Plumbers and Pipefitters Local No. 421 Health and Welfare Plan

Summary of Material Modifications – Effective May 1, 2018
RETIREES (Over Age 65)

This document is a Summary of Material Modifications (SMM) which describes changes to the Plumbers and Pipefitters Local No. 421 Health and Welfare Plan (the Plan). It modifies the language found in your Summary Plan Description (SPD). All statements made in this document are subject to the terms and conditions of the Plan Document. If there is a discrepancy between the SPD or this SMM and the Plan Document, the Plan Document will govern. Copies of the SPD and Plan Document are available for review at any time during normal working hours at the Plan's office.

The Board of Trustees of the Plumbers and Pipefitters Local No. 421 Health and Welfare Plan (the Trustees) announces the following benefit changes for Hospice care for eligible Retirees, which will take effect May 1, 2018.

Hospice Care Benefit Changes

Benefit Description	**Benefit Amount**
Routine Home Care (Days 1-60)	$193.03 per day
Routine Home Care (Days 61+)	$151.61 per day
Continuous Home Care (24 Hours)	$976.80 per day
Inpatient Respite Care	$181.87 per day
General Inpatient Care	$743.55 per day

This Summary of Material Modifications should be kept with your Summary Plan Description. All capitalized terms not defined in this SMM are defined in the SPD or the Plan Document. If you have any questions, please contact the Fund Office at (800) 842-5899.

Plumbers and Pipefitters Local No. 421 Health and Welfare Plan

Summary of Material Modifications – Effective May 1, 2018
RETIREES (Under 65)

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Plumbers and Pipefitters Local No. 421 Health and Welfare Plan

Summary of Material Modifications – Effective January 1, 2017
RETIREES (Under 65)

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The Board of Trustees of the Plumbers and Pipefitters Local No. 421 Health and Welfare Plan (the Trustees) announces the following benefit changes for eligible Retirees, which will take effect January 1, 2017.

Network Changes

- Effective January 1, 2017 the Plan is moving from the Cigna Preferred Provider Organization (PPO) Network to the Cigna Open Access Plus (OAP) Network. Certain providers who are in-network under the PPO Network may be out-of-network under the OAP Network. Please be sure to check the status of any previously in-network providers prior to incurring charges.
- You can expect new ID cards to be mailed to your home address towards the end of December.

Medical Benefit Changes

Annual Deductible	$750 per Individual / $1,500 per Family
Emergency Room Copay	$100 copay per visit

Plumbers and Pipefitters Local No. 421 Health and Welfare Plan

Specialist Office Visit	Subject to Deductible, then 20% Coinsurance
Out of Pocket Maximum	$3,000 per Individual / $6,000 per Family

Prescription Drug Benefit Changes

- Effective January 1, 2017, the Plan will no longer charge a copay for Prescription Drugs. Instead, Participants will be responsible for a 20% coinsurance for any Prescription Drugs filled for themselves or their eligible dependents.
- Effective January 1, 2017, all Participants and their eligible dependents will have a combined Out of Pocket maximum of $3,500 for Prescription Drug benefits.

Retiree Premiums for under 65 Retirees

- Effective January 1, 2017, any NEW (under 65) Retiree will have an increase in the monthly contribution rate. The new monthly contribution rate for NEW (under 65) Retirees will be $3,700 per month.
- Effective January 1, 2017, all CURRENT (under 65) Retirees will have an increase in the monthly contribution rate. The new monthly contribution rate for CURRENT (under 65) Retirees will be $1,200 per month. This premium will also increase in 2018. Effective January 1, 2018, the contribution rate for CURRENT (under 65) Retirees will be $2,400 per month.

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PLUMBERS AND PIPEFITTERS LOCAL NO. 421

HEALTH AND WELFARE PLAN CHANGES

WHAT DO THEY MEAN?

What is an Annual Deductible?

The Annual Deductible is a financial protection for you that is built into the Plan. This is the amount that you must pay before the Plan will begin paying for medical services incurred. The Deductible applies only once in any calendar year, though it may take several claim submissions before the entire Deductible has been satisfied.

You earn credit towards meeting your Deductible each time you incur a claim for services for which you must pay an out of pocket amount. For example, if you are treated in a specialist's office and the doctor orders lab testing with an independent lab, both the charges for services incurred in the office and the charges for the lab work done by the independent lab will apply toward your Annual Deductible.

Effective January 1, 2017, your Annual Deductible will be increased to $750 per individual.

What is an Out of Pocket maximum?

The Out of Pocket maximum is a financial protection for you that is built into the Plan. This is the maximum amount you will have to pay in coinsurance for your covered in-network claims. Once you have met this maximum, the Plan will pay 100% of your covered in-network claims. Your Out of Pocket maximum does not include copays, deductibles or charges incurred with out-of-network providers. In the case of your Prescription Drug benefits, your Out of Pocket maximum does not include prescriptions filled with out-of-network pharmacies.

You earn credit towards meeting your Out of Pocket maximum each time you purchase a Prescription Drug at an in-network pharmacy. For example, if you purchase a medication and have a $200 coinsurance with an in-network pharmacy, that $200 will be applied towards your Prescription Drug Out of Pocket maximum.

Effective January 1, 2017, your Out of Pocket maximum for Prescription Drugs will be increased to $3,500 per individual.

PLUMBERS AND PIPEFITTERS LOCAL NO. 421

HEALTH AND WELFARE PLAN CHANGES

WHAT DO THEY MEAN?

The Trustees want you to receive the most appropriate care for your situation. Sometimes that means going to a hospital emergency room; however, consider this: ***the average hospital emergency room claim is more than ten times more costly than an urgent care center claim****.*

Effective January 1, 2017, your copay for visiting a hospital emergency room will be increased to $100. (This copay will be waived if you are admitted to the hospital.) Your copay for visiting an urgent care center or a convenience care center will be $25.

Right care at the right place
Use the emergency room for the immediate treatment of critical injuries or illness, but for less-serious conditions, you can save time and money at local participating Urgent Care and Convenience Care centers. Costs are lower than the ER and many are conveniently located in retail stores and pharmacies with late-night and weekend hours.

Need help deciding where to go? Your Plan professionals can help you decide which setting is most appropriate and help you find an in-network location.

Cigna Nurseline: Speak to a nurse any time at (800) 768-4695.

How can I pay the lowest copay for my doctor visits?

Start with your Primary Care Physician! *Your Primary Care Physician will coordinate your care and determine when it is appropriate for you to see a specialist. You can avoid unnecessary specialist visits which are more costly to you and the Plan by starting with your primary doctor first.*

Effective January 1, 2017, your copay for visiting a specialist is eliminated. Visits with specialists will now be subject to your Annual Deductible and then payable at an 80% coinsurance rate, leaving you with a 20% balance.

Plumbers and Pipefitters Local No. 421 Health and Welfare Plan

PLUMBERS AND PIPEFITTERS LOCAL UNION 421 HEALTH AND WELFARE PLAN - RETIREE

SUMMARY OF MATERIAL MODIFICATION TO PLAN

The Trustees of the Plumbers and Pipefitters Local No. 421 Health and Welfare Fund are pleased to announce the following improvements in your Plan benefits. *These changes are effective January 1, 2014.*

Removal of Certain Annual/Lifetime Maximums

- Comprehensive medical benefit limit of $300,000 per calendar year has been removed.
- Annual physical examination benefit limit of $300 has been removed.
- Prescription drug benefit limits of $333.33 per month per person and $4,000 per calendar year per person have been removed.
- Durable medical equipment lifetime limit of $2,000 has been removed.
- Lifetime hospice benefit limit of six months has been removed.

Pre-existing Conditions

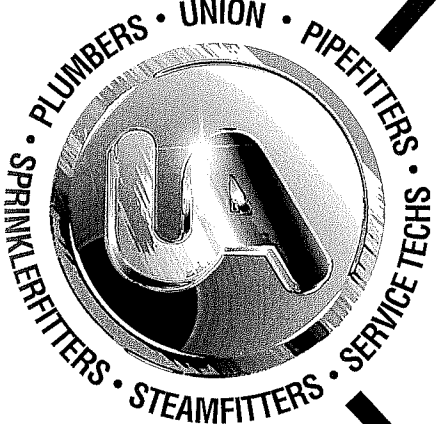
- Pre-existing condition limitations or exclusions no longer apply to employees or their eligible dependents.

If you have any further changes regarding these benefit improvements, please contact the Fund Office at 1-800-842-5899.

Sincerely,

The Board of Trustees

SUMMARY PLAN DESCRIPTION



PLUMBERS AND PIPEFITTERS LOCAL UNION. 421 HEALTH AND WELFARE PLAN

RETIREE AND SPOUSE EDITION
JULY 2011

PLUMBERS AND PIPEFITTERS LOCAL NO. 421 HEALTH AND WELFARE PLAN

IMPORTANT NOTICE

THE TERMS OF THE COLLECTIVE BARGAINING AGREEMENTS BETWEEN YOUR EMPLOYER AND THE PLUMBERS AND PIPEFITTERS UNION LOCAL NO. 421 DETAIL THE BASIS BY WHICH YOUR EMPLOYER HAS AGREED TO MAKE CONTRIBUTIONS TO THIS FUND FOR YOUR COVERAGE. DIFFERENT CONTRIBUTION RATES AND COVERAGES APPLY TO DIFFERENT EMPLOYERS AND CLASSES, AND THE VARIOUS BARGAINING AGREEMENTS ARE NOT NECESSARILY STANDARD AS TO REQUIREMENTS FOR EITHER COVERAGE OR BENEFITS.

ACCORDINGLY, IT IS ABSOLUTELY NECESSARY THAT EACH MEMBER VERIFY HIS OR HER COVERAGE WITH THE ADMINISTRATIVE MANAGER'S OFFICE BEFORE INCURRING EXPENSES UNDER THE PLAN, SO THAT YOU CAN BE SURE THAT THERE IS COVERAGE FOR YOU OR YOUR ELIGIBLE DEPENDENTS. PLEASE REMEMBER THAT NO ONE OTHER THAN THE ADMINISTRATIVE MANAGER'S OFFICE CAN VERIFY YOUR COVERAGE.

FOLLOWING THE ABOVE PROCEDURE WILL PREVENT UNNECESSARY HARDSHIP IF YOU REQUIRE MEDICAL CARE.

PLUMBERS AND PIPEFITTERS LOCAL NO. 421
HEALTH AND WELFARE PLAN
BOARD OF TRUSTEES

UNION TRUSTEES

W. David DeLoach
129 Pinefield Rd.
W. Columbia, S.C. 29170

Perry S. Howard
Plumbers and Pipefitters Local No. 421
2556 Oscar Johnson Dr.
N. Charleston, S.C. 29405

Gary Kinley
127 Tradewinds Ct.
Mooresville, N.C. 28115

Robert A. [Bob] Hughes
Plumbers and Pipefitters Local No. 421
2556 Oscar Johnson Dr.
N. Charleston, SC 29405

EMPLOYER TRUSTEES

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Morgan Mechanical Co.
204 West Stadium Dr.
Eden, N.C. 27288

Chris Bunting
4226 Surles Court
Suite 500
Durham, N.C. 27703

Zane Garldier
10821 NC 87
Reidsville, N.C. 27320

Jack R. Weaver
MCA of the Carolinas
522 Alpine Rd.
Winston Salem, N.C. 27103

ADMINISTRATIVE MANAGER

Core Management Resources Group, Inc.
P.O. Box 1755 [31202]
515 Mulberry St., Ste. 300
Macon, GA 31201
[888] 741-2673

PLAN AUDITOR

LaPadula & Company, C.P.A.'s

PLAN CONSULTANT

Core Management Resources Group, Inc.

PLAN COUNSEL

Charles E. Elrod, Jr.
Parker, Hudson, Rainer & Dobbs LLP

PLUMBERS AND PIPEFITTERS LOCAL NO. 421 HEALTH AND WELFARE PLAN
RETIREE AND SPOUSE TABLE OF CONTENTS

PLUMBERS AND PIPEFITTERS LOCAL NO. 421
HEALTH AND WELFARE PLAN

SCHEDULE OF BENEFITS
[RETIREE & SPOUSE]

LIFE BENEFIT [Self insured through the Health & Welfare Plan]
RETIREES ONLY $1,500
All Life Benefits terminate upon attainment of age [70].

PRESCRIPTION DRUG BENEFIT
[Retirees and their spouse under age 65]
Prescription Drug Card:
$8.00 Co-pay per prescription for Generic Drugs
$25.00 Co-pay per prescription for Name Brand Drugs listed in the Formulary
$45.00 Co-pay per prescription for Name Brand Drugs not listed in the Formulary
*Note: Benefit limited to $250.00 per month per person.
Calendar Year Maximum per person $4,000

Prescription Mail Order - Maintenance drugs such as blood pressure, cholesterol, etc. may be purchased through the mail order for a 90-day supply. You will save using the mail order because you will receive 90 days of prescription medication and only be required to pay 2 co-pays instead of 3 co-pays.
$16.00 Co-pay per prescription for Generic Drugs
$30.00 Co-pay per prescription for Name Brand Drugs listed in the Formulary
$55.00 Co-pay per prescription for drugs not listed in the Formulary.

[Retirees and their spouse over age 65]
No prescription drug benefit is provided by the Plan. Retirees should elect Part D of Medicare when they reach age 65. The Plan will reimburse Retirees and their Spouses premiums up to $50.00 per month per individual.

NOTE: IF GENERIC MEDICINE IS AVAILABLE BUT BRAND NAME IS CHOSEN, YOUR COST WILL BE THE SCHEDULED CO-PAY OR COINSURANCE PAYMENT PLUS THE DIFFERENCE IN RETAIL COST BETWEEN THE GENERIC AND THE BRAND.

COMPREHENSIVE MEDICAL BENEFIT
Maximum Benefits*
Per Calendar Year $300,000

Calendar Year Deductible
Individual $500
Primary Care Physician Office Visit - In **PPO** Deductible waived
Includes: Lab Tests & X-rays billed by the Primary Care Physician [PCP]. PCP's include Family Practitioners, Pediatricians, Obstetricians/Gynecologists and Internal Medicine Physicians.
Co-payment per visit $25.00 then 100%
Specialist Office Visit - In PPO Deductible Waived
Co-payment per visit $25.00 then 100%
Includes: Lab Texts, X-rays and other expenses billed by the Specialist are subject to the calender Year Deductible and Co-Insurance.

NOTE: NON-PPO PHYSICIAN SERVICES, INCLUDING OFFICE VISITS, ARE COVERED AFTER THE CALENDAR YEAR DEDUCTIBLE AND AT THE APPLICABLE COINSURANCE.

Physician Services:*
within **PPO** 80%
out of **PPO** / out of area 70%
out of **PPO** / within area 50%

Inpatient Services:

within **PPO**	80%
out of **PPO** / out of area	70%
out of **PPO** / within area	50%

Maximum Out-of-Pocket [*]

Individual	$3,000 then 100%

SPECIAL NOTE: SOME ANESTHESIOLOGISTS AND THEIR NURSE ASSISTANTS, PATHOLOGISTS, RADIOLOGISTS AND HOSPITALISTS PRACTICING IN PPO HOSPITALS ARE NOT IN THE PPO NETWORK. YOU SHOULD CHECK WITH THE HOSPITAL TO BE CERTAIN THAT THESE PROVIDERS ARE IN THE PPO NETWORK BEFORE ACCEPTING THEIR SERVICES.

Emergency life threatening Non-PPO services in area are payable at 70% by review.

[*] THE MAXIMUM OUT-OF-POCKET DOES NOT INCLUDE ANY CHARGES WHICH ARE INCURRED FOR CO-PAYMENTS, DEDUCTIBLES, NON-PPO CHARGES, SUBSTANCE ABUSE OR ANY OTHER NON-COVERED EXPENSES. THERE IS NO MAXIMUM OUT-OF-POCKET FOR NON-PPO EXPENSES.

Co-payments - Hospital Emergency Room [*]

Per Accident	$25.00 per Accident
Per Sickness	$50.00 per Sickness

[*] Waived if admitted to the same hospital within forth-eight [48] hours.

DURABLE MEDICAL EQUIPMENT BENEFIT*
Lifetime Maximum $2,000

LOCAL AMBULANCE BENEFIT [per occurrence]* $200

HOSPICE CARE*
Lifetime Maximum $100 per day - up to six [6] months

ANNUAL PHYSICAL EXAMINATION BENEFIT*
[SERVICES MUST BE OBTAINED FROM A PPO PROVIDER]
Per Retiree & Spouse only $300

SUBSTANCE ABUSE AND ALCOHOL No Benefit is Provided

* For Retirees and Spouses who are Medicare Eligible, Medicare Part A&B are primary [i.e. Medicare pays first] the Plan is the secondary payor.

ELIGIBILITY RULES
[RETIREE & SPOUSE]

HOW TO BECOME ELIGIBLE - EMPLOYEES

Eligible former employees and their Spouses may continue to be covered under the Retiree Plan as set forth in the **"SCHEDULE OF BENEFITS"**, if they meet the following requirements and make any required self payments on a timely basis.

In order to be eligible for the Retiree Plan, a Retiree must:

1. Be retired and receiving, or be eligible to receive, Benefits from the North Carolina Annuity Plan, the Greenville Plumbers Pension Plan, the Charleston Plumbers Pension Plan or the Columbia Plumbers Pension Plan; and,
2. Be at least age fifty-five [55] and have been active and eligible under the Health and Welfare Plan for at least one [1] year immediately prior to the date of retirement; and,
3. Not be working in the industry.

TERMINATION OF ELIGIBILITY - RETIREES

Your eligibility for Benefits will terminate on:

1. The last day of the Benefit Month for which self contributions are due and have not been paid by you; or,
2. The actual date that You enter any class of employment, or status, for which no Benefits are available.

ELIGIBILITY FOR DEPENDENT SPOUSES ONLY

The initial eligibility of Your dependent Spouse for Benefits is determined by Your eligibility for Benefits.

TERMINATION OF ELIGIBILITY - DEPENDENT SPOUSES

The eligibility of Your dependent Spouse will terminate on the earlier of:

1. The date that he or she ceases to be eligible as Your dependent [see **"GENERAL DEFINITIONS"**]; or,
2. The date of Your death.

NOTE: FOR MEDICARE ELIGIBLE RETIREES MEDICARE PART A & B IS PRIMARY [I.E. PAYS BEFORE THE PLAN FOR RETIREES AND SPOUSES.

GENERAL DEFINITIONS

Certain words or phrases are used in this booklet in a way that may require further definition. The following is a partial listing of such words.

ACCIDENTAL means a loss that results, directly and independently, from a happening that is not expected, foreseen or intended.

ACTIVELY AT WORK or **ACTIVE WORK** means that You are physically and mentally capable of performing, and are performing each of the material duties of Your regular job on a full or part-time basis, as defined in Your collective bargaining agreement. If You are Actively at Work on Your last regular working day, then You shall be deemed to be Actively at Work on each day of paid vacation or regular non-working day on which You are not disabled.

ADOPTED CHILD[REN] means any child[ren] legally placed in a Participant's home by an agency that meets the eligibility requirements of this Plan, whether or not the adoption is final.

ALLOWABLE EXPENSE means any expense for Medically Necessary services, treatments, or supplies, which are covered by any plan or plans under which an Individual is provided Benefits.

AMENDMENT means a formal document, duly adopted by the Trustees, that changes a provision of this Plan.

AVERAGE SEMI-PRIVATE means the standard Charge by the Hospital for Semi-Private Room and Board accommodations, or the average of such Charges where the Hospital has more than one established level of such charges or 80% of the lowest charge made by the hospital for a single bed room and Board accommodation when the hospital does not have semi-private accommodations but not to exceed the average cost for the geographic area.

BENEFICIARY means a person either designated by an employee on an enrollment card or by the terms of the Health and Welfare Plan, who is, or may become, entitled to a Benefit.

BENEFIT means a monetary amount either paid or provided for by the Plan. A Benefit can take the form of a Health Benefit which pays, medical expenses. It can also take the form of a Welfare Benefit which pays an amount to the Employee or his Beneficiary such as a Death Benefit.

BIRTHING CENTER means a part of a Hospital, or a freestanding facility solely engaged in providing an alternative to conventional obstetrics which is licensed as such and operating within the scope of the license.

CERTIFIED NURSE-MIDWIFE means a person who is licensed as such and acting within the scope of that license.

CHARGE means an amount of money expected in payment of services or supplies provided for an injury, illness or condition under treatment.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COLLECTIVE BARGAINING AGREEMENT means any negotiated labor contract between an Employer and the Union, which contract requires the Employer to contribute to the Fund, and any amendment, modification, or renewal thereof.

COMPLICATIONS OF PREGNANCY means any or all of the following:

1. Separate conditions made worse or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortions, other medical problems of similar severity and preeclampsia; or
2. Certain conditions which occur during pregnancy such as, hyperemesis gravidarum, ectopic pregnancy that is ended, non-elective Caesarean section and miscarriages.

CONTRIBUTING EMPLOYER means an Employer that is required to make contributions to the Fund under the terms of a Collective Bargaining Agreement with the Union, or under the terms of a written Participation Agreement with the Plan.

CO-PAY means that portion of the eligible charge that You are required to pay. **For example,** You are required to make a Co-Pay when Your purchase a prescription drug through Your drug card program. A Co-Pay is also required for each Primary Care Physician office visit expense as well as for Hospital Emergency Room services. Co-Pay's do not apply to the satisfaction of Your Calendar Year Comprehensive Major Medical deductible.

COVERED CHARGES means the Reasonable and Customary Charges covered by this Plan that a Covered Individual actually incurs for medical care, treatment, services, and supplies received by or furnished to a Covered Individual by or upon the recommendation and approval of a Physician who is attending such Covered Individual for the necessary treatment of a disease or injury of such Covered Individual. Reasonable and Customary Charges are Covered Charges to the extent such charges are not otherwise excluded or limited by the terms of this Plan and to the extent such charges exceed the deductible (where appropriate) as provided in this Plan.

COVERED EMPLOYMENT means hours worked for an Employer for which said Employer is obligated to make contributions to the Fund pursuant to a Collective Bargaining agreement or other written agreement. Covered Employment also means hours or months worked for the Union for which the Union makes a contribution to the Fund.

CUSTODIAL CARE means care which consists of services and supplies, including room and board and other institutional services, furnished to an individual primarily to assist in activities of daily living, whether or not he or she is disabled. These services and supplies are custodial care regardless of the practitioner or provider who prescribed, recommended or performed them.

DEDUCTIBLE means the amount of covered expenses that an individual must pay before being eligible for Benefits. The Deductible amount, as set forth in the **"SCHEDULE OF BENEFITS"**, is the first dollars of eligible Charges during a calendar year for each eligible participant. To qualify for Comprehensive Medical Benefits, You must first pay the Deductible. The Deductible applies only once in any calendar year, even though You may have several different disabilities. **Co-payments under this, or any other Plan, do not count towards satisfaction of the Plan Deductible.**

DENTIST means a person that is duly licensed to practice dentistry in the state where the dental service is performed, and who is operating within the scope of that license.

DEPENDENT means:

1. Your legal spouse;
2. If you or your spouse are under age 65 then your unmarried children from date of birth, who are dependent upon You for more than one-half of their financial support and who resides with you, including stepchildren, legally adopted children, or children for whom You have been appointed the legal guardian by a court of competent jurisdiction, and who:
   A. are less than nineteen [19] years of age; or,
   B. are less than twenty-five [25] years of age, if they are registered students in regular full-time attendance at accredited trade schools, colleges or universities and, have the same legal address as the covered employee and are dependent on the employee for at least one-half of their support and maintenance; or,
   C. are incapable of self-sustaining employment because of a physical handicap or mental retardation and are dependent on You for support and maintenance, provided that the incapacity started prior to attaining the age at which his or her eligibility would otherwise terminate, and at a time when You were eligible for Benefits under the Plan and notice was submitted to the Fund Office within 31 days of the date the dependents coverage would otherwise terminate.
3. A child for whom coverage must be provided because of a **Q**ualified **M**edical Child **S**upport **O**rder [QMCSO]. A **QMCSO** is a court order, decree or a State administrative order that has the force and effect of law, relating to child support which provides for a child's coverage under the Plan's Benefit program. To be qualified, the **QMCSO** must contain specific information, must be submitted to the Plan Office and must be approved by the Trustees.
4. Effective January 1, 2011 natural born children, adopted children or children placed for adoption may continue their dependent coverage until they reach age 26 **regardless** of their financial dependence on the covered employee or retiree or their student status, marital status or location of residence provided they are not eligible to enroll in another group health plan other then that of their parent. If such child is eligible to enroll in another group plan they are not eligible under this plan.

The term dependent does not include:

1. Any person who is in Full-time military, naval or air service;
2. Any child whose non-custodial parent, if other than an eligible employee, is required to contribute to his or her support by order of any court and is providing medical care protection for such child, unless the child is named in a **QMCSO**. In that case, the child will be eligible for Benefits in accordance with the order; and,
3. Any person who does not meet the above definitions, including, but not limited to, parent's of either spouse and grandchildren.

NOTE: Maternity benefits are provided for the dependent spouse only.

DURABLE MEDICAL EQUIPMENT [**DME**] means medical equipment not otherwise excluded, that is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an Injury or Illness. For the purpose of determining whether a piece of equipment constitutes **DME** for coverage under this Plan, the Administrative Manager may consult the equipment list complied from time to time for use in the administration of the Medicare program. **Examples** of **DME** include, but are not limited to, wheelchairs, hospital beds and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers and other similar convenience items are **NOT** considered **DME**. **DME** does **NOT** include costs related to the purchase, or administration, of oxygen. Under no circumstances will the Plan pay more than the lifetime maximum shown in the **"SCHEDULE OF BENEFITS"** towards the cost of renting or otherwise obtaining **DME.**

ELECTIVE ABORTION means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

EMERGENCY means a condition or situation that is deemed both life threatening and of an urgent nature.

EMPLOYEE means that if You work for a Contribution Employer who has agreed to make contributions to the Fund on Your behalf. You are considered an Employee under this Plan. You are not considered an employee if you are an employer, partner, independent contractor or self-employed person who is prohibited by law from being covered by the Fund or whose coverage would adversely effect the tax status of the Fund. It does include employees of the union.

EMPLOYER means each company or legal entity that has agreed to make contributions to the Fund for persons who are employed by such company or legal entity in accordance with a collective bargaining agreement with a local union to which they are a party.

ERISA means the Employee Retirement Income Security Act of 1974.

EXPENSE means a **"CHARGE"** a person is legally obligated to pay. An Expense is deemed to be incurred on the date the service or supply is furnished, except that an impatient expense in a hospital is incurred on the date of admission. To be considered, an Expense must be covered by the Plan reasonably priced; and, reasonably necessary in light of the injury or illness being treated.

"EXPERIMENTAL OR INVESTIGATIONAL" means a service, supply, care, or treatment that does not constitute accepted medical practice, properly within the range of appropriate medical practice under the standard of the case and by the standards of a reasonably substantial, qualified, responsible, and relevant segment of the medical community or government oversight agencies at the time the service, supply, care, or treatment was rendered.

The Trustees will determine whether a service, supply, care, or treatment is Experimental or Investigational based on the following:

(a) If the service, supply, care, or treatment cannot be lawfully marketed without approval by the United States Food and Drug Administration ("Food and Drug Administration") and approval for marketing has not been granted at the time service, supply, care, or treatment is furnished.

(b) If the service, supply, care, or treatment is subject to review and approval by any Institutional Review Board, or similar governing body, of the treatment facility or federal law requires review or approval.

(c) If the service, supply, care, or treatment is the subject of ongoing Phase I, II, or III, clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with a standard means of treatment or diagnosis.

(d) If prevailing peer-reviewed opinion among medical experts is that additional studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared to standard treatment or diagnosis.

Any Prescription Drug not commercially available for purchase and/or not approved by the Food and Drug Administration is Experiment or Investigational.

EXPLANATION OF BENEFITS [EOB] means a statement outlining Charges, deductibles, exclusions and payments of Benefits.

EXTENDED CARE FACILITY means a licensed institution, other than a Hospital, that provides all of the following:

1. In-patient medical care and treatment to convalescing patients;
2. Full-time supervision by at least one [1] Physician or registered nurse;
3. Twenty-four [24] hour nursing service by licensed professional nurses;
4. Complete medical records for each patient;
5. Utilization review plan for all patients; and,
6. Operation pursuant to law.

It does **NOT** mean a home or facility used primarily for:

1. The care of the aged;
2. The care of drug addicts;
3. The care of alcoholics;
4. Custodial Care; or
5. Education Care.

FUND means the Plumbers and Pipefitters Local No. 421 Health and Welfare Fund.

FUND OFFICE means the administrative office of the Fund.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and includes the Protected Health Information (PHI) standards of privacy as required by the Act.

HOME HEALTH CARE AGENCY means and agency or organization that meets **all** of the following requirements:

1. It is primarily engaged in and federally certified as a home health care agency and duly licensed, if such licensing is required by the appropriate licensing authority, to provide nursing and other therapeutic services;
2. Its policies are established by a professional group associated with such agency or organization, including at least one [1] Physician and at least one [1] registered nurse, to govern the services provided;
3. It provides for Full-time supervision of such services by a Physician or by a registered nurse;
4. It maintains a complete medical record of each patient; and,
5. It has an administrator.

HOME HEALTH CARE PLAN means a program provided through a Home Health Care Agency for Your continued care and treatment established and approved in writing by the attending Physician together with such Physician's certification that the proper treatment of the Sickness or Injury would require confinement as a resident inpatient in a Hospital or in a skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

HOSPICE CARE means care given to a terminally ill person, having six [6] months or less to live, by a Hospice Care Agency. The care must be part of a Hospice Care Program. Please note the limitations on Hospice Care which are shown in Your **"SCHEDULE OF BENEFITS"**.

HOSPICE CARE AGENCY means an agency or organization which has Hospice Care available twenty-four [24] hours a day and meets any licensing or certification standards set forth by the jurisdiction where it is located and which provides:

1. Skilled nursing services;
2. Medical social services;
3. Psychological and dietary counseling; and,
4. Bereavement counseling for the immediate family.

The agency may also arrange for other services which include, but are not limited to:

1. Services of a Physician;
2. Physical or occupational therapy;
3. Part-time home health aide services which mainly consist of caring for terminally ill persons; and,
4. Inpatient care in a facility when needed for pain control and acute and chronic symptom management.

The agency must have personnel which include at least one [1] of each of the following:

1. Licensed or certified social worker employed by the Agency;
2. Pastoral or other counselor;
3. Registered Nurse; and,
4. Physician.

And, the agency must perform all of the following:

1. Establish policies covering the provision of Hospice Care;
2. Assess the patient's medical and social needs;
3. Develop a Hospice Care Program to meet those needs;
4. Provide an ongoing quality assurance program that includes reviews by Physicians other than those who own or direct the agency;
5. Permit all area medical personnel to utilize its services for their patients;
6. Keep a medical record on each patient;
7. Utilize volunteers trained in providing services for non-medical needs; and,
8. Have a Full-time administrator.

HOSPICE CARE FACILITY means a licensed or certified institution specifically designed to provide inpatient Hospice Care which:

1. Is run by a staff of Physicians of which one [1] is on call at all times;
2. Provides nursing services under the direction of a registered nurse twenty-four [24] hours per day;
3. Provides an ongoing quality assurance program that includes reviews by Physicians other than those who own or direct the facility.
4. Keeps a medical record on each patient;
5. Makes Charges to its patients; and,
6. Has a full-time administrator

HOSPICE CARE PROGRAM means a written plan of Hospice Care which is established and reviewed from time to time by:

1. A Physician attending the person; and,
2. Appropriate personnel of a Hospice Care Agency.

Which is designed to provide:

1. Palliative and supportive care to terminally ill persons; and,
2. Supportive care to their families.

And which includes:

1. An assessment of the person's medical and social needs; and,
2. A description of the care to be given to meet those needs.

HOSPITAL means an institution which fully meets every one of the following tests:

1. It is primarily engaged in providing, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis treatment, and care of injured or sick persons by or under the supervision of a Physician;
2. It has a laboratory, X-ray equipment, and an operating room where major surgical operations may be performed;
3. It continuously provides twenty-four [24] hour a day nursing services by Registered Nurses;
4. It is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel or the like; and,
5. It is a licensed hospital which is accredited by the Joint Commission on the Accreditation of Hospitals.

INDIVIDUAL means a Participant or an Eligible Dependent.

ILLNESS [see **"SICKNESS"**]

INJURY means an accidental physical injury to the body caused by unexpected external means that is a non-occupational injury.

INTENSIVE CARE UNIT or **CARDIAC CARE UNIT** means that part of a Hospital specifically designed and permanently equipped and staffed to provide:

1. More extensive care for critically ill or injured persons than available in other Hospital rooms; and,

2. Close observation by trained and qualified personnel whose duties are primarily confined to that part of the Hospital for which an additional Charge is made.

MEDICALLY NECESSARY means that the service received is required to identify or treat the Sickness or Injury which a Physician has diagnosed or reasonably suspects. The service must be:

1. Consistent with the diagnosis and treatment of the condition;
2. In accordance with standards of good medical practice;
3. Required for reasons other than the convenience of You or Your Physician; and,
4. Performed in the least costly setting required by the condition,
5. Is not conducted for research purposes,
6. The Board of Trustees will determine whether a service is medically necessary.

NOTE: THE FACT THAT A SERVICE IS PRESCRIBED BY A PHYSICIAN DOES NOT NECESSARILY MEAN THAT SUCH SERVICE IS MEDICALLY NECESSARY.

MENTAL or **NERVOUS DISORDER** means neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

NAMED FIDUCIARIES means the Board of Trustees.

NETWORK means the Preferred Provider Organization[s] that the Plan has contracted with to provide medical, hospital and other services.

NETWORK HOSPITAL means any hospital participating in the Network which is an approved and accredited hospital recognized as such by the American Hospital Association and which is primarily engaged in providing diagnostic and therapeutic facilities for the medical and surgical care of injured and sick persons on a basis other than as a rest home, a nursing home, a convalescent home, a place for the aged, a place for drug addicts, a place for alcoholics, or any institution which maintains permanent and Full-time facilities for bed care of five [5] or more resident patients; has a doctor in regular attendance; continuously provides twenty-four [24] hour a day nursing service by registered nurses; provided such institution is operating lawfully in the jurisdiction where it is located.

NETWORK PHYSICIAN or **PPO PHYSICIAN** means a doctor or surgeon licensed to practice medicine, that is, as defined elsewhere, a Physician participating within the Network engaged by the Plan. Please also see the definition of **"PHYSICIAN"**, found elsewhere in this booklet.

OCCUPATIONAL ILLNESS or **OCCUPATIONAL INJURY** means a disease or injury that does not arise out of (or in the course of) any work for pay or profit, not in any way results from such work for pay or profit. However, if proof is furnished to the Trustees that an individual covered under a workers' compensation law (or other law of similar purpose) is not covered for a particular disease under such law, that disease shall be considered "non-occupational" regardless of its cause.

In the event an Employee claims that a disease or injury is work connected and the Employer disputes this contention, the Trustees agree to be bound by the final decision of any court or commission that determines this issue. In the event a legal determination is not sought in such case, the Trustees may decide whether the illness or accident is occupational or non-occupational. In the even payments are made under this Plan for a condition later determined to be occupational and compensationable under any workers' compensation or similar law, the Employee receiving the payments is obligated to make restitution (pay back) to the Fund of the amount of benefits received from any settlement or judgment obtained.

NON-PPO means a health care provider that is not in the Preferred Provider Organization network.

OUT OF POCKET MAXIMUM means the amount of money that You must pay directly before the plan coinsurance is increased. Out of Pocket does **NOT** include Co-pays, Deductibles, Non-PPO Charges, Mental and Nervous, Substance Abuse or any non-covered Charges.

PARTICIPANT means each person who has satisfied the Plan's eligibility rules, and on whose behalf contributions are made to the Fund.

PERIOD OF CONFINEMENT means a period which begins on the first day You incur a covered daily Hospital expense and ends at the time of Your medical release from the Hospital. Successive periods of confinement are considered one period of confinement unless:

1. The later confinement is due to causes entirely unrelated to the causes of the earlier confinement;
2. For employees, the confinements are separated by his or her return to Active Work for two [2] weeks; and,
3. For dependents, the confinements are separated by ninety [90] days.

PHYSICAL EXAMINATION means Charges, up to the maximum shown in the **"SCHEDULE OF BENEFITS"**, which are made by a PPO Physician for an annual routine **adult** [participant or spouse] examination. Charges for Pap tests, Mammograms, Cholesterol screening and prostate screening, if not part of Your routine physical examination, are covered under the Comprehensive Medical Benefits and subject to the Calendar Year deductible and coinsurance amounts. If such tests are conducted as part of Your routine physical examination, they will be included under the Annual Physical Examination Benefit, as set forth in the **"SCHEDULE OF BENEFITS"**. Please also see **"PREVENTATIVE CARE** [CHILDREN]" in this section.

PHYSICIAN means an person who is operating within the scope of his or her license and is licensed to prescribe and administer drugs or to perform surgery, or any other licensed practitioner, including but not limited to a licensed psychologist, a licensed chiropractor, a licensed podiatrist, a licensed optometrist, and licensed nurse-midwives [with respect to maternity care] operating within the scope of their license.

PRE-EXISTING CONDITION means a condition for which treatment was recommended or received during the six [6] month period immediately prior to the first day of the eligibility waiting period prior to enrollment for medical coverage or until the date You or Your dependent have been covered for benefits under this Plan for twelve [12] consecutive months, including the eligibility waiting period requirements. However, pregnancy will not be considered as a Pre-Existing condition, nor will any Pre-Existing Condition limitation apply to newborns or to children who are adopted, or placed for adoption, before they are eighteen [18] years of age, as long as the child is enrolled under the plan within the first thirty [30] days after birth, adoption, or placement for adoption or any child who has not attained age nineteen (19). Credit will be given for earlier coverage, however, no crediting of previous coverage will be applied if a participant has gone for sixty-three [63] days without any health care coverage.

PREFERRED PROVIDER ORGANIZATION [PPO] means a network or panel of medical service providers who agree to furnish medical services and be paid on a negotiated fee schedule. You and Your dependents are given incentives to use providers within the **PPO**, but You may also seek covered services outside the **PPO** network, although for a generally higher charge. If you live within North or South Carolina and no PPO provider and/or facility is within fifty [50] miles of Your home or principal place of resident, and You elect to use non-PPO services, Your eligible expenses will be reimbursable on the basis of **"OUT OF PPO/ OUT OF AREA"**, as set forth in the **"SCHEDULE OF BENEFITS".**

PREGNANCY means pregnancy, miscarriage, abortion, childbirth, or Complications from Pregnancy, miscarriage, abortion, or childbirth. This condition is treated the same as any other Illness under this Plan for female Covered Employees, Retirees, and Dependent spouses only. No Pregnancy benefits will be paid for Dependent children.

NOTE: IF NON-EMERGENCY MEDICAL EXPENSES ARE INCURRED BY A PARTICIPANT WHILE OUTSIDE OF THE AREA GENERALLY SERVED BY THIS HEALTH AND WELFARE FUND, THE FUND RESERVES THE RIGHT TO LIMIT THE REIMBURSEMENT FOR SUCH MEDICAL EXPENSES TO WHAT THE REASONABLE AND CUSTOMARY CHARGES FOR SIMILAR SERVICES WOULD HAVE BEEN WITHIN THE GEOGRAPHIC AREA COVERED BY THE HEALTH AND WELFARE FUND.

PRESCRIPTION DRUG means any of the following if Medically Necessary for treatment of a Sickness or Injury and dispensed upon a written prescription by a Physician: (i) a Food and Drug Administration approved drug or medicine that is required to bear the legend "Caution: Federal law prohibits dispensing without a prescription"; and (ii) injectable insulin.

PREVENTATIVE CARE [CHILDREN] means routine **"WELL BABY CARE"** which includes hospital room and board Charges for new born children up to a maximum of three [3] days, and routine examinations and childhood immunizations through age two [2]. **"WELL BABY CARE"** and services **MUST** be provided by a PPO doctor or facility, as defined elsewhere in this booklet.

PRIMARY CARE PHYSICIAN [PCP] means a family practitioner, general practitioner, Doctor of internal medicine, Pediatrician or Obstetrician. All other Physicians are considered Specialists, not Primary Care Physician's.

REASONABLE AND CUSTOMARY CHARGES means that Charges which are made for services or supplies must be Medically Necessary for Your care, and will be considered reasonable and customary based upon the following criteria:

1. The Charges cannot exceed the actual amount billed by the provider of services or supplies;
2. The Charges are limited to the customary Charge based upon the distribution of Charges billed by all providers of services or supplies for a specific service within a specialty and within the geographic area covered by the Health and Welfare Plan; and,
3. The Charges must be reasonable with respect to customary Charges of comparable complexity and difficulty.

RETIREE means a former Covered Employee who has retired from employment with an Employer, who was a Covered Employee at the time of such retirement from employment with the Employer, who has fulfilled the eligibility requirements (see page 2) of this Plan, and is eligible for the benefits provided under this Plan for Retirees.

ROOM AND BOARD means all Charges commonly made by a hospital on its own behalf for room and meals and for all general services and activities essential to the care of bed patients.

SCHEDULE OF BENEFITS means the benefits enumerated in the Appendices attached hereto.

SICKNESS AND ILLNESS means a disease, disorder or condition which requires treatment by a Physician and which is not an Occupational Illness. Sickness includes childbirth, pregnancy or any related condition.

TOTAL DISABILITY or **TOTALLY DISABLED** means, with respect to an active employee, the inability to perform his or her regular occupation due to an Injury or Sickness.

TRUST AGREEMENT means the Agreement and Declaration of Trust of the Plumbers and Pipefitters Local No. 421 Health and Welfare Fund.

"TRUSTEES", "BOARD OF TRUSTEES", or **"BOARD"** means the persons designated to serve as Trustees of the Fund in accordance with the provisions of the Trust Agreement.

UNION means the Plumbers and Pipefitters Local No. 421.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

USUAL, CUSTOMARY AND REASONABLE [UCR]: see **"REASONABLE AND CUSTOMARY CHARGES"**]

WELL BABY CARE: [see **"PREVENTATIVE CARE** [CHILDREN"]

YOU or **YOUR** means an Eligible Employee and each of his or her Eligible Dependents.

LIFE BENEFIT
[EMPLOYEES ONLY]

BENEFITS
Some, but not all, of the Life Benefits provided by the Plan may be insured through a life insurance company. How Your life Benefits are provided is shown in the **"SCHEDULE OF BENEFITS"**. For this reason, the provisions shown herein are for general information only. The actual provisions that control this Benefit are found in the Master Policy of group insurance for the insured program, or in the Plan Document for the self-insured program, both of which are on file at the Administrative Manager's office. If You have any questions regarding this Benefit, contact the Administrative Manager's office. The Benefit shown in the **"SCHEDULE OF BENEFITS"** is payable in the event of an employee's or dependent's death while eligible under this Health and Welfare Plan. Proof of death must first be submitted to the Administrative Manager.

DEFINITIONS
Certain words or phrases are used in this section that may not apply to other coverages and therefore require further definition. They are:

BENEFICIARY means someone specifically named on the Life Benefit enrollment form to receive the Life Benefit.

NOTE: You should update your beneficiary card periodically.

BENEFICIARY DESIGNATION
Any payment for Loss of Life becoming due upon Your death will be payable to Your Beneficiary. If You name more than one Beneficiary, and do not direct otherwise in writing as part of the designation, payment will be made in equal shares to the surviving Beneficiaries. If no Beneficiary has been named, payment will be made to one or more of the following persons, separately or in combination, in the following order:

1. Your surviving spouse;
2. Your surviving child or children, in equal shares;
3. Your surviving parent or parents, in equal shares;
4. Your surviving brothers and sisters, in equal shares;
5. Any person equitably entitled to payment by reason of having paid the Insured's funeral or other expenses incidental to the Insured's last Sickness, not to exceed the maximum amount allowed by state law; or,
6. The executors or administrators of Your estate.

If a Beneficiary is a minor or does not have the legal capacity to sign a receipt for payment, or if there is no court-appointed guardian or conservator, then the Plan will make payment to the person or institution who cares for or supports he Beneficiary. A new Beneficiary may be designated from time to time by filing a written and signed request on a form satisfactory to the Plan. No change of Beneficiary will take effect until received by the Administrative Manager. When the change has been received, whether You or Your dependent are living or not, it will take effect as of the date of execution of the written request, and shall be without prejudice to the Health and Welfare Plan because of any payments made or any actions taken or permitted by the Plan before receipt of the request. Beneficiary change forms can be obtained from the Administrative Manager's Office. Consent of the Beneficiary is **NOT** required to change the designated Beneficiary.

NOTE: Dependent death benefits as reflected in the schedule of Benefits are payable to you as the eligible employee.

CHANGE OF BENEFICIARY
The Beneficiary may be changed from time to time. To make a change, written request should be sent to the Administrative Manager. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by the Plan before the request was acknowledged.

REDUCTION OF LIFE BENEFITS
The amounts of Life Benefits in force may reduce based upon each Participant's attained age. Please see the **"SCHEDULE OF BENEFITS"** for more specific information.

PRESCRIPTION DRUG BENEFIT
(Under Age 65 Retired Participants)

DEFINITIONS
Certain words or phrases are used in this section that do not apply to other coverage and require further definition. They are:

FORMULARY is a listing of preferred medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective medication for the condition which is also the most cost effective medication. Formulary drug listings are available from the Administrative Office.

GENERIC DRUGS means drugs which contain the same active ingredients as brand name drugs but which are almost always less expensive. If generic drugs are substituted for name brand drugs, Benefits are greater and Your Cost will be less, as shown in the **"SCHEDULE OF BENEFITS".**

GENERIC ENFORCEMENT, or **"ENFORCED GENERIC"** means a plan which requires that, if a Generic Drug is available but a Brand Name is chosen, Your cost of that drug will be equal to the prescription drug Co-pay **plus the difference in retail cost between the Generic and the Brand Name medicine.** The plan which is described and available in this booklet is an **"ENFORCED GENERIC PLAN".** You should be aware that, unless Your Doctor specifically requests otherwise at the time that Your prescription is written, the Plan's Generic Enforcement provision will always be applied.

PHARMACIST means a person who is legally licensed as such by the appropriate governmental authority having jurisdiction over such licenser.

PRESCRIPTION means, with respect to an eligible Expenses covered by this Plan, an order issued by a Physician to a Pharmacist for any federal legend drugs or medicines, drugs requiring a prescription under State Law or Compounded drugs unless specifically excluded by this Plan. A prescription is a separate order given by a Physician for each Individual. **Insulin** shall be deemed to be an eligible Expense covered by this Plan.

REASONABLE AND CUSTOMARY EXPENSE means, with respect to the Prescription Drug Benefits, the prevailing wholesale cost of any Federal legend drug or medicine unless specifically excluded by this Plan plus the pharmacy dispensing fee for a Prescription in the area in which it is provided. With respect to insulin purchased with a prescription, Reasonable and Customary shall mean only the prevailing wholesale cost of insulin in the area in which it is provided.

BENEFITS
When Injury or Sickness requires You to incur expense for a Prescription, the Plan will pay, after satisfaction of the applicable deductible, the Reasonable an Customary Expense incurred for such prescription. A valid prescription drug card issued through this Plan must be presented to a Member Pharmacy n order to have the Benefit paid in full after payment of the applicable co-pay amount as shown in the **"SCHEDULE OF BENEFITS".** In the event that Your prescription drug card is lost and a prescription is filled for You, or if a Member Pharmacy is not available to You, the Plan will reimburse You, after completion of a prescription drug claim form, with an amount equal to the wholesale cost of the prescription, plus a pharmacy dispensing fee, minus the applicable co-pay amount.

NOTE: The co-pays is not a Covered Charge and does not apply to the out of pocket expense. Also, please note the monthly maximum benefit reflected in the **"SCHEDULE OF BENEFITS".**

LIMITATIONS AND EXCLUSIONS
See the section noted **"PLAN LIMITATIONS".**

COMPREHENSIVE MEDICAL BENEFITS

COMPREHENSIVE MEDICAL EXPENSE BENEFITS provide broad and extensive coverage to help You pay the costs of most types of medical care. The Medical Expense Benefits are not designed to, and will **NOT**, pay one-hundred percent [100.0%] of the medical expenses that You may incur.

ANNUAL MAXIMUM BENEFIT
The amount payable with respect to all Injuries or Sicknesses during a calendar year will be determined in part by the annual maximum Benefit set forth in the **"SCHEDULE OF BENEFITS".**

DEDUCTIBLE AMOUNT
Certain Comprehensive Medical Benefits become payable after You have satisfied the Calendar Year cash deductible as set forth in the **"SCHEDULE OF BENEFITS".** The deductible applies only once in any calendar year to each Individual even though You may have different disabilities.

BENEFITS
The Plan will pay the percentage or amount shown in the **"SCHEDULE OF BENEFITS"**, in excess of the deductible and all Co-pays, for Medical Expenses covered by the Plan. Charges for Medically Necessary care and services, ordered by a Physician for a non-occupational Injury or Sickness, may include the following:

1. Hospital Care - the Room and Board Charges and miscellaneous Charges during a Hospital confinement, and outpatient Charges if outpatient treatment is provided as an alternative to a Hospital confinement, up to the daily average Charged by the Hospital for semi-private accommodations;
2. Physician Care - treatment by a Physician, whether in or out of a Hospital, for an Injury or Sickness, including diagnosis, x-ray and laboratory services, in-Hospital visits or Physician's office visits;
3. Surgical Care - Physician expenses incurred in connection with a surgical procedure, including anesthetist's Charges;
4. Nursing Services - Private duty nursing services of a Registered Nurse [RN] or Licensed Practical Nurse [LPN] or treatment by a licensed physical therapist;
5. Ambulance service to the Hospital or transfer between Hospitals, if Medically Necessary, provided it is for local travel within a fifty [50] mile radius, and only up to the maximum ambulance Benefit shown in the **"SCHEDULE OF BENEFITS"**;
6. Anesthesia, oxygen and the administration of same;
7. X-ray and laboratory tests;
8. Radium, radioactive isotope or similar therapy;
9. Blood or blood plasma and their administration;
10. The original rental of durable medical equipment, such as a Hospital bed, wheelchair or crutches, **but not oxygen** up to the purchase price of such equipment, but not for replacement of such equipment.
11. Braces, casts or splints;
12. Dental treatment for the repair or replacement within one [1] year of Injury to sound natural teeth that were harmed while You were eligible, removal of tumors or cysts or extraction of impacted teeth;
13. Physician's services provided in connection with spinal treatment, not to exceed the Reasonable & Customary Charge for such services.
14. Outpatient surgery Benefits are payable for covered surgeries and all related Charges, if the surgery is performed in a Physician's office, or as an outpatient in a Hospital or ambulatory surgical facility.

15. Pregnancy related expenses, other than expenses incurred for Elective Abortion, except for complications which are the result of an Elective Abortion;
16. Initial prosthetic devices for a loss or injury while You are covered, but only up to the maximum specified in the Schedule of Benefits, during an Individuals lifetime, and not for replacement of such devices; except for children underage nineteen [19] years.
17. Charges made by an Alternative Birthing Center for medical care and treatment received in connection with a birth up to and including the 48-hour period following delivery.
18. Charges for Certified Nurse-Midwives and licensed Midwives. No Benefit will be paid for the same services furnished by a Physician;
19. If You receive necessary Home Health Care Services upon the recommendation of a Physician, expenses incurred will be payable for the following services and supplies furnished in Your home, not to exceed thirty [30] days in a calendar year for,
    A. part-time or intermittent home nursing care from or supervised by, a registered by, a registered nurse;
    B. part-time or intermittent home health aid services;
    C. physical therapy, occupational therapy, and speech therapy; and,
    D. Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been covered under the Plan if the Individual was confined in the Hospital or in a skilled nursing facility.
20. Room and board and miscellaneous services for an eligible stay in an Extended Care Facility but only up to a total of thirty [30] days in each calendar year. A stay in an Extended Care Facility is covered only if:
    A. the stay begins within seven [7] days after a Hospital stay;
    B. the stay is due to the same or related causes as the Hospital stay;
    C. a Hospital stay would otherwise be needed;
21. Charges for breast cancer screening; mammogram's; prostate screening; and, cholesterol screening;
22. Charges made by a Hospice Care Facility or Hospice Care Agency not to exceed the maximum shown in the **"SCHEDULE OF BENEFITS"**;
23. Charges for Hospital Emergency room care for treatment of an Injury or Sickness within twenty-four [24] hours, subject to the co-payment set forth in the **"SCHEDULE OF BENEFITS"**;
24. Hospital outpatient care;
25. Pre-admission Tests or Exams - Exams made before you enter the Hospital for inpatient surgery, when:
    A. the tests or exams pertain to the planned surgery and are ordered by a Physician;
    B. the Physician requests Hospital admission for surgery and the Hospital confirms the request; and,
    C. the Hospital admits the covered Individual within seven [7] days after the test or exam results are known. The seven [7] day rule will be waived if:
        i. the planned Hospital stay is canceled; or
        ii. a change in the person's condition precludes the need for surgery
26. Preventative Care, when services are obtained by a **PPO** provider. Covered preventative care Charges are:
    A. Preventative Care [Children], through age two [2], to include childhood immunizations [see Definitions section and **"SCHEDULE OF BENEFITS"**];
    B. mammograms
    C. annual pap tests;
    D. adult Physical Exam [see the Definitions section and the **"SCHEDULE OF BENEFITS"**];
    E. prostate screening;
    F. annual cholesterol screening.

27. Prescription drugs as set forth in this Plan and the Schedule of Benefits, when such medications are necessary for the treatment of an acute medical condition, including needles, syringes, or other similar supplies, or injectable Prescription Drugs.
28. Reconstruction of the breast on which a mastectomy has been performed including reconstruction of other breast to produce a symmetrical appearance, breast prothesis and physical complication during all stages of mastectomy including lymphedemas.
29. Diabetic Training or Counseling except of dependent children under age 19.
30. For any care, treatment, service or supply in connection with drug or substance abuse, alcoholism.

LIMITATIONS AND EXCLUSIONS
See the section noted **"PLAN LIMITATIONS"**.

PLAN LIMITATIONS

The Specific and General Limitations that apply to Your Plan are as follows:

LIFE BENEFIT LIMITATIONS
The only Limitations applicable to the Life Benefit are the reductions for age which are noted in the Schedule of Benefits.

PRESCRIPTION DRUG LIMITATIONS
In addition to all other Limitations and Exclusions found in this booklet, the **Prescription Drug Benefit** does **NOT** cover Charges for any loss caused by, incurred for or resulting from:

1. Drugs obtained without a Physician's prescription;
2. Drugs and vitamins prescribed for any dietary purpose;
3. Contraceptives, contraceptive material, or infertility medication, unless specifically noted in the **"SCHEDULE OF BENEFITS:**;
4. Sexual Enhancement Drugs, such as, but not limited to, Viagra;
5. Immunization agents;
6. Injectables, other than Insulin;
7. Appliances, supports, and prosthetic devices such as, but not limited to, canes, crutches wheelchairs, or any means of conveyance or locomotion prescribed for an ambulator patient, braces, splints, bandages, heat devices, hypodermics, syringes or needles;
8. Drugs dispensed by a Hospital, rest home or sanatorium;
9. Drugs for which no Charge is made or for which You are not required to pay;
10. Drugs furnished by, or payable, or for which You are entitled to compensation und any federal government plan or law or under any plan or law of a state or politic subdivision thereof, including any Workers' Compensation Law or similar legislatior
11. Any drug or medication that, when taken or used in accordance with the direction the prescribing Physician is made available in sufficient quantity to provide more th a thirty-four [34] day supply without the necessity for a refill, unless the prior writt consent of the Plan has been obtained, or it is through the mail-order service of the Pl
12. Drugs prescribed for Injury or Sickness resulting from war or any act of war;
13. Drugs that can be legally dispensed without a prescription, such as aspirin, e though the Physician may have prescribed them;
14. A prescription that has been refilled more than five [5] times within a six consecutive month period following the time it was first filled;
15. Diabetic supplies other than Insulin [also see **"MEDICAL BENEFITS"**];
16. Drugs obtained prior to the effective date or subsequent to the termination dat Your coverage; and,
17. Retin A, Rogain, Propecia, Zyban and all other smoking deterrents.
18. Any charge excluded under this Plan.
19. Prescription Drug benefits are not provided if you are retired and age 65 or Please see page 1 for the Part D of Medicare Premium Reimbursement Benefit.
20. There is no Coordination of Benefits for the Prescription Drug Card Program.

MEDICAL BENEFIT LIMITATIONS

In addition to all other Limitations and Exclusions found in this booklet, the **Medical Benefit** does **NOT** cover Charges for any services, supply or loss caused by, incurred for, or resulting from:

1. Cosmetic surgery, unless it is performed as soon as medically feasible and is needed for:
   A. repair of an Injury received while You are covered under this plan;
   B. reconstruction that is incidental to or follows surgery resulting from an Injury or Sickness;
   C. correction of a congenital defect that results in a functional defect of an Eligible Dependent Child; or
   D. correction of a normal bodily function needing repair as a result of an Injury or Sickness. Treatment of an Injury must begin within ninety [90] days of the date of the accident in order to be eligible;
2. Dental care or treatment, except as noted in covered item 12 on page 18
3. Hearing aids or the fitting thereof;
4. Vision care for or in connection with:
   A. exams to determine the need for changes of eyeglasses or lenses of any type, except initial replacements for loss of the natural lens; or,
   B. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia [nearsightedness], hyperopia [farsightedness] or astigmatism [blurring];
5. The use of ambulance service at a cost greater than the maximum shown in the **"SCHEDULE OF BENEFITS"**;
6. Services or supplies in connection with a service related disability in a Service Facility or Veteran's Administration Hospital owned or operated by the U.S. Government, unless otherwise required by law;
7. An Elective Abortion, unless the mother's life would be endangered if the fetus were carried to term;
8. For any care, treatment, service, or supply for non-congenital transexualism, gender dysphoria, or sexual reassignment or change, including, but not limited to, medications, implants, hormone therapy, surgery, or medical or psychiatric treatment.
9. Any treatment, surgical procedure, facility, equipment, drugs, drug usage or supplies requiring Federal or other governmental agency approval that:
   A. is not granted at the time the services are rendered; or
   B. is determined to be experimental or not accepted medical practice;
10. A weight control program or treatment of obesity;
11. Routine physical exams or immunizations, [including routine physical exams or immunizations for children] by non-**PPO** providers.
12. Custodial Care;
13. A Physician, Registered Nurse, Licensed Practical Nurse or physical therapist if such person is a member of Your immediate family or resides with the person receiving treatment;
14. Home Health Care Benefits other than services specifically included in the Home Health Care Plan. In addition, Home Health Care Benefits are not payable for:
   A. any period during which You are not under the continuing care of a Physician;
   B. transportation services; or
   C. services, supplies or treatment not otherwise payable under this section;
15. Any organ transplant procedures that are experimental in nature;
16. Smoking cessation;
17. Personal hygiene, comfort or convenience items such as humidifiers or exercise equipment;
18. Routine foot care, flat foot conditions, supportive devices for such foot conditions, corrective shoes; insoles, or any other orthotic that is not an integral part of a brace.
19. In or out patient care of treatment of behavioral problems, social maladjustment or any other antisocial action;
20. Hospice expenses in excess of any maximum stated in the **"SCHEDULE OF BENEFITS".**

21. Treatment of drug abuse or alcoholism;
22. Treatment in connection with sexual dysfunction, impotence, sexual enhancement or infertility treatment, procedures or drugs;
23. Treatment of Dependent children in connection with pregnancy, except for complications of pregnancy;
24. Any prescription medicine administered or dispensed by a Physician or nurse in a Physician's office except for injected medications;
25. To the extent that You are entitled to receive Benefits under any governmentally mandated no-fault motor vehicle insurance;
26. Any non-prescription medicines; oral or injectable contraceptives or contraceptive device[s]; vitamins, nutrients and food supplements, even if prescribed by a Physician,
27. Treatment of **TMJ** disorder or disfunction by surgery of the **TMJ** or mandible, intraoral prosthetic devices, orthodontics, dental splints or extractions, or any other means, regardless of medical necessity.
28. For any care or treatment in connection with the reversal of surgical sterilization.

GENERAL LIMITATIONS

In addition to all other Limitations and Exclusion found in this booklet, the **Plan Benefits** do **NOT** cover Charges for any loss caused by, incurred for, resulting from or in connection with:

1. Treatment that is not Medically Necessary;
2. Services provided and/or supplies obtained, either prior to the effective date, or subsequent to the termination date, of Your coverage;
3. Any purposely self-inflected Injury while sane or insane;
4. Any Injury or Sickness arising out of, or in the course of, any employment or occupation for which you received, or are entitled to receive, compensation under any Workers' Compensation or similar law;
5. For medical care, services, or supplies received or furnished in connection with, or as a result of, any injury or sickness resulting from, or caused, directly or indirectly, or wholly or partly, by (a) war or any act of war, whether declared or undeclared, (b) service in any military, naval, or air force of any country while such country is engaged in war, whether declared or undeclared, (c) police duty as a member of any military, naval, or air force organization, (d) insurrection, (e) any atomic explosion or other release of nuclear energy (except only when being used solely for medical treatment of a Non-Occupational Disease or Injury) whether in peace or in war and whether intended or accidental, or (f) participation in a riot.
6. Being in excess of the Reasonable and Customary Charge, or Charges for unnecessary care and/or treatment;
7. Services or treatment for which an Individual would be eligible for full or partial payment under any state, municipal, or Federal law or regulation;
8. For services, supplies or treatment received or provided outside of the territorial boundaries of the United States;
9. A failure to keep a scheduled visit or to complete a claim form;
10. A Charge that You are not required to pay, or that You would not be required to pay i there were no plan of coverage;
11. **ANY EXPENSES INCURRED MORE THAN TWELVE [12] MONTHS** PRIOR TC THE DATE THEY ARE SUBMITTED FOR PAYMENT;
12. For care, treatment, services, or supplies received or furnished in connection with, c as a result of, any Injury or Sickness caused by, or contributed to from, engaging in a illegal act or occupation; by committing or attempting to commit any crime, crimin act, assault, or other felony; or by participating in a riot or public disturbance.

COORDINATION OF BENEFITS

The purpose of this Plan is to help employees meet the cost of needed medical care and trea ment. It is not intended that anyone should receive Benefits greater than the actual expens incurred. Benefits payable by this Plan, and any other group medical plans under which Y

may be eligible for Benefits, will be coordinated so that the total Benefits allowed by any and all plans will not exceed one-hundred percent [100.00%] of the Allowable Expense.

The **C**oordination **O**f **B**enefits **["COB"]** provisions will apply separately to all Medical and Dental Benefits provided under this plan.

Quite frequently, because both husbands and wives are working, members of a family are covered under more than one plan of group Benefits. When this happens there are many instances of duplication of coverage. For that reason, a **COB** provision has been adopted by the Trustees which will coordinate the medical and dental Benefits payable, as described in this booklet, with similar Benefits payable under **"OTHER PLANS". OTHER PLANS** include, but are not limited to, any other insured or self insured group employee Benefit plan; no fault automobile insurance; other governmental programs; and, programs required by state or Federal statute, unless otherwise declared by law, but excludes, with respect to eligible active employees and their dependents, Vision benefits, Health Maintenance Organization [HMO] benefits and all Medicare Benefits.

Under the **COB** provision, if an employee or any of his or her dependents are also covered under any other group plan of Benefits, the total payment received for any one person from all such programs combined may not amount to more than one-hundred percent [100.00%] of the Allowable Expense, as defined in the General Definitions section of this booklet. In no event will the amount of Benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved.

NOTE: IN ORDER TO RECEIVE REIMBURSEMENT OF MEDICAL EXPENSES, AN EMPLOYEE MUST REPORT DUPLICATE GROUP HEALTH CARE INSURANCE COVERAGE ON THE STATEMENT OF CLAIM FORM WHICH HE OR SHE SUBMITS. THERE IS NO COB FOR THE PRESCRIPTION DRUG CARD BENEFITS.

WHO PAYS FIRST?

1. When another group plan does not contain a COB provision, that plan is considered Primary and will pay first, regardless of the other coverage. The Plan is considered Secondary and will then pay toward the remaining covered expenses;
2. When the other group plan contains a **COB** provision, the order of Benefit payments will be determined as follows:
   A. the group plan covering the patient as an employee is Primary and pays before the group plan covering the patient as a dependent;
   B. the group plan covering the patient as a dependent of a parent whose birthday [excluding year of birth] falls earlier in the calendar year is Primary and pays before the group plan of the parent whose birthday [excluding the year of birth] falls later in the calendar year;
   C. in situations of divorce, separation and/or divorce and remarriage, Benefits for a child's medical expenses will be payable as follows:
      i. in the case of divorce or separation, the group plan which is Primary shifts to the household where the child resides. This means that if the child lives with the natural mother, her plan pays first and if the child lives with the natural father, then his plan pays first;
      ii. if the parent with whom the child resides later remarries, the order of Benefit is as follows:
         [a] natural parent with whom child resides;
         [b] step parent with whom child resides;
         [c] natural parent not having custody of child;
      iii. however, the order of Benefit payment can change if, in the divorce decree there is a stipulation requiring one of the parents to be financially responsible for Benefits provided by this Plan. In such cases, the plan of the parent with court decreed financial responsibility pays first; the plan of the other natural parent pays second; and, the plan covering the spouse of the parent with court-decreed financial responsibility pays third.

3. When the other group plans do not contain the rule in subsection **"2,B"**, above, the group plan covering the patient as a dependent of a male [Father] is Primary and pays before the group plan covering the patient as a dependent of a female [Mother];
4. The Benefits of a plan which covers a person as an employee who is neither laid off nor retired, are determined before the Benefits of a plan which covers that person as a laid-off or retired employee;
5. When neither **"2"** nor **"3"** determines the order of Benefits, the group plan which has covered the patient for the longer period of time pays first.

HOW TO FILE A CLAIM

In order to assure Yourself of the fastest possible service, all claims should be reported to the Administrative Manager, as soon as possible. Generally, the **PPO** providers will file medical claims for You. The Administrative Manager will furnish You with the claim forms necessary for filing all claims.

Do not wait until You return to work before making a claim for Benefits - do it immediately. It is **Your** responsibility to provide the Administrative Manager with adequate information needed to process Your claim.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT - You must provide written notice of the death and a certified copy of the death certificate to the Administrative Manager.

ALL OTHER CLAIMS - The Administrative Manager, upon receiving a notice of a claim, shall furnish to You such claim forms as are necessary for use in filing proof of loss. Once received, You should:

1. Complete the Employee portion of the claim form by inserting all of the requested information and signing Your name on the specified line;
2. Have Your doctor complete the Physician's portion of the claim form and sign his or her name;
3. Obtain itemized Provider, Hospital and Physician bills which set forth all of the services and treatment received;
4. If the claim is on a dependent child who is a student that is nineteen [19] or more years of age, but less than age twenty-five [25], proof of the dependent's status as a Full-time student must be verified on a form obtained from the Administrative Manager. Failure to furnish such proof with the claim to the Administrative Manager, will result in a delay in the processing of the claim;
5. Forward the completed claim form with substantiating bills to the Administrative Manager's Office at the address listed in the front of this booklet.

PROOF OF LOSS - Written Proof of Loss **["NOTICE OF CLAIM"]** should be furnished to the Administrative Manager within ninety [90] days after the date of the loss for which claim is made. Late proof **MAY** be accepted, but only if, under the particular circumstances, it was furnished as soon as was reasonable possible. However, **IN NO EVENT,** except in the absence of an Employee's legal capacity, will proof be accepted more than one year after the date on which expenses were incurred.

LEGAL ACTION
No action at law or in equity shall be brought against the Plan to recover on any Benefits during the first sixty [60] days, or at any time more than three [3] years following, the submission of written proof of loss to the Plan. Please also see **"PROOF OF LOSS".**

ASSIGNMENT OF BENEFITS
All Benefits will be payable to You, or Your beneficiary, unless You specifically assign them. Once Benefits have been assigned they can **only** be paid according to the written assignment.

In the event that You wish to assign Your medical Benefits, the check will be sent directly to the service provider instead of to You. To assign Benefits, complete the assignment section of the claim form or special forms Your Physician or Hospital may provide.

DISCRETIONARY AUTHORITY OF TRUSTEES
The Trustees are hereby granted discretionary authority to determine eligibility for benefits under this Plan and to construe the terms of this Plan. A decision made by the Trustees that is made pursuant to the discretionary authority granted in this Section 8.7 shall only be overturned by an appropriate court of law if, upon review, such court determines that such decision is arbitrary and capricious or is incorrect as a matter of law.

FACILITY OF PAYMENT OF BENEFITS
If a Participant is a minor or, in the opinion of the Trustees, not competent to give a valid receipt of any Benefit due him, and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of the Participant, the Plan may make direct payment to the Participant or institution appearing to the Plan to have assumed the custody of or the principal support of the Participant.

PHYSICAL EXAMINATION AND AUTOPSY
The Plan, at its own expense, will have the right and opportunity, while a claim is pending, to examine any Participant whose Injury or Sickness is the basis of a claim when and so often as it may reasonable require, and to make an autopsy in the case of death where it is not prohibited by law.

If a Participant dies while Benefits for hospital, nursing, medical or surgical services remain unpaid, the Plan may make direct payment to the person or institution on whose Charges a claim is based, or to any of the following surviving relatives of the Participant: wife, husband, mother, father, child or children, brothers or sister, or to the Participant's executors or administrators.

Any payment by the Plan in accordance with this provision will discharge the Plan from all further liability to the extent of the payment made.

PATIENT-PHYSICIAN RELATIONSHIP
You and Your eligible Dependents will have free choice of any Physician, dentist, chiropractor or nurse - midwives practicing within the scope of their license. The Plan will in no way disturb the patient-Physician relationship.

FALSE, FRAUDULENT, ALTERED OR FORGED CLAIM FORMS
Under Federal and State law it is a crime to file a false or fraudulent claim, or to knowingly help someone else file a false or fraudulent claim, under any of the following conditions:

1. A claim for payment of a health care Benefit for any goods or services that a person knows were not received;
2. A claim for payment of health care Benefits that knowingly misrepresents the patients' diagnosis as part of a scheme to defraud;
3. A statement concerning a material fact used for the determination of health care Benefits or payments that the person knows is false or deceptive.

A violation of the law by submitting a false or fraudulent claim will result in the Health and Welfare Plan filing Charges with the appropriate governmental agency. Additionally, You will be required to pay civil damages.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION
The Plan may, without Your consent or any notice, release to, or obtain from, any insurance company or other organization or person, any information which is necessary to implement the terms of this Plan. If You file a claim for Benefits under this Plan, You may be required to furnish to the Plan such information as is necessary to process Your claim. The Plan will abide by the requirements of the Health Insurance Portability and Accountability Act of 1996 and includes the Protected Health Information [PHI] Standards of Privacy.

RIGHT TO RECOVERY
Whenever payments have been made by the Plan in a total amount, in excess of the maximum allowed under the Plan, the Plan will have the right to offset such excess against future or other Benefits payable, or to recover such payments, to the extent of such excess, from any persons to or for whom such payments were made, any insurance company or any other organization.

TIME LIMITS ON DECISION

1. Claims in General. A Covered Individual who properly files a claim for benefits under this Plan shall be informed of the decision on the claim within ninety [90] days after the date all the materials necessary to process the claim are received by the Fund Office. If special circumstances require an extension of time for processing the claim, the Fund Office shall, prior to the termination of the initial ninety [90] day period, furnish to the Covered Individual a written notice of the extension setting forth the special circumstances requiring an extension of time and the date by which the Fund Office expects to render the benefit determination. In no event shall the extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period.
2. Urgent Care Claims. A Covered Individual who properly files a claim for urgent care benefits under this Plan shall be informed of the decision on the claim within seventy-two [72] hours after the claim is received by the Fund Office, unless the Covered Individual fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan. If a Covered Individual fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan, the fund Office will notify the Covered Individual of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four [24] hours after receipt of the claim by the Fund Office. The Covered Individual will be afforded a reasonable amount of time, taking into account the circumstance, but not less than forty-eight [48] hours, to provide the specified information. The Fund Office shall notify the Covered Individual of the benefit determination as soon as possible, but in no case later than forty-eight [48] hours, to provide the specified information. The Fund office shall notify the Covered Individual of the benefit determination as soon as possible, but in no case later than forty-eight [48] hours after the earlier of (i) the Fund Office's receipt of the Specified information or (ii) the end of the period afforded to the Covered Individual to provide the specified information. An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the Covered Individual's life or health or the Covered Individual's ability to regain maximum function or (ii) in the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
3. Concurrent Care Decisions. If a Covered Individual has been approved for an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of such course or treatment (other than by Plan amendment, termination of this Plan, or the Covered Individual ceasing to be eligible for benefits under this Plan) before the end of such period of time or number of treatments shall be considered an adverse benefit determination, and the Fund Office shall notify the Covered Individual of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Covered Individual to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated. Any request by the Covered Individual to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Fund Office shall notify the Covered Individual of the benefit determination, whether adverse or not, within twenty-four [24] hours after receipt of the claim by the Fund Office, provided that any such claim is made to the Fund Office at least twenty-four [24] hours after receipt of the claim by the Fund Office, provided that any such claim is made to the Fund Office at least twenty-four [24] hours prior to the expiration of the prescribed period of time or number of treatments.
4. Pre-Service Claims. A Covered Individual who properly files a claim for pre-service benefits under this Plan shall be informed of the decision on the claim within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the Fund Office. The period for decision on

the claim may be extended for a period of up to fifteen (15) days if an extension of time for processing the claim is necessary due to matters beyond the control of the Fund, and the Fund Office, prior to the termination of the initial fifteen (15) day period, furnishes to the Covered Individual written notice of such extension. The notice of an extension shall set forth the circumstances requiring an extension of time and the date by which the Fund Office expects to render a decision. If the extension is necessary due to a failure by the Covered Individual to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Covered Individual shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. A pre-service claim means any claim for benefits under this Plan with respect to which this Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

5. Post-Service Claims. A Covered Individual who properly files a claim for post-service under this Plan shall be informed of the decision on the claim within a reasonable period of time, but not later than thirty (30) days after the claim is received by the Fund Office. The period of time, but not later than thirty (30) days after the claim is received by the Fund Office. The period for decision on the claim may be extended for a period of up to fifteen (15) days if an extension of time for processing the claim is necessary due to matters beyond the control of the Fund, and the Fund Office, prior to the termination of the initial thirty (30) day period, furnishes to the Covered Individual a written notice of such extension. The notice of an extension shall set forth the circumstances requiring an extension of time and the date by which the Fund Office expects to render a decision. If the extension is necessary due to a failure by the Covered Individual to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Covered Individual shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. A post-service claim is any claim under this Plan that is not a pre-service claim.
6. Disability Claims. A Covered Individual who properly files a claim for disability benefits under this Plan shall be informed of the decision on the claim within forty-five (45) days after the claim is received by the Fund Office. The period for decision on the claim may be extended for a period of up to thirty (30) days if an extension of time for processing the claim is necessary due to matters beyond the control of the Fund, and the Fund Office, prior to the termination of the initial forty-five (45) day period, furnishes to the Covered Individual written notice of such extension. The period for decision on the claim may be extended for an additional thirty (30) day period if, prior to the end of the first thirty (30) day extension period, and extension of time is necessary due to matters beyond the control of the Fund, and the Fund Office, prior to the expiration of first thirty (30) day period, furnishes to the Covered Individual written notice of extension. Any notice of an extension shall set forth the circumstances requiring an extension of time, and explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve these issues, that the Covered Individual will be afforded at least forty-five (45) days within which to provide the specified information, and the date by which the Fund Office expects to render a decision.
7. Denial of Claim. If a claim is wholly or partially denied, the Fund Office shall furnish to the Covered Individual a written notice of the denial. The notice of denial shall provide (a) the specific reason or reasons for denial; (b) specific reference to pertinent Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and explanation of why such material or information is necessary, and the individuals rights under Section 502(a) of ERISA.

CONSTRUCTION

All questions of interpretation of this Plan shall be decided exclusively by the Trustees in accordance with Federal law. The Trustees shall be the sole arbiter of questions of eligibility and the amounts of Benefits payable.

NOTICE NO FUND LIABILITY

THE USE OF THE SERVICES OF ANY HOSPITAL, CLINIC, DOCTOR, DENTIST, PODIATRIST, OPTICIAN OR ANY OTHER PERSON OR ESTABLISHMENT RENDERING HEALTH CARE OR SERVICES WHETHER SPECIFICALLY DESIGNATED BY THE PLAN OR OTHERWISE [HEREINAFTER REFERRED TO AS "PROVIDER"] UNDER THE PLAN IS THE VOLUNTARY ACT OF THE EMPLOYEE AND/OR HIS DEPENDENT. SOME BENEFITS MAY ONLY BE OBTAINED FROM PROVIDERS DESIGNATED BY THE PLAN. IN SUCH SITUATIONS, THE DESIGNATION IS NOT MEANT TO BE A RECOMMENDATION OR INSTRUCTION TO USE SUCH PROVIDER. AN EMPLOYEE AND/OR HIS OR HER DEPENDENT SHOULD SELECT A PROVIDER OR COURSE OF TREATMENT BASED ON ALL APPROPRIATE FACTORS, ONLY ONE OF WHICH IS COVERAGE UNDER THE PLAN. SAID PROVIDERS ARE INDEPENDENT CONTRACTORS, NOT EMPLOYEES OF THE PLAN. THE FUND IS NOT RESPONSIBLE FOR ANY ACTS OF COMMISSION OR OMISSION OF ANY PROVIDER IN CONNECTION WITH THE SERVICES OR TREATMENTS PROVIDED HEREIN, AND MAKES NO REPRESENTATION REGARDING THE QUALITY OF SERVICE OR TREATMENT PROVIDED BY ANY PROVIDER. EACH PROVIDER IS SOLELY RESPONSIBLE FOR THE SERVICES AND TREATMENTS TO BE RENDERED UNDER THIS PLAN.

LEGAL ENFORCEABILITY

The trustees intend that the terms of this Plan, including those relating to coverage and benefits, are legally enforceable. It is the intention of the Trustees that the conditions required for an Employee to participate, receive coverage, and obtain benefits under this Plan are definitely determinable under the terms of this Plan, and an Employee satisfies such conditions as able to compel such participation, coverage, and benefits.

WORKERS' COMPENSATION

Benefits under this Plan are not in lieu of nor do they affect any requirements for Workers' Compensation insurance.

SAVINGS CLAUSE

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

CLAIMS REVIEW AND APPEAL PROCEDURES

CLAIM DENIAL

If a claim for benefits is denied in whole or in part, you have the right to appeal the denial by giving the Trustees of the Fund written notice within one hundred eighty (180) days from the date of receipt of the denial. Your appeal should include your reason for appeal and any pertinent support data. You have the right to be represented, review pertinent documents, may submit issues and comments and upon request have reasonable access to relevant information pertaining to your claim.

DECISION ON APPEAL

The Board of Trustees shall make a determination no later than the first (1st) meeting of the Board of Trustees after the written request is received in the Fund Office provided the request is received more than thirty (30) days prior to the next meeting. Otherwise, the determination will be made at the next meeting of the Board of Trustees. If special circumstances require a delay in the decision, the Trustees will notify you of the delay, the reason for the delay and the date on which a decision will be rendered. The Trustees shall issue a decision no later than the third (3rd) meeting following the receipt of the original request. The Trustees' decision shall be in writing and shall include the specific reason(s) for the decision and specific references to

the pertinent Plan provisions on which the decision is based. In the case of urgent care, the Fund Office will notify you as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of your request for review or within thirty (30) days for a preservice claim.

GENERAL INFORMATION

IDENTIFICATION [ID] CARD

After You become initially eligible, the Administrative Manager will issue You and ID Card so that when hospitalization is necessary, the card can be presented at the admission desk. **Your ID Card should be kept in Your possession at all times.**

REPORTING CHANGES PROMPTLY

It is **important** that You notify the Administrative Manager whenever You:

1. Acquire a new Dependent;
2. Change Your home address; or
3. Change Your marital status.

MEDICARE

Medicare refers to the Federal Government's insurance plan that was created by Title XVII of the Social Security Act of 1965 and which has undergone several amendments since that time. There are two parts to Medicare. The part of Medicare that pays for hospital bills is called **"PART A"**, and the part which pays for doctor bills and other medical care expenses is called **"PART B".**

Because Medicare is actually administered by the **S**ocial **S**ecurity **A**dministration **["SSA"]** of the Federal Government, this booklet should not be considered Your only source of information about Medicare. For descriptive booklets and other information about all aspects of the Medicare program, contact the **SSA.** Their telephone number and nearest office address can be found in the white pages or Your telephone directory.

Generally, Medicare is available to the following groups of people:

1. All persons, age sixty-five [65] and over, who are also eligible for Social Security Benefits or Railroad Retirement Act Benefits;
2. Certain other persons, age sixty-five [65] and over, that are not eligible for Social Security or Railroad Retirement Benefits, but who are resident citizens, can enroll in Medicare by paying the necessary Medicare premiums;
3. Certain persons, regardless of age, who become disabled or who have a kidney condition that can be classified as **"End Stage Renal Disease"**;
4. Certain resident aliens, if they are eligible for Social Security Benefits or have lived in the United States for at least five [5] years.

If You or Your covered dependent spouse become eligible for Social Security at age sixty-five [65], coverage by Medicare is possible even if You don't retire. As long as You remain actively employed and eligible under this Plan, all other medical Benefits provided under the Plan will remain fully in force, whether or not Your eligible for the health Benefits provided by the Medicare Program.

The Federal Government makes no monthly premium Charge for a person enrolled in Medicare's Part A [except for people in category [2], above]. There **IS** a Charge for Medicare's Part B. Part B Charges vary each year, but the **SSA** can tell You the current amount of that premium and it can also advise You of how it can be paid.

Persons who are eligible for Medicare and wish to enroll must contact their nearest **SSA** office within three [3] months prior to the time they are first eligible to enroll which, for most persons, is age sixty-five [65].

MEDICARE AND THIS PLAN

ACTIVE EMPLOYEES: [MEDICARE SECONDARY]
When an Employee becomes eligible for Medicare and if that Employee is Actively at Work, the Employee and his or her eligible Dependents will remain eligible for all the same Benefits which are provided to all other Employees and Dependents of any age. However, if the Employee or his or her eligible spouse enroll under Medicare **PART A** and/or **PART B**, the Medicare coverages will become Secondary to the Benefits provided by this Plan. This Plan will always provide Primary coverage and Medicare will always be considered to be the Secondary as long as the Employee is Actively at Work, unless the Employee elects otherwise in accordance with this provision, or the Board of Trustees elect Medicare as Primary for Employees in accordance with this Provision.

ACTIVE EMPLOYEES: [ELECTION OF MEDICARE AS PRIMARY]
An Individual eligible for Medicare Benefits may elect Medicare as Primary and thereby waive all coverage under the Plan for those Benefits covered by Medicare. However, an Employee or Dependent will continue to receive Primary coverage under this Plan unless the Administrative Manager is notified in writing to the contrary.

DISABLED EMPLOYEES UNDER AGE SIXTY-FIVE [65]: [MEDICARE SECONDARY]
If You are under age sixty-five [65], and eligible for Medicare by reason of disability, Medicare will provide Secondary coverage and the Plan will be Primary.

When an eligible Employee or Dependent becomes entitled to Medicare Benefits as a result of end stage renal disease, case Benefits are coordinated. During the period outlined below, this Plan's Benefits will be determined before any Benefits payable by Medicare Benefits due to end stage renal disease. The period of primary coverage under this Plan will begin on the earliest of the following dates, and will end no more than thirty [30] months later:

1. The month in which the Covered Family Member began a regular course of renal dialysis;
2. The month in which the covered family member received a kidney transplant;
3. The month in which the covered family member was admitted to a hospital in anticipation of a kidney transplant that was performed within the next two [2] months; or,
4. The second month before the month in which the kidney transplant was performed, if performed more than two [2] months after admission.

RETIRED EMPLOYEES: [MEDICARE PRIMARY]
Medicare is primary to any Benefits payable to retired employees and their eligible dependents under this plan.

CONTINUATION OF COVERAGE UNDER COBRA
[NOT APPLICABLE TO LIFE, AD&D OR LOSS OF TIME BENEFITS]

Federal law mandates that group plans provide Individuals with the option of continuing their medical coverage through self payment of contributions when their coverage terminates under a Plan due to certain Qualifying Events.

QUALIFYING EVENTS
You and Your dependent[s], including a child born or placed for adoption within the period of **COBRA** continuation coverage if reported to the Administrative Manager within thirty [30] days of the birth or the placement for adoption, [see **"MAXIMUM PERIOD ALLOWED UNDER CONTINUATION COVERAGE"**] have the right to continuation coverage if Your regular coverage terminates for certain reasons, **provided the Employee or dependents make the required self payment of contributions.** Continuation coverage is available in the event coverage terminates due to:

1. Termination of the Employee's employment for any reason, except gross misconduct;
2. A reduction in hours worked by the Employee;
3. Death of the Employee;
4. Divorce or legal separation of the Employee and spouse;
5. A dependent child ceasing to be an Eligible Dependent, under the provision of the Plan;

6. A Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare; or,
7. Bankruptcy proceedings under Title 11, United States Code.

TYPE OF BENEFITS PROVIDED FOR CONTINUATION COVERAGE

The Benefits provided to any Individual electing continuation coverage shall be the same Benefits that he or she was eligible to receive on the date before the occurrence of any Qualifying Event. However, Life, Accidental Death and Dismemberment, and Loss of Time Benefits shall **NOT** be available for continuation of coverage under **COBRA**. The provisions relative to the **COBRA** continuation of medical coverage are discussed below. It is important that all family members be aware of these provisions in the event that coverage terminates.

NOTICE REQUIREMENTS

If Qualifying Events in items **"1", "2", "3",** or **"7",** occur, Your employer is required to notify the Administrative Manger. If one of Your dependents would lose coverage due to Qualifying Events numbered **"4", "5",** or **"6",** , You, or Your covered dependents, must notify the Administrative Manager within sixty [60] days of the event, so that the Administrative Manger can provide You and Your covered eligible dependent with appropriate notice of **COBRA** continuation coverage rights and the terms which apply to the continuation coverage. Once having received notice of any of the Qualifying Events from either You or Your employer, the Administrative Manager has fourteen [14] days to notify You of Your rights to continuation coverage. However, if **any** of these events occur, You or Your covered dependents, should also notify the Administrative Manger. You should try to give such notification within thirty [30] days of the qualifying event to assure that no break in coverage occurs.

NOTICE FROM CONTRIBUTING EMPLOYERS

A Contributing Employer must notify the Plan in writing within thirty [30] days following the occurrence of any of the following Qualifying Events:

1. Termination of Your employment;
2. Reduction of Your hours worked;
3. Your death;
4. Your eligibility for Medicare; or,
5. Bankruptcy proceedings under Title 11, United States Code.

This requirement may be met by timely notification to the Administrative Manager on the form designated by the Plan for such purposes.

NOTICE FROM YOUR AND YOUR DEPENDENTS

You or Your Dependents, as applicable, must notify the Administrative Manager in writing no later than sixty [60] days after the following Qualifying Events:

1. Divorce or legal separation from Your spouse, or
2. Your child ceasing to be a Dependent.

MAXIMUM PERIOD ALLOWED UNDER CONTINUATION COVERAGE

Up to a maximum of eighteen [18] months are allowed from the date coverage would have otherwise terminated, if coverage is being continued for You and Your dependents because You ceased covered employment, including retirement, or had a reduction in hours of employment for any reason other than gross misconduct.

Up to a total maximum of thirty-six [36] months from the date coverage would have otherwise terminated are allowed, if coverage is being continued for Your spouse and/or dependent child[ren] for reasons other than those referred to in the preceding paragraph, except not in the case where You initially declined continuation coverage. In this case, Your spouse and/or dependent child[ren] are allowed continuation coverage for the eighteen [18] month maximum period noted above.

Continuation coverage of up to twenty-nine [29] months is available for employees, and Qualified Beneficiaries in the employee's family, with a total disability that occurs within the first sixty [60] days of **COBRA** continuation coverage. A total disability means that You, or Your family member, are eligible for Social Security disability Benefits. The **COBRA** contribution will

be one hundred-fifty percent [150.0%] of the then current normal contribution for coverage after the eighteenth [18th] month. If continued coverage is elected following termination of employment or reduction in work hours, and then another of the events listed in the section entitled Qualifying Events occurs during that continuation period, Your dependents may continue their coverage for up to thirty-six [36] months, rather than eighteen [18] months. However, the thirty-six [36] month period will be measured from the date of Your termination of employment or reduction in work hours and not from the date of the second event.

SELF-PAYMENT OF CONTRIBUTIONS

Self payment, if elected, must be made from the date of termination.

1. If You elect to continue coverage within sixty [60] days after Your eligibility terminates, contributions due for the period between termination and the election date must be postmarked and sent to the Administrative Manager within forty-five [45] days after the election.
2. After the initial election and payment of contributions, subsequent payments must be postmarked and sent to the Administrative Manager before the last day of the month for which coverage is to be provided. Once You are initially notified, You will not receive any further notices from the Plan or the Administrative Manger.
3. The contribution rate for continuation coverage will be determined according to Federal law and is guaranteed not to change during the twelve [12] month rate period following a rate change. Thereafter, contribution rates are subject to change at the beginning of each rate period, or sooner if Benefit modifications are made to the Plan.
4. If Benefits provided to active Employees and/or their Dependents changes, Your continuation coverage will also change.
5. You will be notified of any change in contribution rates the You are required to pay.
6. The full contribution rate must be paid, minus any contribution which is made by Your Employer on Your behalf. **NO LAPSE IN COVERAGE IS PERMITTED.**
7. If Benefits provided to active employees and/or their dependents changes, Your continuation coverage will also change.
8. You will be notified of any change in contribution rates that You are required to pay.
9. The full contribution rate must be paid, minus any contribution which is made by Your employer on Your behalf.

FINANCIAL RESPONSIBILITY FOR FAILURE TO GIVE NOTICE

If an individual fails to give proper notice within sixty [60] days of the date of the Qualifying Event, or a Contributing Employer within thirty [30] days of the date of the Qualifying Event, and as a result, the Plan pays a claim of an Individual whose coverage terminated due to a Qualifying Event and who does not elect continuation of coverage under this provision, then the Individual or the Contributing Employer, as appropriate, shall be obligated to reimburse the Plan for any claims that should not have been paid, If an Individual fails to reimburse the Plan, then all amounts due may be deducted from other Benefits payable on behalf of that Individual.

If a Contributing Employer fails to give proper notice within thirty [30] days of the Qualifying Event as required, and the Individual is, as a result, permitted to elect, and does elect continuation coverage more than thirty [30] days after the date of the Qualifying Event, the Employer shall be obligated to reimburse the Plan for all claims paid by the Plan on behalf of the Individual. The Trustees, in their sole discretion, may limit the application of this subsection where it appears, based on all circumstances, that the Individual would have elected continuation coverage within sixty [60] days of the Qualifying Event had notice of the right to such an election been provided during the period.

ELECTION REQUIREMENTS

You must elect to make self payments of contributions within sixty [60] days from the date You are notified by the Administrative Manager of Your right to maintain Your eligibility through self payment, which ever is later. In order to make election, You must sign a written election form approved by the Board of Trustees.

NOTE: IF AN ELECTION IS NOT MADE AND POSTMARKED WITHIN THE TIME PERIODS STATED IN THE NOTICE FROM THE ADMINISTRATIVE MANAGER, YOU CANNOT CONTINUE COVERAGE UNDER THIS PLAN.

TERMINATION OF COBRA COVERAGE [ALL INDIVIDUALS]
COBRA continuation coverage will terminate on the earliest of:

1. The first day of the month for which contribution is not paid on time;
2. The date You become covered under another employer sponsored group health plan but only if such other plan does not contain any pre-existing condition exclusion or if such pre-existing condition exclusion does not apply to the **COBRA** qualified beneficiary due to his or her prior creditable coverage and that does not exclude or limit coverage for pre-existing medical conditions;
3. The date You become entitled to Medicare Benefits; or,
4. The date that the Plan stops providing any group health plan to any Employee;
5. The date the Employer is no longer a Contributing Employer and does not have a Collective Bargaining Agreement requiring contribution to the Fund; or,

If You do not elect and pay contributions for **COBRA** continuation coverage on a timely basis, You will no longer be covered under the Plan. Any claims filed during the election period or following termination for non-payment of contribution will not be paid. **REINSTATEMENT OF COVERAGE UNDER COBRA IS NOT PERMITTED.**

Full details of **COBRA** continuation coverage will be furnished to You and/or Your dependents when the Administrative Manager receives notice that one of the qualifying events described above has occurred. We therefore urge You and Your covered dependents to contact the Administrative Manger as soon as possible after the occurrence of one [1] of those events.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT

The Family Medical Leave Act **"[FMLA"]** of 1993 requires Contributing Employers with fifty [50] or more employees to provide eligible employees with up to twelve [12] weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for their own Sickness, or to care for a seriously ill child, spouse or parent.

In compliance with the provisions of the **FMLA**, Your Contributing Employer is required to maintain Your preexisting coverage under the plan during Your period of leave under the **FMLA** just as if You were actively employed. Your coverage under the **FMLA** will cease once the Administrative Manager is notified or otherwise determines that You have terminated employment, exhausted Your twelve [12] week **FMLA** leave entitlement. Or You inform the Administrative Manager of Your intent not to return from leave. Your coverage will also cease if Your Contributing Employer fails to maintain coverage on Your behalf.

Once the Administrative Manager is notified or otherwise determines that You are not returning to employment following a period of **FMLA** leave, You may elect continued coverage under the **COBRA** continuation of coverage rules. The Qualifying Event entitling You to **COBRA** continuation coverage is the last day of Your **FMLA** leave.

If You fail to return to covered employment following Your leave, the Plan may recover the value or Benefits it paid to maintain Your health coverage during the period of **FMLA** leave, unless Your failure to return was based upon the continuation, recurrence, or onset of a serious health condition that affects You or a family member and which would normally qualify You for leave under the **FMLA**. If You fail to return from **FMLA** leave for impermissible reasons, the Plan may offset payment of outstanding medical claims incurred prior to the period of **FMLA** leave against the value of the Benefits paid on Your behalf during the period of **FMLA** leave.

CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The **U**niformed **S**ervices **E**mployment and **R**eemployment **R**ights **A**ct of 1994 **["USERRA"]** requires that the Plan provide You the right to elect continuous health coverage for You and Your Dependent[s] for up to eighteen [18] months, beginning on the date Your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below.

If You are absent from employment by reason of service in the uniformed services, You can elect to continue coverage for Yourself and Your Dependent[s] under the provisions of the **USERRA**. The period of coverage for You and Your Dependent[s] ends on the earlier of:

1. The end of the eighteen [18] month period beginning on the date on which Your absence begins; or
2. The day after the date on which You are required under **USERRA**, but fail, to apply for or return to a position of employment for which coverage under this Plan would be extended. **For Example,** for periods of service over one-hundred-eighty [180] days, generally You must reapply for employment within ninety [90] days of discharge.

You must notify Your Contributing Employer or the Administrative Manager that You will be absent from employment due to military service unless You cannot give notice because of military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. You also must notify the Administrative Manager if You wish to elect continuation coverage for Yourself or Your Dependent[s] under the provisions of **USERRA**. If You satisfy the Plan's eligibility requirements at the time You enter the uniformed services, You will not be subject to any additional exclusions, or a waiting period of coverage under the plan, when You return from uniformed service, provided that You qualify for coverage under **USERRA.**

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 [ERISA]

PLAN NAME
Plumbers and Pipefitters Local No. 421 Health and Welfare Plan.

BOARD OF TRUSTEES
A Board of Trustees is responsible for the administration of this Health and Welfare Plan. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Employers who have entered into collective bargaining agreement which relate to the Health and Welfare Plan. The names and addresses of the Trustees are as follows:

BOARD OF TRUSTEES

UNION TRUSTEES

W. David DeLoach
129 Pinefield Road
W. Columbia, SC 29170

Perry S. Howard
Plumbers and Pipefitters Local No. 421
2556 Oscar Johnson Drive
N. Charleston, SC 29405

Gary Kinley
127 Tradewinds Court
Mooresville, NC 28115

Robert A. [Bob] Hughes
Plumbers and Pipefitters Local No. 421
2556 Oscar Johnson Drive
N. Charleston, SC 29405

EMPLOYER TRUSTEES

Jeffery R. Morgan
Morgan Mechanical Company
204 West Stadium Dr
Eden, NC 27288

Chris Bunting
4226 Surles Court
Suite 500
Durham, NC 27703

Zane Gauldin
10821 NC 87
Reidsville, NC 27320

Jack R. Weaver
Weaver Plumbing, Inc.
522 Alpine Rd
Winston Salem, NC 27103

PLAN ADMINISTRATION

The day to day administration of the Plan is handled by Core Management Resources Group, Inc., the Administrative Manager.

IDENTIFICATION NUMBER

The number assigned to the Board of Trustees by the Internal Revenue Service is EIN 56-6085074.

PLAN'S FISCAL YEAR END

The date that the Plan Year ends is the last day of December.

SOURCE OF CONTRIBUTIONS

The amount of each employers contributions is determined by the provisions of their collective bargaining agreement with employee representatives. Employee payroll deductions are also a source of contributions.

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan's agent for service of legal process is:

Charles E. Elrod, Jr.
Parkers, Hudson, Rainer & Dobbs LLP
Attorneys at Law
1500 Peachtree Center - South Tower
225 Peachtree Street, N.E.
Atlanta, Georgia 30303

Service of legal process may also be made upon any Trustee.

FUNDING MEDIUM

Benefits are provided from the Plan's assets which are accumulated under the provisions of the Collective Bargaining Agreement and Trust Agreement, and are held in a Trust Fund for the purposes of purchasing insurance, providing Benefits to covered persons and defraying reasonable administrative expenses.

PLAN ASSETS

All assets and reserves are invested by the Board of Trustees.

PLAN TERMINATION

The right to terminate the Plan is reserved to the Board of Trustees and to the Employers and Union who are signatory to the Plan's Trust Agreement. Circumstances under which the Plan may be terminated include, but are not limited to:

1. When there are no longer sufficient assets to continue the Benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's Benefits, alter or postpone the method of paying Benefits or take other actions consistent with its obligation to maintain the maximum possible Benefits within the limits of the Plan's resources;
2. When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;
3. When the last surviving Participant or beneficiary entitled to receive Benefits has died;
4. With respect to a particular Employer, when the Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when the Employer is declared by the Board of Trustees to be in default; or,
5. With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules an Regulations. If the Plan were to terminate, the Board of Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

FILING CLAIMS

Refer to the section entitled **"HOW TO FILE A CLAIM"** for information on filing claims.

APPEAL OF DENIED CLAIMS

Refer to the section entitled **"CLAIMS REVIEW AND APPEAL PROCEDURES"** for information on appealing denied claims.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 [ERISA]

As a Participant in the Plumbers and Pipefitters Local No. 421 Health and Welfare Plan, You are entitled to certain rights and protection under **ERISA** which provides that all plan Participants shall be entitled to:

1. Examine, without Charge, at the Administrative Manager's office, all plan documents, including collective bargaining agreements; a list of the employers and employee organizations participating in the Plan; and, copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.
2. Obtain copies of all Plan documents; a list of the employers and employee organizations participating in the Plan; and, other Plan information upon written request to the Administrative Manager. The Administrative Manager may make a reasonable Charge for the copies. It is suggested that You contact the Administrative Manager's Office to determine the cost prior to requesting any copies.
3. 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 financial report.
4. File suit in a federal court if any materials requested are not received within thirty [30] days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. In such case, the court may require the Plan Administrator to provide materials and pay You up to one-hundred dollars [$100.00] a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

In addition to creating rights for Plan Participants, **ERISA** imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as Fiduciaries in the law. Fiduciaries must act solely in the interest of the Plan Participants and they must

exercise prudence in the performance of their Plan duties. Fiduciaries who violate **ERISA** may be removed and required to make good any losses they may have caused the Plan.

Your employer may not fire You or discriminate against You to prevent You from obtaining a Benefit from the Plan, or from exercising Your rights under **ERISA.**

You have the right to go to court to enforce any of the rights to which You are entitled, or to seek correction if You have reason to believe that the Plan is not being handled prudently and solely in the interests of Plan Participants. If You are unsuccessful in Your lawsuit, the court may, in its discretion, require You to pay the legal costs of the suit, including attorney fees.

If You have any questions about this statement or about Your Rights Under **ERISA**, You should contact the Administrative Manger's Office or the nearest Office of Pension-Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the division of Technical Assistance and Inquires, Pension & Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight [48] hours following a vaginal delivery, or less than ninety-six [96] hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider [**for example,** Your Physician, nurse midwife, or Physician assistant], after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the forty-eight [48] hour [or ninety-six [96] hour] stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight [48] hours [or ninety-six [96] hours.]

IMPORTANT NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans and insurance issuers offering group health insurance coverage that includes medical surgical Benefits with respect to a mastectomy, shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall, at a minimum, provide for:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
3. prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

As part of the Plan's Schedule or Benefits, such Benefits are subject to the Plans appropriate cost control provisions such as deductibles and coinsurance.

SUBROGATION REIMBURSEMENT

SUBROGATION

In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts

of omissions of any person or entity, or which arise under any no fault coverage, uninsured motorist coverage, underinsured motorist coverage or any other type of first party coverage [for the purposes of this provision, collectively referred to as **"OTHER COVERAGE"**]. The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or cost in order to obtain a recovery from any person, entity, or Other Coverage. **The "MAKE-WHOLE" rule shall not apply.**

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

REIMBURSEMENT

Each Covered Person hereby agrees to reimburse the Plan, for any Medical Benefits paid by the Plan, out of any monies recovered from any person, entity, or Other Coverage as the result of judgement, settlement, or otherwise, regardless of how those monies are classified. The Plan has the right to be reimbursed in an amount equal to the amount of Medical Benefits paid hereunder, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. **The "MAKE-WHOLE' rule shall not apply.**

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such monies in trust for the Benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses [whether fees or costs] associated with the Plan's attempt to recover such monies from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan administrator may require to facilitate enforcement of its rights under this Plan.

Without the written consent of the Plan Administrator, the Plan will not pay or be responsible for, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

For purposes of this provision, the term **"COVERED PERSON"** includes anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ADMINISTRATIVE SIMPLIFICATIONS (HIPAA-AS)

As your health plan, we are required by applicable federal and state laws to maintain the privacy of your protected health information [**PHI**]. We want you to be aware of our privacy

practices, our legal duties, and your rights concerning your **PHI**. We will follow the privacy practices that are described in this notice while it is in effect. This notice took effect **August 1, 2006,** and will remain in effect until a revised notice is issued.

We reserve the right to change our privacy practices and the terms of this notice at anytime and to make the terms of our notice effective for all **PHI** that we maintain.

HOW WE CAN USE OR DISCLOSE PHI

We must disclose your **PHI** to you, we may disclose your **PHI** to a doctor, dentist or a hospital when requested, in order for the treating provider to provide treatment to you. We may use and disclose **PHI** to pay claims for services provided to you by doctors, dentists or hospitals. We may also disclose your **PHI** to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities, to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management or to communicate with you about health related benefits and services or about treatment alternatives that may be of interest to you, to another health plan or a health care provider subject to federal privacy laws, as long as the plan provider has or had a relationship with you and the **PHI** is disclosed only for certain health care operations of that plan or provider.

We may also use **PHI** when required by the Courts, Law Enforcement or Public Health and Safety authorities, Federal Officials for lawful National Security reasons, as permitted by Workers' Compensation or similar laws. **PHI** may be used for enrollment and disenrollment information, to obtain premium bids, to decide benefits modifications to the Plan and for benefit research.

AUTHORIZATION: You may give us written authorization to use your **PHI** or to disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. The law permits in certain circumstances to disclose your **PHI** to family, friends and others, we will only do so in the event of an emergency or similar circumstance unless otherwise authorized by you.

ACCESS: With limited exceptions, you have the right to review in person, or obtain copies of your **PHI.** We reserve the right to impose reasonable fees associated with this access request as allowed by law.

PRIVACY NOTICE: You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of or questions about this notice, please contact the Fund Office:

Core Management Resources Group, Inc.
c/o Mr. Steve Blascovich
P.O. Box 840
Macon, Georgia 31202-1755
Phone 1-888-741-2673