered into a Non-Bargaining Participant Agreement with the Fund;
3. A Contributing Employer and are covered under a Participation Agreement between an Employer and the Fund;
4. A Contributing Employer and are covered under a Helper-Tradesmen Participation Agreement;
5. The Fund; or,
6. The Union.

If you are in the eligible class, you become eligible as follows:

1. If you are in the eligible class on the effective date of this revised Plan and you were covered under the prior Plan, you will become eligible on the effective date of this revised Plan;
2. If you are in the eligible class on the effective date of the revised Plan and you were not covered under the prior Plan or if you enter the eligible class after the effective date of the revised Plan, then if you work 360 hours during any consecutive 6 month period, you will become eligible on the first day of the second calendar month following the month in which the 360th hour is worked. For example, if you were hired on January 25, 2020, you must complete 360 hours to be eligible for coverage within six months of your hire date, or by July 25, 2020. If you complete 360 hours on April 17, 2020, you would become eligible for coverage on June 1, 2020. After becoming initially eligible for coverage, you will maintain eligibility for coverage by completing 140 hours in each Qualifying Period, by having 140 hours in your Hour Bank or, provided you have a combined 100 hours between your worked hours and hours in your Hour Bank, by Self-Paying the difference between 140 hours and your total of hours works and the hours in your Hour Bank multiplied by pro-rated contribution rate.

3. If you return to the eligible class after your coverage under this revised Plan has been terminated for 12 months, then if you work 360 hours during any consecutive 6 month period, you will become eligible on the first day of the second calendar month following the month in which the 360th hour is worked.

4. If you are a Non-Bargaining Employee, you will be eligible on the first day of the second month following your date of employment. Your enrollment forms must be received by the tenth day of the month preceding the date of eligibility. For example, if you were hired on January 25, 2020, you will be eligible on March 1, 2020. Your enrollment forms, premium statement, and check must be received by the Fund Administrator by February 10, 2020.

   Once you complete four consecutive months of Helper-Tradesman coverage, if you later transition to Journeyman status, you would not need to meet the requirements set forth in paragraph 2 above for initial coverage as a Journeyman but instead will be able to maintain eligibility for coverage by completing 140 hours in each Qualifying Period, by having 140 hours in your Hour Bank or, provided you have a combined 100 hours between your worked hours and hours in your Hour Bank, by Self-Paying the difference between 140 hours and your total of hours worked and the hours in your Hour Bank multiplied by the pro-rated contribution rate.

5. If you are an eligible Helper-Tradesman, you will be eligible on the first day of the month following the completion of a 60-day waiting period. Your enrollment forms must be received by the tenth day of the month preceding the date of eligibility. For example, if you were hired on January 25, 2020, you will be eligible on April 1, 2020. Your enrollment forms, premium statement, and check must be received by the Fund Administrator by March 10, 2017.

7. If your coverage is terminated and remains terminated for twelve months, you must satisfy the requirements for initial eligibility in order to being receiving coverage again.

8. The Union or your Contributing Employer may agree to provide you with immediate eligibility for coverage for up to two months. In this case, your Hour Bank will begin with a deficit of 360 hours. Any hours you work during those two months will be treated as follows: Any hours you work up to 99 hours will not remain in your Hour Bank but will be forfeited to the Fund. Any hours you work from 100 to 139 hours may be used to qualify you to self-pay for coverage in the future, and any hours you work over 140 hours will automatically be used to repay the deficit of 360 hours in your Hour Bank. You must accumulate 140 hours in your Hour Bank during this two month period in order to continue coverage beyond the end of the second month without self-paying for coverage.

Special Eligibility Rules for Retirees

Medical Benefits:

If you retired on or prior to January 1, 2019, you are also in the eligible class for medical benefits if:

1. You have not attained age 65 or otherwise lost eligibility status under the Plan;
2. You were continuously covered under the Plan immediately prior to receiving retirement benefits from the Pension Fund or Social Security; and
3. Your monthly self-payments are received on a timely basis.

Retiree coverage is no longer available for individuals who retire after January 1, 2019.

If you are eligible for medical benefits after your retirement, your Spouse and your eligible Dependents covered under the Plan prior to your retirement may also remain in the eligible class for medical benefits until the earliest of:

1. The date you attain age 65 or otherwise lose eligibility status under the Plan;
2. The date that Spouse or Dependent attains age 65 or otherwise loses eligible status under the Plan (i.e. through divorce);
3. The date your monthly self-payments are not received on a timely basis.

Life Insurance Benefits:

If you retired on or prior to January 1, 2019, you will be eligible for life insurance after your retirement if you were covered under the Plan's life insurance through the date on which you attain age 65, you were actively working through the date on which you attain age 65 and you had either (a) at least 12 months of active life insurance coverage immediately preceding the later of the date on which you attain age 65 or retire or (b) at least 12 months of continuous active life insurance coverage after the date on which you attain age 65.

If you retired before October 1, 1992, you are also in the eligible class for life insurance benefits if you were continuously covered as a participant under the comprehensive medical benefits portion of the Plan both on and before September 30, 1992 and prior to your death.

Medical Coverage for Your Dependents

(Note: Dependents are not eligible for life and AD&D insurance benefits.)

The term "**Dependent**" means

1. An Eligible Employee's lawful spouse;

   Or,

2. Any of the following persons, beginning from birth and lasting until his or her 26th birthday:
   a. The natural born child of an Eligible Employee;
   b. The adopted child of an Eligible Employee or child placed in the home of an Eligible Employee for the purpose of adoption;
   c. The foster child or other child of whom an Eligible Employee is the legal guardian; or
   d. The child of an Eligible Employee's Spouse, if the Spouse is an eligible Dependent under this Plan and if a divorce decree or other court order has ordered that the Spouse provide medical coverage for such child.
3. A never married child who would otherwise cease to be eligible under the Plan by virtue of attaining the age limitation for a Dependent may qualify as a Dependent if he or she is incapable of self-support due to a disability or handicap. For eligibility to be established and maintained, the disability or handicap must have occurred prior to the child's attainment of age 26 and the Eligible Employee must submit, on at least an annual basis, or as requested by the Fund Administrator, documentation of the continuation of the disability or handicap and a copy of the Federal income tax return confirming the child's status. Should the Dependent recover from the disability or handicap such that he or she is capable of self-support, the child will no longer be eligible for coverage under the Plan. All other Plan provisions will continue to apply.

In any event, no benefit claim payment shall be made on behalf of a Dependent until the Eligible Employee has provided proof of the individual's status, as described below and as may be required by the Fund Administrator.

Spousal Enrollment Requirements

If your spouse is employed and their employer offers medical coverage, they must enroll in such coverage. For this purpose, medical coverage offered by your spouse's employer does not include a plan for which your spouse is required to pay the entire cost of such coverage (i.e., coverage for which there is no subsidy provided by your spouse's employer). If your spouse is offered coverage for which he or she is required to cover the entire cost of coverage, the Plan will require proof that there is no employer contribution to the cost

of coverage in order to avoid the Plan's general requirement that a spouse enroll in such coverage.

The Plan will be secondary to your spouse's other coverage. All participants must complete a spousal certification during the completion of the Fund's annual demographics form. If it is discovered that a spouse has the ability to obtain coverage through their employer and they elect to not obtain such coverage, the Plan will immediately terminate coverage and request reimbursement for any claims paid by the Plan on behalf of the spouse. The participant will then be responsible for any claims paid by the Plan on behalf of the spouse.

Documentation for Dependents

The following is a list of the documentation that the Fund will accept as proof of your Dependent's status. You should be aware, however, some coverage situations require different evidence to establish and maintain eligibility. Therefore, the Fund may require more than one of the following categories of proof, at its sole discretion.

1. **For your Spouse:** your Spouse's birth certificate and:
   a. Your marriage certificate; or
   b. The county courthouse registration of your common-law marriage (also referred to as an informal marriage).
2. **For your Children**:
   a. Your natural born child/ren birth certificate/s;
   b Your Spouse's divorce decree or other court order, confirming that your Spouse has been ordered to provide medical coverage for his or her child;
   c. A court's decree naming each adopted child or each child who has been placed in your home for purposes of adoption;
   d. A court's decree granting you legal guardianship for each foster child or another child;
   f. A court-issued Qualified Medical Child Support Order (QMCSO) for each child for whom you or your Spouse are required to provide health care coverage;
   g. Continuing disability documentation and a copy of your Federal income tax return showing that you claim the disabled child as your Dependent; and/or
   h. At the Fund's sole discretion, other reasonable evidence attesting to the above.

Reporting Changes in the Eligibility of Dependents

You should notify the Fund Administrator any time that you acquire a Dependent, for example, upon marriage or the birth or adoption of a child. You must also notify the Fund Administrator when a Dependent is no longer eligible.

If you enroll a child in the Plan and the child later becomes eligible for employer-sponsored health coverage (other than through the employer of his or her parent), then you must notify the Fund Administrator to end the child's participation in the Plan. Failure to notify the Fund Administrator once a Dependent is no longer eligible to participate in the Plan may constitute fraud.

Waiving Dependent Coverage

A participant may waive coverage for a Spouse or other Dependent by signing a waiver of coverage in the form provided by the Fund Administrator. Coverage for your Spouse may not be waived in anticipation of a divorce (i.e., before the divorce is final) and coverage for a Dependent may not be waived for purposes of obtaining entitlement to Medicaid coverage.

In the event coverage is waived, except in the case of HIPAA special enrollment rights or an applicable qualified Medical Child Support Order, the individual for whom coverage has been waived may not be re-enrolled in Plan coverage earlier than the first day of the calendar year that begins at least 12 months following the effective date of the waiver of coverage. For example, a Dependent for whom coverage is waived as of July 1, 2020 may not re-enroll in Plan coverage until the calendar year beginning January 1, 2022.

Effective Dates for Coverage

For Medical Benefits: You will be covered on the date you become eligible. Your dependents will be covered beginning on the date each dependent becomes eligible.

For Life and AD&D Benefits: Coverage will begin on the date you become eligible; provided that:

1. You have completed a full day of Active Work on that date;
2. You have completed a full day of Active Work on your last regularly scheduled work day and are able to work on the date you become eligible; or,
3. For Retirees and Self-Pay Employees, you are able to engage in your normal activities.

   You will be considered unable to engage in your normal activities if, due to an Injury or Illness, you are medically confined or regularly treated by a Home Health Agency under a plan of treatment established and approved by a Physician. ("Medically confined" means that, due to Injury

or Illness, a person is an inpatient at a Hospital, Convalescent Facility, Hospice or any other facility engaged in the treatment of Injury or Illness.)

If you do not meet the requirements of 1, 2 or 3 above, the life and AD&D insurance coverage will become effective on the date you return to Active Work, or for Retirees and Self-Pay Employees, the date you are able to engage in your normal activities.

CHANGING YOUR PLAN ELECTIONS AND DEPENDENTS

To comply with the Federal legislation commonly referred to as "HIPAA", the Plan will provide the following special enrollment periods with respect to medical coverage during which you may change your elections under the Plan:

1. **Individuals Losing Other Coverage**. An Employee who is eligible, but not enrolled, for coverage under the Plan (or a dependent of an Employee if the dependent is eligible, but not enrolled, for coverage under the Plan) may become covered under the Plan if each of the following conditions is met:

    a. the Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent;

    b. the Employee's or Dependent's coverage described above:

        (I) was under a COBRA continuation provision and the coverage under that provision was exhausted; or

        (II) was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated.

    c. The Employee makes the new benefit election to add coverage no later than 30 days after the date of exhaustion of coverage described above;

    d. The Employee's or Dependent's Medicaid or children's health insurance plan coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination;

    e. The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a children's health insurance plan, and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

2. **New Dependents**. If a person becomes a Dependent of an Employee through marriage, birth, or adoption or placement for adoption, and therefore is eligible for coverage under the Plan except for any enrollment restrictions, the Employee, the new Dependent and, in the case of birth or adoption or placement for adoption, the spouse of the Employee, may

become covered under the Plan, provided the Employee makes the new benefit election within the 90-day period beginning on the later of the date the Dependent coverage is made available or the date of the marriage, birth, adoption or placement for adoption.

3. **Effective Dates**. Coverage for Dependents added through marriage is effective as of the date all of the paperwork necessary to establish eligibility, in the Fund's sole discretion, is received by the Fund Administrator, provided it is received within the 90-day period mentioned above. Coverage for Dependents added through birth, adoption or placement for adoption is effective on the date of birth, adoption, or placement for adoption provided all of such necessary paperwork is received within the 90-day period. Otherwise, coverage for Dependents will be effective on the first day of the month after all necessary paperwork is provided.

TERMINATION OF COVERAGE

When Coverage Ends

1. Your Plan coverage will cease on the earliest of the following dates:
   a. the date the Plan ceases;
   b. the date the Plan ceases to provide coverage to the class of Employees in which you belong;
   c. the date you are no longer a member of the eligible class;
   d. the date ending the period which applies to the last full or partial contribution made by you or on your behalf, if you are required to pay a part of the cost of the Plan;
   e. the first day of any Benefit Period, if fewer than 140 hours for the applicable Qualifying Period were credited to you, unless you are eligible under the terms of the Plan to continue as a Self-Pay Employee and make all required contributions as such;
   f. the first day of any Benefit Period, if fewer than 100 hours for the applicable Qualifying Period were credited to you, including both hours worked and hours in your Hour Bank;
   g. the first day of any Benefit Period next following the determination that you are no longer dependent for your livelihood on Covered Employment as defined by the Collective Bargaining Agreement;
   h. the first day of any Benefit Period next following the determination that you are performing any employment in the Pipe Fitting Industry within the jurisdiction of the Union and the employment is not covered by a Collective Bargaining Agreement between the Employer and the Union; or
   i. with respect to life and AD&D coverage, the date you enter into full-time active duty with the armed forces of any country.
2. Your Dependents' medical coverage will cease on the earliest of the following dates:
   a. the date ending the period which applies to the last full or partial contribution made by you or on your behalf for such Dependent coverage, if you are required to pay a part of the cost of the Plan;
   b. the date your coverage ceases;
   c. the date a Dependent ceases to be eligible as a Dependent, except as provided under the section "For Handicapped Children";
   d. the date you provide the Plan with proof of your Dependent's other available medical coverage (in which case you may not again re-enroll your Dependent in Plan coverage); or,

e. the first day of any Benefit Period next following the determination that you are performing any employment in the Pipe Fitting Industry within the jurisdiction of the Union and the employment is not covered by a Collective Bargaining Agreement between the Employer and the Union.

When Coverage Ends for a Handicapped Child

Medical care benefits may be continued for a never married dependent child who is mentally or physically handicapped and unable to earn a living and who is dependent upon you for support. Within 31 days after the Dependent reaches the otherwise applicable age limit, you must:

1. Furnish proof of the Dependent's handicap; and,
2. Agree to make the required contributions, if any.

Any coverage continued for the dependent child will cease as provided under 2.a. or 2.b above. Also, the coverage will cease when the handicap ceases or at the end of the 31-day period after any required proof is not furnished.

During the first 2 years of the continued coverage, proof of the handicap may be required at reasonable intervals. After the 2-year period, proof of the handicap will not be required more often than once a year.

Extended Benefits Provisions

If coverage ends while your Dependent or you are totally disabled by an Injury or Illness for which Covered Expenses are being incurred, benefits will be paid for those Covered Expenses after that date for that Injury or Illness.

However, no benefits will be paid after the earliest of:

1. The date the total disability ceases.
2. The date the person becomes covered under a similar group plan.
3. The date the maximum benefits are paid for that Injury or Illness.
4. 12 months from the date coverage for your Dependent or you ends.
5. 3 months from the date the Plan terminates.

Continuation of Eligibility During a Military Leave

If you are eligible to take a leave of absence under the Uniformed Services Employment and Re-employment Rights Act of 1993 ("USERRA"), you are entitled to COBRA-like continuation of coverage rights for your Comprehensive Medical Benefits. You must notify the Fund Administrator

that you have been called to duty. If you have Comprehensive Medical Benefits coverage under the Plan, you may elect to continue that coverage for up to twenty-four (24) months if your election took place after December 10, 2004, or eighteen (18) months if your election began earlier than that, subject to all applicable rules of USERRA. You are required to self-pay 102% of the full cost of the premium for such coverage; provided, however, that if your military leave is less than thirty-one (31) days, you may not be required to pay more than your share of the cost of benefits than if you were an active Employee. You and your Covered Dependents will be subject to any termination of or changes in the Plan that are made while you are on USERRA leave to the same extent as if you had not taken leave and were covered as an Eligible Employee.

Upon your return to work for a Contributing Employer from military leave following an honorable discharge within the time period required by USERRA, your Hour Bank will be restored and you will be entitled to resume your Comprehensive Medical Benefits coverage, without exclusions or waiting periods (except with respect to any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service) on the same basis as is offered to similarly situated employees at the time you return. This applies to both Employee and Dependent coverages, without regard to whether continuation of coverage was elected. If, however, you are not honorably discharged, or if you do not return to work or are not available for work for a Contributing Employer within the time period required by USERRA, you will forfeit your Hour Bank.

The above provision notwithstanding, this Plan will comply with all requirements of USERRA and all future amendments. In the event the Plan or any associated summary plan description shall, by its wording, conflict with USERRA, then USERRA shall apply.

Family and Medical Leave Act (FMLA)

If you are eligible for the benefits provided by this Plan and eligible for a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), your eligibility and Hour Bank will be preserved and you are entitled to continue the Fund's health care coverage during the period of the FMLA leave. You and your eligible Dependents are entitled to continue the same health care coverage you had under this Plan immediately before your FMLA leave. Of course, you and your Covered Dependents will be subject to any termination of or changes in the Plan that are made while you are on FMLA leave to the same extent as if you had not taken leave.

As explained in the Fund's FMLA Policies and Procedures, your Employer must notify the Fund of the type and duration of the FMLA leave that you have requested and are entitled to receive.

Your Employer must also continue to make contributions to the Fund to maintain your coverage during the FMLA leave at the hourly rate specified by the Board of Trustees.

The above provision notwithstanding, this Plan will comply with all requirements of the FMLA and all future amendments. In the event the Plan or any associated summary plan description shall, by its wording, conflict with the FMLA or any regulations finalized thereunder, then the FMLA or such associated regulation shall apply.

Special Continuation of Medical Coverage

For Your Dependents and You -

1. If your Active Work ends as the result of a labor dispute, arrangements may be made by your Union to continue your coverage under the Plan for a period not to exceed 6 months. For this to happen, certain conditions of the Plan must be met. One of these conditions requires that at least 75% of the Employees covered under the Plan agree to make the required contribution for the coverage as provided in the Plan. Your coverage ceases when Active Work ends unless arrangements are made within the time allowed. You should inquire of the Union that represents you regarding arrangements for continuation of your coverage during a labor dispute.

   Coverage may be continued under this provision or under any provision requiring the Plan to offer continuation of coverage under any federal law. Coverage may not be continued under both provisions.

2. If your coverage would terminate due to insufficient hours, you will receive a notice describing your rights to continue coverage under COBRA, provided you pay the required contributions to the Plan when due. The complete COBRA provisions are outlined elsewhere in this document.

   If you are a Retired Employee who retired on or prior to January 1, 2019, your coverage will continue, subject to the terms and conditions of the Plan, including, without limitation, the Plan Sponsor's right to terminate, suspend, withdraw from, amend or modify the Plan at any time, provided you make the required self-payment contribution to the Plan when due and as long as you meet the eligibility requirements as set forth in "Coverage for You" elsewhere in this document.

   If you are a widow or widower of an Active Employee or Retired Employee who retired on or prior to January 1, 2019, you may elect to have your medical coverage continued under the Plan, provided you make

the required self-payment contributions when due. This continued coverage will end on the sooner of the:

a. End of the month in which you remarry; or,

b. Date your coverage under the Plan terminates in accordance with any other Plan provision.

Coverage for a widow or widower of an Active or Retired Employee may be continued under this provision or under any provision requiring the Plan to offer continuation of coverage under any Federal law. Coverage may not be continued under both provisions.

Effective as July 1, 2010, coverage for all Retired Employees and Covered Dependents will terminate upon the earlier of their 65th birthday or their eligibility for Medicare. When a Retired Employee's coverage terminates due to his attainment of age 65 or eligibility for Medicare, his Covered Dependent(s) may elect to continue coverage under any provision requiring the Plan to offer continuation of coverage under any Federal law for a period up to 36 months or until the Covered Dependent attains age 65 or becomes eligible for Medicare, whichever occurs first.

Any individual who retires after January 1, 2019, will no longer be eligible for retiree coverage.

3. If you become totally disabled, while covered under the Plan as an Active Employee, your Hour Bank will be credited with 35 hours per week up to a maximum of 26 weeks. A week is considered 5 days, Monday through Friday. Seven hours are posted per day, 35 hours per week. You do not have to be confined in a Hospital to receive these Hour Bank credits; however, you must be under the personal care of a medical Physician and you cannot work for pay or revenue anywhere on any day when you receive this credit. A Physician's statement must be submitted to certify total disability. The Physician's statement is subject to the reasonable review by the Plan Administrator or the Fund Administrator.

   A period of disability ends and a new one begins when you return to work in Covered Employment for a period of 4 consecutive weeks. When the causes for the disability are different, a new period of disability begins after you return to work for one day.

   Proof of disability should be provided as soon as reasonably possible, but in no event more than 6 months following the onset of the disability.

MEDICAL COVERAGE BENEFITS

Schedule of Benefits

Eligible Employees and Dependents Medical Benefits (including Helper-Tradesmen):

Out-of-Pocket Maximums:

Self-only $5,100

Family coverage $10,200

Calendar Year Maximums:

Spinal Care . . . . . Annual Maximum of $500 of Covered Expenses for treatment/diagnostic services per calendar year per Eligible Individual

TMJ Care . . . . . Maximum of $60 of Covered Expenses for non-surgical treatment/diagnostic services per Non-PPO physician visit; 50 visits per calendar year per Eligible Individual;

Foot Care . . . . . Maximum of $60 of Covered Expenses for treatment/diagnostic services for Non-PPO physician visit; 50 visits per calendar year per Eligible Individual; subject to the Deductible and co-insurance provisions

Coverage, Deductibles and Co-insurance:

Deductible . . . . . $1,250 per Eligible Individual per calendar year; $3,600 per family per calendar year

(All benefits are subject to the Deductible and co-insurance provisions unless otherwise specifically noted.)

Newborn Care . . . . . Out-patient well baby care, 75% PPO or Non-PPO Covered Expenses; Deductible waived; Non-PPO maximum $500, then 10% of eligible expenses incurred for the first 12 months (or up to 1 year of age).

Supplemental Accident Benefit . . . . . 100% of the first $300 of Covered Expenses per accident provided treatment is received within 72 hours of the accident; balance of expenses subject to the Deductible and co-insurance provisions

Co-Insurance: (1)(2)

Preferred Provider Organizations (PPO) . . . . 75% of Covered Expenses

PPO Preventive Care . . . . . 100% of Covered Expenses

Non-PPO Physician Charges . . . . . 50% of Covered Expenses

Non-PPO Facility Charges . . . . . Not covered

Non-PPO Emergency Charges . . . . . 75% of Covered Expenses

PPO TMJ Care . . . . . 50% of Covered Expenses; subject to Plan Maximums

Non-PPO Physician TMJ Care Charges . . . . . 50% of PPO-allowed Covered Expenses; subject to Plan Maximums

Maternity Care . . . . . Covered the same as any other health care claim for Employees and dependent wives

Hospital Room and Board: (1)(2)

PPO . . . . . 75% of Covered Expenses;

Non-PPO . . . . . Not covered

Intensive/Cardiac/Neonatal Care Unit: (1)(2)

PPO . . . . . 75% of Covered Expenses;

Non-PPO . . . . . Not covered

Elective Surgery: (1)(2)

PPO . . . . . 75% of Covered Expenses per procedure

Non-PPO Physician Charges . 50% of Covered Expenses per procedure

Non-PPO Facility Charges . . . . . Not covered

Cholesterol Tests; . . . . . 75% PPO or Non-PPO

Complete Blood Counts; . . . . . Covered Expenses;
Diagnostic X-Rays; Deductible waived; maximum
Electrocardiograms; Fecal Blood of $500 per calendar year
Tests; Routine Gynecological Exams; per Eligible Individual
Immunizations; Mammograms; Occult Blood (unless PPO Preventive Care)
Counts; Pap Smears; Pelvic Exams;
Physical Exams; Prostate Cancer Testing;
Sigmoidoscopy; Stress Tests; Routine and
Microscopic Urinalysis and Colonoscopy
Well Child Care (1 year and over)]

SAV-RX Options:

Prescription Drug Card Benefits:

Generic Drug Prescriptions . . . . . 50% of actual prescription drug cost; maximum of 30-day supply.

Brand Name Drug Prescriptions. . 50% of actual prescription drug cost; maximum of 30-day supply.

SAV-RX Options Mail Order

Mail Order Drug Prescriptions . . . 50% of actual prescription drug cost per 90 day new or refill prescription.

(1) **ALL** non-emergency hospitalizations including those related to maternity **MUST** be pre-certified and **ALL** emergency hospitalizations must be certified within 48 hours of the Hospital admission (or 72 hours if the admission occurs on a weekend or legal holiday). Failure to properly pre-certify a non-emergency hospitalization or certify an emergency hospitalization within the 48 or 72 hours **WILL** result in benefits being paid at 50% of Covered Expenses. Benefits paid at the 50% co-insurance rate are **NOT** subject to the 100% co-insurance provisions. NO benefits are payable for non-emergency Friday, Saturday or Sunday Hospital confinements or for confinements that continue beyond the number of days authorized at the time of the certification. However, the Plan does not, pursuant to Federal law, require that a provider obtain pre-certification for maternity-related hospitalizations of less than 48 hours for a vaginal delivery or 96 hours for a caesarian section delivery. Additional lengths of stay, however, must be pre-certified.

(2) **ALL** elective surgical procedures **MUST** be pre-certified. This includes out-patient surgery and tests or procedures involving an invasion of the

body **MUST** also be pre-certified. Failure to properly pre-certify elective out-patient surgery and/or invasive tests **WILL** result in benefits being paid at 50% of Covered Expenses. However, the Plan may not, under Federal law, restrict benefits for any Hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. However, the Plan does not, pursuant to federal law, require that a provider obtain pre-certification for maternity-related hospitalizations of less than 48 hours for a vaginal delivery or 96 hours for a caesarian section delivery. Additional lengths of stay, however, must be pre-certified.

Contracted and Non-Contracted Provider Options

While nothing can prevent you from seeking medical care from any physician you wish, the Plan's reimbursements are limited in certain ways. You have a choice of going to a Preferred Provider Organization (PPO) provider (also called a Contracted Provider in this document) or going to a Non-PPO provider (also called a Non-Contracted Provider in this document). However, Non-PPO physician charges are covered at a lower co-insurance percentage than PPO physician charges and coverage is not provided for facility charges received at a Non-PPO facility.

The co-insurance percentage will vary depending on which type of provider you choose. There is a benefit to seeking medical care from a PPO provider - 75% co-insurance. (Covered Expenses from physicians incurred as a result of out-patient treatment and/or services for TMJ and foot disorders are covered at 50% of the PPO allowance for PPO physicians and at 50% up to a maximum allowable charge of $60 for Non-PPO physicians.) PPO physicians are available only in certain locations.

The benefits for services and supplies of a Non-PPO physician will be subject to the Non-PPO provider co-insurance percentage, which is 50%, of the Usual and Customary Charge. (Covered Expenses incurred as a result of physician treatment for TMJ and foot disorders are covered at 50% up to a maximum allowable charge of $60 for Non-PPO physicians even if the service or supply is ordered by a PPO physician.) The Plan provides no coverage for treatment charges from a Non-PPO medical facility, other than for emergencies as described below.

In limited circumstances, however, the PPO provider co-insurance percentage may apply even if the provider is a Non-PPO provider when:

1. A Physician who is a PPO provider confirms in writing that the proper care for the Eligible Individual is not available from a PPO provider;
2. The Eligible Individual has no choice because of a condition which requires immediate treatment to prevent loss of life or impairment of

bodily functions. (If the Eligible Individual is confined in a non-PPO facility, the person may, at no further expense to that person, be moved to a facility which is a PPO facility when the Physician verifies the person's condition is stable, recovering and no longer in a life-threatening condition. At that time, if the person elects not to be moved, reimbursement for the remaining Covered Expenses for that confinement and any subsequent treatment by Non-PPO providers shall not be covered.); or,

3. The Eligible Individual receives treatment performed in a PPO facility by a Non-PPO provider, whether or not the treatment is performed as a result of a life-threatening condition, when the individual had no choice of provider (such as hospital-based ancillary physicians).

In such a case, the PPO provider co-insurance percentage will be applied to the portion of the Physician charges that fall within the Usual and Customary Charges.

A searchable list of PPO Network providers can be accessed online at the Zenith American Solutions or BCBS websites – www.zenith-american.com www.bcbsil.com – where they will have links to both the medical and pharmacy PPO network sites. For even more updated information, call the PPO Network phone number on your ID Card. You should be aware that medical providers are added and deleted from the list regularly, so you should check the lists of network providers immediately PRIOR to you obtaining medical treatment, if possible.

Regardless of whether or not you choose a PPO or a Non-PPO provider, all of the Plan's benefits are coordinated with those of other plans under which you or one of your Dependents are covered. For a more detailed explanation of how Coordination of Benefits works, see the "Coordination of Benefits" section elsewhere in this document.

Covered Expenses Incurred while Covered

In order for medical benefits to be paid under the Plan, the Covered Expenses must be incurred while you or your Dependent are either:

1. Covered under the Plan as an Active Employee, Self-Pay Employee or Retired Employee; or,
2. Covered under the Extended Benefits provisions of the Plan.

Deductible Provisions

The Plan has two separate Deductibles, an individual deductible of $1,250 and a family deductible of $3,600. The Deductible applies separately to each Eligible Individual once each calendar year except as provided in the following paragraphs. Combined deductibles for all your family members

may be used to satisfy the family deductible; however, no one person can contribute more than the individual deductible amount toward the family deductible.

Calendar Year Maximum Provisions

The term "Calendar Year Maximums" refers to those benefits that have an annual benefit payment limit as shown in the Schedule of Benefits. They apply separately to the Covered Expenses of each Eligible Individual. In no event will the benefit payments by this Plan exceed:

1. **Spinal care** - $500 per calendar year per Eligible Individual. This benefit is subject to the Deductible and co-insurance provisions.
2. **TMJ Care** - Maximum of 50 visits per calendar year. This benefit is subject to the Deductible and co-insurance provisions.
3. **Foot Care** - Maximum of 50 visits per calendar year. This benefit is subject to the Deductible and co-insurance provisions.

Hospital Confinement/Elective Surgery Review And Approval

REMEMBER! The Plan requires that all Hospital admissions, elective surgical procedures and/or invasive tests be reviewed and approved in advance by Blue Cross Blue Shield. Blue Cross Blue Shield can be contacted at the phone number on your identification card. In addition, emergency Hospital admissions must be certified by Blue Cross Blue Shield within 48 hours of the admission (or 72 hours if the admission occurs on a weekend or legal holiday). Non-compliance will result in lesser benefits being paid.

While you may receive assistance with the certification process from a provider, it is ultimately your (or a family member's) responsibility to meet this requirement.

Examples of surgical procedures which require Pre-certification:

1. Adenoidectomy
2. Arthroscopy
3. Bariatric Lap Band Surgery
4. Breast biopsy
5. Carpal tunnel release
6. Cataract extraction
7. Dilation and curettage
8. Hammertoe procedure
9. Hemorrhoidectomy
10. Herniorrhaphy
11. Meniscectomy
12. Myringoplasty
13. Tonsillectomy
14. Tubal Ligation

Out-of-Pocket Maximums

The Plan protects you from catastrophic medical costs by limiting the amount you must pay out of your own pocket each year for the combination of Deductibles and Coinsurance. Once your share of Covered Expenses reaches the out-of-pocket limit described in the Schedule of Benefits, the Plan pays 100% of most Covered Expenses for the rest of the calendar year. Your out-of-pocket maximum is based upon the number of people you cover and whether you use network providers.

The following do not count toward the annual out-of-pocket maximum:

1. Charges that exceed the Covered Expenses as determined by the Claims Administrator;
2. Charges that exceed program limits;
3. Charges for non-covered services.

9 Ways to Control Your Health Care Expenses

You can control your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing all 9 Ways to Control Your Health Care Expenses, you will positively affect your pocketbook and your health.

1. **Treat yourself right.** Many Injuries or Illnesses can be prevented. Major Illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing Illness, both major and minor. Remember to wear your seatbelts when driving and take the time to be careful around your home to avoid unnecessary household accidents.
2. **Ask "dumb" questions.** Actually, the only dumb questions are the ones you don't ask.
    - Ask about charges on your Hospital bill if you don't understand them. All Hospitals have people who can help answer your questions.
    - Patients who are informed about what to expect during their Hospital confinement usually recover faster and have fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!
    - Inquire about the costs of medications. Generic drugs often cost less than name brands and your Physician may prescribe generic drugs if you ask.
    - If you have any doubts or questions about a treatment or procedure

your Physician has recommended for you, seek a second opinion from another Physician or health care professional.

3. **Don't be in when you can be out.** Ask your Physician about the use of out-patient services in your Hospital or Physician's office for tests, treatment and many types of minor surgery. Out-patient is always less expensive than a Hospital confinement and can often accomplish the same objective.
4. **Use the emergency room for "emergencies".** Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.
5. **Understand your coverage before you have to use it.** Make sure you understand your health coverage. Read this Booklet. It describes how the benefits work and what is not covered.
6. **The shorter your Hospital confinement, the less YOU pay.** When it's practical, have tests performed before you enter the Hospital. And, except in emergencies, avoid being admitted to the Hospital at night or on a holiday or weekend because you may spend unnecessary time waiting for surgery or special treatment. Also, it is important to leave the Hospital when you no longer are in need of medical care.

   Remember - your benefits will be reduced if it is determined your Hospital confinement was unnecessary, begins on a weekend or holiday when admission at that time is not Medically Necessary or you remain in the Hospital for more days than have been certified as Medically Necessary for your condition.
7. **Don't expect a "free lunch".** Be a cost-conscious consumer. Even though the Plan or the government may pay for most of your health care needs, the services and treatments you receive are never free. If you make an effort to control how you use health care services, everyone will benefit ... especially you!
8. **Watch for early warnings!** Learn the early warning signs of Illnesses such as heart disease and cancer. Early detection of Illnesses could save your life and will save you money.
9. **Use the Preferred Provider Organization (PPO).** Your benefits under the Plan are only available if you use PPO Providers (except in limited circumstances; see the "Choice of Providers" section elsewhere in this document).

These 9 steps should lead you to better health and lower medical expenses!

MEDICAL BENEFITS DEFINITIONS

To better understand the medical benefits provided by this Plan, you should know the following terms:

1. **Birthing Center** - A place licensed as such by an agency of the state. If the state does not have any license requirements, the Birthing Center must meet all of the following tests:
   a. It is primarily engaged in providing birthing services for low risk pregnancies;
   b. It is operated under the supervision of a Physician;
   c. It has a least one licensed registered nurse certified as a nurse midwife in attendance at all times;
   d. It has a written agreement with a licensed ambulance service for that service to provide immediate transportation of your Dependent or you to a Hospital, as provided in Item e below if an emergency arises; and,
   e. It has a written agreement with a Hospital located in the immediate geo-graphical area of the Birthing Center to provide emergency admission of your Dependent or you.
2. **Care of Spinal Conditions** - Care connected with the detection or correction by manual or mechanical means of:
   a. Structural imbalance;
   b. Distortion;
   c. Subluxation; and,
   d. Provided such care is for purposes of:
      (I) Removing nerve interference and its effects;
      (II) Interference which is the result of or related to distortion; and/or,
      (III) Misalignment or subluxation of or in the spinal column.
3. **Complications of Pregnancy** - The term "Complications of Pregnancy" means:
   a. Conditions requiring Hospital confinement (when the pregnancy is not terminated) provided the diagnosis/es is/are distinct from the pregnancy but are adversely affected by the pregnancy or is/are caused by the pregnancy; such as nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity (Complications of Pregnancy does not include false labor, occasional spotting, Physician prescribed rest

during the period of the pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct Complication of Pregnancy); or,

b. Non-elective cesarean section, ectopic pregnancy that is terminated and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not probable.

4. **Contracted Provider** - A health care provider that contracts with the Plan, either individually or through a PPO, to provide a service or supply covered under the Plan for a Pre-determined Charge.

5. **Convalescent Facility** - A legally operating institution or a distinct part of one which:

   a. Is supervised by a resident Physician or a resident registered nurse;

   b. Requires that the health care of each patient be under the supervision of a Physician;

   c. Requires that a Physician be available to furnish Medically Necessary care in emergencies. Provides 24-hour nursing services;

   d. Provides facilities for the full-time care of 5 or more patients; and,

   e. Keeps clinical records on all patients.

6. **Covered Expenses** - The items of expense for which Comprehensive Medical Benefits may be paid are called "Covered Expenses". A partial list of Covered Expenses is outlined on the following pages.

7. **Crisis Stabilization Unit** - A 24-hour live-in program that is short term in nature and that provides strict supervision and highly structured activities to persons who show signs of acute and intense psychiatric crisis.

8. **Custodial Care** - Services, including room and board, or supplies provided to a person which consists primarily of that basic care given to maintain life and/or comfort with no reasonable expectation of cure or improvement of the Illness or Injury.

9. **Eligible Individual** - The term "Eligible Individual" refers to those Employees who have satisfied the initial eligibility requirements (outlined elsewhere herein), as well as their eligible Dependents, if any.

10. **Experimental and/or Investigational Services** - Services which have not been clinically proven to be safe and effective based upon available professional assessments. The Plan reserves the right to make the final determination in case a dispute should arise. Your rights to appeal a decision made by the Plan appear elsewhere in this document.

11. **Home Health Care Agency** - The term "Home Health Care Agency" means a:
    a. Hospital certified by the State Public Health Law to provide home health care services;
    b. Public home health care service certified as approved by the State Public Health Law; or,
    c. Home Health Care Agency that is federally certified.
12. **Hospital** - An institution legally operating as a Hospital which is:
    a. Mainly engaged in providing inpatient medical care for the diagnosis and treatment of an Injury or Illness and routinely makes a charge for such care;
    b. Supervised by a staff of Physicians on the premises;
    c. Providing 24-hour nursing services by registered nurses on the premises;
    d. Operated with organized facilities for operative surgery on the premises.
    e. In no event will "Hospital" include any institution:
        (I) Which is run mainly as a rest, nursing or convalescent home;
        (II) For which any part is mainly for the care of the aged; or,
        (III) Which is engaged in the schooling of its patients.
13. **Illness** - Sickness or disease. Illness also includes:
    a. Pregnancy with respect to a covered Employee or a Covered Dependent wife; and
    b. Complications of Pregnancy with respect to all Plan participants.

    Elective abortions are not included in the definition of "Illness" unless the health of the mother would be in danger if the pregnancy continued or the pregnancy is the result of rape or incest.
14. **Injury** - Accidental bodily Injury which requires treatment by a Physician.
15. **Inpatient Hospital Confinement** - Any Hospital Confinement exceeding 24 hours. All Inpatient Hospital Confinements must be pre-certified, with the exception of those for pregnancies, as listed elsewhere in this document.
16. **Intensive/Cardiac/Neonatal Care Unit** - A unit that is reserved for seriously ill or critically injured patients who need constant observation as prescribed by the attending Physician.

    The unit must provide:

a. Room and board;

b. Nursing care by nurses assigned only to the unit; and,

c. Special equipment or supplies on an immediate standby basis for the unit only.

17. **Medically Necessary and/or Medical Necessity** - Services or supplies provided by:

    a. A Hospital;

    b. A Physician;

    c. Another qualified provider as determined by the Plan; and,.

    d. These services or supplies are Medically Necessary if they are:

        (I) Required for the diagnosis and/or treatment of the particular condition, disease, Injury or Illness;

        (II) Consistent with the symptom or diagnosis and treatment of the condition, disease, Injury or Illness;

        (III) Commonly and usually noted throughout the medical field as proper to treat the diagnosed condition, disease, Injury or Illness; and,

        (IV) The most fitting supply or level of service which can safely be given to your Dependent or you.

    e. When assessing the Medical Necessity of inpatient care, medical symptoms or conditions must require that the proposed services or supplies cannot safely be delivered on an out-patient basis.

    f. Services and/or supplies with respect to a condition, disease, Injury or Illness are not considered Medically Necessary if made, prescribed or delivered solely for the convenience of the patient or the provider. However, coverage is provided for certain non-Medically Necessary items, such as tubal ligations, vasectomies and oral contraceptives.

    g. The fact that a Physician has performed or prescribed a procedure or treatment or prescribed services does not mean that it is Medically Necessary.

18. **Medicare** - Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is now or as it may be amended.

19. **Non-Contracted Provider** - A health care provider which does not have a contract with the Plan to provide services or supplies which are covered under the Plan for a Pre-determined Charge.

20. **Physician** - The term "Physician" means:

    a. A legally licensed Physician or surgeon;

b. Any other legally licensed practitioner of the healing arts rendering services:

(I) Which are covered under the Plan;

(II) For which benefits are required by applicable law to be provided when rendered by such a practitioner; and,

(III) Which are within the scope of the individual's license.

21. **Pre-determined Charge -** The amount of money the Contracted Provider has contracted with the Plan to accept as payment in full for a service or supply that is covered under the Plan.

22. **TMJ Care** – Diagnostic and non-surgical treatment connected with the detection or correction of temporomandibular joint disorders. TMJ Care does not include dental work; such as, but not limited to, orthodontics, fixed or removable bridgework and/or dentures, inlays, onlays, crowns or equilibration, whether done for dental or medical reasons.

23. **Usual and Customary Charge** – The dollar amount that is the lower of the provider's charge or 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same similar service within the geographic area. Contact the Claims Administrator to find out if a provider's proposed charges are within the Usual and Customary Charge limits.

    In circumstances regarding the use of Contracted Providers, the agreement the Plan has with that provider or the network of providers in which the provider participates sets the rate that the Plan will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

Remember: The plan cannot reimburse charges above the Usual and Customary limit, consider charges above the Usual and Customary limit when determining the level of benefits the Plan will pay, or count the charges toward satisfying your annual deductible or coinsurance limits. For the Fund to recognize a provider's fee above the Usual and Customary level as a Covered Expense, there must be documentation, acceptable to the Claims Administrator, verifying that there was something out of the ordinary to warrant the higher charge.

MEDICAL COVERED EXPENSES

All of the Covered Expenses listed in this document shall only be covered if they are incurred and provided to your Dependents or you while they and you are covered by the Plan, as applicable. A charge will be considered incurred as of the date on which the service or supply that results in the charge made is rendered or provided. This means that if your Dependent or you incur expenses after the date the coverage under the Plan has ceased, those expenses will not be considered as Covered Expenses. This is true even though the expenses relate to a condition that began while your Dependent or you were covered by this Plan. The only exception to this provision is the Extended Benefit provisions outlined elsewhere herein. In no event will benefits be paid on behalf of an Eligible Individual which exceed the maximum benefit allowances that appear in the Schedule of Benefits. Unless otherwise specified in this document, all Covered Expenses are subject to the Deductible and co-insurance provisions described under the section "Medical Coverage Benefits".

Covered Expenses are charges for the services and supplies shown below. The services or supplies must be both Medically Necessary for the treatment or diagnosis of an Injury or Illness ordered or prescribed by a Physician, and charges will be covered only to the extent that they do not exceed the Pre-determined Charge if provided by a Contracted Provider or the Usual and Customary Charge generally made in the same locality under similar conditions if provided by a Non-Contracted Provider (to the extent such charges are covered). Covered Expenses also include, however, certain non-Medically Necessary items, including without limitation tubal ligations, vasectomies and oral contraceptives. To the extent that benefits are available for prescription drugs and medicines, coverage will also be provided for special dietary formulas Medically Necessary for the treatment of phenylketonuria or other heritable diseases. (The term "heritable disease" means an inherited disease that may result in mental or physical retardation or death.)

Medical benefits under the Plan include but are not limited to the following Covered Expenses:

1. **Supplemental Accident Benefit** - The Deductible is waived and the Plan will pay 100% of the first $300 of Covered Expenses for each accidental Injury sustained by your Dependents or you. The balance of the Covered Expenses will be covered the same as any other health care claim subject to the Deductible and co-insurance provisions.
2. **Non-Surgical Newborn Care and Immunizations** - The Deductible is waived and the Plan will pay 100% of the first $500 of Covered Expenses for the routine pediatric care of a newborn child rendered by a Physician

in a Hospital from the date of birth through the date of discharge from the Hospital as well as the Covered Expenses for required immunizations.

3. **Spinal Care** - After the Deductible, the Plan will pay up to a maximum of $500 per calendar year of the Covered Expenses incurred by your Dependents or you for treatment and/or diagnostic services, excluding supplies and/or appliances, resulting from the manual or mechanical manipulation of the spine and the surrounding area. All Covered Expenses are subject to the Deductible and co-insurance provisions.
4. **TMJ** - After the Deductible, the Plan will allow up to a maximum of 50 visits per calendar year for treatment and/or diagnostic services resulting from temporomandibular joint or craniomandibular disorders. All Covered Expenses are subject to the Deductible and co-insurance provisions.
5. **Foot Care** - After the Deductible, the Plan will allow up to a maximum of 50 visits per calendar year for treatment resulting from weak, strained or flat feet or instability or imbalance of the feet or for foot conditions such as tarsalgia, metatarsalgia or bunions (other than operations involving the exposure of bones, tendons or ligaments), or the removal by cutting of toe nails (other than the removal of the nail matrix or root) or superficial lesions of the feet including corns, calluses and hyperkeratosis.
6. **Surgical and/or Non-Surgical Inpatient or Outpatient Hospital Care:** * - 75% of the charges by a PPO Hospital for services and supplies required for treatment which is provided by the Hospital and used while at the Hospital for:
    a. Room, board and general nursing care except that part of the Hospital's daily charge in excess of the Hospital's charge for its greatest number of 2-bed rooms will be excluded from Covered Expenses (If the Hospital does not have 2-bed rooms, that part of the daily charge in excess of other area Hospitals' prevailing rates for 2-bed rooms will be excluded from Covered Expenses);
    b. Intensive care while confined in an Intensive/Cardiac/Neonatal Care Unit except that part of the Hospital's daily charge in excess of 2 times the Hospital's charge for its greatest number of 2-bed rooms will be excluded from Covered Expenses (If the Hospital does not have 2-bed rooms, that part of the Hospital's daily charge in excess of 2 times other area Hospitals' prevailing rate for 2-bed rooms will be excluded from Covered Expenses);
    c. Charges for other Hospital services and supplies required for treatment except those charged by outside agencies and supplies which are not used while confined in the Hospital as a bed-patient;*

d. A surgical operation; however, assistant surgeons' eligible charges will be calculated based on 20% of the surgeon's fee;

e. Treatment of Injuries; and

f. Medical emergencies.

7. **Convalescent Facility Care** - If your Dependent or you are admitted to the facility within 7 days following confinement in a Hospital for at least 5 consecutive days, coverage is provided for: *

   a. Room, board and general nursing care except that part of the facility's daily charge which exceeds 50% of area Hospitals' prevailing rate for 2-bed rooms will be excluded from Covered Expenses; and,

   b. Charges for medical services and supplies required for treatment which are provided by the facility and used while in the facility as a bed-patient. Charges incurred after the 60th day of confinement for any one disability will be excluded from Covered Expenses.

8. **Local Ground Professional Ambulance Service** - The Plan will pay the Covered Expenses incurred by your Dependent or you for local ambulance service to and from the nearest Hospital Facility where care and treatment can be given.

9. **Physician's Fees** - The Plan will pay 75% of the Covered Expenses incurred by your Dependent or you which is charged by a PPO Physician for: *

   a. Surgical operations which do not appear in the Elective Surgery Review and Approval list or which do appear in that list when pre-certification is obtained prior to the surgery;

   b. Assisting at surgery when required for medical reasons; or,

   c. Administration of a general anesthetic by other than the operating surgeon.

10. **Hyperalimentation or Total Parenteral Nutrition (TPN)** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you provided they or you are recovering from or preparing for surgery.

11. **Private Duty Nursing Care** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you for private duty nursing provided the care is given by a registered nurse or a licensed practical nurse; other than a person related by blood or marriage or who ordinarily resides in your or your Dependent's home. All care must be Medically Necessary and is subject to Case Management Review.

12. **Home Health Agency** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you provided that the plan of care:
    a. Is prescribed by a Physician;
    b. Is reviewed and approved by the Physician every 2 weeks;
    c. Contains a statement expressing the belief of the Physician and the Home Health Agency that:
        (I) The number of days of home health care does not exceed the number of days of confinement in a Hospital or Convalescent Facility which would have otherwise been required;
        (II) The home health care will probably cost less per day than the daily rate for confinement in a Hospital or Convalescent Facility;
        (III) Confinement in a Hospital or Convalescent Facility would otherwise be required; and,
        (IV) A copy of the plan of care is provided to the Plan by the Eligible Individual or the Eligible Individual's Physician for review by Case Management.
    d. Home health care includes:
        (I) Skilled nursing care provided the care is given by a registered nurse, a licensed vocational nurse or a licensed practical nurse other than a person related by blood or marriage or who ordinarily resides in your or your Dependent's home provided it is deemed Medically Necessary upon review by Case Management.
        (II) Home health aide provided the care is given by a registered nurse, a licensed vocational nurse or a licensed practical nurse other than a person related by blood or marriage or who ordinarily resides in your or your Dependent's home provided it is deemed Medically Necessary upon review by Case Management.
    e. Home health care does not include housekeeping or Custodial Care.
13. **Initial Purchase of Artificial Limbs and/or Eyes** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you provided the loss of the limb or eye is the result of:
    a. An accidental Injury; or,
    b. A surgical operation.

Charges for the replacement of artificial limbs and/or eyes will only be considered Covered Expenses if the purchase is for a person who is under the age of 18 and the cause is due to skeletal growth.

14. **Purchase of Medical/Surgical Supplies** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you which result from the purchase of Medically Necessary Medical/Surgical Supplies which is used in conjunction with the treatment of an Injury or Illness such as, but not limited to:
    a. Rigid back or leg braces;
    b. Splints or casts for the treatment of any part of the legs, arms, shoulders, hips or back;
    c. Specialized surgical dressings or bandages;
    d. Crutches;
    e. Trusses;
    f. Insulin and other supplies used only for the care or monitoring of diabetic patients; and,
    g. Colostomy sets.
15. **Rental of Durable Medical Equipment** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you which result from the rental (but not to exceed the purchase price) of Medically Necessary Durable Medical Equipment which is used in conjunction with the treatment of an Injury or Illness such as, but not limited to:
    a. Hospital bed or manually operated wheelchair;
    b. Breathing assistance apparatus;
    c. Kidney dialysis equipment;
    d. Oxygen and the equipment required to administer the oxygen; and,
    e. Other durable therapeutic medical equipment made and used only for the treatment of an Injury or Illness.
16. **Diagnostic X-Ray and Laboratory Services** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you provided the services are performed by licensed medical personnel operating within the scope of their license for:
    a. Diagnostic X-Ray and laboratory services required for the investigation of specific symptoms and/or complaints;
    b. Physiotherapy;
    c. Speech and hearing therapy; and,

d. Use of X-Ray, radium and other radioactive substances for treatment.

17. **Birthing Center** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by a Dependent wife or an Employee at a Birthing Center. *

18. **Other Transportation** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you which are as a result of transportation within the United States or Canada by railroad or scheduled commercial airline to, but not from, a Hospital which is equipped to furnish special treatment for an Injury or Illness.

19. **Organ Transplant** - After the Deductible, subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you as a result of the following procedures:

    a. Inpatient screening;

    b. Organ procurement, including the transportation of the organ, patient and/or donor;

    c. Surgery for the patient and donor;

    d. Follow-up care in the patient's home or a Hospital; and,

    e. Immuno-suppressant drugs; provided:

        (I) The transplantation is not considered experimental or investigational by the American Medical Association; and,

        (II) The recipient and/or donor is admitted to a transplant center program in a major medical center which has been approved by either the federal government or the appropriate state agency of the state in which the center is located.

    Organ donor coverage is provided to your spouse, children, parents, brother and sisters as explained in the Limitations and Exclusions section of this plan document.

20. **Drugs and Medicines** - After the Deductible and subject to the co-insurance provisions, the Plan will pay the Covered Expenses incurred by your Dependent or you provided the drugs and medicines (a) can only be legally obtained by the written prescription of a Physician, (b) which are approved by the U. S. Food and Drug Administration for the general use by humans, and (c), with regard to the Prescription Drug Card benefits offered by the Plan, are consistent with the table of covered prescription drug benefits below. **

21. **Mastectomy Coverage** - In accordance with the requirements of the Women's Health and Cancer Rights Act of 1998, the Plan includes coverage for breast reconstruction surgery in connection with a

mastectomy procedure. Breast reconstruction surgery in connection with a mastectomy shall, at a minimum, provide for:

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

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

c. Prostheses and physical complications for all stages of mastectomy, including lymphedemas, all in a manner determined in consultation with the consulting Physician and the patient.

As part of this Plan's Schedules of Benefits, such benefits are subject to this Plan's appropriate cost control provisions such as annual deductibles and co-insurance provisions.

22. **Bariatric Lap Band Surgery** - The Plan will cover bariatric lap band surgery, subject to preauthorization by Blue Cross Blue Shield in advance of the treatment. A listing of the PPO network facilities meeting the above requirements may be obtained from Blue Cross Blue Shield.

    In addition, all other terms of the Plan will continue to apply.

23. **Wellness Benefits** - The Deductible is waived and the Fund will pay 75% of the PPO Covered Expenses up to a maximum of $500 per calendar year per Eligible Individual for the following Wellness Benefits (to the extent such Wellness Benefits are not considered Preventive Care by the Administrator):

    a. **Cholesterol Tests** to measure the fat levels in the blood that may indicate heart disease risk factors;

    b. **Complete Blood Counts** to check for anemia, bone marrow function, etc.;

    c. **Diagnostic X-Rays** to detect physical abnormalities;

    d. **Electrocardiograms (EKG)** to record the electrical activity of the heart while exercising to detect heart abnormalities when under physical duress;

    e. **Fecal Blood Tests** to determine whether or not there is blood present in the stool which may be an early warning sign of colon cancer;

    f. **Routine Gynecological Examinations** including general breast and pelvic examinations;

    g. **Immunizations** including, but not limited to, Tetanus, Diphtheria, Hepatitis A and B and influenza;

    h. **Mammograms** (baseline at age 35 and annually after age 40) consisting of an X-Ray of the breast tissue to detect lumps which may be cancerous; ***

i. **Occult Blood Counts** to detect a minute quantity of blood in feces that is not apparent on visual inspection;

j. **Pap Smears** to detect abnormal cells which are an early indication of cervical cancer;

k. **Pelvic Examinations** to examine a woman's cervix for abnormalities;

l. **Physical Examinations** including well child check-ups;

m. **Prostate Cancer Testing** including the Prostate Specific Antigen (PSA) test to detect prostate cancer and other prostate illnesses;

n. **Sigmoidoscopy** consisting of the examination of the lower segment of the rectum and large intestine to check for polyps and other indicators of colon/rectum cancer;

o. **Stress Tests** to detect abnormalities when the body is subjected to physical stress;

p. **Routine and Microscopic Urinalysis** to detect blood and bacteria in the urine that may be caused by tumors or infections. In addition, sugar in the urine may be a sign of diabetes. Other portions of the test indicate the ability of the kidney/s to function properly; and,

q. **Colonoscopy** including the examination of the upper and lower colon to detect signs of colon and/or rectal cancer.

These Wellness Benefits are in addition to the covered diagnostic expenses provided by the Fund. As is the case with all of the benefits provided by the Plan, the Trustees reserve the right at any time to amend, modify or discontinue any benefit provided under the Plan.

24. **Preventive Care -** The Deductible is waived and the Fund will pay 100% of the PPO Covered Expenses for the Preventive Care services, which generally include recommended screenings and immunizations. To confirm whether a specific service is considered Preventive Care, please contact the Claims Administrator.

25. **Prescription Drug Card Benefits** – New and refill prescriptions filled through the SAV-Rx contracted pharmacy network are subject to the following co-payments:

    a. Prescriptions purchased at a network pharmacy:

        • New and refill prescriptions written to dispense generic drugs and brand name drugs are subject to a co-payment equal to 50% of the actual prescription drug cost per 30-day supply;

    b. Prescriptions purchased through the mail order drug program:

        • New and refill prescriptions written to dispense generic drugs and brand name drugs are subject to a co-payment equal to

50% of the actual prescription drug cost per 90-day supply. (The address to send your mail order prescriptions is Sav-Rx, P.O. Box 8, Fremont, NE 68026.)

The following categories of drugs are not covered by the Plan:

- Glucose Monitors) (other than through the Sav-Rx Free Meter program. Contact Sav-Rx for details.)
- Other Syringes – This would be all syringes except for Diabetic Insulin Syringes
- Devices/Appliances
- Abortifacient
- Drugs used for Hypoactive Sexual Desire Disorder (HSDD)
- Drugs used for Cosmetic Purposes
- Fertility Drugs
- Lupron
- Mental Health Drugs – Antidepressants, Antipsychotics, Anti-Anxiety, Hypnotics/Sleep, and Substance Dependency Medications
- Over the Counter Product – Vitamins, Prenatal Vitamins, Non-Sedating Antihistamines, Proton Pump Inhibitors (PPI's)
- Expenses related to gene therapy, as described in the Limitations and Exclusions section.

* **ALL** non-emergency hospitalizations **MUST** be pre-certified and **ALL** emergency hospitalizations must be certified within 48 hours of the Hospital admission (or 72 hours if the admission occurs on a weekend or legal holiday). Failure to properly pre-certify a non-emergency hospitalization or certify an emergency hospitalization within the 48 or 72 hours **WILL** result in benefits being paid at 50% of Covered Expenses. However, the Plan does not, pursuant to federal law, require that you or your provider obtain pre-certification for maternity-related hospitalizations of less than 48 hours for a vaginal delivery or 96 hours for a caesarian section delivery. Additional lengths of stay, however, must be pre-certified.

ALL elective surgical procedures **MUST** be pre-certified. This includes out-patient surgery and tests or procedures involving an invasion of the body, which **MUST** also be pre-certified. Failure to properly pre-certify elective out-patient surgery and/or invasive tests **WILL** result in benefits being paid at 50% of Covered Expenses. However, the Plan may not,

under Federal law, restrict benefits for any Hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. However, the Plan does not, pursuant to federal law, require that a provider obtain pre-certification for maternity-related hospitalizations of less than 48 hours for a vaginal delivery or 96 hours for a caesarian section delivery. Additional lengths of stay, however, must be pre-certified.

Benefits paid at the 50% co-insurance rate do NOT count towards the 100% co-insurance maximums. NO benefits are payable for non-emergency Friday, Saturday or Sunday Hospital confinements or for confinements that continue beyond the number of days authorized at the time of the certification.

** The Eligible Individual must file the original prescription drug and medicine receipts with the claim form to receive benefits for these Covered Expenses. The Fund Administrator will only accept photocopies when the Plan pays on a secondary benefit basis. Secondary benefit basis is explained in the Coordination of Benefits provisions of this document.

*** A "low-dose mammography screening" is defined as the X-Ray examination of the breast using equipment designed specifically for mammography including the X-Ray tube, filter, compression device, screens, films and cassettes which has an average radiation exposure delivered to less than one rad mid-breast with 2 views for each breast.

Limitations and Exclusions

Along with other limitations and exclusions specifically stated herein, benefits will not be paid for charges that are attributable to:

1. An Injury arising from any employment or occupation.
2. An Illness covered by Workers' Compensation.
3. Expenses incurred after the date coverage under the Plan ceases for your Dependents or you for any reason. This also applies even though the expenses relate to a condition that began while your Dependents or you were covered. The only exception to this provision is described under the Extended Benefits provisions.
4. Medical examinations not required for treatment of an Injury or Illness.
5. Routine eye examinations, eye refractions, eye glasses, contact lenses or any type of surgery or appliance used to improve visual acuity and their fittings (except as specifically provided under Covered Expenses).
6. Purchase, fitting, or adjustment of hearing aid/s.
7. Except as explained under Mastectomy Coverage elsewhere in this document, cosmetic or reconstructive procedures and any related service

or supplies which alter the appearance but do not restore or improve impaired physical function except when performed for the:

a. Repair of defects resulting from an accident;

b. Replacement of diseased tissue which was surgically removed; or,

c. Treatment of a birth defect in a child.

8. Experimental and/or investigational services.
9. Custodial Care.
10. Services and/or supplies not specifically listed under Covered Expenses.
11. Services and/or supplies for which the Eligible Individual is not required to pay.
12. Treatment or surgery to change the Eligible Individual's gender.
13. Birth control measures (other than sterilization procedures including without limitation vasectomies or tubal ligations or oral contraceptives).
14. Procedures to reverse sterilization.
15. Education or training.
16. Food supplements.
17. Equipment or supplies made or used for physical fitness, athletic training or general health up-keep.
18. Usual and normal home medical supplies or first aid items.
19. Dental work or treatment which includes Hospital and/or professional charges in connection with:

    a. Operation or treatment in connection with the fitting or wearing of dentures;

    b. Orthodontic care or treatment of malocclusion;

    c. Non-surgical TMJ Care (refer to the Definitions section); or,

    d. Dental care for any operation on or treatment of or to the teeth or the supporting tissues of the teeth except for:

        (I) Removal of tumors;

        (II) Removal of impacted wisdom teeth; and,

        (III) Treatment of an Injury to sound natural teeth other than by eating or chewing (including their replacement) due to an accident occurring while covered under the Plan and for expenses incurred within 2 years from the date of the accident.

19. Treatment of weight loss when another underlying severe medical condition is not present. Severe medical conditions include but are not limited to:
    a. Diabetes;
    b. Hypertension; or,
    c. Cardiovascular disease.
20. Fertility tests, treatment of infertility, artificial insemination or in-vitro fertilization.
21. Services or supplies rendered to a person while acting as a donor of any organ or body element other than for and by a family member such as the Employee, the Employee's spouse, natural mother or father or a natural brother or sister.
22. Elective abortions unless the pregnancy was a result of rape or incest or the life of the mother would be in danger if the pregnancy continued.
23. Services performed by:
    a. Your spouse or you; or,
    b. Your spouse's or your parent(s), sister(s), brother(s) or child(ren).
24. Cosmetic Surgery, unless it is required:
    a. Because of an accidental bodily Injury;
    b. As reconstructive surgery when the service is incidental to or follows surgery which results from trauma, infection, or other disease of the involved part;
    c. As reconstructive surgery because of congenital disease or anomaly of a Dependent child which has resulted in a functional defect; or,
    d. As covered pursuant to the Women's Health and Cancer Rights Act of 1998.
25. Services or supplies which are not Medically Necessary to the treatment of an Illness or Injury, except where coverage is specifically provided for herein.
26. Services or supplies (other than for complications) related to a dependent child's pregnancy, except as specifically provided under Covered Expenses.
27. Services or supplies related to an intentionally self-inflicted injury, unless the injury was a result of an underlying medical condition.
28. Services or supplies incurred as a result of an act of war, whether declared or not, or any related act.
29. Services or supplies incurred as a result of a covered individual's participation in a riot or civil disorder, as well as those incurred as the

result of the covered individual's commission or attempted commission of a felony.

30. Treatment for Mental/Nervous/Emotional Disorders.
31. Treatment for Drug/Alcohol/Substance Dependency.
32. Effective on and after September 11, 2019, expenses related to gene therapy, which typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help a body fight or treat disease, or inactivating genes that cause medical problems, even if those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are not considered experimental or investigational. Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma, and gene therapy for hemophilia.

COORDINATION OF MEDICAL BENEFITS

1. **Application** - If any individual covered under this Plan, which includes this Plan and any other medical care expense benefits provided through or by this Plan, is also covered under one or more other plans, the benefits payable with respect to him/her under this Plan will be coordinated with benefits payable with respect to him/her under all other plans. Coordination will apply in determining the benefits payable with respect to an eligible individual for any claim determination period if, for the allowable expense incurred during that period, the sum of the benefits which would be payable under:

   a. This Plan in the absence of Coordination; or,

   b. All other plans in the absence of provisions for Coordination in those plans, would exceed those allowable expenses.

   Except as provided in the following paragraph, when Coordination of Benefits applies to the benefits payable with respect to an individual for a claim determination period, the benefits that would be payable for allowable expenses incurred during that period under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so the sum of those reduced benefits and all the benefits payable for those allowable expenses under all other plans will not exceed the total of those allowable expenses. Benefits payable under all other plans include the benefits that would have been payable had claim been properly made for them.

   If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following paragraph would require this Plan to determine its benefits before the other plan and the other plan which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, then the benefits of the other plan will be ignored for the purposes of determining the benefits of this Plan.

2. **Order of Benefit Determination** - The rules establishing the order of benefit determination are:

   a. The benefits of a plan which covers the individual as an Active Employee will be determined before the benefits of this Plan which covers that individual as a Covered Dependent or Retiree or as individual using Hour Bank hours in order to be eligible for coverage.

   b. Except for cases of a person for whom a claim is made as a Dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses a claim is based as a Covered Dependent of a person whose date of birth,

excluding year of birth, occurs earlier in a calendar year, will be determined before the benefits of a plan which covers such person as a Covered Dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If neither plan has these provisions regarding Dependents, resulting in each plan determining its benefits before the other or in the case of a plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rules set forth in the plan which does not have the provisions of this Plan will determine the order of benefits. However:

(I) When the parents are separated or divorced and the parent with custody of the Covered Dependent child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody; or,

(II) When the parents are divorced and the parent with custody of the Covered Dependent child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of the plan which covers that child as a Dependent of the step-parent, and the benefits of a plan which covers that child as a Dependent of the parent without custody will be determined last.

Notwithstanding paragraphs (I) and (II), if there is a court decree which establishes financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent child.

c. When the rules in paragraphs a. and b. above do not establish the order of benefit determination, the benefits of a plan which has covered the eligible individual for whom a claim is made for the longer period of time will be determined before the benefits of a plan which has covered the eligible individual for the shorter period of time.

3. **Coverage By Medicare** - The Covered Expense will be based on the primary/ secondary position determined by the Medicare rules as those rules may, from time to time, be amended.

When Coordination of Benefits operates to reduce the total amount of benefits otherwise payable during any claim determination period with

respect to an eligible individual covered under this Plan, each benefit that would be payable in the absence of Coordination of Benefits will be reduced proportionately and the reduced amount will be charged against any applicable benefit limit of this Plan.

4. **Release of Information** - For the purpose of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Plan may, without the consent of or notice to any eligible individual, release to or obtain from an insurance company or other organization or individual any information concerning any eligible individual, which the Plan considers to be necessary for those purposes. Any eligible individual claiming benefits under this Plan, will furnish to the Plan the information as may be necessary to implement the above provisions.
5. **Payment to Insurance Carriers** - Whenever payments which should have been made under this Plan have been made under any other plan or plans, the Plan has the right, exercisable alone and in its sole discretion to pay to any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. The amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan will be fully discharged from liability under this Plan.
6. **Recovery** - Whenever payments have been made by the Plan at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Plan has the right to recover these payments, to the extent of the excess, from any entity or individual, as the Plan determines appropriate.

You and Medicare

Active Employees

1. Current laws and regulations require that the Plan provide primary group health coverage for Active Employees and their eligible Dependents when the Active Employee or the:
    a. Spouse of an Active Employee is age 65 or over and the Plan has 20 or more Employees.
    b. Dependent of an Active Employee is covered by Medicare on the basis of End Stage Renal Disease and then only for the first 30 consecutive months of Medicare entitlement.
    c. Dependent of an Active Employee is covered by Medicare on the basis of a total disability and the Plan has 100 or more Employees.
2. In the above situations, Medicare will provide supplemental coverage. This will not apply if the Employee or Dependent elects, in writing, to

terminate participation in the Plan and have Medicare provide primary coverage.

3. The law does not permit the Plan to provide medical benefits supplementing Medicare for those Active Employees and Dependents. If you elect Medicare as your primary coverage, you must terminate participation in the Plan and have only Medicare.
4. You should contact the Fund Administrator if you wish to terminate your participation in the Plan and have Medicare provide your health care benefits. Otherwise, the Plan will continue to provide you primary health care benefits with Medicare providing supplemental coverage.
5. When Medicare is primary, Medicare Parts A & B benefits will be considered paid even if you or a Dependent are not covered by Medicare Parts A & B. In other words, no whether you have elected Medicare Part B or not, the Fund will reduce its payment for your claims as if you had.

Retired Employees

1. For most Retirees, Medicare will provide primary coverage and the Plan will provide supplemental benefits. The 2 exceptions to this are as follows:
2. For Retirees under age 65 who are covered by Medicare due to total disability, other than End Stage Renal Disease, the Plan will determine who will provide primary coverage based on Medicare regulations.
3. For Retirees under age 65 who are covered by Medicare on the basis of End Stage Renal Disease, primary benefits will be provided by the Plan for a period of 30 months or until age 65, whichever occurs first.
4. When Medicare is primary, Medicare Parts A & B benefits will be considered paid even if you or a Dependent are not covered by Medicare Parts A & B. In other words, whether you have elected Medicare Part B or not, the Fund will reduce its payment for your claims as if you had.

CLAIMS PROCEDURES FOR MEDICAL BENEFITS

The following paragraphs (called the "Claims Procedure" in this document) apply to all claims for medical benefits under this Plan.

This Claims Procedure explains the rules that must be followed by the Plan when making decisions on claims or appeals. This Claims Procedure also explains the rules that you must follow to make claims under the Plan and to appeal the denial of any claim. Any reduction or termination of a Plan benefit will be treated as a claim denial and will be subject to the rules in this Claims Procedure. You can appeal a reduction or termination of Plan benefits the same way you can appeal any other claim denial.

You may authorize another person to represent you in making a claim for a Plan benefit or in appealing the denial of a claim under the Plan. In the case of an Urgent Care Claim or Appeal (as defined below), the Plan will treat any physician (or other licensed or certified health care professional) who has knowledge of your medical condition as your authorized representative. See Designating an Authorized Representative at the end of this section for further details on how you may authorize another person to represent you under these Claims Procedures.

You may not sue for any Plan benefits until you have gone through all of the appeal procedures provided for below.

Claims Administrators

The rest of this Claims Procedure sometimes refers to a "Claims Administrator". These administrators are responsible for handling your claims and appeals. Who acts as the Claims Administrator with respect to a particular claim or appeal depends on the type of benefit involved. The chart below identifies the Claims Administrator for the various types of medical benefits provided under the Plan.

Type of Benefit	Claims Administrator
Outpatient Prescription Drug	SAV-RX P.O. Box 8, Fremont, NE 68026 1-800-228-3108
All Medical Claims	Medical Claims Administrator BlueCross BlueShield P.O. Box 805107, Chicago, IL 60680-4112 Toll Free: 800-810-2583 www.bcbsil.com
All Medical Appeals	Medical Appeals Administrator BlueCross BlueShield P.O. Box 2401, Chicago, IL 60690 Toll Free: 800-810-2583 www.bcbsil.com

Types of Claims and Appeals

This Claims Procedure provides some different rules for the following different types of claims and appeals:

A Post-Service Claim is a claim for a benefit that the Plan does not require you to have pre-approved (approved before you obtain the medical care) in order to obtain the maximum Plan benefit. Most claims under the Plan will be Post-Service Claims. A Post-Service Appeal is an appeal of a Post-Service Claim denial.

A Pre-Service Claim is a claim for a benefit that the Plan does require you to have pre-approved (approved before you obtain the medical care) in order to obtain the maximum Plan benefit. This includes things like required pre-certification, case management or utilization review, and requests to extend a course of treatment that has previously been pre-approved. The other provisions of this document will tell you when these types of approval are required in order for you to obtain the maximum Plan benefit. A Pre-Service Appeal is an appeal of a Pre-Service Claim denial.

An Urgent Care Claim (or an Urgent Care Appeal) is a Pre-Service Claim (or appeal of a Pre-Service Claim) where delaying a decision on the claim (or appeal) until the usual deadline (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) would, in the opinion of a physician who has knowledge of your medical condition, subject you to severe and unmanageable pain. The Plan will treat a claim or appeal as an Urgent Care Claim or Appeal if the physician treating you advises the Plan that it meets the criteria for an Urgent Care Claim or Appeal as defined above. Whether a claim or appeal meets the Urgent Care criteria is determined at the time that the claim or appeal is being considered. For example, a denied Urgent Care Claim may no longer meet the Urgent Care criteria when it is being considered on appeal if circumstances have changed (like your condition has improved).

Making A Claim

You may make Pre-Service Claims and Urgent Care Claims (requests for pre-approvals required by the Plan in order to obtain maximum Plan benefits) by calling the appropriate Claims Administrator listed in the chart above. The Claims Administrator will assist you with your request for pre-approval. Your claim will be considered filed on the date that you call the Claims Administrator and state that you are requesting pre-approval for an Urgent Care Claim or, for another Pre-Service Claim, the date you complete and return a claim form to the Claim Administrator.

For Post-Service Claims, you may call the Claims Administrator to obtain a claim form or you may obtain a claim form from the Claims Administrator's

web site. These claims must be filed at the address indicated in the chart above and will be considered filed when received at that address.

In most cases, providers performing services will file claims for payment on your behalf, and payment will be made on your behalf directly to the providers.

Be sure to keep copies of any documents you send to the Claims Administrator.

Claims under the Plan must be received no later than 12 months after the date of the loss. However, a claim may still be considered if, in the sole discretion of the Plan Administrator, it was not possible to file the claim within this time and the claim, as well as proof of the impossibility of filing, was furnished to the Plan as soon as possible. However, in no event will an expense be considered if the proof for that expense is furnished more than 1 year after the date the expense was incurred.

The Claims Administrators identified in the chart above have been delegated certain responsibilities for determining benefits under the Plan, as further described in the following paragraphs of this Claims Procedure. If you have any questions concerning a claim, contact the appropriate Claims Administrator's office. Claims will be approved or denied by the Claims Administrator based on the applicable terms of the Plan.

Information and Consents Required From You In Connection With Claims

As a condition of receiving benefits under the Plan, you and your Covered Dependents consent to:

- The release of any information the Claims Administrator requests to parties who need the information for claims processing purposes, and,
- The release of medical information, in a form that prevents individual identification, to a Contributing Employer for use in its occupational health activities or for financial analysis.

Medical information released to a Claims Administrator will not be used to affect your continued employment, pay, promotion or other incidents of employment.

In considering a claim or appeal, the Claims Administrator has the right to require examination of the claimant when and as often as may be required. They may also have autopsies performed in the case of a death, when permitted by state law.

The Claims Administrator also has the right to review a physician's or dentist's statement of treatment, study models, pre- and post-operative X-rays, and any

additional evidence deemed necessary by the applicable Claims Administrator, in its sole discretion, as evidence on which a claim or appeal under this Plan may be based.

Before denying any claim or appeal, the Claims Administrator will review any applicable lists of covered and excluded benefits (and any other lists developed for this Plan) to confirm that the denial is appropriate. The applicable Claims Administrator shall maintain records of claim decisions, based on type of service or supply, for all claims that are not expressly covered by a Plan inclusion or exclusion list. The Claims Administrator shall then review the appropriate such records when making decisions on claims or appeals for services or supplies that are not expressly covered by a Plan inclusion or exclusion list.

Timing Rules

For all claims and appeals, the time frame during which a decision must be made begins when the claim or appeal is filed as required by these Claims Procedures, even if all of the information necessary for the Claims Administrator to make a benefit decision is not included in the filing. (A written claim is not considered filed before it is received by the Claims Administrator.) However, the deadline for a decision on certain claims (but not for a decision on appeal) can be extended as discussed in the following paragraphs if you do not provide all of the necessary information. If this happens, you will be given a notice of the additional information that is needed. The deadline for making the benefit decision on your claim will be extended by the length of time that passes between the date you are notified that more information is needed and the date that your response is received by the Claims Administrator.

All deadlines described in this Claims Procedure are based on calendar days (not business days), and can be extended by agreement between you and the Claims Administrator, but any extension of a deadline must be in writing.

Deadlines for Decisions on Claims

In general, the Claims Administrator must notify you of its decision on your claim within the time frame indicated in the chart below:

For this type of claim:	Initial determinations will be made:
Urgent Care Claims	As soon as possible, but not longer than 72 hours after the claim is received
Pre-Service Claims	Within a reasonable time after the claim is received, which will not be later than 15 days after the claim is received
Post-Service Claims	Within a reasonable time after the claim is received, which will not be later than 30 days after the claim is received

However, the deadline for a decision on a Pre-Service or Post-Service Claim (but not an Urgent Care Claim) may be extended for up to 15 days if special circumstances beyond the control of the Plan exist that require an extension (for example, if you do not provide all of the necessary information for the Claims Administrator to make a decision). If the Claims Administrator needs to extend the deadline for deciding your claim, you will be notified in writing before the deadline described in the chart above. That notice will state why the extension is required and when the Claims Administrator expects to make the decision on your claim. If the extension is necessary because you did not provide all of the information necessary to make a decision on your claim, the notice will specifically describe the required information and you will be given at least 45 days after you receive the notice to provide that information.

Some Special Rules for Urgent Care Claims and Other Pre-Service Claims Improperly Filed Claims

In some cases, if you try to make an Urgent Care Claim or other Pre-Service Claim and you do not make the claim the right way (as required by these Claims Procedures), the Claims Administrator will notify you that you did not file the claim properly and will let you know how you can file the claim properly. (You may be notified orally. If you are notified orally, you may request a written notice.) You will only be notified if (i) you made the improper claim to someone at the Fund who is customarily responsible for handling benefit matters, or to the Claims Administrator, or to a case management or utilization review or similar company that provides services to the Plan, and (ii) your improper claim included your name, the specific medical condition or symptom, and the specific proposed treatment, service or product that you are trying to get approved. If you meet these requirements, you will be notified that you did not properly file your claim as soon as possible, but not later than 24 hours after the improperly filed Urgent Care Claim is received or not later than 5 days after any other improperly filed Pre-Service Claim is received.

Incomplete Urgent Care Claims

If you properly make an Urgent Care Claim, but you do not provide the Claims Administrator with all of the information that it needs to make a decision on your claim, the Claims Administrator will notify you of the specific information needed to complete your claim within 24 hours after receiving the incomplete claim. You will be given a reasonable period of time (which cannot be less than 48 hours) to provide the information. The Claims Administrator must notify you of its decision as soon as possible, but in no event later than 48 hours after it receives the specified information (or 48 hours after the deadline for you to provide the specified information, if that is earlier).

Extensions and Terminations of Pre-Approved Benefits

If an ongoing course of treatment has been pre-approved as an Urgent Care Claim or other Pre-Service Claim, you may desire to obtain an extension of the approved benefit or the Plan may determine that the benefit should no longer be continued. If either of these things happen, some special deadlines may apply which are described below.

If you make an Urgent Care Claim that is a request to extend a previously approved course of treatment, the Claims Administrator must notify you of its decision on that request within 24 hours after the request is received. However, this special rule will only apply if you request the extension at least 24 hours before the end of the previously approved course of treatment. (Any other request to extend previously approved treatment will be treated like any other new Urgent Care Claim or a new Pre-Service Claim, as applicable.)

If the Claims Administrator determines that benefit payments for a previously approved course of treatment should be stopped before the scheduled end of that approved treatment, the Claims Administrator must give you a notice (which will be treated as a claim denial) and must allow you adequate time to appeal that claim denial and receive a determination on the appeal before the Plan stops paying benefits for that treatment. The rules and deadlines that apply to appeals of claim denials are described below.

Written Approval Notices

In general, the Plan is not required to provide you with a written notice if a claim is approved, however, the Plan must give you a written or electronic notice by the deadline indicated above if an Urgent Care or Pre-Service Claim is approved.

Denials of Claims

If any part of your claim is denied, you will be given a written or electronic notice that will include:

- Information identifying the claim, including the date of service, the health care provider, the claim amount, the diagnosis code and its meaning and the treatment code and its meaning;
- The specific reason(s) for the denial, including the denial code and its meaning and a description of any standard used to deny the claim;
- A reference to each of the specific provision(s) of the Plan on which the denial is based;
- A description of any additional material or information you must provide in order for your claim to be approved, and an explanation of why that material or information is necessary;

- If any internal rule, guideline or protocol was relied on in denying the claim, either that specific rule, guideline or protocol, or a statement that a rule, guideline or protocol was relied on in denying the claim and that a copy will be provided to you free of charge on request;
- If the claim denial was based on an exclusion or limit like "medical necessity" or "experimental treatment," either an explanation of the scientific or clinical judgment for the exclusion or limit as applied to your circumstances, or a statement that such an explanation will be provided to you free of charge upon request;
- An explanation of the Plan's appeal procedures, including external review procedures, and the time limits that apply;
- A statement that you can file a lawsuit under ERISA if your claim is denied on final appeal;
- If your denied claim was an Urgent Care Claim, a description of the faster appeals process that applies to Urgent Care Appeals; and
- A statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established to help claimants with plan claims and internal and external reviews, including contact information.

If your denied claim was an Urgent Care Claim, the information described above may first be provided to you orally, and a written or electronic notice will be given to you within 3 days after the oral notice.

If your denied claim is based on a finding that you are not eligible for a benefit because you are not disabled (such as under the Extended Benefits provisions of the Plan) the notice will also:

- Include an explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of health care professionals treating you or vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denied claim without regard to whether the advice was relied upon in making the denial; and
    - A disability determination you presented to the Plan made by the Social Security Administration;
- Include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- Describe any specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relief upon in making the claim denial;
- Include a statement prominently displayed in the relevant non-English

language for certain counties clearly indicating how to access language services provided by the Claims Administrator.

Appealing a Denied Claim

If any part of your claim is denied, you can appeal that denial directly to the Claims Administrator. Your appeal must be made in writing within 180 days after the date you receive the claim denial. The contact information for the Claims Administrator is in the chart at the beginning of this Claims Procedure.

You may give the Claims Administrator written comments, documents, records and other information relating to your claim for benefits that you want to have considered on appeal. You are also entitled, upon request, to see and get a free copy of any Plan policy statement or guideline that relates to the denied benefit, even if the policy statement or guideline was not relied on in denying the claim. You may also request to see all documents, records, and other information relevant to your claim for benefits and to get free copies of that information. This includes any information that:

- Was relied on in making the benefit decision;
- Was submitted, considered or generated in making the benefit decision, even if it was not relied on;
- Shows that administrative procedures or safeguards were followed to make sure that the benefit decision was appropriately made based on the Plan documents (excluding information in other claimant's files); or,
- Is a statement of policy or guidance under the Plan concerning the denied treatment or benefit for your diagnosis, even if it was not relied on in making the benefit decision.

Special Rule for Urgent Care Appeals

If you are making an Urgent Care Appeal, you may appeal orally to the Claims Administrator. In addition, all communications between you and the Plan regarding your Urgent Care Appeal may be conducted by telephone, facsimile, or any other available expedited method of communication.

Review of Denied Claim On Appeal

The Claims Administrator will reconsider any denied claim that you appeal by the deadline. The Claims Administrator must consider all comments, documents, records, and other information provided by you relating to the claim, even if this information was not submitted or considered in the original claim decision. The review will not give deference to the claim denial and will not be made by the person who made the original claim denial, or a subordinate of that person.

In deciding an appeal of any claim denial that is based on a medical judgment (including things like whether a treatment is experimental or not medically

necessary), the Claims Administrator must get advice from a health care or vocational expert who has training and experience in the area of medicine in question. Upon request, you will be provided the names of any such experts who were consulted in connection with your claim, even if the advice was not relied upon in making the denial. The health care professional consulted by the Claims Administrator cannot be a person who was consulted by the Claims Administrator in connection with the claim denial (or a subordinate of the person who was consulted in the original claim).

If your appeal is based on a finding that you are not eligible for a benefit because you are not disabled, the Claims Administrator will provide you with any new rationale on which an appeal denial may be based as well as any new or additional evidence considered, relied upon, or generated in connection with the claim. This information will be provided as soon as possible and sufficiently in advance of the date on which the appeal denial notice must be provided, in order to give you a reasonable opportunity to respond prior to that date.

Deadlines for Decisions On Appeal

The Claims Administrator must make its decision on your appeal within the time frame indicated in the chart below:

For this type of Appeal:	The time limit for a final determination is:
Urgent Care Appeal	As soon as possible after the appeal is received, but not longer than 72 hours
Pre-Service Appeal	Within a reasonable time after the appeal is received, but not longer than 30 days
Post-Service Appeal	Within a reasonable time after the appeal is received, but not longer than 60 days (or the first Trustees meeting scheduled for at least 30 days after the appeal is received)

If your appeal is based on a finding that you are not eligible for a benefit because you are not disabled (such as under the Extended Benefits provisions of the Plan), you will ordinarily be notified of the decision not later than 45 days after the appeal is received. This time period may be extended up to an additional 30 days due to circumstances beyond the Claims Administrator's control. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

Denials of Appeals

If any part of your claim is denied on appeal, you will be given a written or electronic notice that will include:

- Information identifying the claim, including the date of service, the health care provider, the claim amount, the diagnosis code and its meaning and the treatment code and its meaning;

- The specific reason(s) for the denial, including the denial code and its meaning and a description of any standard used to deny the claim;
- A reference to each of the specific Plan provision(s) on which the denial is based;
- If any internal rule, guideline or protocol was relied on in denying the appeal, either include that specific rule, guideline or protocol, or a statement that such was relied on and that a copy will be provided to you free of charge on request;
- If the claim denial on appeal was based on an exclusion or limit like "medical necessity" or "experimental treatment," either the scientific or clinical judgment for the exclusion or limit as applied to your circumstances, or a statement that such an explanation will be provided to you free of charge upon request;
- A statement that you are entitled, upon request, to see all documents, records, and other information relevant to your claim for benefits (as described above under "Appealing A Denied Claim") and to get free copies of that information;
- A statement describing any further appeal procedures offered by the Plan, including external review procedures, and any applicable deadlines, and your right to obtain further information about any such procedures;
- A statement regarding the availability of any applicable office of health insurance consumer assistance or ombudsman established to help claimants with plan claims and internal and external reviews, including contact information;
- A statement of your right to file a lawsuit under ERISA Section 502(a) if your final appeal is denied and an explanation that in order to file such a lawsuit, you must first obtain an external review if external review is available for your claim; and,
- The following statement, even though mediation is not offered by the Fund: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If your denied appeal was an Urgent Care Appeal, the information described above may first be provided to you orally, and a written or electronic notice will be given to you within 3 days after the oral notice.

If your denied appeal is based on a finding that you are not eligible for a benefit because you are not disabled (such as under the Extended Benefits provisions of the Plan) the notice will also:

- Include an explanation of the basis for disagreeing with or not following:

- The views you presented to the Plan of health care professionals treating you or vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denied appeal without regard to whether the advice was relied upon in making the denial; and
- A disability determination you presented to the Plan made by the Social Security Administration;
- Describe any specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relief upon in making the appeal denial;
- Include a statement prominently displayed in the relevant non-English language for certain counties clearly indicating how to access language services provided by the Claims Administrator; and
- Describe any applicable contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which this period ends.

Requesting External Review

In order to request external review of your denied claim, you must submit a written request for external review to the Claims Administrator within four months of your receipt of the denied appeal or, if later, 48 hours after you receive notice that your request for external review is incomplete.

Within five business days of receiving your request for external review, the Claims Administrator will determine whether:

- you had Plan coverage at the relevant time;
- the denied appeal involves medical judgment or a rescission of coverage;
- you have completed the required internal review procedures (or the internal review procedures are "deemed" complete because of the Plan's failure to meet all of the requirements in this claims procedures); and
- you have provided all information and forms required to process an external review.

The Claims Administrator will issue written notice to you within one business day of completing this preliminary review. If your request is complete but not eligible for external review, the notice will include the reasons the request for external review is ineligible as well as contact information for the DOL's Employee Benefits Security Administration. If your request is not complete, the notice will describe the information needed to complete the request. You will have until the later of the end of the four month period or 48 hours after receipt of this notice to complete your request.

External Review by Independent Review Organization

If the Claims Administrator determines that your request for external review if eligible for external review, it will be assigned to one of the independent review organizations with which the Plan has a contract. Within five business days after assigning the request to an independent review organization, the Plan will provide the independent review organization the documents and information that were considered in making the appeal denial.

The independent review organization will provide you with written notice that your request has been accepted. The notice will include a statement that you may submit, within ten business days, additional information in writing that the independent review organization must consider (it may also agree to consider additional information submitted after ten business days). Within one business day of receiving any additional information, the independent review organization must forward it to the Plan. The Plan may reconsider its appeal denial based on this additional information. If the Plan reverses its appeal denial and provides coverage or payment, it will provide written notice to you and to the independent review organization within one business day after making its decision. The independent review organization will terminate the external review if it receives this notice.

Unless the Plan reverses its decisions, the independent review organization will review all of the information and documents submitted by you within the deadline described above. In reaching its decision, the independent review organization will make its own independent decision of the claim and will not be bound by any decisions or conclusions reached during the Plan's internal claims and review process.

In addition to the documents and information provided by the Plan and you, the independent review organization will consider the following information or documents if they are available and the independent review organization considers them appropriate:

- your medical records;
- your attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treated provider;
- the terms of the Plan unless the terms are inconsistent with applicable law;
- appropriate practice guidelines, which must include applicable evidence-based standards;
- any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable review; and

- the opinion of the independent review organization's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider them appropriate.

Expedited External Review

You may request an expedited external review when you receive:

- a claim denial that involves a medical condition for which the time allowed for completion of an expedited internal review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal review; or
- a final internal appeal denial, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal appeal denial concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

Denials of External Review

If any part of your claim is denied on appeal, you will be given a written or electronic notice that will include:

- Information identifying the claim, including the date of service, the health care provider, the claim amount, the diagnosis code and its meaning and the treatment code and its meaning;
- The specific reason(s) for the denial, including the denial code and its meaning and a description of any standard used to deny the claim, and the reason for the previous appeal denial;
- The date on which the independent review organization received the request for external review and the date of its decisions;
- Specific reference to the evidence or documents (including specific Plan provisions and evidence-based standards) considered in reaching the decision;
- The principal reason(s) for the decision, including the rationale for the decisions and any evidence-based standards that were relied upon;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to the Plan or to you;;
- A statement that review by a judge may be available to you; and
- Current contact information, including phone number, for any office of health insurance consumer assistance or ombudsman.

Such notice will be furnished within 45 days after the independent review organization receives the request for external review. In the case of an expedited external review, such notice will be furnished within 72 hours after the independent review organization receives the request for external review. If the notice related to an expedited external review is initially provided otherwise than in writing, written confirmation shall be provided within 48 hours of the initial notice.

Exhaustion of Administrative Remedies Required

Completion of the Plan's Claims Procedure is required prior to the commencement of any legal or equitable action in connection with a claim for benefits under the Plan by a Claimant or any other person or entity claiming rights individually or through a Claimant.

Authority of the Claims Administrator to Make Final Binding Decisions on Appeal

The Plan Administrator has the full discretion and authority to make final determinations of all questions relating to eligibility for any Plan benefit and to interpret the Plan for that purpose. While the Plan Administrator has full discretion and authority to finally grant or deny benefits under the Plan, it has delegated that responsibility to the Claims Administrator for the prudent administration of claims and appeals. Plan benefits will be paid only if the Claims Administrator decides in its sole discretion that the applicant is entitled to them. The Claims Administrator's determination on appeal will be final and binding.

Designating an Authorized Representative

You may designate someone else to pursue a claim or appeal on your behalf under the Plan. In order for another person to be considered your "Authorized Representative" for purposes of pursuing your benefits or appealing an adverse benefit determination on your behalf, an individual must satisfy one of the following requirements:

- You have given written consent for the individual to represent your interests;
- The individual is authorized by law to provide substituted consent for you (e.g. – parent of a minor, legal guardian, foster parent, power of attorney);
- For pre-service, urgent care or ongoing claims only, the individual is your immediate family member (e.g. - spouse, parent, child, sibling);
- For pre-service, urgent care or ongoing claims only, the individual is your primary caregiver; or,
- For claims involving pre-service, urgent care and inpatient concurrent review, the individual is a health care professional with knowledge of your medical condition.

COBRA CONTINUATION PROVISIONS

Continuation of Coverage

Notwithstanding any provision of this Plan that terminates coverage, Qualified Beneficiaries who would otherwise lose coverage under the group health portion of this plan as a result of a qualifying event have the right to elect coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, or "COBRA"). The term "Qualified Beneficiaries" shall refer to (i) individuals who are covered under the Plan on the day before the qualifying event or (ii) any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. A covered Employee can be a Qualified Beneficiary only in connection with a qualifying event that is the termination (other than for gross misconduct) or reduction of hours of the covered Employee's employment or that is the bankruptcy of the employer. Qualified Beneficiaries may elect to continue coverage in accordance with the following:

1. **Termination of Employment** - Upon termination of employment (other than for termination due to gross misconduct), reduction of hours, the Employee's employer filing for Chapter 11 reorganization or the Employee's failure to return to work at the end of FMLA leave, which, in the absence of COBRA, would cause the Employee or the Employee's Covered Dependents to lose coverage under the Plan prior to the end of the maximum COBRA coverage period, Employees who are Qualified Beneficiaries may continue coverage for up to 18 months for himself or herself and his/her Covered Dependents.
2. **Dependent's Continuation** - Covered Dependents who are Qualified Beneficiaries may continue coverage for up to 36 months upon the following events if the event causes a loss of Plan coverage for the Dependents:
    a. death of the Employee;
    b. divorce or legal separation by the Employee from his/her spouse;
    c. the Employee becoming covered for benefits under Title XVIII of the Social Security Act (Medicare) as amended from time to time;
    d. a dependent child ceasing to be a Covered Dependent as defined herein;
    e. the spouse's employer files for Chapter 11 reorganization.
3. **End of Continuation Coverage** - The 18- or 36-month continuation period for Qualified Beneficiaries ends on the earliest of the following dates:
    a. the date the Fund ceases to provide any group health plan to any Employee;

b. the first day of the month for which full, timely payment is not made;

c. the date he/she becomes covered under another group plan; or

d. the date he/she becomes covered for benefits under Medicare.

NOTE: If a Covered Person becomes covered under another group plan which limits or excludes such person's Pre-existing Condition, any individual so limited or excluded may continue Plan coverage until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Plan.

4. **Disability Continuation Extension** - If an Employee or his Covered Dependent who is a Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on the date of the qualifying event or at any time within the first 60 days of COBRA continuation coverage, then each Qualified Beneficiaries' coverage under COBRA may be continued for up to 11 additional months. In order to obtain this additional extension of self-pay rights, the totally disabled individual is required to notify the Plan's Fund Administrator in writing within 60 days of the date Social Security determines that he/she was disabled and within the initial 18-month period of COBRA coverage. The individual is also required to notify the Plan's Fund Administrator in writing within 30 days of any final Social Security determination that he/she is no longer disabled. The additional disability extension of self-payment rights will terminate at the end of the month following the month in which the final Social Security determination is made that the individual is no longer disabled or when the premium for such coverage is not received on time and in full by the Plan at the address to which the Qualified Beneficiary has been instructed to mail such payment.

Notification Requirements

1. **Employees** - The Fund Administrator will determine if an Employee has suffered a termination of employment or reduction in hours from the employment activity reports submitted to the Fund Administrator by Contributing Employers. The Fund Administrator will notify an Employee who has lost eligibility under the Plan of that fact. Notice to the Employee constitutes notice to all resident Dependents. The Employee will have only until the later of 60 days from the date of such notice or 60 days from the date eligibility is lost to notify the Fund Administrator in writing by completing, executing and returning the Plan's COBRA election form to the Fund Administrator. Employees will then have 45 days from the date of such election to send payment of the COBRA premium in full for such period to the Plan's Fund Administrator. COBRA payments are due in full on the first day of each month and must be received by the Plan's Fund Administrator within 30 days of the due

date. When an Employee elects to continue coverage under these COBRA provisions, he **MUST** make the first full payment retroactive to the beginning of the continuation period or coverage is automatically terminated retroactive to the date coverage would have otherwise terminated.

2. **Dependents** - Dependents whose coverage under this Plan is terminated as a result of the Plan's terms by divorce or legal separation or a dependent child ceasing to be a dependent child as defined by the Plan are responsible for notifying the Plan's Fund Administrator of those facts within 60 days of the affecting event. (Notifications by phone or email are not sufficient.) The Fund Administrator will then notify the Dependent/s of their rights under these provisions within 14 days. Dependents whose coverage under this Plan is terminated pursuant to the Plan's terms by the Employee becoming entitled to Medicare or death will be notified of this fact by the Fund Administrator. Notice to the Employee's spouse constitutes notice to all other resident Dependents. The Dependent will then have only until the later of 60 days from the date of such notice or 60 days from the date eligibility is lost to notify the Fund Administrator in writing by completing, executing and returning the Plan's COBRA election form to the Fund Administrator. The Dependent will have 45 days from the date of such election to send payment of the COBRA premium in full for such period to the Plan's Fund Administrator. COBRA payments are due in full on the first day of each month and must be received by the Plan's Fund Administrator within 30 days of the due date. If a Dependent elects to continue coverage, he **MUST** make the first full payment retroactive to the beginning of the continuation period.
3. Elections made by an Employee or Covered Dependent shall be deemed to include all Dependents who would otherwise lose coverage unless the person electing coverage informs the Fund Administrator otherwise.
4. It is critically important that the Plan's Fund Administrator be notified in writing immediately if an Employee or Covered Dependent ever changes their address. Notices required to be sent by the Plan to Employees and/or Covered Dependents will be sent to the address the Fund Administrator has on file for such persons, and the Plan will have no other obligation to send such notices if it turns out they were sent to an incorrect address. Therefore it is vital that you protect your right to receive these important notices by timely updating the address the Plan has for you.

Individuals Whose Eligibility is Affected by Multiple Events

Notwithstanding anything to the contrary in these provisions, no person may enjoy any one continuous self-pay coverage extension under this Plan beyond

36 months from the end of the month in which the first event giving rise to the self-payment rights with respect to that individual occurred.

Cost of Continuation Coverage

The cost of COBRA coverage is generally 102% of the full cost of such coverage, but is 150% of the full cost of such coverage for months 19-29 of an extended period of disability coverage as long as the disabled Qualified Beneficiary is in the coverage group and the coverage would not be required to be provided in the absence of the disability extension.

Notice Address

All notices required to be sent in this COBRA Continuation Section to either the Plan or the Plan's Fund Administrator shall be sent to Zenith American Solutions at the address listed in the back of this document.

ACTS OF THIRD PARTIES AND SUBROGATION

The Plan shall be subrogated to all of the rights, claims, demands, actions, recoveries or rights of recovery (collectively referred to in this section as "rights of recovery") of the covered individual against a Third Party (as defined below) to the extent of any and all amounts paid or payable under the Plan, past or future, due to an injury, illness, sickness or other condition for which a covered individual has, may have, or asserts, any rights of recovery against a Third Party under any legal theory of any type and without regards to how such recovery is characterized. The Plan shall be subrogated to the covered individual's rights of recovery regardless of whether payment has actually been made to the covered individual under the Plan and regardless of whether the covered individual has been fully compensated or made whole.

In the event any individual receives any recovery, whether by settlement, agreement, judgment or otherwise, arising out of an injury, illness, sickness or other condition for which the covered individual has, may have, or asserts, any rights of recovery against any third party, any liability or other insurance covering the third party or the covered individual, the covered individual's own uninsured motorist insurance or underinsured motorist insurance or no-fault or school insurance coverages which are paid or payable, or any other responsible party (the "Third Party"), the Plan shall be entitled to immediate and first reimbursement from the proceeds of any such recovery, to the full extent of benefits paid under the Plan, regardless of whether the covered individual has been fully compensated or made whole and regardless of the fault or negligence of the covered individual.

The Plan's rights of reimbursement and subrogation shall be from the first monies to be paid to or received by the individual without deductions of any type, including costs and attorney fees, except that the Plan shall have the right to negotiate its lien in whatever manner benefits the Plan as a whole.

The Plan is not required to help the covered individual to pursue his or her claim for damages or personal injuries, or to participate in or pay any of the covered individual's associate costs, including attorney's fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat the Plan's right to subrogation. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent.

If the Plan incurs attorneys' fees and costs in order to collect funds recovered from a third party held by a covered individual or the representative of such covered individual, the Plan has the right to recover those fees and costs from the covered individual.

As a condition precedent to the payment of benefits under the Plan, the covered individual shall execute (or secure the execution of) and deliver such

instruments and papers and do whatever else is necessary, in the Fund's sole discretion, to execute, protect and secure the Plan's rights. However, the Plan shall have a right to reimbursement and subrogation pursuant to the terms of the Plan regardless of whether the covered individual executes and delivers such documents. The covered individual shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation, which finding of prejudice shall be made by the Fund in its sole discretion.

The covered individual must promptly notify the Fund Administrator of the possibility of obtaining a recovery, whether by settlement, judgment, agreement or otherwise, for personal injury for which the Plan has provided or may be responsible for providing benefits for the covered individual. The covered individual shall not enter into a settlement regarding such personal injury, however, without the prior written consent of the legal representative specified by the Trustees. The Plan may enforce its subrogation and reimbursement rights by requiring the covered individual to assert a claim to any of the foregoing coverages to which he/she may be entitled.

The Plan shall have a lien on all sums recovered in connection with the loss causing the payment of benefits under the Plan to the extent of its own payments. The Plan shall also be entitled to recover from the covered individual or any other beneficiary of the Plan, any amounts paid under the Plan which are in excess of amounts actually owed under the Plan, including the right to deduct the amount of excess payment from any subsequent payable benefits. If the covered individual or any other beneficiary accepts payment from the Plan, that person does so pursuant to the provisions of the Plan.

HIPAA PRIVACY AND SECURITY

The Plan may disclose protected health information (or "PHI") to the Plan Sponsor as the Plan Sponsor has provided a certification that its use of and access to PHI shall only be the minimum necessary to accomplish the permitted purposes, which are outlined in this section. Included elsewhere in this document is the Plan's Notice of Privacy Practices, a separate copy of which may be provided to you upon your request.

The Plan has appointed a Privacy Official, who is responsible for:

1. Training employees who handle PHI to do so in a way which reasonably prevents inadvertent disclosures thereof;
2. Establishing a complaint mechanism whereby Participants may dispute the Plan's, its business associates' and the Plan Sponsor's uses and disclosures of PHI;
3. Overseeing the Plan's use and disclosure of PHI for "Payment, Treatment and Health Care Operations," as those terms are defined in HIPAA, and to take reasonable steps to ensure that PHI is used solely by the Plan for those reasons;
4. Overseeing the Plan Sponsor's access to, use and disclosure of PHI to determine that such use and disclosure is consistent with the provisions stated herein and the certification provided by the Plan Sponsor;
5. If any health plan portion of this Plan is funded through an insurance contract, reasonably ensuring that the insurer complies with HIPAA as a "covered entity", as such is therein defined; and,
6. Establishing procedures whereby:
    a. Participants may request access and copies of PHI, amendments to such PHI, and restrictions and confidential communication methods regarding the use and/or disclosure of such PHI;
    b. Participants may request an accounting of disclosures of PHI made by the Plan for other than Payment, Treatment and Health Care Operations in the 6-year period prior to the request for the accounting (but no further back than April 14, 2003);
    c. The Plan may evaluate, and then approve or deny, any such requests for access, amendments, restrictions, confidential communication methods and accountings; and,
    d. The Plan may charge for copies, summaries, multiple requests for accountings and any other work regarding the use and disclosure of PHI, consistent with the HIPAA.

Access to PHI – While the Plan Sponsor has access to PHI, it shall:

1. Not use or disclose PHI other than as permitted by this document, as it may hereafter be amended from time-to-time, or as required by law;
2. Ensure that any agents or subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions applicable to the Plan Sponsor, including reasonable and appropriate security measures for electronic PHI;
3. Not use or disclose PHI for employment-related actions and decisions, or in connection with any other non-group health employee welfare benefits plan or benefit sponsored by the Plan Sponsor, including, but not limited to, any disability benefits and the life and AD&D coverage provided by this Plan;
4. To the extent that the Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, including, but not limited to, any security incident relating to electronic PHI, to report such improper uses or disclosures to the Plan's Privacy Official;
5. Make PHI available to participants in the Plan for access, amendment and an accounting of disclosures, upon request and to the extent mandated by applicable law;
6. Make the Plan Sponsor's internal practices and records relating to the use and disclosure of PHI available to the Secretary of Health & Human Services upon request and for the purposes of determining the Plan's compliance with HIPAA;
7. If feasible, return and destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
8. Ensure that there is an adequate separation between the Plan and the Plan Sponsor as set forth below, and which separation shall be supported by reasonable and appropriate security measures; and
9. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits for the Plan.

General Disclosures – The Plan may disclose summary health information to the Plan Sponsor for any purpose. Furthermore, the Plan may also disclose to the Plan Sponsor information on whether an individual is participating in the Plan.

Separation between Plan and the Plan Sponsor – The following representatives of the Plan Sponsor shall have access to PHI for the following permitted uses:

1. The Fund Coordinator and appropriate staff of the Fund Coordinator shall have access to PHI to perform administrative functions necessary to carry out the administration and operations of the Plan, and to otherwise assist in the functions necessary for the Plan Sponsor to carry out settlor functions;
2. Appropriate accounting and treasury personnel of the Plan Sponsor to arrange for funding for the Plan and to submit any required filings with appropriate governmental authorities;
3. Appropriate employment-related personnel of the Plan Sponsor for payroll and enrollment purposes;
4. Appropriate personnel employed by either the Fund or the Plan Sponsor as independent contractors to provide other necessary administrative services to the Plan that include, but are not limited to:
    a. Insurance agents and consulting firms engaged to provide consulting services, obtain insurance and/or reinsurance quotes and to assist in designing and administering Plan benefits;
    b. Actuaries retained to assess the Plan's ongoing funding obligations;
    c. Lawyers retained to perform legal services for the Plan and the Fund;
    d. Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities;
    e. Financial accounting firms engaged to help determine Plan costs; and,
    f. Claims processing companies engaged to assist the Plan Administrator in the processing and appeal of benefit claims, obtain insurance and/or reinsurance quotes, and to otherwise assist in designing and administering Plan benefits.

Sanctions – If the persons described in this section do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

NOTICE OF PRIVACY PRACTICES

This notice describes the ways in which the Plan and any party that assists in the administration of Plan medical claims, may use and disclose the protected health information related to your medical benefits under the law. Any reference in this Notice to we, us or our refers to the Plan alone and not to your employer and/or any of its affiliates or subsidiaries.

PLEASE NOTE: The vast majority of your protected health information resides with our business vendors (such as Zenith American Solutions and BlueCross BlueShield). To access the information contained in their files, contact the vendor directly at the address or phone number listed on your member ID card or described in the Plan's summary plan description.

Plan Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we intend to protect the confidentiality of that information. The Plan, similar to your doctor, must create a record of the health care claims you or your doctor submits for payment. These records are used to administer the Plan.

This notice applies to all of the medical records we maintain. While your personal doctor or health care provider may have different policies regarding his/her use and disclosure of your medical information, this notice will tell you about the ways in which the Plan intends to use and disclose your protected health information. It also describes our obligations and your rights regarding such use and disclosure. We are required by law to ensure that medical information that identifies you is kept private to the extent possible. As a result, we are giving you this notice of our legal duties and privacy practices with respect to your protected health information, and we expect to follow the terms of this notice now and in the future.

How the Plan Uses and Discloses Medical Information

The following categories describe different ways in which we may use and disclose your protected health information. While not every use or disclosure in a category will be described, each use or disclosure we are permitted to make without your authorization will fall within one of the described categories.

For Treatment. The Plan may use or disclose your protected health information to help your doctors provide you with medical treatment. To that end, we may disclose your protected health information to all medical providers who are involved in taking care of you.

For Payment. The Plan may use or disclose your protected health information to determine your eligibility for benefits, pay the Plan's portion of the medical bill, determine benefit responsibility under the Plan, or coordinate Plan coverage with benefits you may be receiving from another plan. For example, if asked by your doctor, we, or one of the Plan's service providers, might disclose your medical history in order to determine whether a proposed treatment is experimental, investigational, or medically necessary. We may also share your protected health information with a utilization review or pre-certification service provider. We may share your protected health information with another party at our discretion to assist with the adjudication or subrogation of health claims, or to another health plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose your protected health information about you for other necessary Plan operations. For example, we may use our participants' protected health information to conduct quality assessment and improvement activities, underwriting, premium rating, and other activities relating to Plan coverage. We may also use your protected health information to conduct or arrange for medical review, legal services, audit services, fraud and abuse detection programs, and business planning and development such as cost management, business management and general Plan administrative activities. The Plan will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. The Plan may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. The Plan may contract with individuals or other entities known as "Business Associates" to perform various functions on behalf of the Plan or to provide certain services. In order to perform these functions or provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate that processes claims for Plan benefits or provides other services to the Plan, such as utilization management or pharmacy benefit management, but only after the Business Associate has agreed to implement the appropriate safeguards in a Business Associate Agreement with the Plan.

As Required By Law. The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information to the federal Department

of Health & Human Services, or the Centers for Disease Control when required by law to do so.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. For example, we may disclose your protected health information in a proceeding regarding the licensing, or the revocation of a license, of a physician.

Special Situations

The Plan may also use or disclose your protected health information without your authorization in certain special situations. While not every use or disclosure in a category will be listed below, each use or disclosure we are permitted to make without your authorization will fall within one of the categories described in this notice.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. We may disclose your protected health information for public health activities, including but not limited to the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; or,
- to notify a government authority if we believe a person has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a federal or state health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may release your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- or about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release your protected health information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

Government Audits. We may be required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the privacy rules governing health plans.

Disclosures to You. At your request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individuals authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide us with a written authorization and any supporting documents (i.e. power of attorney).

Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to the member. This includes mail relating to the member's spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested restrictions or confidential communications (see below under "Your Rights"), and if the Plan has agreed to the request, we will send mail as provided by the request for restrictions or confidential communications.

Your Rights Regarding Medical Information About You

You have the following rights regarding your protected health information maintained by the Plan:

Right to Inspect and Copy. You have the right to inspect and copy your protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To do this, you must submit your request in writing via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

Your request must include your name, Social Security number, work and home addresses and telephone numbers in order to receive a response. You must also identify the name of the health plan to which your inquiry applies and be specific about the time period and subject for which you are requesting information.

If you request a copy of the information, we may charge a fee for the costs of compiling, copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, we will tell you why and you may request a review of the denial.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, you must provide a reason for your request, and the request must be made in writing and submitted via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

We are not required to agree to your request.

We may deny the request for an amendment if it is not in writing or does not include a valid reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the protected health information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

Your request must state a time period in which the disclosures occurred, but may not be longer than six years from the date of your request and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you

for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone (other than a medical provider) who is involved either in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We are not required to adopt special mailing instructions such as registered or certified mail.

To request confidential communications, you must make your request in writing via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

While we will not ask you the reason for your request, the Plan will only accommodate reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Copy of This Notice. You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon your request.

To request a copy of this notice, you must make your request in writing via U.S. Postal Service to the HIPAA Privacy Officer at the address listed at the end of this Notice.

Changes to This Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. You will be provided a new notice within 60 days if there is a material revision.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the federal Department of Health and Human Services. To file a complaint with the Plan, contact in writing via U.S. Postal Service:

HIPAA Privacy Official
Pipe Fitters Local Union No. 211 Welfare Trust Fund
c/o Zenith American Solutions
9555 W. Sam Houston Parkway, Suite 400
Houston, TX 77099

You will not be penalized for filing a complaint. For more information, you may call the Privacy Officer at 1-800-682 PIPE (7473). As with all correspondence with the Privacy Officer called for in this Notice, you must identify both yourself and the Plan in which you participate in order to receive a response.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. If you provide an authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care and benefits provided to you. Furthermore, you should be aware that any disclosure we make pursuant to your authorization strips that information of the protection of the Plan's privacy guidelines.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In general, a Qualified Medical Child Support Order (QMCSO) is a type of court order that gives a Dependent child the right to participate in the Plan, if the child does not otherwise qualify due to residency status. The court order must satisfy certain specific conditions under federal law to qualify as a QMCSO. The Fund Administrator will notify you if a medical child support order that applies to you is received.

Notification of Receipt of Child Support Order

Upon receipt by the Fund Administrator of a medical child support order ("Order"), the Fund Administrator shall notify the participant and the potential alternate recipient of the medical child support order within fifteen (15) business days of receipt that the Order has been received. "Alternate Recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. The notification shall describe the procedures for determining whether the medical child support order is a QMCSO and shall inform the Alternate Recipient of his right to designate a representative to receive notices sent to the Alternate Recipient with respect to the Order. The Alternate Recipient must inform the Fund Administrator in writing that a representative has been designated, whereupon the Administrator shall furnish all such notices to the designated representative. NOTE: All correspondence with the participant and Alternate Recipient shall be directed to the address included in the Order, or, if the Order does not specify addresses, to the last address of the Alternate Recipient known to the Plan Administrator

The Fund Administrator shall determine if the Order is a QMCSO within sixty (60) days of receipt of such Order, pursuant to the procedures outlined herein, unless circumstances cause a delay. If a delay is required, the potential Alternate Recipient shall be notified of any such delay in writing.

The Fund Administrator shall determine if a Medical Support Notice is a National Medical Support Notice that operates as a QMCSO within forty (40) business days of receipt of the National Medical Support Notice and notify the State Agency issuing the notice and the custodial parent of when the coverage is effective, and any steps that must be taken to effect coverage or the reasons the notice is not acceptable.

If the Alternate Recipient is a minor, the Fund Administrator may send copies of notices with respect to an Order to the Alternate Recipient's designated representative. If such a representative is unknown, the Fund Administrator shall send notices to the Court or agency that produced the Order.

Procedures to Determine if Order is a QMCSO

The Fund Administrator shall review the Order and verify that the following items are appropriately addressed:

- The Order must create or recognize the existence of an Alternate Recipient's right to receive benefits for which the Participant or beneficiary is eligible under the Plan or to assign those rights;
- The Order must identify the Plan(s) to which it applies and the parties that will be responsible for paying the premiums for the benefits that are the subject of the Order;
- The Order must clearly specify the name and last known mailing address of each Alternate Recipient covered by the Order (Note that, to the extent provided in the Order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of the Alternate Recipient.);
- The Order must clearly indicate the name and last known mailing address (if any) of the participant or, if the mailing address is not specified, if it is known to the Fund Administrator;
- The Order must specify in a reasonable description the type of coverage to be provided by the Plan to each Alternate Recipient or the manner in which the type of coverage is to be determined (With respect to a National Medical Support Order, if the type of coverage is not specified, the Fund Administrator will act as if all options are designated.);
- The Order must specify the period of time to which the Order applies (This requirement can be met by (1) the recitation of a span of time (e.g., "for 24 months"); (2) the recitation of a certain age of the Alternate Recipient; or (3) the indication of an indefinite duration with a specified event that will terminate the Order (e.g., "until further order of the Court").);
- The Order must not require the Plan to provide any type or form of benefit not otherwise provided under the Plan; and,
- The Order must be issued by either a court of competent jurisdiction or pursuant to a competent administrative process established under State law and having the force and effect of law under State law and it must clearly be an order, judgment, decree, approval of a settlement, or a National Medical Support Notice.

If the Fund Administrator determines the Order satisfies all of the above requirements, then it shall notify, in writing, each of the Alternate Recipient(s) and the participant or designated representative and the sender of the Order, if different, that the Order is a QMCSO and of the action to be taken. The Fund Administrator should also notify the Participant that they must execute

a new salary redirection election to cover the cost of such coverage or otherwise notify the party responsible to pay for the coverage of their obligations with respect to payment for the coverage. The Fund Administrator shall also provide health benefit coverage to the Alternate Recipient(s) at the time and in the manner indicated in the QMCSO without regard to any enrollment season restrictions under the plan. (Upon request by the sender, the Fund Administrator shall supply the sender with (1) the name of the health insurance carrier or third party administrator for the Plan; (2) the policy number, if any; (3) a copy of the policy, if any, and schedule of benefits; (4) a health insurance membership card; and (5) claim forms.)

If the Fund Administrator determines that the Order is not a QMCSO, then it shall notify, in writing, each of the proposed Alternate Recipient(s), the participant (or their designated representatives) that the Order is not a QMCSO and why the Order failed to qualify as such and of their right to appeal such decision. If the Fund Administrator is ever unsure of whether the Order is a QMCSO, it should contact the Benefits Committee for a final determination. If a modified Order is received by the plan, the Fund Administrator shall send the participant and the Alternate Recipient a notice of the entry of such Order and shall proceed in accordance with these procedures.

Procedures Regarding National Medical Support Notices and Noncustodial Parent Participants

If an appropriately completed National Medical Support Notice is issued for a child of a participant under the Employees' Benefit Plan who is a noncustodial parent of the child and the Notice is deemed to be a QMCSO, the Fund Administrator, within 40 business days after the date of the National Medical Support Notice, shall:

- Notify the State agency issuing the National Medical Support Notice with respect to such child whether coverage of the child is or will become available under the terms of this Plan and, if so, whether such child is covered under this Plan and either the effective date of the coverage or, if necessary, any steps that must be taken by the custodial parent (or by the official of a State or political subdivision thereof whose name and address have been substituted for the name and address of such Alternate Recipient) to effectuate the coverage;
- Notify the participant, each Alternate Recipient, and the custodial parent that coverage of the Alternate Recipient(s) is or will become available (notification of the custodial parent is deemed notification of the Alternate Recipient(s) if they reside at the same address);
- Provide to the custodial parent (or such substituted official) and the State agency issuing the Notice a description of the coverage available and any forms or documents necessary to effectuate such coverage; and,

- Notify the State agency and the custodial parent of any additional steps to be taken or, if no other information or action is required, include the Alternate Recipient(s) in the available coverage.

Furthermore, upon receipt of an appropriately completed National Medical Support Notice, the Fund Administrator shall send the participant, the Alternate Recipient and the state agency issuing the Notice a notice of receipt of the National Medical Support Notice. If the custodial parent is not eligible to participate in the plan described in the National Medical Support Notice, the Fund Administrator shall so notify the State agency issuing the Notice with respect to such Alternate Recipient within 20 business days.

A child covered pursuant to an appropriately completed National Medical Support Notice shall be treated as an Alternate Recipient covered under the group health plan pursuant to a QMCSO.

Treatment of Alternate Recipient under a QMCSO

The Plan shall afford coverage to each Alternate Recipient under a QMCSO as a participant under the plan for all reporting and disclosure requirements imposed by ERISA. Furthermore, the Plan shall treat each Alternate Recipient under a QMCSO as a beneficiary under the Plan for all purposes other than the reporting and disclosure requirements.

Cost of QMCSO Benefits

The premiums for coverage provided under the QMCSO shall be paid by the party designated as responsible for paying for such coverage in the Order. In the event the Order does not specify the party responsible for payment for the Alternate Recipient's coverage under the Order, then the Order shall not be considered a QMCSO, and copies of these procedures shall be sent to the Participant, Alternate Recipient and the court or appropriate administrative body which produced the Order.

QMCSO and Medicaid

The plan shall not consider the Alternate Recipient's eligibility for Medicaid when enrolling the Alternate Recipient in the plan. The plan shall comply with the Alternate Recipient's assignment rights under Medicaid, if any.

Payments or Reimbursements under a QMCSO

The plan shall be able to pay or reimburse the Alternate Recipient or the Alternate Recipient's custodial parent for any benefit payments due under the plan to or on behalf of the Alternate Recipient.

LIFE AND AD&D COVERAGE BENEFITS

Life and AD&D benefits under the Plan are insured by Union Labor Life under group policies.

Schedule of Benefits

BENEFITS FOR EMPLOYEES OTHER THAN NON-BARGAINING EMPLOYEES AND HELPER-TRADESMEN

Life Insurance Benefit

All eligible individuals $10,000

Accelerated Life Insurance Benefit

All eligible individuals $5,000

Accidental Death and Dismemberment (AD&D) Benefit

FOR LOSS OF:	**THE BENEFIT IS:**
LIFE	$10,000
TWO HANDS	$10,000
TWO FEET	$10,000
SIGHT OF TWO EYES	$10,000
ONE HAND AND ONE FOOT	$10,000
ONE HAND AND SIGHT OF ONE EYE	$10,000
ONE FOOT AND SIGHT OF ONE EYE	$10,000
ONE HAND OR ONE FOOT	$5,000
SIGHT OF ONE EYE	$5,000

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

BENEFITS FOR NON-BARGAINING EMPLOYEES

Life Insurance Benefit

All eligible individuals. $10,000

Accidental Death and Dismemberment (AD&D) Benefit

FOR LOSS OF:	THE BENEFIT IS:
LIFE	$10,000
TWO HANDS	$10,000
TWO FEET	$10,000
SIGHT OF TWO EYES	$10,000
ONE HAND AND ONE FOOT	$10,000
ONE HAND AND SIGHT OF ONE EYE	$10,000
ONE FOOT AND SIGHT OF ONE EYE	$10,000
ONE HAND OR ONE FOOT	$5,000
SIGHT OF ONE EYE	$5,000

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

More Information About Life Insurance Coverage

Benefit Determination – The amount of life insurance benefit as shown in the Schedule of Benefits above will be the amount in force for you on the date of your death, subject to all the terms and conditions of the Plan.

Benefit Payment – Payment will be made to your named Beneficiary upon Union Labor Life's receipt of proof of death, as provided under the Claim Payment section below.

You may make an absolute assignment of all the incidents of ownership of your life insurance benefits under the Plan, but only if Union Labor Life is given actual notice of the assignment. Any such assignment will not take effect with Union Labor Life prior to the date a copy of the assignment is received at Union Labor Life's Home Office at the address indicated in this booklet. Union Labor Life assumes no responsibility for the validity or sufficiency of any such assignment. Collateral assignments, by whatever name, are not permitted.

Conversion of Life Insurance

If an individual's life insurance coverage, or any portion thereof, terminate, he or she is entitled to convert all or a portion of the amount of life insurance coverage which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy") issued by Union Labor Life directly to the individual. The individual will not be required to submit evidence of insurability to convert.

Conversion Rights, upon Individual Termination or Class Change – If your life insurance coverage, or any portion thereof, terminate because:

1. you cease to be in an eligible class appearing under the section on "Eligibility"; or
2. you transfer from one eligible class to another, and the class to which you have transferred, offers lesser benefits;

you may convert up to the amount of life insurance which terminated, less any amount for which you become eligible under this Plan or under any other group policy within 31 days from the date of termination.

Conversion Rights Upon Individual Reduction due to Age or Retirement – If your life insurance coverage is reduced because of your:

1. age; or
2. retirement;

you may convert up to the amount of the reduction.

Conversion Rights upon Policy or Class Termination – If your life insurance coverage terminates because:

1. this Plan terminates; or
2. this Plan is amended to terminate coverage for a Class of Eligible Individuals under which you were covered;

you may convert to an amount that does not exceed the lesser of the following, provided you have been continuously covered for life insurance coverage under the Plan for at least 5 years:

1. The amount of life insurance coverage in effect for you on the date of coverage termination, less any amount for which you are eligible or become eligible under the Plan within 31 days after the date of termination; or
2. $1,000.00.

Conversion Period – To qualify for a Conversion Policy, an individual must submit a written application to Union Labor Life and pay the first premium due within 31 days from the date his or her life insurance coverage terminates under this Plan.

Notice of Conversion Privilege – The Plan will notify you of your right to convert. If the notice is not given by the 16th day of the 31-day conversion period described above, you will have an additional period in which to convert. The additional period will expire 15 days from the date you are notified, but in no event will the right to convert be extended more than 91 days beyond the date your life insurance coverage terminates under this Plan. Written notice presented to the individual, or mailed to his or her last known address, shall constitute notice for purpose of this provision.

Conversion Policy – An individual who is eligible to convert is entitled to convert to any individual policy which is then being offered by Union Labor Life , other than term insurance, or insurance which provides disability or other supplemental benefits. However, the conversion policy, may, if the individual chooses, be preceded by single premium term insurance of not more than one year. Regardless of the type of policy, once a Conversion Policy is purchased by you, such a policy represents a direct contractual relationship between you and Union Labor Life. The Fund is not a party to any such relationship and bears no responsibility for the provision of benefits from a conversion policy.

Premium Rates – The premium rates for the conversion policy will be Union Labor Life's premium rates in effect for the amount and type of policy elected and based on the individual's class of risk and attained age (age nearest birthday at the date of issue of the conversion policy) on the effective date of the conversion policy.

Effective Date of Conversion Policy – The individual life insurance conversion policy will take effect at the end of the thirty-one day period provided the premium has been paid before the end of such period.

Death Within the Conversion Period – If an individual dies during the 31-day conversion period, the maximum amount of life insurance which he or she was entitled to convert will be paid as a benefit under this Plan; the benefit will be paid to the last Beneficiary named by the individual, whether or not conversion was applied for, and any premium paid.

If a conversion policy was applied for, such conversion policy will be null and void even if the conversion policy had been issued; and no death claim will be payable under the conversion policy. Union Labor Life will return any premium paid for the conversion policy.

Limitation on Amount Converted – An individual who holds an individual policy of life insurance obtained through the conversion privilege of this Plan, will not be entitled to exercise the conversion privilege more than one time, even if he or she is otherwise eligible, as long as any such individual life insurance policy remains in force, unless he or she provides evidence of

insurability which is satisfactory to Union Labor Life. The effective date of such individual policy shall be designated by Union Labor Life.

Lifetime Limit on Amounts Converted – The maximum amount of Life Insurance for which an individual can purchase a conversion policy can never exceed the maximum amount of life insurance coverage for which the individual was covered under this Plan.

Waiver of Premium for Life Insurance Benefits

If you become Totally Disabled (as defined below) while covered under this Plan and prior to attainment of age 60 and remain Totally Disabled for at least 9 consecutive months, your life insurance will be continued without payment of premium while your Total Disability continues. The initial continuation of your insurance under this provision will be for 12 months from the date the premium payments for you have ceased, but in no event longer than 24 months from the date Total Disability began.

"Totally Disabled" and "Total Disability" for the Waiver of Premium provisions mean your complete inability, due to injury or illness, to engage in any business, occupation or employment, for which you are qualified or become qualified by reason of education, training or experience for pay, profit or compensation.

In order for your insurance under this provision to continue, you must:

1. Remain disabled; and
2. Submit satisfactory written proof (the "Initial Proof") to Union Labor Life within twelve months from the date premium payments on your behalf ceased, but in no event longer than 24 months from the date Total Disability began.

If acceptable written proof is not received within the twelve month period as shown in item 2. above, any life insurance continued under this Waiver of Premium provision will terminate at the end of such twelve month period.

The Initial Proof must show that the Total Disability:

1. Began while you were covered under this Plan;
2. Began before you attain age 60; and
3. Has existed continuously for 9 consecutive months.

Upon Union Labor Life's receipt of the satisfactory Initial Proof, life insurance for you may be continued for further successive 12 month periods if:

1. You remain Totally Disabled; and
2. Acceptable written proof of the continued Total Disability is received each year at by Union Labor Life within 3 months prior to each

anniversary of the date Union Labor Life receives the Initial Proof. Such proof must be sent to Union Labor Life at your own initiative; Union Labor Life shall not be required to request such proof.

Benefit Amount – The amount of life insurance that will be continued under this provision will be the amount of insurance in force for you on the date premium payments for you ceased.

Right to Require Examination –Union Labor Life has the right to have you examined at its own expense, by a doctor of its choice, at any reasonable time during the course of your Total Disability. However, Union Labor Life will not require such an examination more than once a year after your insurance has been continued for at least two full years under this provision.

Accelerated Life Insurance Benefit

The following acceleration provisions shall apply to the life insurance benefits of this Plan only.

Definitions – The following definitions are applicable only to these acceleration provisions:

"Accelerated Benefit(s)" means the amount of life insurance that will be paid in accordance with the terms and conditions of this Plan prior to your death if the conditions of this Accelerated Life Insurance Benefit provision are met.

"Covered Person" means an individual who: (1) is eligible under the classes of eligible individuals under this Plan; (2) is an active employee; (3) has been covered under this Plan for a minimum of two years; and (4) is not Totally Disabled, or on Waiver of Premium or Extended Death Benefit, on the effective date of this Plan.

"Totally Disabled" and "Total Disability" means your complete inability, due to injury or illness, to engage in any business, occupation or employment, even on a part-time basis, for which you are qualified or become qualified by reason of education, training or experience, for pay, profit or compensation.

"Terminal Illness" or "Terminally Ill" means a determination is made that you, while covered under this Plan, has a life expectancy of six months or less as the result of a medical condition caused by injury or illness.

Benefit Amount – The benefit payable under these acceleration provisions is the Accelerated Benefit amount shown on the life insurance Schedule of Benefits.

Payment of the Accelerated Benefit – Payment of the Accelerated Benefit shall be made in one lump sum to you, or to the entity or party so designated

in writing by you. Only one Accelerated Benefit shall be payable per person covered for Accelerated Benefits.

Effect on Life Insurance Amount – Once the Accelerated Benefit has been paid, the Life Insurance amount on the covered person shall be reduced by the amount of the Accelerated Benefit payment. The remaining Life Insurance amount will remain in effect, subject to any reduction or termination and all other conditions and terms of this Plan. The amount of Life Insurance available for conversion shall be reduced by the amount of the Accelerated Benefit payment.

Conditions For Which Accelerated Life Benefits Are Payable – "Condition(s)" means any of the medical conditions and circumstances for which Accelerated Life Insurance benefits are payable under this Plan. Benefits shall be payable under this Plan for the following Condition(s):

1. A Terminal Illness which results in a life expectancy of not more than 6 months;
2. A medical condition which requires extraordinary medical intervention, such as, but not limited to, major organ transplant or conditions for artificial life support, without which death would result;
3. A medical condition which requires continuous confinement in an eligible Institution if the covered person has been confined a minimum of 6 months, and such covered person is expected to remain in such or similar Institution for the remainder of his or her life:
   a. after the covered person's effective date of coverage under this Plan; and
   b. while this Plan is in effect as to such covered person.

   "Institution" means a nursing home or skilled nursing facility, which is licensed as such by the state, and which provides skilled nursing care by registered graduate nurses, under the direction of at least one physician.
4. A medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following: (a) coronary artery disease which results in acute infarction or which requires surgery; (b) permanent neurological deficit which results from cerebral vascular accident; (c) end stage renal failure; or (d) Acquired Immune Deficiency Syndrome.

Requirements for Payment of the Accelerated Life Benefit – Payment of an Accelerated Benefit is subject to the following:

1. The request for payment of the benefit must be made to Union Labor Life in writing by the covered person or such person's legal representative.

2. The diagnosis of a Condition must be made:
   a. by a licensed qualified physician who is other than the covered person or a member of such covered person's family;
   b. after the covered person's effective date of coverage under this Plan; and
   c. while this Plan is in effect as to such covered person.
3. The written consent of an assignee or irrevocable beneficiary, if any, must be given to Union Labor Life .
4. The covered person, at his or her own expense, must provide proof satisfactory to Union Labor Life of the diagnosis and effect on life expectancy; such proof shall include, but is not limited to, clinical, radiological and laboratory evidence.

   If the covered person dies after a request is made for the Accelerated Benefit, but before such benefit is paid, the Accelerated Benefit is not payable. The Life Insurance Amount under the Plan will be paid to the Beneficiary as if no request for Accelerated Benefits had been made.

Medical Determination – If you and Union Labor Life do not agree on the diagnosis of the Condition or its effect on life expectancy, either may request, in writing, an additional medical determination. The procedure shall be as follows:

1. You and Union Labor Life shall each select an independent physician.
2. Both physicians will: (a) examine you and all your medical records; and (b) submit a written opinion.
3. If both physicians do not agree, they will choose a third disinterested physician acceptable to both.
4. The third physician will examine you and your medical records, and submit a written opinion as to a final determination.
5. If the opinion of the third physician is in favor of the covered person, Union Labor Life will pay the expenses of the physicians involved.
6. If the opinion of the third physician is in favor of Union Labor Life, Union Labor Life will pay the expenses of its physicians and of the third physician; and the covered person shall pay the expenses of his or her physician.

   It is agreed that this will be the sole remedy for resolving any differences of medical opinion and determination for purposes of accelerated life insurance benefits under this Plan.

Waiver Of Premium (Extended Death Benefit) – The request for Accelerated Benefits and the submission of supporting medical evidence may be used to comply with the requirements for submission of written proof of

Total Disability under the provision titled Waiver of Premium for Life Insurance Benefits. In all other respects, all other conditions of the Waiver of Premium or Extended Death Benefits provision shall remain in full force and effect, and shall apply only to those persons as outlined therein.

Conversion – Regardless of anything to the contrary in this Plan, this Accelerated Life Insurance Benefit may not be converted to an individual policy. The amount of life insurance available for conversion shall be reduced by the amount of the Accelerated Benefits payment.

Exceptions to Applicability of Accelerated Benefits – This Accelerated Life Insurance Benefit provision provided herein shall not apply:

1. To any life insurance with a face amount of less than $10,000;
2. To request for payment of the benefit for any other reason other than a Condition as described in this Plan;
3. If the required premium for group Life Insurance under this Plan is due and unpaid;
4. To any supplemental life benefits, accidental death and dismemberment benefits or to any other benefits provided by Union Labor Life except for the group Life Insurance benefits provided under this Plan;
5. When all or a portion of your life insurance benefits are to be paid as part of a divorce settlement;
6. If your life insurance under this Plan has been in force for less than two years, or if you are Totally Disabled or on Waiver of Premium on the effective date of this Plan or this Accelerated Life Insurance Benefit provision, whichever is later;
7. If you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
8. If you are required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement; or
9. If the illness or injury which caused the medical condition is caused by intentional self-inflicted injury or attempt at suicide.

Tax Implications – Neither Union Labor Life nor the Fund shall be responsible for any tax or any other effects of any Accelerated Benefits payment. The receipt of an Accelerated Benefit will reduce the death benefit, and may be taxable income to the covered person or to the covered person's Beneficiary. The covered person and the Beneficiary should consult with a personal tax advisor.

More Information About AD&D Insurance

Upon receipt of due proof of loss, Accidental Death and Dismemberment Benefits will be paid if:

1. You, while covered under this benefit, suffer an accidental injury; and
2. As the direct result of the accident, and independent of all other causes, you suffer a Covered Loss within 90 days after the accident.

A "Covered Loss" means permanent loss of:

1. Life;
2. A hand, by severance at or above the wrist joint;
3. A foot, by severance at or above the ankle joint; or
4. An eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under the provision titled **"AD&D Exclusions"** under this Section, and subject to all the terms and conditions of this Plan. The amount of benefit to be paid for a Covered Loss is listed in the Schedule of Benefits

Beneficiary – For a covered loss, benefits shall be paid directly to you. In case of loss of life, benefits will be paid to your Beneficiary. The Beneficiary shall be the party or parties elected by you and so designated on your annual demographics form provided by the Fund Administrator.

You may at any time change your Beneficiary, without the consent of the previously named Beneficiary. Such change must be requested on a form furnished by or acceptable to Union Labor Life, and the change shall take effect upon receipt of the signed form at Union Labor Life's Home Office.

See the section "Life and AD&D Claim Payments" for additional provisions concerning Beneficiaries.

AD&D Exclusions – No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. Bodily or mental illness or disease of any kind;
2. Medical or surgical treatment of an illness or disease;
3. Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
4. Suicide or attempted suicide while sane or insane;
5. Intentional self-inflicted injury;
6. Participation in, or the result of participation in, the commission of a felony, or a riot, or a civil commotion; or
7. War or act of war, declared or undeclared; or any act related to war, or insurrection.

Life and AD&D Claim Payments

The Beneficiary (Life Insurance and AD&D Benefits) – Your Beneficiary is the party or parties named by you, as shown on Union Labor Life's records,

to receive the benefits payable under this Plan upon your death. You may name one or more Beneficiaries to receive the death benefit. You may designate anyone you wish as your Beneficiary by filing a designation with the Fund Administrator on the form designated by the Fund, which has been approved by Union Labor Life.

You may change the Beneficiaries at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing sent to the Fund Administrator, and using the form designated by the Fund, which has been approved by Union Labor Life. Such change will take effect upon receipt of the signed form at the Home Office of Union Labor Life.

Upon receipt of Satisfactory Proof of Claim, Union Labor Life will pay the benefit due to your named Beneficiary as follows:

1. If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by you when the Beneficiaries were named.
2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:
   a. The surviving spouse;
   b. Your children, in equal shares;
   c. Your parents, in equal shares;
   d. Your brothers and sisters, in equal shares; or
   e. The executors or administrators of your estate.

   In order to determine which class of individuals is entitled to the death benefit, Union Labor Life may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, Union Labor Life will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, Union Labor Life will pay the benefit to his or her legal guardian. If there is no legal guardian, Union Labor Life may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. Union Labor Life will be fully discharged of its liability for any amount of benefit so paid in good faith.
4. If an individual appears to Union Labor Life to be equitably entitled to compensation because he or she has incurred expenses on behalf of your burial, Union Labor Life may pay to such individual the expenses incurred up to $500 from the life insurance proceeds. Such payment,

however, shall not exceed the amount due under the Plan. Union Labor Life will be fully discharged of its liability for any amount of benefit so paid in good faith.

Physical Examination and Autopsy – Union Labor Life will have the right to examine any person as often as it may require and to perform an autopsy where not forbidden by law. This will be at the expense of Union Labor Life.

Life and AD&D Insurance Claims Procedures

Claims for Life or AD&D Benefits

An Employee or Beneficiary wishing to present a claim for life or AD&D insurance benefits must obtain a claim form from the Fund Administrator for these benefits. The applicable section(s) of the form must be completed by the Employee (if possible), the Employee's Employer, the Fund and the Employee's attending physician or hospital, all as applicable. Claims related to eligibility shall be decided by the Trustees. All other claims will be submitted to Union Labor Life.

An Employee or Beneficiary must submit the claim form for life or AD&D benefits or a written notice of your claim to Union Labor Life within 90 days after the loss, or as soon as possible. If the claim form is not provided to you within 15 days after you have sent a notice of the claim, you may submit a written statement of the nature and extent of your claim to Union Labor Life within the 90 day period or as soon as reasonably possible.

For life insurance and AD&D insurance benefits, a written decision regarding payment of a claim must be provided to you by Union Labor Life no more than 90 days after its receipt of your claim. This 90 day time period may be extended up to an additional 90 days due to circumstances beyond Union Labor Life's control. If your appeal is based on a finding that you are not eligible for a benefit because you are not disabled, the written decision must be provided to you no more than 45 days after Union Labor Life's receipt of your proof of loss. This 45 day time period may be twice extended up to an additional 30 days due to circumstances beyond Union Labor Life's Administrator's control. Any notice of extension will indicate the special circumstances requiring an extension and the date by which a decision is expected.

The written decision will include specific reasons for the decision and specific references to the plan provision(s) on which the decision is based. Beneficiary designations on file with the Fund Administrator or Union Labor Life at the time a claim is filed shall be the only designation used to determine the payment of benefits, and the payment of benefits pursuant to that designation

shall operate as a complete discharge of any liabilities of the Plan, the Fund Administrator, and Union Labor Life.

If a claim for life and AD&D insurance benefits is either wholly or partially denied, notice of the decision shall be furnished to the claimant in writing by Union Labor Life. This written decision will:

- Give the specific reason for the denial;
- Make specific reference to the plan provision on which the denial is based;
- Provide a description of any additional information necessary to complete the claim determination and an explanation of why it is necessary; and,
- Provide an explanation of the review procedures available to the claimant to appeal the decision.

If the claim is based on a determination of your disability (such as under the Extended Benefits provisions of the Plan), the written decision will also:

- Include an explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of health care professionals treating you or vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denied claim without regard to whether the advice was relied upon in making the denial; and
    - A disability determination you presented to the Plan made by the Social Security Administration;
- Include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- Describe any specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relief upon in making the claim denial; and
- Include a statement prominently displayed in the relevant non-English language for certain counties clearly indicating how to access language services provided by the Claims Administrator.

Appealing a Denied Claim

On any denied claim for such benefits, a claimant may ask for a full and fair review of the denial. The claimant may:

- Request a review upon written application within 60 days of receipt of the claim denial (180 days if the claim denial is based on a determination that the claimant is not disabled);

- Review pertinent documents related to the appeal; and,
- Submit issues and comments in writing as part of the review process.

If the claim is based on a determination of disability, the claimant may also have reasonable access to, and copies of, all documents and other information relevant to the claim free of charge upon request and shall have the right to have identified to him or her the medical or vocational experts whose advice was obtained in connection with the claim denial, even if the advice was not relied upon in making the denial. Additionally, the review of the denial shall not give deference to the original decision and shall be made by an independent fiduciary.

If your appeal is based on a finding that you are not eligible for a benefit because you are not disabled, the Claims Administrator will provide you with any new rationale on which an appeal denial may be based as well as any new or additional evidence considered, relied upon, or generated in connection with the claim. This information will be provided as soon as possible and sufficiently in advance of the date on which the appeal denial notice must be provided, in order to give you a reasonable opportunity to respond prior to that date. Upon request, you will be provided the names of any such experts who were consulted in connection with your claim, even if the advice was not relied upon in making the denial.

In deciding an appeal of any claim denial that is based on a medical judgment (including things like whether a treatment is experimental or not medically necessary), the Claims Administrator must get advice from a health care or vocational expert who has training and experience in the area of medicine in question. The health care professional consulted by the Claims Administrator cannot be a person who was consulted by the Claims Administrator in connection with the claim denial (or a subordinate of the person who was consulted in the original claim).

The request for review should be submitted to the Fund Administrator. Appeals related to eligibility shall be decided by the Fund Administrator. All other appeals shall be decided by Union Labor Life. A decision on the appeal will be made no more than 60 days after receipt of the request for review. This 60 day time period may be extended up to an additional 60 days due to circumstances beyond Union Labor Life's control. If the appeal is based on a finding that the claimant is not eligible for a benefit because he or she is not disabled (such as under the Extended Benefits provisions of the Plan), the written decision must be provided no more than 45 days after Union Labor Life's receipt of the appeal. This 45 day time period may be twice extended up to an additional 30 days due to circumstances beyond Union Labor Life's control. Any notice of extension will indicate the special circumstances requiring an extension and the date by which a decision is expected.

The written decision will include:

- The specific reason(s) for the denial;
- A reference to each of the specific Plan provision(s) on which the denial is based;

If the appeal is based on a finding that the claimant is not eligible for a benefit because he or she is not disabled, the written decision will also:

- Include an explanation of the basis for disagreeing with or not following:
    - The views you presented to the Plan of health care professionals treating you or vocational professionals who evaluated you;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your denied claim without regard to whether the advice was relied upon in making the denial; and
    - A disability determination you presented to the Plan made by the Social Security Administration;
- Describe any specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relief upon in making the claim denial; and
- Include a statement prominently displayed in the relevant non-English language for certain counties clearly indicating how to access language services provided by the Claims Administrator; and
- Describe any applicable contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which this period ends.

Completion of these claims procedures for life and AD&D insurance benefits is required prior to the commencement of any legal or equitable action in connection with a claim for benefits under the Plan by a Claimant or any other person or entity claiming rights individually or through a Claimant.

Authority of Union Labor Life to Make Final Binding Decisions on Appeal

The Plan Administrator has the full discretion and authority to make final determinations of all questions relating to eligibility for any Plan benefit and to interpret the Plan for that purpose. While the Plan Administrator has full discretion and authority to finally grant or deny benefits under the Plan, it has delegated that responsibility to Union Labor Life for the prudent administration of claims and appeals for life and AD&D benefits. These benefits will be paid only if Union Labor Life decides in its sole discretion that the applicant is entitled to them. Union Labor Life's determination on appeal will be final and binding.

Designating an Authorized Representative

You may designate someone else to pursue a claim or appeal for life or AD&D benefits on your behalf under the Plan. In order for another person to be considered your "Authorized Representative" for purposes of pursuing your life or AD&D benefits or appealing an adverse benefit determination on your behalf for such benefits, an individual must satisfy one of the following requirements:

- You have given written consent for the individual to represent your interests; or
- The individual is authorized by law to provide substituted consent for you (e.g. – parent of a minor, legal guardian, foster parent, power of attorney).

Payment of Claims - All medical benefits under the Plan will be paid to you, if living, your treating medical provider or, otherwise as applicable, to your estate. If your estate will not be probated, the Plan may use its discretion in disbursing benefits which would otherwise be payable to your estate, not to exceed $2,000. The Plan will be discharged to the extent of any benefit payments that were made in good faith.

If benefits are being provided by the Texas Department of Human Services for medical services rendered to a dependent child and there is a court order which requires you to pay child support or which gives you possession of or access to that child, benefits payable under this Plan for those services will be paid directly to the Texas Department of Human Services provided that written notice of this requirement is received when the claim is first submitted.

No Assignment – No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. You may not assign your right to receive benefits under the Plan, or to bring a claim or lawsuit for benefits or for breach or violation of any other duty or obligation owed to you under the Plan, to any third party, including a health provider. These rights are yours alone and may not be transferred to another party. No other person or entity, including a medical provider, is permitted to bring a claim against the Plan under ERISA or any other law through a purported assignment and any attempt to assign these rights will be void and unenforceable.

This does not mean, however, that you may not authorize the Plan to pay a provider directly for its charges for medical services provided to you. In fact, you will be deemed to have authorized the Plan to pay medical providers directly for their covered charges upon your accepting coverage under the Plan unless you revoke this authorization by providing written notice to the Plan Administrator.

However, your authorization for the Plan to make these direct payments does not mean that you have assigned to the provider any legal right enforceable by the provider to the benefits payable under the Plan, or the right to bring a claim or lawsuit for benefits under the Plan or for breach or violation of any other duty or obligation owed to you under the Plan (or ERISA or other law). Nor does this direct payment mean that the Plan recognizes any purported assignment of benefits or claims asserted by the provider. These legal rights to benefits and claims remain yours and yours alone. In no event will the Plan be liable to any third party to whom you may be liable for medical care, treatment, or other services or any other third party.

Physical Examination and Autopsy - The Plan has the right to examine any person as often as it may require and perform an autopsy where not forbidden by law. This will be at the expense of the Plan.

Legal Actions - You must exhaust all claims procedures set forth in the Plan before bringing a legal or equitable action for Plan benefits. You (and any other claimant claiming rights through you) must bring any legal or equitable action to contest a final benefit determination made with respect to a claim under this Plan within 1 year following the issuance of the final benefit determination (or, if earlier, within 3 years from the date written proof of loss was required to be furnished).

Clerical Error - Any clerical error by the Plan Administrator, a Claims Administrator or the Fund Administrator, or any agent thereof, in keeping pertinent records, depositing or otherwise receiving required contributions for coverage or a delay in making any coverage changes will neither invalidate coverage otherwise validly in force or continue coverage validly terminated. No inference of coverage shall be communicated to any person merely by the Plan's receipt or deposit of payments for coverage. An equitable adjustment of contributions will be made when an error or delay is discovered. If any overpayment occurs, the Plan retains a contractual right to the overpayment, regardless of who has possession of the monies.

Rights of Recovery – Whenever payments have been made by the Plan in excess of the maximum amount of payment necessary to satisfy the terms and intent of this Plan, the Plan and/or the Fund Administrator, acting on behalf of the Plan, shall have the right, in their sole discretion, to recover such excess payments.

Waiver or Estoppel – No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other Plan provision.

Conformity with the Law – If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Statements – All coverage provided under the Plan is based on the truthfulness of statements made by Eligible Individuals, either in a written enrollment form or otherwise. Coverage can be voided for any Eligible

Individual for any misrepresentation or fraudulent misstatement made to a Contributing Employer, the Plan Administrator, a Claims Administrator or the Fund Administrator by or on behalf of such Eligible Individual. Furthermore, Eligible Individuals shall provide the Plan Administrator, any Claims Administrator and/or the Fund Administrator with such information and evidence as may reasonably be requested from time to time for the purpose of administering the Plan.

ALL ELIGIBLE EMPLOYEES ARE REMINDED THAT THEY MUST NOTIFY THE FUND ADMINISTRATOR WHEN:

1. There is a change of address.
2. New Dependents are to be covered. (Provide certified copies of the birth certificates or adoption papers)
3. There is a divorce/legal separation. (Provide court certified divorce/legal separation papers)
4. There is a marriage. (Provide a certified copy of the marriage certificate)
5. A Dependent ceases to be a Dependent (e.g. reaches age 26, all as further described elsewhere in this document).

NOTICE

This Plan will not be deemed to constitute a contract of employment or give any Employee of a Contributing Employer the right to remain in the service of the Employer or to interfere with the right of the Employer to discharge any Employee. These issues are covered by your Collective Bargaining or Participation Agreement.

You MUST satisfy all of the eligibility provisions in order to be eligible for the benefits of this Plan. Possession of this Booklet does not automatically entitle you to Plan benefits.

ERISA & LEGAL PROVISIONS

The following information, together with the information contained in this Plan, comprise the Summary Plan Description under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, only for the benefits described herein:

1. The name of the Plan is Pipe Fitters Local Union No. 211 Welfare Trust Fund.
2. The name, address and telephone number of the Plan Sponsor, who is also the Plan Administrator, is:

   Joint Board of Trustees
   Pipe Fitters Local Union No. 211
   Welfare Trust Fund
   P.O. Box 721708 • Houston, TX 77272-1708
   Tel. (713) 219-1200
   Toll Free Tel. 1-800-682-PIPE (7473)

3. The name, address and telephone number of the agent for service of legal process for the Plan is:

   Baker Botts L.L.P.
   ATTN: Mark Bodron
   One Shell Plaza
   910 Louisiana • Houston, TX 77002
   Tel. (713) 229-1742

4. The name and address of the Claims Fiduciary for the Life and Accidental Death & Dismemberment Insurance portion of the plan is:

   Union Labor Life
   1625 Eye Street, N.W. • Washington, D.C. 20006

5. The name and address of the Claims Fiduciaries for the Medical Benefits portion of the Plan is:

   BlueCross BlueShield
   P.O. Box 805107 • Chicago, IL 60680-4112
   Tel. 1-800-810-2583
   www.bcbsil.com

   SAV-RX
   P.O. Box 8 • Freemont, NE 68026
   1-800-228-3108

6. The name and address for the Fund Administrator is:

Zenith American Solutions
Attn: Fund Manager
9555 W. Sam Houston Parkway, South, Suite 400
Houston, TX 77099

7. The Plan Identification Number is 501 and the Employer Identification Number assigned is 74-6063911. The Plan's fiscal records are maintained on a Plan year basis ending December 31 each year.
8. The cost of the Plan is borne by the Contributing Employers and Self-Pay Employees.
9. The Comprehensive Medical Benefits are provided from the Plan's assets which are accumulated under the provisions of the Trust Agreement and held in a trust fund for the purpose of providing benefits to you and your Covered Dependents, and their beneficiaries, and deferring reasonable administrative expenses. The life and AD&D insurance benefits are provided through the insurance contract with Union Labor Life.
10. As a participant in the Pipe Fitters Local Union No. 211 Welfare Trust Fund, 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 work sites and union halls, all documents governing the Plan including insurance contracts, collective bargaining and participation 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining and participation agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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.

Receive a summary of material reduction in covered services or benefits provided under the plan within 60 days after the adoption of the changes

(unless summaries of changes to the plan are provided at regular intervals of 90 days).

Continue Group Health Plan Coverage

Continue health care coverage for your self, 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 the COBRA Continuation Provisions section of this Summary Plan Description (the front part of this Booklet) and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Newborn's and Mother's Health Protection Act

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon persons 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 one hundred ten dollars ($110) a day until you receive the materials, unless the materials were

not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court upon the exhaustion of the appeal procedures contained herein. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order and/or medical child support order, you may file suit in a 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 your claim is 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, NW, Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Plan Sponsor's Right to Amend or Terminate the Plan

THE RIGHT IS RESERVED IN THE PLAN FOR THE PLAN SPONSOR TO TERMINATE, SUSPEND, WITHDRAW, AMEND OR MODIFY THE PLAN, COVERING ANY ACTIVE EMPLOYEE OR CURRENT OR FUTURE RETIREE, IN WHOLE OR IN PART AT ANY TIME. ANY SUCH CHANGE OR TERMINATION IN BENEFITS:

1. WILL BE BASED SOLELY ON THE DECISION OF THE PLAN SPONSOR; AND,
2. MAY APPLY TO ALL ACTIVE EMPLOYEES, CURRENT RETIREES OR FUTURE RETIREES, AS EITHER SEPARATE GROUPS OR AS ONE GROUP.