PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630
WELFARE FUND
c/o National Employee Benefits Administrators, Inc.
1920 North Florida Mango Road • West Palm Beach, Florida 33409
(561) 478-0095 • (800) 822-5899

April 24, 2020

On March 17, 2020 the Trustees of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (Fund) agreed to expand the benefits to cover medically necessary screening and testing for the Coronavirus 2019 (COVID-19), including the associated visit without deductibles, copays or coinsurance for the duration of the emergency. The Trustees recognize that many health care providers are not scheduling in-person visits. Instead, physicians are offering to see patients through tele-health visits via video or audio consultations during the COVID-19 emergency. The Trustees have therefore expanded the benefits to temporarily cover medically necessary telehealth visits for all covered conditions from March 1, 2020 until August 31, 2020. The coverage for Schedule of Benefits A and C is summarized below.

Schedule of Benefits A and C

COVID – 19

Services covered in-network and out-of-network for COVID-19 include:

- For the duration of the emergency the following are covered without deductible, copays or coinsurance
    - Medically necessary diagnostic tests for COVID-19 approved by the FDA, or performed in a certified laboratory or developed in a State under conditions set out in the Coronavirus Aid, Relief, and Economic Security Act
    - Related items and services provided during health care provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of the test
    - Prior authorization is not required for these tests related to a COVID-19 diagnosis
- Medically necessary treatment will be at normal plan benefits subject to deductibles, copays and coinsurance.

Telehealth Visits

The Fund will cover medically necessary telehealth visits both in-network and out-of-network for covered non-COVID-19 conditions (medical and mental health) on a temporary basis subject to the Fund's deductibles, copays and coinsurance. This coverage will be in effect from March 1, 2020 until August 31, 2020.

Schedule of Benefits B

Since the Schedule of Benefits B is a Medicare supplemental benefits package, it covers some expenses not paid in full by Medicare for Medicare eligible retirees. Medicare has made temporary benefit changes in response to the Coronavirus emergency. The Fund will continue pay its portion of the Medicare Approved Amounts in accordance with the Schedule of Benefits B.

Other Changes

As the Fund was receiving federal subsidies for the prescription drug program for Medicare retirees, it had to comply with a special provision in the Affordable Care Act to cover certain expenses effective January 1, 2017 including pregnancy-related expenses for dependent children and services related to sex transformation surgery and gender dysphoria. Since the Fund is no longer receiving those subsidies, the Trustees are making the following changes to the Fund effective July 1, 2020.

Dependent Child Pregnancies

The Fund will no longer cover maternity or other pregnancy-related medical and prescription drug expenses for dependent children such as pre-natal and post-natal care, surgical care and delivery and hospital care effective July 1, 2020. The Fund will still cover treatment for a dependent daughter who received treatment prior to July 1, 2020 for a pregnancy that began before that date and continues after that date. The coverage will continue through the conclusion of the pregnancy and up to eight weeks post-partum for related post-partum care. An updated Summary of Benefits and Coverage is attached.

Transgender Transition Services

The Fund will no longer cover gender transition services such as sex transformation services, dysfunctions or inadequacies and ancillary services related to gender transition or gender dysphoria effective July 1, 2020. This applies to all transgender transition related medical, mental health and prescription drug services.

For questions about benefits and coverage, please call 1-800 822-5899. NEBA will be able to answer your benefit coverage questions. NEBA's member portal is at https://v2.mybenefitplaninfo.com/neba

The Trustees continue to reserve the right to amend, modify, or terminate the Fund and any or all benefits provided thereunder.

NOTICE OF GRANDFATHER HEALTH PLAN STATUS

The Affordable Care Act is the common name for federal health care reform legislation enacted in March of 2010. The Affordable Care Act requires that certain changes be made to health care benefit programs such as the benefit packages offered under the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("Plan"). The Affordable Care Act also provides, however, that plans that existed on March 23, 2010 when the Act became law are considered "grandfathered" and do not have to comply with all of the requirements under the Act.

The Plan's Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act and applicable regulations. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain health care coverage that was already in effect when that law was enacted. Because the Plan is grandfathered the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. Grandfathered health plans must still comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 822-5899.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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Change to Pre-authorization Requirement of Certain Medical Services – February 1, 2020

The Board of Trustees of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (the "Plan" adopted an expansion of Cigna's care management pre-authorization program for Plan A to include certain outpatient services effective September 1, 2019. This notice modifies the pre-authorization program so that pre-authorization is no longer required for high-tech radiology services effective February 1, 2020. Your physician can order services such as MRI, CT scans, PET scans and nuclear authorization without seeking a pre-authorization from eviCore (Cigna's vendor). You will still need pre-authorization for outpatient services such as:

- Injectable drugs such as those for immune therapy, hormone therapy, hemophilia therapy, chemotherapy, and high dollar drugs
- Home infusion therapy (intravenous, enteral, and parenteral therapy)
- Outpatient procedures such as reconstruction, removal of implants, nasal surgery, and vein therapy
- Sleep management such as home sleep test and unattended sleep study

You will also continue to need pre-authorization for all inpatient admissions and for chiropractic visits, physical and occupational therapy visits (after the initial five visits). **YOU WILL RECEIVE A NEW MEDICAL ID CARD** that lets providers know the types of services that should be pre-authorized. You can also call Cigna yourself to ensure the process is started.

How outpatient care pre-authorization works:

- Present the ID Card which lets your physician know that pre-authorization review for certain outpatient services is necessary PRIOR to services being rendered.
- In-Network – The Cigna in-network physician is responsible for requesting a review PRIOR to services being rendered, via phone call to CareAllies.
- Out-of-Network – you should ask your physician to contact Cigna at the number on the back of your ID card to request the review. You can also call to start the process.
- When submitting the request the physician should submit all of the necessary supporting clinical information to ensure timely review. For urgent services, your physician should request an expedited review.
- The expected turnaround time is within ten days for Routine services and less than 72 hours for Urgent services.
- If the review is denied:
    - Both the physician (phone or fax) and the member (mail) will receive the denial rationale, how to appeal the decision, and a number to call with questions.

Who is responsible for getting the pre-authorization?

Your referring physician should request the pre-authorization:

- If your referring physician is in-network, they should handle this for you.

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- If your physician is out-of-network, you must ask them to call Cigna and request the pre-authorization.
- The pre-authorization does not apply to retired participants who are eligible for Medicare.

YOU WILL RECEIVE A NEW MEDICAL INSURANCE CARD IN THE MAIL. Please discard the old card and replace it with this new one. The new ID card contains this reminder to providers to obtain the pre-authorization: "**For Inpatient and Pre-certification of Outpatient Procedures, call: 1.800.768.4695**". **Please present your new card when seeking medical care after February 1, 2020.**

If you have additional questions or concerns regarding the pre-authorization process, please call the number at the back of your ID card or NEBA at 1-800-822-5899.

The attached Summary of Benefits and Coverage reflects the pre-authorization requirements for inpatient admissions, certain outpatient procedures and rehabilitation services through Cigna's CareAllies.

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NONDISCRIMINATION STATEMENT

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Spanish

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French Creole

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ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-561-478-0095 (TTY: 1-800-822-5899).

Vietnamese

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-561-478-0095 (TTY: 1-800-822-5899).

Portuguese

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Chinese

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注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-561-478-0095（TTY：1-800-822-5899）。

French

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Tagalog

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Russian

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Arabic

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German

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Preauthorization of Certain Medical Services – September 1, 2019

The Board of Trustees of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (the "Plan" adopted an expansion of Cigna's voluntary care management pre-authorization program that currently applies to inpatient admissions and certain outpatient therapies to include other outpatient services. The program is designed to help you find out in advance if a service is medically necessary and helps you get the right care in the right setting. It also may save you from costly and unnecessary or potentially experimental and investigational procedures. The changes are effective September 1, 2019. You will receive a new medical ID card that lets providers know that these services should be preauthorized.

What additional services should be preauthorized?

The list below has some examples of services that should be preauthorized. Please note that it is not an all-inclusive list.

- High-tech radiology services such as MRI, CTA scans, PET scans, and nuclear cardiology
- Injectable drugs such as those for immune therapy, hormone therapy, hemophilia therapy, chemotherapy, and high dollar drugs
- Home infusion therapy (intravenous, enteral, and parenteral therapy)
- Outpatient procedures such as reconstruction, removal of implants, nasal surgery, and vein therapy
- Sleep management such as home sleep test and unattended sleep study

Who is responsible for getting the preauthorization?

Your referring physician should request the preauthorization:

- If your referring physician is in-network, they should handle this for you.
- If your physician is out-of-network, you must ask them to call Cigna and request the preauthorization. You can also call Cigna yourself to ensure the process is started.

Does this change apply to me?

The changes apply to Plan A that covers:

- Complete Coverage Bargaining Unit Employees/Journeymen Employees and their Dependents
- Non-Bargaining Unit Employees and their Dependents
- Helper Employees and their Dependents (As determined by the Board of Trustees)
- Retirees under age 65
- Retirees' Dependents under age 65

Things to note:

- Preauthorization that is requested by someone other than the referring physician may be denied due to lack of clinical information.
- It's a good idea to make sure your preauthorization is approved prior to having the service performed.

- Cigna may contact you if your authorized procedure can be performed at a lower cost in-network facility that will save you out of pocket expense.
    - For example: If you are scheduled to have an MRI done at a hospital, Cigna may request that you have the MRI performed at a non-hospital facility to save you money.
- The preauthorization does not apply to retired participants who are eligible for Medicare.
- If your request is denied, your doctor should contact Cigna to determine the reason for denial. They can also request a peer-to-peer review with a Cigna Medical Director. In many cases, the denial can be approved once additional clinical information is provided by your doctor.
- You will receive a new insurance card in the mail. **Please present your new card when seeking medical care after September 1, 2019.**

If you have additional questions or concerns regarding the preauthorization process, please call the number at the back of your ID card or NEBA at 1-800-822-5899.

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Summary of Material Modifications – January 1, 2019

This document is a "Summary of Material Modifications" (SMM) which describes changes to the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (the "Plan"). This SMM 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.

Certain sections of the SPD changed as a result of Prescription Drug Coverage being provided by the **Humana Medicare Employer™ PDP Plan** for Medicare eligible retirees over age 65 and retirees' dependents over age 65 effective January 1, 2019. The claim procedures with respect to loss of time benefits changed to incorporate the requirements of final Department of Labor regulations regarding disability claim procedures effective on April 1, 2018. The changed sections are reproduced below.

PERSONS ELIGIBLE FOR BENEFITS

II. Retirees

The Plan offers retiree coverage to those who qualify. Retirees under age 65 are eligible for benefits under Schedule of Benefits A. Retirees who have reached age 65 are eligible for benefits under Schedule of Benefits B, which is a Medicare Supplement Plan that wraps around Medicare Part A and Part B coverage, and an Employer Group Waiver Program (EGWP) through an authorized insurance company. Retirees' Dependents may also be eligible for coverage, as described further in this SPD, and may also be eligible for benefits under Schedule A or B depending on their age.

The Board of Trustees has full authority and power to adopt a plan of benefits and establish the contribution to be paid for retiree coverage. The Board of Trustees reserves the right to amend, modify or terminate retiree coverage at any time.

The following eligibility rules apply to Covered Employees who have retired from active service and meet requirements for retiree coverage.

Initial Eligibility

You are eligible for coverage as a Retiree if you satisfy all of the following requirements:

(i) you are a retiree under the Pension Plan of the Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund and were a Covered Employee under this Plan immediately prior to retirement;

(ii) you are not eligible for coverage under this Plan as an active employee;

(iii) you have attained age 45 or are qualified for a disability benefit;

(iv) you elect retiree coverage within 12 months of receipt of payment of the first retirement benefit or within 12 months following termination of coverage as an active employee, whichever is later;

(v) if you are age 65 or older, you are enrolled for both Medicare A & B as well as for Medicare Part D through the EGWP; and

(vi) you have a minimum of 2,000 hours of paid contributions into the Welfare Fund during the last five consecutive calendar years prior to retirement. Notwithstanding the above, if you were Totally Disabled during one of the five consecutive calendar years prior to retirement and eligible to self-pay contributions, the hours that were self-paid during that year up to a maximum of six consecutive calendar months shall count towards this hour requirement. This credit will apply only once.

IV. Dependents

Conditions for Dependent Coverage
A Retiree's Dependent spouse age 65 or older must be enrolled for both Medicare Parts A and B as well as for Medicare Part D through the EGWP in order to be eligible for benefits under the Plan.

BENEFITS AVAILABLE UNDER THE PLAN

II. Prescription Drug Benefits

Types of Benefits and Administrators under Schedules A, B and C
The Board of Trustees has selected **CVS/Caremark** to serve as the Pharmacy Benefits Manager (PBM) for the prescription drug benefits under Schedules of Benefits A and an EGWP insurance company Humana to help deliver prescription drug benefits under Schedules of Benefits B. The Board of Trustees has selected **NEBA** to administer prescription drug benefits under Schedule of Benefits C. They also selected Labor First as your advocate to help with any prescription drug coverage issues under Schedule of Benefits B.

FOR BENEFITS UNDER SCHEDULES A AND B: CVS/Caremark serves as the PBM and Claims Administrator for prescription drug benefits under Schedules A. Humana serves as the insurance company to deliver prescription drug benefits under Schedule B. Both **CVS/Caremark and Humana have a broad network of pharmacies and a mail-order program through which you can obtain covered prescription drug benefits.** You can obtain information about CVS/Caremark network pharmacies by visiting the website at https://www.caremark.com/wps/portal/LOCAL_PHARMACY_UNAUTH or calling 1-866-260-4646. You can obtain information about Humana network pharmacies by visiting the website at Humana.com or calling your dedicated Labor First Member Advocate at 1-855-893-0560.

Claims Submission and Payment of Cost Sharing Obligations
You must follow CVS/Caremark rules and procedures for Schedule A and Humana's rules and procedures for Schedule B in order to receive covered prescription drug benefits. Some medications require pre-authorization. You may also be required to meet certain requirements or follow certain protocol, such as when your prescription is subject to clinical management rules.

Pharmacy Network Benefits
FOR BENEFITS UNDER SCHEDULES A AND B: YOUR PRESCRIPTION DRUG BENEFITS ARE PROVIDED EXCLUSIVELY THROUGH CVS/CAREMARK'S AND HUMANA'S NETWORK OF PHARMACISTS depending on whether you are covered by Schedules of Benefits A or B. You should always obtain your prescriptions through a network pharmacist in order to receive your benefits. **Both have a broad network of pharmacies and a mail-order program through which you can obtain covered prescription drug benefits.** You can obtain information about the CVS/Caremark network pharmacies by calling 1-866-260-4646 or visiting the website at https://www.caremark.com/wps/portal/LOCAL_PHARMACY_UNAUTH. You can obtain information about Humana network pharmacies by visiting the website at Humana.com or calling your dedicated Labor First Member Advocate at 1-855-893-0560. **THERE ARE NO OUT OF NETWORK PRESCRIPTION DRUG BENEFITS.**

Covered Prescription Drug Charges

Covered Prescription Drug Charges under all Schedules include only charges for Prescription drugs and medicine obtainable only by a prescription and dispensed by a licensed pharmacist.

FOR BENEFITS UNDER SCHEDULE A: Covered Prescription drugs and medicine must be administered through CVS/Caremark and the CVS/Caremark pharmacy network in order to be covered. Covered drugs include outpatient drugs and medications, insulin, syringes when dispensed for use with insulin, oral contraceptives and diaphragms, diabetic supplies, inhaler spacers and peak flow meters for pediatric asthma and erectile dysfunction drugs. CVS/Caremark maintains a prescription drug formulary and drugs that are not on the formulary are generally not covered by the Plan. To find out if a particular drug is on CVS/Caremark's Formulary List, you can enter the name of the drug on their website or call them at 1-866-260-4646. In limited circumstances, drugs that do not appear on the Formulary List may be covered by the Plan if your Doctor obtains pre-authorization from CVS/Caremark due to medical necessity. **THERE ARE NO OUT-OF-NETWORK BENEFITS.**

FOR BENEFITS UNDER SCHEDULE B: Covered Prescription drugs and medicine must be provided through the Humana Medicare Employer™ PDP Plan. Details of the benefits are stated in their Evidence of Coverage document.

Exclusions and Limitations

Prescription drug benefits are subject to certain exclusions and limitations, as set forth in the Plan Document, Schedules of Benefits, Evidence of Coverage document and SBCs. EACH **SCHEDULE OF BENEFITS A, B AND C HAVE SPECIFIC LIMITATIONS ON BENEFITS THAT MAY NOT CROSS APPLY.**

Please see the section in this SPD titled "Exclusions and Limitations" for a list of exclusions and limitations that apply to all benefits under this Plan. The following exclusions and limitations also apply to prescription drug benefits offered under the Plan's Schedule of Benefits A and C. Details of the exclusions and limitations that apply to Schedule of Benefits B are found in the Humana Medicare Employer™ PDP Plan's Evidence of Coverage document.

II. Submitting Claims

Submitting Prescription Drug Claims

If you receive benefits under Schedules of Benefits A or B, you will typically not have to submit prescription drug claims, as most benefits are determined at the pharmacy when you received your prescription drugs. If you need to submit a prescription drug claim outside of this typical process, it must be submitted to CVS/Caremark, following CVS/Caremark's rules and procedures for Schedule A benefits or to Humana Medicare Employer™ PDP Plan following Humana's rules and procedures for Schedule B benefits. *All claims for benefits must be made within one year of the date the claim was incurred.* CVS/Caremark will serve as the Claims Administrator and will make initial claims determinations for Schedule A benefits. The Claims Determinations, Adverse Benefit Determinations, and Appeals of Adverse Benefit Determinations procedures set out in the SPD apply to CVS/Caremark. Humana will serve as the authorized insurance company and Claim Administrator and will make claim determinations for Schedule B benefits in accordance with the rules set out in their Evidence of Coverage.

c/o National Employee Benefits Administrators, Inc.
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(561) 478-0095 | (800) 822-5899

Claim Procedures

III. Claim Determination Procedures

C. Time Period for Determination of Loss of Time Claims

Upon submission of a claim for Loss of Time benefits, the Claims Administrator will process the claim and notify the Participant of an adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Claims Administrator for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the Participant prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making a determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain 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 those issues, and you shall have at least 45 days within which to provide the specified information.

The Board of Trustees shall ensure that all claims and appeals for Loss of Time benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions. Accordingly, any decisions regarding hiring, compensation, termination, promotion or similar matters with respect to any individual (such as a claim adjudicator or medical or vocation expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

IV. Adverse Benefit Determinations

B. Manner and Content of Notification of Adverse Benefit Determinations

(8) For Loss of Time benefits:
The notification of an adverse benefit determination for Loss of Time benefits shall also set forth:

a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i). The views presented by the Participant to the Plan of health care professionals treating the Participant and vocational professionals who evaluated the Participant;

(ii). The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
(iii). A disability determination regarding the Participant presented by the Participant to the Plan made by the Social Security Administration;

b. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

c. If an internal rule, guideline, protocol, standard or other similar criterion was relied upon in making the adverse determination, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

d. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits, within the meaning of 29 CFR §2560.503-1(m)(8);

e. The notification shall be provided in a culturally and linguistically appropriate manner within the meaning of 29 CFR §2560.503-1(o).

V. Appeals of Adverse Benefit Determinations

C. Additional Time Period and Procedures for Appeals of Claims for Medical, Prescription Drug, Vision and Loss of Time/Disability Benefits
An adverse benefit determination on an appeal of a claim for Loss of Time benefits shall also:

a. provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under this section to give the Participant a reasonable opportunity to respond prior to that date; and
b. if the determination is based on a new or additional rationale, provide the Participant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under this section to give the Participant a reasonable opportunity to respond prior to said date.

C. Manner and Content of Notification of Decision after Appeal
(8) In the case of an adverse benefit determination for disability benefits, the notification shall also set forth the following information

a. Any applicable contractual limitations period that applies to the claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim.

b. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i). The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii). The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii). A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

c. The notification shall be provided in a culturally and linguistically appropriate manner within the meaning of 29 CFR §2560.503-1(o).

PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

NOTICE OF GRANDFATHER HEALTH PLAN STATUS

The Affordable Care Act is the common name for federal health care reform legislation enacted in March of 2010. The Affordable Care Act requires that certain changes be made to health care benefit programs such as the benefit packages offered under the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("Plan"). The Affordable Care Act also provides, however, that plans that existed on March 23, 2010 when the Act became law are considered "grandfathered" and do not have to comply with all of the requirements under the Act.

The Plan's Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act and applicable regulations. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain health care coverage that was already in effect when that law was enacted. Because the Plan is grandfathered the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. Grandfathered health plans must still comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 822-5899.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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NONDISCRIMINATION STATEMENT

Plumbers and Pipefitters Local Union No. 630 Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

Spanish

Plumbers and Pipefitters Local Union No. 630 Welfare Fund cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-561-478-0095 (TTY: 1-800-822-5899).

French Creole

Plumbers and Pipefitters Local Union No. 630 Welfare Fund konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-561-478-0095 (TTY: 1-800-822-5899).

Vietnamese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-561-478-0095 (TTY: 1-800-822-5899).

Portuguese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-561-478-0095 (TTY: 1-800-822-5899).

Chinese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund
遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-561-478-0095（TTY：1-800-822-5899）。

French

Plumbers and Pipefitters Local Union No. 630 Welfare Fund respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-561-478-0095 (ATS : 1-800-822-5899).

Tagalog

Sumusunod ang Plumbers and Pipefitters Local Union No. 630 Welfare Fund sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-561-478-0095 (TTY: 1-800-822-5899).

Russian

Plumbers and Pipefitters Local Union No. 630 Welfare Fund соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-561-478-0095 (телетайп: 1-800-822-5899).

Arabic

يلتزمPlumbers and Pipefitters Local Union No. 630 Welfare Fundبقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-561-478-0095 (رقم هاتف الصم والبكم: 1-800-822-5899).

Italian

Plumbers and Pipefitters Local Union No. 630 Welfare Fund è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-561-478-0095 (TTY: 1-800-822-5899).

German

Plumbers and Pipefitters Local Union No. 630 Welfare Fund erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-561-478-0095 (TTY: 1-800-822-5899).

PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

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Summary of Material Modifications – January 1, 2019

This document is a "Summary of Material Modifications" (SMM) which describes changes to the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (the "Plan"). This SMM 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.

COMPLETE COVERAGE BARGAINING UNIT EMPLOYEES/JOURNEYMEN EMPLOYEES AND THEIR DEPENDENTS
NON-BARGAINING UNIT EMPLOYEES AND THEIR DEPENDENTS
HELPER EMPLOYEES AND THEIR DEPENDENTS (As determined by the Board of Trustees)
RETIREES UNDER AGE 65 AND
RETIREES' DEPENDENTS UNDER AGE 65

Cigna OAP Network

The Board of Trustees is pleased to announce a new PPO medical network to provide greater provider access, offers deeper discounts, additional savings to the Fund and its participants and improved support to both you and your covered dependents. The Fund is transitioning to Cigna's Open Access Plus ("OAP") network effective **January 1, 2019.** Cigna OAP will replace PPOPlus as the Fund's PPO network.

As a reminder, if you use a medical provider in the Fund's PPO network, your out-of-pocket cost will generally be less than if you use a non-PPO provider. Your plan design benefit in terms of deductible, coinsurance and out-of-pocket limits are not changing and will remain the same.

If you use a provider that is not in the Cigna OAP network on or after January 1, 2019, your out-of-pocket costs could be substantially greater than if you use a Cigna OAP network provider. As of that effective date, PPOPlus will no longer serve as the Fund's PPO network. Therefore, you should confirm that your providers are in the Cigna OAP network in order to receive the maximum benefits from the Fund. As a note, most all of the PPOPlus doctors and hospitals participate in the Cigna OAP network so we do not anticipate to see much disruption.

With the move to the Cigna OAP network we encourage each member and dependent to select a Primary Care Provider (PCP) doctor, as your personal doctor. Your PCP can get to know you and your health risks and opportunities, help coordinate care to get you well and act as a personal health advocate. Selecting a PCP is recommended but not required. To select a PCP please log on to mycigna.com, under the FIND PROVIDERS AND COST tab you will select the SELECT OR CHANGE A PCP link. From there you will find easy to follow instructions.

PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630
WELFARE FUND

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Our partnership with Cigna allows us to offer you the following services:

- Over one million in-network health care provider locations, nationwide
- 24-hour health information support by calling the number on the back of your ID card
- Maternity support and prenatal education for mothers-to-be
- Transplant Support and access to Centers of Excellence
- Discounts on products and services not covered by your health plan through Healthy Rewards, call to learn more 1-800-558-9443
- Access to our Cigna Care Designated Providers
- Providers identified for superior performance in quality and cost efficiency

Will I have to switch from my current provider?

With Cigna's strong network of hospitals, primary care physicians and specialists, your current provider may be participating in the Cigna OAP network. But before making an appointment, we encourage you to verify your provider is in the Cigna OAP network by accessing the online provider directory at **www.Cigna.com** and click on FIND PROVIDERS AND COSTS. You may also contact Cigna at 1-800-768-4695 to find out if a specific provider is in the Cigna OAP Network.

Prior Authorization requirement for chiropractic treatment, physical therapy and occupational therapy

A medical necessity review or prior authorization is required after the initial five (5) visits for chiropractic treatment, physical therapy and occupational therapy. In-network providers will call in to obtain the prior authorization on the patient's behalf after the initial 5 visits, if more visits are needed. Out-of-network providers will need to call the number on the ID Card.

New Insurance Card:

You will receive a new insurance card by January 1st, 2019.

Please continue to use your existing card through 12/31/2018. **You must present your new card when seeking medical care effective January 1st, 2019**.

Should you have any questions or concerns regarding this notice, please call NEBA at 1-800- 822-5899.

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

NOTICE OF GRANDFATHER HEALTH PLAN STATUS

The Affordable Care Act is the common name for federal health care reform legislation enacted in March of 2010. The Affordable Care Act requires that certain changes be made to health care benefit programs such as the benefit packages offered under the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("Plan"). The Affordable Care Act also provides, however, that plans that existed on March 23, 2010 when the Act became law are considered "grandfathered" and do not have to comply with all of the requirements under the Act.

The Plan's Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act and applicable regulations. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain health care coverage that was already in effect when that law was enacted. Because the Plan is grandfathered the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. Grandfathered health plans must still comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 822-5899.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NONDISCRIMINATION STATEMENT

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Spanish

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-561-478-0095 (TTY: 1-800-822-5899).

French Creole

Plumbers and Pipefitters Local Union No. 630 Welfare Fund konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-561-478-0095 (TTY: 1-800-822-5899).

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Vietnamese

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-561-478-0095 (TTY: 1-800-822-5899).

Portuguese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-561-478-0095 (TTY: 1-800-822-5899).

Chinese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund
遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-561-478-0095（TTY：1-800-822-5899）。

French

Plumbers and Pipefitters Local Union No. 630 Welfare Fund respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.
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Tagalog

Sumusunod ang Plumbers and Pipefitters Local Union No. 630 Welfare Fund sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-561-478-0095 (TTY: 1-800-822-5899).

Russian

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ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-561-478-0095 (телетайп: 1-800-822-5899).

Arabic

يلتزمPlumbers and Pipefitters Local Union No. 630 Welfare Fundبقوانين الحقوق المدنية الفدرالية
المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-561-478-0095 (رقم هاتف الصم والبكم: 1-800-822-5899).

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

Italian

Plumbers and Pipefitters Local Union No. 630 Welfare Fund è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.
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German

Plumbers and Pipefitters Local Union No. 630 Welfare Fund erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-561-478-0095 (TTY: 1-800-822-5899).

PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

Summary of Material Modifications – January 1, 2019

This document is a "Summary of Material Modifications" (SMM) which describes changes to the Plumbers and Pipefitters Local Union No. 630 Welfare Fund (the "Plan"). This SMM 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.

RETIREES OVER AGE 65 AND RETIREES' DEPENDENTS OVER AGE 65

The Board of Trustees is pleased to announce a change to your Prescription Drug Coverage effective **January 1, 2019**. Your prescription drug benefit will now be provided by **Humana Group Medicare Prescription Drug Plan** effective January 1, 2019. The Plan has retained Labor First, a firm that specializes in the implementation and ongoing member service of retiree health and drug programs, to help you with the transition. Our goal is to maintain and enhance your benefit, improve operational and administrative workflow, and to strengthen the financial position of the Plan. While we understand transitions can be difficult, every attempt has been made to mitigate any plan disruption.

Important things to know:

- Your prescription drug benefit coverage in terms of deductible remain the same and copayments will be similar although medications can change tiers year to year and carrier to carrier.
- You will be able to use most retail pharmacies for 30-day and 90-day supplies, as the Humana Medicare Rx Plan has a pharmacy network that contains over 65,000 in-network pharmacies nationwide.
- You do not need to obtain new prescriptions if you use your local pharmacy and have active refills available. Simply show them your new ID card after January 1, 2019.
- Humana Group Medicare Prescription Drug Plan also offers the Humana Pharmacy Mail Order program.
    - Any current scripts you have with mail order will not be transferring. If you choose to use mail order scripts will need to be sent from your doctor to the new Humana mail order program. You will be receiving more information in December.
- We suggest you fill any open scripts prior to the plan change.
- Some medications may require Prior Authorizations, Step Therapy, or Quantity Limit Restrictions.
    - You will need to resubmit certain prior authorizations with the current plan to the new plan. You will be receiving more information in December.

What mailings to expect in the coming months:

- You will receive a Humana Pre-Kit in late November.
- You will receive your confirmation letter in early December.
- You will receive a Humana ID card in mid/late December.
- You will receive your Humana Welcome Kit by the end of January with your Evidence of Coverage (EOC).

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

Will there be a retiree meeting scheduled?
Labor First will present details of the new plan and answer questions at a retiree meeting on December 10, 2018. Enclosed you will find the meeting flyer and RSVP information.

Labor First is available to provide ongoing support with any questions or problems you may have. Your dedicated Plumbers & Pipefitters Local Union No. 630 Welfare Fund retiree advocates can assist you with drug coverage questions, prior authorizations, tier exceptions, vacation overrides, mail order, ID card replacements, pharmacy/provider outreach, Medicare Social Security support or any other questions or issues with your new Rx plan. Your Plumbers and Pipefitters Local 630 Welfare Fund retiree advocates are also able to assist you in reviewing your current medications on the formulary, including tier designation or if any additional approval is required.

Enclosed is a summary of the new prescription plan. If you have questions about any of this information, please do not hesitate to call Labor First at (561) 264-0690 or Toll Free (855) 893-0560 (TTY 711).

NOTICE OF GRANDFATHER HEALTH PLAN STATUS

The Affordable Care Act is the common name for federal health care reform legislation enacted in March of 2010. The Affordable Care Act requires that certain changes be made to health care benefit programs such as the benefit packages offered under the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("Plan"). The Affordable Care Act also provides, however, that plans that existed on March 23, 2010 when the Act became law are considered "grandfathered" and do not have to comply with all of the requirements under the Act.

The Plan's Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act and applicable regulations. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain health care coverage that was already in effect when that law was enacted. Because the Plan is grandfathered the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. Grandfathered health plans must still comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (800) 822-5899.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

c/o National Employee Benefits Administrators, Inc.
1920 N. Florida Mango Road | West Palm Beach, Florida 33409
(561) 478-0095 | (800) 822-5899

NONDISCRIMINATION STATEMENT

Plumbers and Pipefitters Local Union No. 630 Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

Spanish

Plumbers and Pipefitters Local Union No. 630 Welfare Fund cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-561-478-0095 (TTY: 1-800-822-5899).

French Creole

Plumbers and Pipefitters Local Union No. 630 Welfare Fund konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-561-478-0095 (TTY: 1-800-822-5899).

Vietnamese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-561-478-0095 (TTY: 1-800-822-5899).

Portuguese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-561-478-0095 (TTY: 1-800-822-5899).

Chinese

Plumbers and Pipefitters Local Union No. 630 Welfare Fund
遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-561-478-0095（TTY：1-800-822-5899）。

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Tagalog

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Russian

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Arabic

يلتزمPlumbers and Pipefitters Local Union No. 630 Welfare Fundبقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.
(رقم هاتف الصم 1-561-478-0095ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-822-5899.)والبكم:

Italian

Plumbers and Pipefitters Local Union No. 630 Welfare Fund è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-561-478-0095 (TTY: 1-800-822-5899).

German

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-561-478-0095 (TTY: 1-800-822-5899).

Summary Plan Description

of the

HEALTH AND WELFARE PLAN

provided through the

PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

Effective January 1, 2017

WELFARE PLAN OF THE PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

To All Eligible Participants:

We are pleased to present this Summary Plan Document ("SPD"), which describes the major features of the Welfare Plan ("the Plan") offered through the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("the Fund"). The Plan is managed and operated by the Fund's Board of Trustees and is designed so that you can receive the most comprehensive benefits possible within the resources available to the Fund.

This booklet is an easy-to-read description of the Plan. It describes eligibility rules, benefits, claim procedures and information about the administration of the Plan. The Plan is governed by certain documents, including your Collective Bargaining Agreement or Participation Agreement, the Plan Document, the Trust Agreement, and agreements with insurance companies and other service providers. We have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the governing documents, the governing documents or contract provisions will control. Capitalized terms in this SPD are used in the same manner as they are used in the Plan Document.

Please keep this booklet in a safe place for quick reference. If you have any questions about your eligibility or the benefits to which you are entitled, please contact the Plan's Third Party Administrator, National Employee Benefits Administrators at 1-800-822-5899.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

WELFARE PLAN OF PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 630 WELFARE FUND

A Multiemployer Health and Welfare Benefit Plan

IMPORTANT INFORMATION

The Plan is sponsored and administered under the joint control of labor and management trustees. The Board of Trustees consists of both Union and Employer representatives, selected by Plumbers and Pipefitters Local Union No. 630 ("the Union") and the Employers who have entered into Collective Bargaining Agreements ("CBA") with the Union requiring contributions to the Plan for the benefit of their Employees.

The Plan is sponsored by the:

BOARD OF TRUSTEES

Members, as of January 1, 2017:

Union Trustees

Bill Pickrell
Local Union No. 630
1900 N. Florida Mango Road
West Palm Beach, FL 33409
bpickrell630@bellsouth.net
(561) 689-8400

Mark F. Woodard
Local Union No. 630
1900 N. Florida Mango Road
West Palm Beach, FL 33409
Lu630or1@Uanet.org
(561) 689-8400

George "Steve" Stripling (Effective 3/7/17)
Local Union No. 630
1900 N. Florida Mango Road
West Palm Beach, FL 33409
LU630or@uanet.org
(561) 689-8400

Management Trustees

Susan Stokes
E.C. Stokes Mechanical
2001 7th Avenue North
Lake Worth, FL 33461
Sstokes@Stokes.com
(561) 582-3589

Steve Irwin
Farmer & Irwin Co.
3300 Avenue K
Riviera Beach, FL 33404
Sirwin@Fandicorp.com
(561) 842-5316 Ext. 354

Michael Senecal
Hill York Air Conditioning Services & Energy Solutions
3921 Westgate Avenue
West Palm Beach, FL 33409
Msenecal@Hillyork.com
(561) 689-7355 Ext. 3304

The Plan is administered by the **BOARD OF TRUSTEES** with the assistance of the:

THIRD PARTY ADMINISTRATOR

National Employee Benefits Administrators, Inc. ("NEBA")
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

The Third Party Administrator ("NEBA") handles day to day administration for the Plan. The Board of Trustees is the Plan Administrator. You can call the Third Party Administrator with any questions relating to the Plan.

PLAN IDENTIFICATION INFORMATION

Federal Identification Number: 59-6134296

Plan Number: 501

PLAN YEAR

The Plan Year is based on the calendar year beginning on January 1st each year.

FUND COUNSEL and AGENT FOR LEGAL PROCESS

Howard S. Susskind, Esq.
Sugarman & Susskind, PA
100 Miracle Mile, Suite 300
Coral Gables, Florida 33134

Service of Process may also be made upon a Plan Trustee or upon the Board of Trustees, the Plan Administrator, c/o NEBA.

GENERAL PLAN DESCRIPTION

Health and Welfare Benefit Plan

The Plan is an employee benefit plan that provides medical, prescription drug, dental, vision, loss of time, death, and accidental death or dismemberment benefits to participants as provided under the terms of the Plan and pursuant to applicable Collective Bargaining Agreements or Participation Agreements. The Plan is subject to and must comply with the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

Funding Sources for Benefits

The Plan is primarily funded by Employer contributions made as required under the terms of applicable Collective Bargaining Agreements and Participation Agreements. All contributions are held in a Trust Fund managed by the Board of Trustees as provided in the Trust Agreement. The Trust Fund's assets include all contributions and investment earnings. All benefits and expenses of the Plan, including premiums for any insurance policies obtained by the Board of Trustees as the method of providing benefits, are paid using Trust Fund assets.

Rights and Responsibilities of the Board of Trustees

The Board of Trustees has full and exclusive power and authority, in its sole discretion, to:

- construe and interpret the terms of the Plan,
- determine the status and rights of participants, beneficiaries and other persons,
- determine all questions of coverage and eligibility for benefits,
- make rulings and prescribe procedures,
- gather needed information,
- exercise all of the power and authority contemplated by ERISA with respect to the Plan,
- employ or appoint persons to help or advise in any administrative functions,
- appoint investment managers and trustees, and
- do all other things needed to operate, manage and administer the Plan.

Any decisions of the Board of Trustees shall be final and binding on all parties, including Employees, Dependents, beneficiaries, Employers, Unions, and all other persons involved or affected. In addition to the Board of Trustees the Plan may have other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others.

Plan Amendment and Termination

The Plan may be amended by the Trustees, in their discretion, upon majority vote of the Trustees. All amendments shall be in writing and signed by the Trustees.

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time:

(a) to terminate or amend either the amount or conditions with respect to any benefits even though such termination or amendment affects claims which have already been incurred;
(b) to alter or postpone the method of payment of any benefit; and
(c) to amend or rescind any other provisions of the rules and regulations contained herein.

Circumstances under which the Plan may be terminated include, but are not limited to:

(a) When there are no longer sufficient assets to continue the benefits of the Plan.
(b) When there are no longer any Employers who are required to make contributions under an applicable Collective Bargaining Agreement; or
(c) When the last surviving Covered Person entitled to receive benefits has died.

In the event of termination of the Plan, the Board of Trustees shall, within the limits of the Fund's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining assets of the Fund be used in a manner which best carries out the basic purpose for which the Fund was established.

Right to Examine Relevant Documents

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Collective Bargaining Agreements are contracts between an Employer and a Union that require certain health care benefits for covered Employees. Copies of such agreements may be obtained by participants and beneficiaries by submitting a written request to the Plan Administrator. Copies of the agreements are also available for examination at the office of the Third Party Administrator.

A complete list of the employers and employee organizations sponsoring this Plan may be obtained by participants and beneficiaries by submitting a written request to the Third Party Administrator. The list is also available for examination by participants and beneficiaries at the office of the Third Party

Administrator. Participants and beneficiaries may also receive from the Third Party Administrator, upon written request, information as to whether a particular employer or employee organization participates in the Plan; if the employer or employee organization does participate in the Plan then contact information is also available.

You also have the right to examine documents governing the Plan at the office of the Third Party Administrator, such as insurance contracts, and you have a right to examine the Plan's annual report (Form 5500 Series) that is filed each year.

Grandfathered Plan Status

The Plan Trustees believe that this Plan is a grandfathered plan as defined under the terms of the Affordable Care Act, and are administering this Plan accordingly. A grandfathered plan is a health plan that was in operation at the time the Affordable Care Act was passed. Grandfathered plans are required to maintain or improve benefits as they existed before enactment of the Affordable Care Act in March of 2010. As long as the plan maintains its grandfathered status it is not required to comply with all standards imposed by the Affordable Care Act. Please read the following required information carefully.

> This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-822-5899. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PERSONS ELIGIBLE FOR BENEFITS

I. Bargaining Unit Employees

Employees who are members of bargaining units are eligible for benefits under this Plan if they work for one or more Employers that are required to contribute to the Fund on their behalf under a Collective Bargaining Agreement ("CBA"). Bargaining Unit Employees may be eligible for benefits under Schedule of Benefits A or C, as determined by the Plan's Trustees based on the negotiated contribution rate in the applicable CBA.

In order to maintain eligibility for benefits, Bargaining Unit Employees must either be working for one or more Employers who have entered into a Collective Bargaining Agreement which obligates the Employer to make contributions to this Fund, or be Available for Work with such an Employer, as defined in the Glossary. This condition shall not apply to any Bargaining Unit Employee who cannot work due to illness, disability or retirement. A Bargaining Unit Employee shall be presumed to be unavailable for full-time work with a contributing Employer if such person is employed full-time performing work in the trade for a non-signatory employer.

Any Medicare-eligible Bargaining Unit Employees will not be eligible to participate in this Plan if they enroll in Medicare Part D.

A. Complete Coverage Bargaining Unit Employees/"Journeyman Employees"

The following rules apply to you if you are covered under a CBA between the Union and your Employer, and you are employed in any job classification other than Helper, Pre-Apprentice or Apprentice-Applicant, including as a Journeyman, Foreman, Apprentice, or Diver. The term used in the Plan Document to describe this class of employees is "Complete Coverage Bargaining Unit Employees". In this SPD this class will be described as "Journeyman Employees". Journeyman Employees and their Dependents are eligible for benefits under Schedule of Benefits A.

As a Journeyman Employee you may be eligible for Plan benefits during a "Coverage Period" of about 3 months based on contributions made to the Fund for your work during a "Work Period", also of about 3 months. How the Work Periods and Coverage Periods are defined and used is described in detail below.

Initial Eligibility

Your Employer will start to make contributions to the Fund on your behalf once you start working in a job classification under the CBA that requires contributions. NEBA, the Plan's Third Party Administrator, will review the hours for which contributions have been paid for each newly hired Bargaining Unit Employee each quarter, around January 1, April 1, July 1 and October 1, of each year, to determine if you are eligible for coverage during the associated Initial Coverage Period. Once you satisfy the minimum hour requirement for the first time you will be eligible for benefits during the Initial Coverage Period that corresponds to the Work Period during which the hour requirement was satisfied. The Fund must have received contributions for at least 455 work hours in order for you to be eligible for coverage during the corresponding Initial Coverage Period. The Work and Initial Coverage Periods are as follows:

Work Period	Initial Coverage Period
January 1 through March 31	June 30 through September 30
April 1 through June 30	September 29 through December 31
July 1 through September 30	December 30 through March 31
October 1 through December 31	April 1 through June 30 in a non-leap year March 31 through June 30 in a leap year

If contributions are made on your behalf for at least 100 work hours in a Work Period but less than the required 455, you may be eligible to make a self-contribution in order to obtain initial coverage during the corresponding Initial Coverage Period, under the same standards described below under the heading "Contributions for Continued Eligibility".

Continued Eligibility

Once you earn initial eligibility you will remain eligible for coverage for each subsequent Coverage Period as long as contributions are made to the Fund on your behalf for at least 455 work hours during the corresponding Work Period, or otherwise credited as discussed below. NEBA will review the hours for which contributions have been paid each quarter, around January 1, April 1, July 1 and October 1, each year, to determine if you are eligible for coverage during the associated Continued Coverage Period. The Work and Continued Coverage Periods are as follows:

Work Period	Continued Coverage Period
January 1 through March 31	July 1 through September 30
April 1 through June 30	October 1 through December 31
July 1 through September 30	January 1 through March 31
October 1 through December 31	April 1 through June 30

Contributions for Continued Eligibility

You can accumulate contribution hours in order to maintain your eligibility for coverage if contributions are made or credited to the Fund on your behalf for any of these reasons:

1. Work Hours – Hours you've worked for which your Employer makes contributions to the Fund under a CBA are used to determine your continued eligibility.

2. Reciprocal Hours – Hours you've worked for an employer who makes contributions pursuant to a Reciprocal Agreement approved by the Board of Trustees are used to determine your continued eligibility, after the contributions are received. Often this employment is outside of the Union's jurisdiction and contributions are transferred to the Fund on your behalf.

3. Hour Bank Hours – Hours in your Hour Bank can be credited towards the required number of hours needed to maintain eligibility for benefits. You must use hours in your hour bank before being eligible to make self-contributions, unless you are disabled.

4. Self-contributions – if you are Available for Work and contributions were made on your behalf for at least 100 work hours during a Work Period, you can make a self-contribution in order to maintain coverage during the corresponding Coverage Period. You first have to use any hours in your Hour Bank towards the number needed to maintain coverage. If you are still short then you can self-pay for the remaining needed contributions. The self-contribution amount is based on the difference between the number of hours contributed to the Fund on your behalf (and hour bank hours if applicable) and the minimum number of hours required to be paid during any Work Period, multiplied by a contribution rate to be determined by the Board of Trustees. You can make self-contributions as described here for both initial and continued eligibility.

5. Self-contributions for periods of disability – You can make contributions to the Fund to maintain your coverage during periods of disability if you meet the conditions listed below. If you satisfy these conditions you are eligible to self-pay contributions to satisfy the minimum hour requirement for coverage for each calendar month of proven disability, up to a maximum of six consecutive calendar months for any one disability. The self-pay contribution shall be determined by multiplying the minimum number of hours required for coverage each month by a contribution rate determined by the Board of Trustees.

Disability Status

In order to make disability self-payments you must be able to medically substantiate to the satisfaction of the Board of Trustees, in its sole discretion, that 1) you are or were Totally Disabled and unable to work in the trade, as defined in the Glossary; 2) your disability prevented you from working for a contributing Employer for a minimum of twenty consecutive days in a calendar month; and 3) you were working for a signatory Employer as of the day the accidental Injury occurred or the Illness commenced that resulted in your disability.

Hour Bank

Occasionally your Employer(s) may make contributions to the Fund on your behalf for more than 455 hours worked in a Work Period. Any contribution hours paid to the Fund in excess of 455 hours in a Work Period will be credited to your hour bank, up to a maximum of 200 banked hours at any time. You can then use hours credited to your hour bank as needed to maintain eligibility for benefits, as discussed above.

Termination of Eligibility

Your eligibility for benefits will terminate on the earliest of: (i) the last day of the Coverage Period that corresponds to the last Work Period for which contributions for the required number of work hours were paid to the Fund on your behalf; (ii) the date that the Plan terminates, or (iii) the date you are no longer Available for Work, as defined in the Glossary.

Reinstatement of Eligibility

If your eligibility for benefits has terminated, and you subsequently meet eligibility requirements in a Work Period, your eligibility will be reinstated on the first day of the Initial Coverage Period that corresponds to the Work Period for which contributions are made on your behalf for a minimum of 455 work hours.

B. Helper and Pre-Apprentice Bargaining Unit Employees

The following rules apply if you are a Bargaining Unit Employee covered under a CBA between the Union and your Employer, and you are employed in the job classifications of Helper or Pre-Apprentice. In this SPD this class will be described as "Helper Employees". Helper Employees who meet the following eligibility requirements will be eligible for benefits under either Schedule of Benefits A or C as determined by the Plan's Trustees based on the negotiated contribution rate in the applicable Collective Bargaining Agreement.

Effective July 1, 2016 the Board of Trustees determined that eligible Helper Employees will receive benefits under Schedule of Benefits A based on negotiated contribution rates in the Collective Bargaining Agreement in effect from July 1, 2016 through June 30, 2019.

As a Helper Employee you may be eligible for Plan benefits during a "Coverage Period" of about 3 months based on contributions made to the Fund for your work during a "Work Period", also of about 3 months. How the Work Periods and Coverage Periods are defined and used is described in detail below.

Initial Eligibility

Your Employer will start to make contributions to the Fund on your behalf once you start working in a job classification under the CBA that requires contributions. NEBA, the Third Party Administrator, will review the hours for which contributions have been paid for each newly hired Bargaining Unit Employee each quarter, around January 1, April 1, July 1 and October 1, of each year, to determine if you are eligible for coverage during the associated Initial Coverage Period. Once you satisfy the minimum hour requirement for the first time you will be eligible for benefits during the Initial Coverage Period that corresponds to the Work Period during which the hour requirement was satisfied. The Fund must have received contributions for at least 455 hours in order for you to be eligible for coverage during the corresponding Initial Coverage Period. The Work and Initial Coverage Periods are as follows:

Work Period	Initial Coverage Period
January 1 through March 31	June 30 through September 30
April 1 through June 30	September 29 through December 31
July 1 through September 30	December 30 through March 31
October 1 through December 31	April 1 through June 30 in a non-leap year March 31 through June 30 in a leap year

Continued Eligibility

Once you earn initial eligibility you will remain eligible for coverage for each subsequent Coverage Period as long as contributions are made to the Fund on your behalf for at least 455 work hours during the corresponding Work Period. NEBA will review the hours for which contributions have been paid each quarter, around January 1, April 1, July 1 and October 1, each year, to determine if you are eligible for coverage during the associated Continued Coverage Period. The Work and Continued Coverage Periods are as follows:

Work Period	Continued Coverage Period
January 1 through March 31	July 1 through September 30
April 1 through June 30	October 1 through December 31
July 1 through September 30	January 1 through March 31
October 1 through December 31	April 1 through June 30

Contributions for Continued Eligibility

You can accumulate contribution hours in order to maintain your eligibility for coverage if contributions are made to the Fund on your behalf for any of these reasons:

1. Work Hours – Hours you've worked for which your Employer makes contributions to the Fund under a CBA are used to determine your continued eligibility.

2. Reciprocal Hours – Hours you've worked for an employer who makes contributions pursuant to a Reciprocal Agreement approved by the Board of Trustees are used to determine your continued eligibility, after the contributions are received. Often this employment is outside of the Union's jurisdiction and contributions are transferred to the Fund on your behalf.

3. Hour Bank Hours – Hours in your Hour Bank can be credited towards the required number of hours needed to maintain eligibility for benefits. You must use hours in your hour bank before being eligible to make self-contributions, unless you are disabled.

4. Self-contributions – if you are Available for Work and contributions were made on your behalf for at least 100 work hours during a Work Period, you can make a self-contribution in order to maintain coverage during the corresponding Coverage Period. You first have to use any hours in your Hour Bank towards the number needed to maintain coverage. If you are still short then you can self-pay for the remaining needed contributions. The self-contribution amount is based on the difference between the number of hours contributed to the Fund on your behalf (and hour bank hours if applicable) and the minimum number of hours required to be paid during any Work Period, multiplied by a contribution rate to be determined by the Board of Trustees. You can make self-contributions as described here for both initial and continued eligibility.

5. Self-contributions for periods of disability – You can make contributions to the Fund to maintain your coverage during periods of disability if you meet the conditions listed below. If you satisfy these conditions you are eligible to self-pay contributions to satisfy the minimum hour requirement for coverage for each calendar month of proven disability, up to a maximum of six consecutive calendar months for any one disability. The self-pay contribution shall be determined by multiplying the minimum number of hours required for coverage each month by a contribution rate determined by the Board of Trustees.

Disability Status

In order to make disability self-payments you must be able to medically substantiate to the satisfaction of the Board of Trustees, in its sole discretion, that 1) you are or were Totally Disabled and unable to work in the trade, as defined in the Glossary; 2) your disability prevented you from working for a contributing Employer for a minimum of twenty consecutive days in a calendar month; and 3) you were working for a signatory Employer as of the day the accidental Injury occurred or the Illness commenced that resulted in your disability.

Hour Bank

Occasionally your Employer(s) may make contributions to the Fund on your behalf for more than 455 hours worked in a Work Period. Any contribution hours paid to the Fund in excess of 455 hours in a Work Period will be credited to your hour bank, up to a maximum of 200 banked hours at any time. You can then use hours credited to your hour bank as needed to maintain eligibility for benefits, as discussed above.

Termination of Eligibility

Your eligibility for benefits will terminate on the earliest of: (i) the last day of the Coverage Period that corresponds to the last Work Period during which contributions for the required number of minimum hours were paid to the Fund on your behalf; (ii) the date that the Plan terminates or (iii) the date you are no longer Available for Work, as defined in the Glossary.

Reinstatement of Eligibility

If your eligibility for benefits has terminated, and you subsequently meet eligibility requirements for a Work Period, your eligibility will be reinstated on the first day of the Initial Coverage Period that corresponds to the Work Period for which contributions are made on your behalf for a minimum of 455 work hours.

II. Retirees

The Plan offers retiree coverage to those who qualify. Retirees under age 65 are eligible for benefits under Schedule of Benefits A. Retirees who have reached age 65 are eligible for benefits under Schedule of Benefits B, which is a Medicare supplemental benefit package. Retirees' Dependents may also be eligible for coverage, as described further in this SPD, and may also be eligible for benefits under Schedule A or B depending on their age.

The Board of Trustees has full authority and power to adopt a plan of benefits and establish the contribution to be paid for retiree coverage. The Board of Trustees reserves the right to amend, modify or terminate retiree coverage at any time.

The following eligibility rules apply to Covered Employees who have retired from active service and meet requirements for retiree coverage.

Initial Eligibility

You are eligible for coverage as a Retiree if you satisfy all of the following requirements:

(i) you are a retiree under the Pension Plan of the Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund and were a Covered Employee under this Plan immediately prior to retirement;

(ii) you are not eligible for coverage under this Plan as an active employee;

(iii) you have attained age 45 or are qualified for a disability benefit;

(iv) you elect retiree coverage within 12 months of receipt of payment of the first retirement benefit or within 12 months following termination of coverage as an active employee, whichever is later;

(v) if you are age 65 or older, you are enrolled for both Medicare A & B and not enrolled for Medicare Part D; and

(vi) you have a minimum of 2,000 hours of paid contributions into the Welfare Fund during the last five consecutive calendar years prior to retirement. Notwithstanding the above, if you were Totally Disabled during one of the five consecutive calendar years prior to retirement and eligible to self-pay contributions, the hours that were self-paid during that year up to a maximum of six consecutive calendar months shall count towards this hour requirement. This credit will apply only once.

If you retired on or before April 1, 2007, you are eligible for coverage as a Retiree if you satisfy all of the following conditions:

(i) you were a Non-Bargaining Unit Employee who had been a Covered Employee under the Welfare Plan for at least fifteen (15) years immediately prior to retirement;

(ii) you are entitled to Medicare benefits; and

(iii) you met the requirements listed in paragraph (a) above (other than being a retiree under the Pension Plan of the Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust fund).

Continued Eligibility

You will remain eligible for benefits if (i) you pay your required contributions on time; (ii) you enroll for Medicare coverage as of the earliest date that you are eligible to receive benefits under Medicare (typically your 65th birthday); and (iii) you do not return to work in the plumbing and pipefitting industry for a non-signatory employer.

You have the option to drop retiree coverage under this Plan one time to try other insurance (other than active coverage under this Plan) for up to one year and still be able to return to coverage under this Plan.

Required Contributions

Retirees must self-pay quarterly contributions to the Fund in order to maintain eligibility for coverage. As a Retiree you must make required payments for you and your dependents within 15 days of the beginning of each Coverage Period. Coverage Periods for Retiree coverage are the same as those for Bargaining Unit Employees, as explained in this SPD.

A Retiree's coverage shall automatically terminate without notice if payment is not received within the 15-day grace period. There is no right of reinstatement if eligibility is terminated for non-payment of premium. Retirees may pre-pay premiums up to a maximum of six months in advance or as otherwise provided by the Trustees from time to time.

Return to Work

If you return to covered employment and qualify for coverage as an active employee, you can elect whether to be covered as an active employee or as a retiree. If you elect active employee coverage and you retire again later you will have to meet all of the eligibility rules above for Initial Eligibility for Retirees to be eligible for coverage as a Retiree. If you return to covered employment but do not elect coverage as an active employee you can continue to be covered as a Retiree during the period of covered employment as long as you continue to satisfy eligibility conditions for Retiree coverage.

If you are eligible for Retiree coverage and return to work in the plumbing and pipefitting industry for a non-signatory employer, your eligibility for Retiree coverage (and the eligibility of your Dependents) will be suspended while you work for a non-signatory employer, for up to one year. If you continue to work in the plumbing and pipefitting industry for a non-signatory employer for more than one year, your eligibility and your Dependents' eligibility will be terminated.

If your eligibility and your Dependents' eligibility for benefits were suspended while you worked in the plumbing and pipefitting industry for a non-signatory employer, and you stop working for such an employer within one year, then you and your Dependents will be able to return to coverage under the Plan if you request re-instatement within 30 days following termination of work in the plumbing and pipefitting industry for a non-signatory employer. You may only have your eligibility and your Dependents' eligibility for benefits suspended once under this provision. If you are reinstated and again return to work in the plumbing and pipefitting industry for a non-signatory employer, your eligibility and your Dependents' eligibility for benefits will be terminated.

Termination of Eligibility

Your eligibility for benefits will terminate on the earliest of: (i) the last day of the Coverage Period for which you've made timely payment; (ii) the date you no longer meet eligibility requirements for retiree coverage; (iii) the date upon which you violate any rule of eligibility; or (iv) the date that the Plan terminates.

III. Non-Bargaining Unit Employees

The following rules apply if you are not covered by a Collective Bargaining Agreement but are instead covered under a Participation Agreement with the Board of Trustees. A Participation Agreement is an agreement between an Employer and the Board of Trustees in which an Employer agrees to make monthly contributions to the Plan for coverage for its employees who do not belong to covered bargaining units. Such employees are referred to as Non-Bargaining Unit Employees. Non-Bargaining Unit Employees and their Dependents are eligible for benefits under the Schedule of Benefits A.

Initial and Continued Eligibility

You will be eligible for benefits as a Non-Bargaining Unit Employee on the first day of the month for which contributions have been paid on your behalf for the entire month pursuant to the terms of a Participation Agreement. Coverage shall continue thereafter on a monthly basis for each month for which required contributions are timely paid.

Contribution Schedule

Your employer must make contributions on your behalf at the rate determined by the Board of Trustees and following administrative rules and procedures as determined by the Board of Trustees and administered by the Third Party Administrator.

Hour Bank: Use of Earned Hours

Non-Bargaining Unit Employees cannot accrue hours in an hour bank. However, if a person earned hour bank hours as a Bargaining Unit Employee, and then becomes covered as a Non-Bargaining Unit Employee with a signatory Employer within thirty (30) days following employment as a Bargaining Unit Employee, then such Employee's earned hour bank hours can be used for continued coverage as agreed to between such Employee and Employer.

Termination of Eligibility

Your eligibility for benefits shall terminate immediately and without notice on the earlier of: (i) the first day of the month for which contributions have not been timely paid; (ii) the date upon which you violate any rule of eligibility; (iii) the date on which your employer is no longer signatory to a collective bargaining agreement requiring contributions to the Fund on behalf of its bargaining unit employees; or (iv) the date of termination of the Plan.

Reinstatement of Eligibility

Your eligibility may be reinstated only upon payment of required contributions, your employer's signing of a new Participation Agreement if necessary, and upon approval of the Board of Trustees.

IV. Dependents

The following rules apply to coverage for Dependents.

Definition of Dependent

The term "Dependent" is defined in the Plan Document as:

1. A Covered Employee's spouse or a Retiree's spouse, not legally separated from the Covered Employee or Retiree, and
2. A Covered Employee's child(ren), or a Retiree's child(ren), from birth until the end of the month in which such child turns twenty six (26) years old. The term "child" or "children" means a Covered Employee's natural child, adopted child, stepchild and/or foster child, as described in Section 152(f)(1) of the Internal Revenue Code. In addition, "child" also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by a Covered Employee or Retiree.

Dependent Coverage Generally

Your coverage under the Plan includes coverage for your Dependents. Generally, your Dependents are eligible for benefits as of the first day that you are eligible for benefits, or the first day that a person becomes your Dependent, such as when you get married or have a baby.

You must submit an application to the Third Party Administrator in order for your Dependents to be covered under the Plan. Please contact the Third Party Administrator for application forms. You may also be required to provide certain information regarding your Dependent from time to time in order for your Dependents to maintain eligibility for coverage, as required by the Third Party Administrator under its procedures.

An Employee's Dependents are covered under the same Schedule of Benefits as the Employee. A Retiree's Dependent spouse under age 65 will be eligible for benefits under Schedule of Benefits A and a Retiree's Dependent spouse over age 65 will be eligible for benefits under Schedule of Benefits B, as long as applicable conditions for Retiree Dependent coverage are met.

Conditions for Dependent Coverage

Medicare eligible Dependent spouses are not eligible for coverage under this Plan if they enroll in Medicare Part D. A Retiree's Dependent spouse age 65 or older must be enrolled for both Medicare Parts A and B and not enrolled for Medicare Part D in order to be eligible for benefits under the Plan.

Dependent Coverage Termination

Your Dependents' eligibility ends on (i) the date on which you are no longer eligible for benefits, (ii) the date on which your Dependent no longer meets the Plan's definition of Dependent, (iii) the date your Dependent no longer satisfies applicable conditions for Dependent coverage, or (iv) the date the Plan terminates.

Dependent Continuation Coverage after Employee/Retiree Death

Coverage for your Dependents will continue upon your death to the end of the last month that you would have remained covered, taking into account all hours due to be reported, any available hour bank hours, and any self-contribution payments creditable to you as of the date of death. If you were eligible to make a self-contribution to continue coverage at the time of your death then your Dependents may make a self-contribution to continue coverage for the corresponding Coverage Period.

If you were eligible for Retiree benefits at the time of your death, your surviving Dependent spouse may make self-contributions to continue coverage for himself/herself and for any other Dependents who were eligible for coverage as of the date of your death. The self-contribution will be permitted until your surviving spouse becomes eligible for another group health plan or Medicare.

If you were eligible for Retiree benefits at the time of your death and your surviving Dependent spouse was eligible under both Medicare and the Plan, your surviving spouse may make self-contributions for himself/herself for up to 90 days of continued coverage after the end of the last month that you would have remained covered.

BENEFITS AVAILABLE UNDER THE PLAN

I. Medical Benefits

You are eligible for medical benefits under either Schedule A, B or C. EACH SCHEDULE HAS DIFFERENT BENEFITS, LIMITATIONS AND EXCLUSIONS. Along with this SPD you have been given the Schedule of Benefits that lists your medical benefits and you cost sharing obligations, along with a Summary of Benefits and Coverage ("SBC"). Please look at these documents for the description of your covered benefits. Your Schedule of Benefits and your SBC are attached to and incorporated into this Summary Plan Description.

Journeyman Employees and their Dependents; Non-Bargaining Unit Employees and their Dependents; Retirees under age 65; and Retirees' Dependents under age 65 are eligible for the benefits described in Schedule of Benefits A.

Retirees over age 65 and Retirees' Dependents over age 65 are eligible for a Medicare Supplement Plan that wraps around Medicare Part A and Part B coverage, as described in Schedule of Benefits B.

Effective July 1, 2016 Helper Employees and their Dependents are eligible for the benefits described in Schedule of Benefits A.

Types of Benefits and Administrators under Schedules A, B, and C

The Board of Trustees has selected **Cigna** to help deliver medical benefits under Schedule of Benefits A, and the Plan's Third Party Administrator, **NEBA**, to administer the claims. The Board has also selected **NEBA** to administer medical benefits under Schedules of Benefits B and C.

FOR BENEFITS UNDER SCHEDULE A: Cigna and NEBA work together to process claims for medical benefits under an arrangement called "shared administration". **Cigna provides access to its preferred provider network and discount pricing, and NEBA serves as the Claims Administrator for claims for medical benefits.** Cigna has a broad network of doctors and hospitals that offer covered medical services. You can obtain information about your Cigna preferred provider network by calling **1-800-768-4695** or by selecting information about Cigna medical shared administration services for Taft-Hartley Plan members at www.CignaSharedAdministration.com. You can also verify a contracted Preferred Provider by accessing the CIGNA website at www.cigna.com/SA-PPO2.

FOR BENEFITS UNDER SCHEDULE B: NEBA administers medical claims under Schedule B and serves as the Claims Administrator. This benefit schedule is a Medicare supplemental benefits package, which covers some expenses not paid in full by Medicare for Medicare eligible retirees.

FOR BENEFITS UNDER SCHEDULE C: NEBA administers medical benefits under Schedule C and serves as the Claims Administrator. **Schedule C medical benefits do not have a preferred provider network.** Benefits under Schedule C are often provided as reimbursement for covered expenses.

Your Cost Sharing Obligations

Your Schedule of Benefits and your SBC list what you have to pay for covered services. Some services require a copayment amount, and some services are subject to your deductible and coinsurance. Your Schedule of Benefits and SBC explain in detail how much you will have to pay for different types of services.

Your Deductible

This Plan has a deductible requirement, which is the amount you must pay toward covered services before the Plan pays benefits. The Deductible is applied once each calendar year for each Covered Person's medical benefits incurred during that year. There is a per person deductible and a family deductible. If you have Dependents, you must pay the deductible for each of them until you reach the family limit. The applicable Schedule of Benefits lists your deductible and describes which amounts paid for Covered Medical Charges are attributable to a Covered Person's deductible. Copayments are not applied towards a Covered Person's deductible. There are also some benefits that are not subject to the deductible.

Your Copayments

Copayments are the amounts you must pay for certain services such as in-hospital days, emergency room, or physician office visits. The amount you pay is subtracted from the covered costs. Your Schedule of Benefits and your SBC list your copayment requirements for different services.

Your Coinsurance

Coinsurance is the percentage of covered costs that you must pay after you have met the deductible. Your Schedule of Benefits and your SBC list your coinsurance requirements for different services.

Your Out of Pocket Maximum

Your Schedule of Benefits and your SBC also list your Out of Pocket Maximum. This is the most you will be required to pay for in-network covered costs each year. The Plan will pay 100% of in-network covered costs after the amounts you paid as your cost sharing obligations for in-network covered services reach the applicable maximum. Not all expenses apply towards your Out of Pocket Maximum. Please note that Schedule of Benefits C has an Out of Pocket Maximum that is not limited by network benefits.

Claims Submission and Payment of Cost Sharing Obligations

Claims for benefits must be submitted within one year of the date a service was provided or the date of an event that forms the basis for a claim. Claims can be submitted by your provider if your provider is able and willing to file on your behalf. If your provider does not submit your claim then you will need to submit your claim using the procedures listed later in this SPD under the heading "Claims Procedures".

If you are covered under Schedule A **and you obtain health care from the doctors, hospitals, and other providers in the Plan's preferred provider network,** the providers will usually submit claims to Cigna. You may be required to pay your required share of the cost at the time that you receive services.

If you are covered under Schedule A **and you obtain health care from a doctor, hospital, or other provider that is NOT in the Plan's preferred provider network,** your provider might submit your claim to Cigna on your behalf, and you may be required to pay your required share of the cost at the time that you receive services. If your provider does not submit your claim then you may have to pay for services in full and submit a claim for reimbursement to Cigna afterwards.

If you are covered under Schedule B your provider will likely submit claims to Medicare and may submit claims to NEBA on your behalf. You may be required to pay your required share of the cost at the time that you receive services. If your provider does not submit your claim to NEBA on your behalf then you may have to pay the covered amount and submit a claim for reimbursement to NEBA along with the Medicare explanation of benefits afterwards.

If you are covered under Schedule C your provider might submit claims to NEBA on your behalf. You may be required to pay your required share of the cost at the time that you receive services. If your provider does not submit your claim then you may have to pay for services in full and submit a claim for reimbursement to NEBA afterwards.

Preferred Provider Organization (PPO) Network Benefits

IF YOU ARE COVERED UNDER SCHEDULE A YOUR BENEFITS ARE PROVIDED THROUGH CIGNA'S PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK. You should always try to obtain services from in-network providers. The Plan pays a higher benefit if you use in-network providers, and your costs will be lower, as described in your Schedule of Benefits and your SBC. In-network providers have agreed to provide services at discounted fees, so the Plan's costs will also generally be lower. Cigna has a broad network of doctors and hospitals that offer covered medical services. You can obtain information about your Cigna preferred provider network by calling **1-800-768-4695** or by selecting information about Cigna medical shared administration services for Taft-Hartley Plan members at www.CignaSharedAdministration.com. You can also verify a contracted Preferred Provider by accessing the CIGNA website at www.cigna.com/SA-PPO2.

Out of Network Benefits

IF YOU ARE COVERED UNDER SCHEDULE A YOU ALSO HAVE OUT OF NETWORK BENEFITS. If you choose to obtain services from a provider that is not in the PPO network your cost sharing will be higher, as

described in your Schedule of Benefits and SBC. Your benefits will be lower and will be paid under different rules. Out of network benefits are paid using a Fee Schedule established by the Trustees and rules described in the Schedule of Benefits. In other words, the Plan decides how much it will pay for out of network services based on its own rules, not the amount charged by an out of network provider. The Fee Schedule used for out-of-network charges is the 25th percentile of the ADP Context fee schedule. Certain out-of-network exceptions as identified in the Schedule of Benefits are at the 85th percentile of the ADP Context fee schedule.

Out of network preventive care benefits are not covered. If you choose to use an out of network provider for your wellness care your costs will not be covered under this Plan.

Your Schedule of Benefits also describes special Fee Schedules that apply if you receive emergency services or if you receive services at an in-network hospital or in-network outpatient facility from an out of network provider and a network provider is not available. Your out of network benefits will be higher under these circumstances, as described in your Schedule of Benefits.

Schedule C Fee Schedule

IF YOU ARE COVERED UNDER SCHEDULE C YOUR BENEFITS ARE PAID USING A FEE SCHEDULE ESTABLISHED BY THE TRUSTEES AND RULES DESCRIBED IN THE SCHEDULE OF BENEFITS. In other words, the Plan decides how much it will pay for services based on its own rules, not the amount charged by a provider. You should refer to the Schedule of Benefits to review what types of services are covered and what Your Coinsurance may be for each service.

ID Cards

Please present your ID card when you obtain health care services. Your ID card lists your member information and phone numbers that you can use to contact Cigna or NEBA. If you need a replacement card please contact NEBA to order it.

Date of Charges Incurred

Covered Medical Charges are considered to be incurred on the date a Covered Person receives the services or supplies for which the charge is made.

Benefits Payable

Benefits are payable under the conditions listed in your applicable Schedule of Benefits and SBC, including your cost sharing obligations and applicable limitations and exclusions. The total amount payable will not exceed any applicable Maximum Benefit set forth in the Schedules of Benefits.

Schedule B has limitations and exclusions that are not applicable to Schedule A. In particular Schedule B does not provide coverage for skilled nursing facilities or wellness benefits as they are covered by Medicare.

Schedule C has limitations and exclusions that are not applicable to Schedules A and B. In particular Schedule C does not provide coverage for mental health conditions or wellness benefits, and there are maximum benefit amounts for certain benefits, as described in Schedule of Benefits C.

You may be required to satisfy other conditions as well, such as pre-certification requirements.

If you are covered under Schedule A, before you are admitted to a hospital, the hospital will need to contact Cigna to pre-certify your inpatient stay prior to the hospital stay. Hospitals that are in the Cigna preferred provider network are usually responsible for making the call to Cigna. The phone number is included on your ID card.

Case Management and other Cigna Services

If you are covered under Schedule A, Cigna provides services that may be helpful to you in connection with managing your medical needs.

If either you or your covered Dependent needs extensive and costly long-term medical treatment, you may benefit from Cigna's case management program. Under this program, medical professionals work with you and your physician to provide assistance and coordinate care for serious illnesses such as cancer, or chronic illnesses such as diabetes or heart disease. Participation is voluntary.

Cigna offers other benefits such as a nurse-line for telephone access to medical care professionals to answer commonly asked questions about healthcare. There is also a maternity management program that works with you to achieve a healthy outcome for both the mother and the baby. You have access to an electronic health library for information on disease states and questions to ask your doctor, discounts on certain programs, a health risk assessment to help you determine your risk of medical conditions and what to do to reduce the chances of getting these conditions.

Cigna also offers an organ transplant program that provides access to Centers of Excellence for certain transplants along with case management to help navigate the process.

Covered Medical Charges

Covered Medical Charges include only charges and fees for covered medical benefits that: (a) are not excluded by other provisions of this Plan; (b) are Medically Necessary for the care and treatment of a Covered Person; (c) are recommended by an attending Physician; and (d) are subject to the provisions and limits described in the Plan Document and applicable Schedule of Benefits.

(A) 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. Miscellaneous charges include operating room, medicine, drugs, un-replaced blood and blood plasma, anesthetic, x-ray and other imaging examinations, radiation treatment, physiotherapy, laboratory tests, surgical dressings, medical supplies and hospital ambulance service.

(B) Physician Care- Treatment by a Physician, whether in or out of a hospital, for an Injury or Illness, including diagnosis, imaging and laboratory services, in-hospital visits or Physician's office visits.

(C) Surgical Care- Surgical Care by a Physician (regardless of whether performed in a hospital), for any operation resulting from a non-occupational Injury or Illness.

(D) Ambulance Charges- Ambulance Charges for Emergency Injury or Illness, including local transportation and Medically Necessary air transportation to a hospital. Ambulance Charges for Medically Necessary local or air transportation among health care facilities.

(E) Nursing Services- Private Duty nursing services of a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.).

(F) Anesthesia Charges- for anesthesia and the administration thereof (other than local infiltration or digital block anesthesia), when not included in Hospital Charges.

(G) Therapy- When ordered by a Physician, the treatment for physical, speech or occupational therapy as provided by a licensed therapist for rehabilitation of an Injury or Illness and subject to ongoing referrals by attending Physician(s).

(H) Treatment by a Physician, Dentist or dental surgeon for fractured jaw or injury to sound natural teeth, including the repair or replacement thereof, within six months after the date of an Injury.

(I) X-Ray, radium, radioactive isotope, chemotherapy or similar therapy.

(J) Diagnostic imaging services such as X-Rays and laboratory services, excluding dental X-rays unless rendered for treatment of a fractured jaw or of injury to sound natural teeth within six months after the date of an Injury.

(K) Medical Supplies and Durable Medical Equipment- blood and blood plasma, artificial limbs and eyes, surgical dressings, medically necessary dressings and supplies, casts; splints, trusses, braces, crutches, rental of wheel chairs, hospital bed, iron lung or other durable therapeutic devices including oxygen and the rental of equipment for its administration, up to the amount of the reasonable purchase price, as determined by the Trustees, of any such equipment.

(L) Corneal Lens- the initial corneal lens following cataract surgery.

(M) Hospice Care Benefits.

(N) Initial Prosthetic Devices.

(O) Outpatient Physician Services.

(P) Hospital Emergency Room Care- Charges for hospital emergency room care for treatment of an Emergency Illness or Injury.

(Q) Hospital Outpatient Care.

(R) Skilled Nursing Facility Care.

(S) Ambulatory Surgical Center Care in connection with Outpatient surgery.

(T) Home Health Care -The following services provided by a Home Health agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a home health agency and supervised by a registered nurse employed by the home health agency while receiving the services listed in 1 or 2 above.
5. Medically necessary supplies provided by the home health agency.

(U) Services at Urgent Care Facilities and Retail Health Clinics.

(V) Advanced Imaging Procedures – including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan),

Magnetic Resonance Spectroscopy (MRS scan), and Magnetic Resonance Angiogram (MRA scan).

(W) Custom orthopedic shoes, custom therapeutic shoes and custom molded foot inserts, foot orthoses or foot orthotic devices for the prevention and treatment of diabetes-related foot complications.

Wellness Benefits

Preventive care services are covered only if provided by in-network providers and paid in accordance with Schedule of Benefits A. These include some common treatments for adults and well child care, and are not limited to those shown below. Covered tests are based on each Covered Person's age, gender and family history as recommended by a Physician and in accordance with nationally accepted published guidelines. **Wellness benefits are not covered under Schedules of Benefits B and C.**

(A) **Preventive Care for Adults:** The following preventive care/wellness services for Adults will be covered once per calendar year unless indicated otherwise.

1. Office Visits
2. Blood Tests
3. EKG
4. Urinalysis
5. Pap Smear Test
6. Mammogram Annually (once per year at age 35 and over)
7. Prostate Examination
8. Colonoscopy (once every 10 years at age 50 and older)
9. Adult Vaccines
10. Influenza Vaccine
11. Pneumococcal Vaccine (once for ages 65 and older or younger than 65 for those with Risk Factors)

(B) **Well Child Care**

1. Newborn well child care in the hospital
2. Periodic office visits as required up to age 18 years
3. Required Immunizations at various intervals up to age 18 years as determined by a Physician
4. Hearing Tests (between ages 4 and 10)

Benefits Required under Federal Law

Covered medical benefits will always include all benefits required to be provided under ERISA, the Affordable Care Act, and any other applicable federal law, including the following:

Hospital Length of Stay after Childbirth

This Plan provides maternity benefits in compliance with Federal law. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal

delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The hospital length of stay begins at the time of delivery of the newborn if delivery occurs in the hospital or at the time of admission to the hospital if delivery occurs outside a hospital.

Reconstructive Surgery after Mastectomy

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) this Plan provides coverage to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for: (a) All stages of reconstruction of the breast on which the mastectomy was performed including coverage for nipple and areola reconstruction and/or repigmentation; (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) Prostheses; and (d) Treatment of physical complications of mastectomy, including lymphedema. Coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and Coinsurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

Parity for Mental Health Benefits

This Plan provides mental health benefits in compliance with Federal law. The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires that any group health plan that includes mental health benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. Your Plan is designed to comply with the requirements of this federal law. **Note, however, that not all Schedules of Benefits offer mental health benefits and that the Plan does not offer substance abuse disorder benefits.**

Affordable Care Act Benefits

This Plan provides benefits in compliance with the Affordable Care Act ("ACA"). This Plan was in existence before the ACA was passed, and it has maintained compliance with the ACA as a grandfathered plan, which means that the Plan is regulated differently under the ACA than newer plans or plans that have lost grandfather status.

Exclusions and Limitations

Medical benefits are subject to certain exclusions and limitations, as set forth in the Plan Document, Schedules of Benefits, and SBCs, which are summarized below. SCHEDULES OF BENEFITS B AND C EACH HAVE SPECIFIC LIMITATIONS ON BENEFITS THAT DO NOT APPLY UNDER SCHEDULE OF BENEFITS A.

Please see the section in this SPD titled "Exclusions and Limitations" for a list of exclusions and limitations that apply to all benefits under this Plan. The following exclusions and limitations also apply to all medical benefits offered under the Plan. The Plan does not pay for benefits described below:

1. Schedule of Benefits C does not provide coverage for mental health conditions or wellness benefits.
2. Schedule of Benefits B does not provide coverage for wellness benefits or for skilled nursing care.

3. Any treatment that is not Medically Necessary in accordance with generally accepted medical standards is not covered.
4. Any treatment that is Experimental is not covered.
5. Treatment of teeth, gums, etc. is not covered, except as a result of an accident, as specifically provided in the Plan.
6. TMJ syndrome- medical benefits are not provided for any care or treatment of the teeth or the fitting or wearing of dentures; or any care or treatment of teeth, gums, jaws or jaw joints, including, but not limited to atrophy of the lower jaw, occlusion, maxillo-facial, cranio-facial, skeleto-facial or orthognathic surgery, prognathism,. microgenia, apertognathia and retrognathia; however, this exclusion shall not apply to treatment of Injury to sound natural teeth (including their replacement) or the jaws if treatment is given within six months after the date of Injury.
7. Eye refractions, the fitting or cost of eyeglasses, contact lenses, and lens implants are not covered.
8. Treatment for weak, strained, flat, unstable or unbalanced feet, and foot care solely for improvement of comfort or appearance, including care for metatarsalgia, subluxations, corns, bunions (except capsular and bone surgery), and calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) is not covered.
9. Reversals of sterilization are not covered.
10. Procedures for (a) infertility; (b) sterility; or (c) hormone therapy that is not Medically Necessary are not covered.
11. Preconception testing or genetic testing is not covered.
12. Cosmetic surgery is not covered, other than under the exceptions described below. Cosmetic surgery includes but is not limited to: (a) surgery to upper and lower eyelid; (b) penile implants; (c) augmentation or reduction mammoplasty; (d) full or partial face lifts; (e) dermo or chemo abrasion or scar revision; (f) lift, stretch, or reduction of abdomen, buttocks, thighs, or upper arm; (g) silicone injections to any part of the body; (h) otoplasty; (i) rhinoplasty. Cosmetic surgery may be approved for coverage upon recommendation of a Physician if it is related to either (a) correction of a congenital anomaly of a covered dependent child or (b) an accidental Injury and charges are incurred within 12 months following the accidental Injury. Surgical procedures that are deemed to be Medically Necessary are not excluded by this provision.
13. Services or treatment for substance abuse are not covered, including conditions caused by the use of alcohol, narcotics, hallucinogens, barbiturates, marijuana, amphetamines or similar drugs or substances, or other controlled substances.
14. Services or treatment for Injuries caused by the use of alcohol, narcotics, hallucinogens, barbiturates, marijuana, amphetamines or similar drugs or substances, or other controlled substances, are not covered.
15. Treatment for intentionally self-inflicted injuries is not covered, unless the treatment is related to a health condition.
16. Hearing aids and corrective shoes are not covered.
17. Any form of food supplement or augmentation is not covered (unless necessary to sustain life in a critically ill person).
18. Custodial Care expenses are not covered.

19. Preventive care services for examinations or tests that are not related to treatment of an Illness or Injury are only covered as provided in the appropriate Schedule of Benefits.
20. Charges incurred as a result of exogenous or morbid obesity are not covered, including any surgery, revision or repair as a result thereof; any exercise program; and/or for weight control or removal of weight or fat, whether for obesity or for any other diagnosis and whether by diet, injection of any fluid, or use of any medication or surgery of any kind or stapling (internal or external).
21. Charges for services in connection with education, learning or developmental disabilities, including autism, autism spectrum disorders, and pervasive developmental disorders or delays, are not covered.
22. Acupuncture is not covered.
23. Counseling or testing concerning genetic disorders is not covered. This limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a pregnancy which is covered by the Plan.
24. Charges for care, services or treatment required as a result of complications from a treatment or procedure that was not covered under the Plan are not covered.
25. Care, treatment, services and supplies reimbursable under any other provisions of this Plan are not covered as medical benefits.
26. Care, treatment, services and supplies for which benefits are not payable under any other provisions of this Plan due to deductible, copayments or co-insurance provisions are not covered as medical benefits.
27. Custom orthopedic shoes, custom therapeutic shoes and custom molded foot inserts, foot orthoses or foot orthotic devices, unless such items are for the prevention and treatment of diabetes-related foot complications.

II. Prescription Drug Benefits

You are eligible for prescription drug benefits under either Schedule A, B or C. EACH SCHEDULE HAS DIFFERENT BENEFITS, LIMITATIONS AND EXCLUSIONS. Along with this SPD you have been given the Schedule of Benefits that lists your prescription drug benefits and your cost sharing obligations, along with a Summary of Benefits and Coverage ("SBC"). Please look at these documents for the description of your covered benefits. Your Schedule of Benefits and your SBC are attached to and incorporated into this Summary Plan Description.

Journeyman Employees and their Dependents; Non-Bargaining Unit Employees and their Dependents; and Retirees under age 65 and their Dependents under age 65 are eligible for the benefits described in Schedule of Benefits A.

Retirees over age 65 and Retirees' Dependents over age 65 are eligible for benefits described in Schedule of Benefits B.

Effective July 1, 2016, Helper Employees and their Dependents are eligible for the benefits described in Schedule of Benefits A.

Types of Benefits and Administrators under Schedules A, B, and C

The Board of Trustees has selected **CVS/Caremark** to serve as the Pharmacy Benefits Manager (PBM) and help deliver prescription drug benefits under Schedules of Benefits A and B. The Board of Trustees has selected **NEBA** to administer prescription drug benefits under Schedule of Benefits C.

FOR BENEFITS UNDER SCHEDULES A AND B: CVS/Caremark serves as the PBM and Claims Administrator for prescription drug benefits under Schedules A and B. **CVS/Caremark has a broad network of pharmacies and a mail-order program through which you can obtain covered prescription drug benefits.** You can obtain information about CVS/Caremark network pharmacies by visiting the website at https://www.caremark.com/wps/portal/LOCAL_PHARMACY_UNAUTH or calling 1-866-260-4646.

FOR BENEFITS UNDER SCHEDULE C: NEBA administers prescription drug benefits under Schedule C and serves as the Claims Administrator. **Schedule C prescription drug benefits do not have a pharmacy network.**

Your Cost Sharing Obligations

FOR BENEFITS UNDER SCHEDULES A AND B: Your Schedule of Benefits and your SBC list the applicable deductible, copayments and coinsurance that you will be required to pay for different types of prescription drugs. Some prescription drugs may be subject to different cost sharing requirements, as listed in your Schedule of Benefits and your SBC.

FOR BENEFITS UNDER SCHEDULE C: Your Schedule of Benefits and your SBC list the applicable deductible and coinsurance that you will be required to pay for different types of prescription drugs. The Plan will pay the percentage of cost shown on the Schedule of Benefits, and you will be required to pay the difference. Some prescription drugs may be subject to different cost sharing requirements, as listed in your SBC and Schedule of Benefits.

Your Deductible

FOR BENEFITS UNDER SCHEDULES A AND B: This Plan has a separate deductible for prescription drug benefits under Schedules A and B, which is the amount you must pay towards your prescription drug costs before the Plan pays benefits. The deductible is applied once each calendar year for each Covered Person's prescription drug costs during that year.

FOR BENEFITS UNDER SCHEDULE C: The prescription drug benefit deductible is the same as the medical benefits deductible.

Out of Pocket Maximum for Retirees and their Dependents

Retirees' out of pocket expenses for prescription drugs are subject to an Out of Pocket Maximum. The Plan will pay 100% of covered prescription drug charges after a Retiree or his Dependent has paid cost sharing obligations that reach the applicable maximum in a calendar year. The deductible, coinsurance and copayments you pay count towards the applicable maximum. This benefit is listed in the Schedules of Benefits A and B and the SBCs for Schedules A and B.

Claims Submission and Payment of Cost Sharing Obligations

Claims for benefits must be submitted within one year of the date a service was provided or the date of an event that forms the basis for a claim.

FOR BENEFITS UNDER SCHEDULES A AND B: ***If you obtain your prescription from a network pharmacist you will usually be required to pay your share of the cost at the pharmacy when you receive prescription drugs.*** The pharmacist will advise you of any cost sharing requirements, including the amount of any copayments, deductible or coinsurance. You will pay the actual prescription cost if it is a lower amount than the applicable copayment. You may be able to obtain prescription drugs through the mail order benefit with different cost sharing obligations.

You must follow CVS/Caremark rules and procedures in order to receive covered prescription drug benefits. Some medications require pre-authorization. You may also be required to meet certain requirements or follow certain protocol, such as when your prescription is subject to clinical management rules.

There are no out of network prescription drug benefits. If you need to submit a prescription drug claim that was not submitted by your pharmacist please follow the procedures listed later in this SPD under the heading "Claims Procedures".

FOR BENEFITS UNDER SCHEDULE C: If you are covered under Schedule of Benefits C, you must submit your reimbursement claims for prescription drug benefits to NEBA. **You must follow NEBA's rules and procedures in order to receive your prescription drug benefits under Schedule C.** Please see the section titled "Claims Procedures" in this SPD.

Pharmacy Network Benefits

FOR BENEFITS UNDER SCHEDULES A AND B: YOUR PRESCRIPTION DRUG BENEFITS ARE PROVIDED EXCLUSIVELY THROUGH CVS/CAREMARK'S NETWORK OF PHARMACISTS. You should always obtain your prescriptions through a network pharmacist in order to receive your benefits. **CVS/Caremark has a broad network of pharmacies and a mail-order program through which you can obtain covered prescription drug benefits.** You can obtain information about CVS/Caremark network pharmacies by You can obtain information about CVS/Caremark network pharmacies by visiting the website at https://www.caremark.com/wps/portal/LOCAL_PHARMACY_UNAUTH or calling 1-866-260-4646. **THERE ARE NO OUT OF NETWORK PRESCRIPTION DRUG BENEFITS.**

Benefits Payable

Prescription drug benefits are payable based on your applicable Schedule of Benefits. Schedule of Benefits C includes limitations and exclusions for Prescription Drug Benefits that are not applicable to Schedules of Benefits A and B. The total amount payable will not exceed any applicable Maximum Benefit set forth in the Schedules of Benefits.

You may be required to satisfy other conditions as well, such as pre-authorization requirements described below.

Clinical Management Rules and Limitations

FOR BENEFITS UNDER SCHEDULES A AND B: Certain drug categories require additional steps or conditions for dispensing, including the following:

(1) Prior Authorization review for selected drug categories, including specialty drugs, such as but not limited to oral fentanyl products, duragesic patches, etc.
(2) Quantity Limits on certain drug categories such as but not limited to analgesic narcotics, anti-coagulants, propoxyphene containing products, extended release morphine, nasal sprays used for management of pain, erectile dysfunction, etc.

(3) Post Limit review if a Physician requests additional quantities of drug categories such as but not limited to nasal sprays used for management of pain, extended release morphine, oxycontin, dolophine, etc.

Covered Prescription Drug Charges

Covered Prescription Drug Charges under all Schedules include only charges for Prescription drugs and medicine obtainable only by a prescription and dispensed by a licensed pharmacist.

FOR BENEFITS UNDER SCHEDULES A AND B: Covered Prescription drugs and medicine must be administered through CVS/Caremark and the CVS/Caremark pharmacy network in order to be covered. Covered drugs include outpatient drugs and medications, insulin, syringes when dispensed for use with insulin, oral contraceptives and diaphragms, diabetic supplies, inhaler spacers and peak flow meters for pediatric asthma and erectile dysfunction drugs. CVS/Caremark maintains a prescription drug formulary and drugs that are not on the formulary are generally not covered by the Plan. To find out if a particular drug is on CVS/Caremark's Formulary List, you can enter the name of the drug on their website or call them at 1-866-260-4646. In limited circumstances, drugs that do not appear on the Formulary List may be covered by the Plan if your Doctor obtains pre-authorization from CVS/Caremark due to medical necessity. **THERE ARE NO OUT-OF-NETWORK BENEFITS.**

The list of CVS/Caremark's Formulary Drugs includes five types of prescription drugs:

(1) Generic Drugs - A generic drug is identical -- or "bioequivalent" -- to a brand name drug and is generally cheaper than the brand name drug.

(2) Preferred Brand Name Drugs – Preferred brand name drugs are medications that are produced and sold under the original manufacturer's name and which are more cost-effective than non-preferred brand name drugs (described below).

(3) Non-Preferred Brand Name Drugs - These drugs are typically more expensive drugs than preferred brand name drugs. If you elect to fill a prescription for a Non-Preferred Brand Name Drug, you will pay the highest copayment.

(4) Specialty Drugs – These are generally high cost drugs and require education and support from a pharmacist. These drugs are usually dispensed by CVS/Caremark's specialty pharmacy. Most of these drugs require pre-authorization.

(5) Compound Drugs – A compound drug is one made by combining, mixing or altering ingredients to create a customized drug that is not otherwise commercially available. These drugs also require pre-authorization.

FOR BENEFITS UNDER SCHEDULE C: Your benefits are not provided through a pharmacy network and thus you are not limited to obtaining services from participating pharmacies in order to receive benefits.

Exclusions and Limitations

Prescription drug benefits are subject to certain exclusions and limitations, as set forth in the Plan Document, Schedules of Benefits, and SBCs. **SCHEDULES OF BENEFITS C HAS SPECIFIC LIMITATIONS ON BENEFITS THAT DO NOT APPLY UNDER SCHEDULES OF BENEFITS A AND B.**

Please see the section in this SPD titled "Exclusions and Limitations" for a list of exclusions and limitations that apply to all benefits under this Plan. The following exclusions and limitations also apply to all prescription drug benefits offered under the Plan. The Plan does not pay for benefits described below:

(A) Certain drugs are not covered by the Plan. These include, but are not limited to, the following:

1. Non-Federal legend drugs;
2. All anti-obesity drugs – or weight loss medications such as Meridia or Xenical;
3. Nutritional Supplements;
4. Fertility agents or drugs such as Clomiphene, Clomid, Serophenes, Lutrepulse Kit, Metrodin, Pergonal, Profasi, or Pregnyl;
5. Growth hormones such as Humatrope, Nutropin, or Protropin;
6. Cosmetic agents such as Retin-A, Differin, Avita, Renova, Propecia, or Rogaine;
7. Smoking cessation agents such as Zyban or ProStep;
8. Topical fluoride or dental products such as Luride or Phos-Flur;
9. Emergency contraceptives such as Preven or Plan B;
10. Injectable contraceptives such as Depo-Provera;
11. Injectable delivery devices (syringes for use other than insulin);
12. Anabolic steroids such as Anadrol, Oxandrin, or Winstrol;
13. Legend vitamins including prenatal vitamins; and
14. Hematological agents such as Folic Acid or Iron Dextran products.
15. Bulk ingredients and certain bulk compounding ingredients such as bulk chemicals and compound kits.

(B) Certain drugs not normally covered by the Plan will be covered if a Physician determines that such drugs are Medically Necessary to treat other medical conditions, based on a diagnosis. When this occurs, a Physician must indicate the medical necessity on the prescription along with the diagnosis code (ICD9 code). A Covered Person must also provide the diagnosis code to a pharmacist filling the prescription.

The following drugs may be covered under the conditions described here. This list is not exhaustive.

1. Wellbutrin-SR 150mg;
2. Proscar;
3. Accutane;
4. Thalomid;
5. Hormone Replacement medication (i.e., testosterone enanthate);
6. Blood glucose monitoring machines (only covered for Type I or juvenile diabetes).

(C) No payment will be made for expenses incurred:

1. For Experimental drugs or for drugs labeled: "Caution – limited by federal law to investigational use";
2. For drugs obtained from a non-participating mail order pharmacy;
3. For any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician's order;
4. For more than a 30-day supply when dispensed in any one prescription order through a retail pharmacy;

5. For more than a 90-day supply when dispensed in any one prescription order through a participating mail order pharmacy;
6. For indications not approved by the Food and Drug Administration;
7. For prescription charges covered by other insurance, including, but not limited to, group insurance, auto insurance, home-owners insurance and business risk insurance, (coordination of benefits does not apply to prescription drugs benefits);
8. For prescriptions an eligible person is entitled to receive without charge under any state's Workers' Compensation law, state disability or any municipal, state or federal program;
9. For drugs intended for use in a Physician's office or another facility other than home use or other than specialty drugs authorized by CVS/Caremark for administration in the Physician's office or similar site;
10. For therapeutic devices, supplies or appliances, such as diagnostic tests for cholesterol, ovulation or fertility;
11. For support garments and other non-medical substances;
12. For abortifacients; and
13. For charges for the administration/injection of any drug.

(D) Additional exclusions under Schedule of Benefits C:

1. All oral contraceptives including emergency contraceptives such as Preven or Plan B;
2. Relenza Diskhalers or Tamiflu caps;
3. Impotence drugs such as Viagra, Caverject, Muse, Edex, or forms of Testosterone.

III. Dental Benefits

The Board of Trustees has selected the **Cigna Dental SAR PPO Network** to help deliver dental benefits under Schedule of Benefits A and B, and the Plan's Third Party Administrator, **NEBA**, to administer the claims. NEBA serves as the Claims Administrator for dental benefits.

DENTAL BENEFITS ARE ONLY AVAILABLE UNDER SCHEDULES OF BENEFITS A AND B. SCHEDULE OF BENEFITS C DOES NOT INCLUDE DENTAL BENEFITS.

Schedules of Benefits A and B describe your dental benefits along with your cost sharing obligations. Your Schedule of Benefits is an important part of this document and is attached to and incorporated into this Summary Plan Description.

Your Cost Sharing Obligations

Your Schedule of Benefits lists what you have to pay for different types of covered services. Benefits are subject to your deductible, coinsurance requirements, and are limited by certain benefit maximums.

When you obtain dental care your dentist will often submit claims on your behalf. You may be required to pay your share of the cost at the time that you receive services. If your provider does not submit your claim then you may have to pay for services in full and submit a claim for reimbursement to NEBA afterwards.

Your Deductible

This Plan has a deductible requirement, which is the amount you must pay toward services before the Plan pays benefits. The deductible is applied once each calendar year for each Covered Person's dental benefits during that year. Your Schedule of Benefits shows the deductible applicable to each Covered Person. As noted in the Schedules of Benefits the Plan begins to pay benefits for covered basic and major care services after each person has met his/her per person calendar year deductible. ***There is no deductible for covered preventive and diagnostic care services.***

Cigna Dental PPO Network

The Cigna Dental PPO network includes many dental care providers who have agreed to provide quality dental services at negotiated rates. Each time you seek dental care you are able to select any licensed dental provider, whether they are a network provider or not. However, if you use a CIGNA Dental SAR PPO network provider your costs will be lower because fees will be based on reduced negotiated fees instead of a provider's regular fees.

For a list of dental network providers, call CIGNA at 1-800-CIGNA24 and mention the 3330825 account number or visit the CIGNA web site at www.cignadentalnetworksolutions.com/. To find out more about the dental plan, call NEBA at 1-800-822-5899.

Out-of-Network Coverage

If a network provider isn't available, or if you decide not to use a network provider, you still have coverage under the plan at the same coinsurance levels. However, you may be required to pay amounts above your coinsurance if your dentist charges more than the reasonable and customary charge allowed under the Plan.

This reasonable and customary charge is based on what other dental providers charge for the same service in the same geographic area. The Plan will pay benefits based on the reasonable and customary charge. So, if your dentist's charges are within the "reasonable and customary" charge, you will be responsible for the applicable deductible and coinsurance, as you would for an in network provider. However, if your out of network dentist's charge is above the reasonable and customary charge, you must pay the cost difference plus any applicable deductible and coinsurance.

Maximum Annual Dental Benefit

There is a Maximum Annual Dental Benefit that the Plan will pay each year for each person covered. Once the maximum is met, you are responsible for any further dental costs for the rest of the calendar year. The Maximum Annual Dental Benefit is shown in the Schedule of Benefits.

For children up to age 19, there will be no calendar year maximum dental benefit limit for covered dental check-up services such as routine oral exams, which are still subject to any other visit limits. The Maximum Annual Dental Benefit will continue to apply for other dental benefits.

Covered Dental Charges and Coinsurance

In-network dental services providers have typically agreed to a negotiated discounted rate. Covered dental charges are based on that rate, including the amount that you will be required to pay as coinsurance. For services provided by out of network providers, the covered benefit amount is determined based on reasonable and customary charges for necessary care, appliance or other dental material listed as covered dental services.

The Plan pays the percentage of covered charges listed in the Schedules of Benefits for covered preventive and diagnostic care services without a deductible. The Plan pays the percentage of covered charges listed

in the Schedule of Benefits for covered basic and major care services only after you have met your per person calendar year deductible.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the overall charge will be apportioned to each of the separate visits or treatment and the pro-rata charge will be considered to be incurred as each visit or treatment is completed.

Covered Dental Services

Covered Dental Services are grouped into three categories: preventive and diagnostic care, basic care, and major care.

(A) Preventive and Diagnostic Care

- i. Two routine oral exams per calendar year
- ii. Two cleanings per calendar year
- iii. One bitewing X-ray per person per calendar year
- iv. One full mouth X-rays per person every 2 years
- v. Emergency palliative treatment for pain
- vi. Topical application of fluoride is limited to once per year for eligible Dependents under age 19

(B) Basic Care

- i. Dental x-rays not included in Preventive and Diagnostic Care
- ii. Oral surgery
- iii. Periodontics (gum treatments)
- iv. Endodontics (root canals)
- v. Extractions
- vi. Re-cementing bridges, crowns or inlays
- vii. Fillings, other than gold
- viii. General anesthetics, upon demonstration of Medical Necessity
- ix. Antibiotic drugs

(C) Major Care

- i. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- ii. Installation of crowns.
- iii. Installing precision attachments for removable dentures.
- iv. Initial installation of fixed bridgework to replace one or more natural teeth.
- v. Dental implants.
- vi. Prosthodontics – Fixed
  - a) Crowns when used as an element of a bridge
  - b) Bridge pontics - Limitation - Re-cementation of a fixed bridge shall be limited to once in a 3-year period.
  - c) Restoration of crowns, jackets, posts and copings
- vii. Prosthodontics – Removable

a) Complete acrylic base upper and lower denture
b) Upper or lower partial denture of chrome-cobalt alloy
c) Upper or lower acrylic partial denture
d) Addition of clasp or rest to existing partial removable dentures
e) Replacing a clasp with a new clasp on a partial denture
f) Adding additional clasps and/or teeth
g) Repair of bridgework and removable dentures
h) Repairing of broken acrylic denture base
i) Rebasing or relining of removable dentures - Limitations - Reline of an upper or lower complete or partial denture shall be limited to once in a 3-year period. - Adjustment of dentures shall be limited to once in a 6-month period

Exclusions and Limitations

Please see the section in this SPD titled "Exclusions and Limitations" for a list of exclusions and limitations that apply to all benefits under this Plan.

Dental services that are not included as Covered Dental Services are not covered by the Plan. Services not covered include, but are not limited to:

1. Dental treatment before coverage is in effect or after it is canceled or for a person who is not eligible.
2. Dental services or supplies not recommended or approved by an attending Dentist.
3. Any work not done by a Dentist, except x-rays ordered by a Dentist and services by a dental hygienist under the Dentist's supervision.
4. Replacement retainers.
5. Treatment of TMJ disorders or malocclusion involving joints or muscles by methods that may include wiring, surgical alteration or repositioning teeth or the jaw.
6. Cosmetic dentistry, unless necessary because of an Injury. Facings on molar crowns or pontics are always considered cosmetic and are not covered.
7. Appliances or restorations for the purpose of splitting or changing the height of teeth to restore proper bite.
8. Bridges and dentures for the same teeth replaced in less than 60 months.
9. Extra cost for a more expensive or elaborate course of treatment instead of a less expensive treatment that would produce professionally satisfactory results.
10. Bone grafts and transplants.
11. Charges for broken or missed dental appointments.
12. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
13. Fissure Sealants.
14. Oral hygiene, plaque control programs or dietary instructions.
15. Services that are payable under any medical expense benefits of the Plan.
16. Personalization of dentures.
17. The cost to replace lost, missing or stolen prosthetic devices or appliances.
18. Administrative costs of completing claim forms or reports or for providing dental records.

19. Services not reasonably necessary, not customarily performed, or Experimental for the dental treatment of a specific condition of a Covered Person.

Pre-Determination of Benefits

If you plan to have dental work costing more than $300, you have the option of asking for a "predetermination of benefits." This lets you know-ahead of time what your treatment will cost and how much the plan will pay. It is not a requirement, and dental benefits will not be affected if you choose not to request a pre-determination of benefits.

In order to obtain a pre-determination of benefits your dentist must submit a description of the proposed treatment on a dental claim form to NEBA. NEBA will request x-rays or other supporting information if it is necessary, or your dentist could submit them with the initial description. After NEBA reviews the treatment plan, you and your dentist will be notified of the anticipated benefits that the plan will pay based upon the information available to NEBA at the time the predetermination of benefits is issued. *A predetermination of benefits is not binding.* Your claim will be adjudicated at the time of receipt based on the circumstances that exist at that time.

Submitting a Claim

Dental benefit claims for services provided by in-network providers are typically submitted by your provider at the time you receive services, and out of network providers might also submit claims on your behalf. All claims are submitted to NEBA. In the event that you need to submit a dental claim, please follow the procedures listed later in this SPD under the heading "Claims Procedures".

Claims for benefits must be submitted within one year of the date a service was provided or the date of an event that forms the basis for a claim.

IV. Vision Benefits

The Board of Trustees has selected **Superior Vision** to provide vision benefits under the Plan. Superior Vision provides benefits through an insurance policy and serves as the Claims Administrator. You can obtain information about Superior Vision benefits and providers by calling Superior Vision at 800-507-3800 or visiting the Superior Vision website at www.superiorvision.com.

VISION BENEFITS ARE ONLY AVAILABLE UNDER SCHEDULES OF BENEFITS A AND B. SCHEDULE OF BENEFITS C DOES NOT INCLUDE VISION BENEFITS.

You have been given a certificate from Superior Vision describing your vision benefits, including a schedule of benefits and a list of covered services. The Superior Vision certificate is an important part of this document, and is attached to and incorporated into this Summary Plan Description.

Your Cost Sharing Obligations

Your Superior Vision certificate lists your benefits and what you have to pay for different types of covered services. Superior Vision has a network of vision care providers that have agreed to provide benefits at discounted pricing. If you receive services or supplies from a Superior Vision network provider you will be required to pay your share of the cost at the time of service and Superior Vision will pay your network provider directly. You will not need to submit a claim.

If you receive services outside of the Superior Vision network you will be required to pay for the complete cost of services or supplies and submit a claim to Superior Vision with supporting documents under Superior Vision's rules and procedures.

Vision Benefits Payable

Your vision benefits are payable as described in the Superior Vision certificate. Benefits for both in and out of network services and supplies are subject to maximum benefit limitations, copayments, and frequency limits, as listed in your Superior Vision certificate. The amount of the benefit payable may depend upon compliance with Superior Vision rules and requirements. You must follow Superior Vision's rules and procedures in order to receive covered vision benefits.

Submitting a Claim

If you receive benefits from an out of network provider you will need to submit a claim in order to obtain reimbursement for covered vision benefits. Please follow the procedures listed later in this SPD under the heading "Claims Procedures".

Please note that Superior Vision requires that claims be submitted within 90 days, unless it is not reasonably possible to submit a claim within that time period.

V. Loss of Time Benefits

The Plan offers Loss of Time (short term disability) benefits, as described below. **NEBA** administers loss of time benefits and serves as the Claims Administrator.

Bargaining Unit Employees receiving benefits under Schedule A are eligible for Loss of Time benefits. Retirees, Non-Bargaining Unit Employees, and Dependents are not eligible for Loss of Time benefits.

Schedule of Benefits A describes available Loss of Time benefits and annual limits on the amount of benefits that you may claim. Your Schedule of Benefits is important and is attached to and incorporated into this Summary Plan Description.

Loss of Time Benefits Payable

If, as a result of accidental bodily Injury or Illness, you become Totally Disabled, the Plan shall pay, for each day you are so disabled, the applicable amount specified in the Schedule of Benefits, commencing with the applicable day specified in the Schedule of Benefits. Payment of any one period of disability, whether due to one or more causes, shall not exceed the applicable Maximum Benefit Period specified in the Schedule of Benefits. Successive periods of disability not separated by return to or availability for work will be considered one period of disability unless the subsequent disability is due to a cause or causes entirely unrelated to the previous disability.

In order to be eligible for the benefit, you must have been working for or Available for Work with an Employer signatory to a collective bargaining agreement on the day of the accidental bodily Injury or onset of the Illness giving rise to the disability. You shall be presumed to be unavailable for full-time work with a contributing employer if you are employed full-time performing work at the trade for a non-signatory employer.

The Board of Trustees reserves the right to require that you be examined by a Physician selected by the Trustees and to rely on that Physician's findings to determine eligibility for Loss of Time benefits.

Submitting a Claim

You must submit a claim to NEBA to obtain your Loss of Time benefits. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form.

Claims for benefits must be submitted within one year of the date that forms the basis for a claim.

VI. Death and Accidental Death or Dismemberment Benefits

The Plan offers Death and Accidental Death or Dismemberment benefits, as described below. **NEBA** administers these benefits and serves as the Claims Administrator.

Bargaining Unit Employee receiving benefits under Schedule A are eligible for Death and Accidental Death or Dismemberment Benefits. Retirees, Non-Bargaining Unit Employees, and Dependents are not eligible for Death and Accidental Death or Dismemberment benefits.

Schedule of Benefits A describes available Death and Accidental Death or Dismemberment benefits and limits on the amount of such benefits. Your Schedule of Benefits is important and is attached to and incorporated into this Summary Plan Description.

Death Benefit Payable

The Death Benefit amount provided in the Schedule of Benefits shall be payable in the event of a covered Bargaining Unit Employee's death from any cause that occurs at any time while such Employee was covered under the Plan. Such amount shall be payable in a single lump sum. The Death Benefit shall be payable only if written notice of death and proof of claim is received by the Board of Trustees. The Death Benefit provided by the Plan is not assignable.

Accidental Death or Dismemberment Benefits Payable

An Accidental Death or Dismemberment benefit is payable for losses described below resulting from injuries sustained by a covered Bargaining Unit Employee in an accident that occurred while such employee was eligible for benefits under the Plan. The loss must occur within 90 days after an accident and must be a direct result from injuries sustained in such accident, independent of all other causes. If more than one such loss is sustained as a result of the accident, payment shall be made for only the one loss for which the largest amount is payable, and no loss sustained prior to such accident will be included in determining the amount payable. The injuries must be evidenced by a visible wound or contusion on the exterior of the body, except in case of drowning or internal injuries revealed by an autopsy.

The Accidental Death or Dismemberment benefit is a one-time payment in the amount set forth in Schedule of Benefits A. Not more than the full amount of benefit is payable for any loss resulting from injuries sustained in any one accident. Benefits are paid to a living covered employee or otherwise to such employee's designated beneficiary under the Plan. This benefit may not be assigned.

Accidental Death or Dismemberment benefit is payable as follows:

For accidental loss of:	*Amount Payable:*
Life; or One Hand and One Foot; or One Hand and Sight of One Eye; or One Foot and Sight of One Eye; or Both Hands; or Both Feet; or Sight of both Eyes:	the full amount listed in the Schedule of Benefits
One Hand; or One Foot; or Sight of One Eye:	one half of the amount listed in the Schedule of Benefits

Loss of hand or foot means actual severance through or above the wrist or ankle joint. Loss of sight of an eye means the entire and irrecoverable loss of sight of such eye.

No Accidental Death or Dismemberment benefit is payable from loss resulting from:

1. bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment therefore;
2. bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of bodily injury for which accidental death or dismemberment benefits are payable);
3. the commission or attempt to commit any crime or assault;
4. war, whether declared or undeclared, or insurrection;
5. travel or flight as a pilot or crew member in any kind of aircraft; or
6. the use or influence of any alcohol, hallucinogen, heroin, narcotic, amphetamine, stimulant, barbiturate, tranquilizer, or any controlled substance, except as prescribed by a Physician.

Plan Beneficiaries

Death and Accidental Death Benefits are payable to the beneficiaries whom you have designated under the Plan. You may name a new beneficiary at any time by filing a written request on a form satisfactory to the Board of Trustees. Beneficiary change forms can be obtained from the Third Party Administrator. A named beneficiary's consent is not required to change or add a person as a beneficiary. Such change shall not take effect unless filed in the Fund Office, but if filed, shall take effect on the date the request is signed, but without prejudice to the Plan on account of any payment made prior to the receipt of such request.

If more than one beneficiary is designated and their respective interests are not specified, such beneficiaries shall share equally, except that if any designated beneficiary is not living at the time of a Covered Employee's death, the share that such beneficiary would have received shall, unless specified otherwise, be payable equally to the remaining designated beneficiaries.

If a deceased Covered Employee failed to name a beneficiary prior to death, or if all named beneficiaries are not living at the time of a Covered Employee's death, Death and Accidental Death benefits shall be paid, at the option of the Board of Trustees, to any of the deceased Covered Employee's following surviving relatives:

(1) spouse,
(2) child(ren) in equal shares,
(3) parents in equal shares,
(4) siblings in equal shares, or
(5) executors or administrators of decedents' estate.

The Board of Trustees may, in its discretion, pay up to $3,000.00 of the Death benefit to any person it determines to be equitably entitled to receive the payment by reason of having incurred funeral or other expenses incident to a deceased Covered Employee's last illness or death. Such payment shall be considered proper payment of the Death Benefit to the extent paid and the beneficiary shall be entitled to receive only the remainder, if any, of the proceeds.

If a beneficiary is a minor, or, in the opinion of the Trustees, is incapable of giving valid receipt for any payment due, and if no request for payment has been made by a duly appointed guardian or committee of the beneficiary, the Board of Trustees may, at its option, make payment to any person or institution appearing to the Plan to have assumed the custody of and/or the principal support of the beneficiary.

Extension of Death Benefit after Disability

A covered Bargaining Unit Employee is entitled to an extension of death benefits if (1) he submits to the Trustees due proof that he became Totally Disabled before attaining his 60th birthday and before the date

of termination of his coverage under the Plan, and (2) he submits satisfactory proof of such disability so that it is received by the Trustees within twelve months from the date of commencement of such disability.

The Death benefit payable as a result of such an extension shall not exceed the amount in place at the commencement of the extension. The death benefit payable will be reduced on account of any change in the Employee's classification or in the terms of the Plan which would have resulted in a reduced amount if he had not been disabled. In no event shall such amount be reduced because of any change in the classification resulting from the disability which qualified the Employee for the extension. The extension shall become effective on the date of commencement of such disability. Subject to the provisions below, the extension shall continue as long as the Employee remains so disabled and submits satisfactory proof of disability when and as required by the Trustees.

The extension shall cease on the earlier of: (1) the date the employee ceases to be totally and continuously disabled, or (2) the date upon which the employee fails to furnish satisfactory proof of disability as required. If on the date the extension ceases such person is not in an eligible status under the Plan, his coverage shall automatically terminate.

Written notice of death of an employee whose coverage is being continued under the extension must be furnished to the Trustees within twelve months after the date of death. If notice of death as required is not given, the Plan shall not be liable for any payment on account of such death.

Submitting a Claim

You must submit a claim to NEBA to obtain Death and Accidental Death or Dismemberment benefits. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. The Death Benefit shall be payable only if written notice of death and proof of claim is received by the Board of Trustees.

Claims for benefits must be submitted within one year of the date that forms the basis for a claim.

VII. Exclusions and Limitations

The following exclusions and limitations apply to all medical, dental, vision, prescription drug, loss of time, and accidental death and dismemberment benefits provided under this Plan. There are also additional exclusions and limitations that apply only to specific types of benefits, as noted elsewhere in this SPD, the Plan Document and the Schedules of Benefits. The Plan will not pay benefits under any of the following conditions:

1. Charges due to an Injury or Illness arising out of and in the course of any occupation for compensation, profit or gain, whether covered by Workers' Compensation or not;
2. Experimental procedures, surgery, drugs, treatments, equipment, devices or services;
3. Any treatment deemed not to be Medically Necessary in accordance with generally accepted medical standards;
4. War, or any act of War, whether declared or undeclared;
5. Participating in an insurrection, riot or civil commotion;
6. The commission or attempted commission of an illegal act;
7. Charges that a Covered Person is not required to pay;
8. To the extent that payment is unlawful where the Covered Person resided when expenses were incurred;
9. Charges which would not have been made if the person were not covered by this Plan;

10. For care, treatment, services and supplies received in a hospital or facility owned or operated by the United States Government or any of its agencies for which the Covered Person is not required to pay, or which would not be made in the absence of insurance;
11. Services received from a person who is related to a Covered Person by blood or marriage;
12. Any amounts in excess of the Fee Schedule or any Benefit Maximum as set forth in the Schedule of Benefits;
13. Charges that are paid, or would have been paid, under a "no fault" motor vehicle insurance policy or as personal injury protection (PIP) benefits, as required by law, without regard to the purchase of such insurance by, or on behalf of, a Covered Person. If a Covered Person fails, for any reason whatsoever, to obtain a "no fault" motor vehicle insurance policy and/or PIP benefits, the Plan shall not pay benefits that would have been paid under such provisions if the Covered Person had such insurance in effect with no deductible.

FEDERAL LAW RIGHTS FOR ENROLLMENT AND COVERAGE

I. Special Enrollment Rights under HIPAA

"Special Enrollment" rights are sometimes allowed under Federal law (HIPAA) to allow employees or dependents to enroll outside of the open enrollment period or after initial eligibility. This section describes when you may have special enrollment rights.

New Dependents: If you enroll in the Plan at the time you are first eligible and you remain eligible for coverage you can enroll a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship by submitting a request for enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Limited "Special Enrollment" rights are also allowed under Federal law (HIPAA) if you decline or waive enrollment in the Plan and do not have other health insurance. Under these special enrollment rights you may request enrollment for yourself and/or your dependents outside of open enrollment if:

- You have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship and
- You request enrollment within 31 days after the marriage, birth, adoption, placement for adoption or legal guardianship.

Loss of Other Coverage: If you decline or waive enrollment in the Plan because you have other health insurance coverage, you may be allowed "special enrollment" rights in the future if:

- You are covered under another group health plan or health insurance program at the time you waive coverage under the Plan;
- You lose eligibility for the health care coverage you had at the time of waiver, or the employer sponsoring the other coverage stops contributing towards such other coverage; and
- You make application for enrollment in the Plan within 30 days after your other coverage ends.

Loss of Medicaid or State Child Health Insurance Program: There are special rules for employees and dependents of employees who are eligible for Medicaid or a State Child Health Insurance Program. If an employee (or eligible dependent of such employee) experiences a loss of eligibility for Medicaid or a State Child Health Insurance Program, they have a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days after the loss of eligibility.

Premium Assistance: If an employee (or eligible dependent of such employee) is determined to be eligible for premium assistance by Medicaid or a State Child Health Insurance Program (including under

any waiver or demonstration project conducted under or in relation to such a program), such person has a Special Enrollment right to request enrollment in the Plan provided a request for enrollment is made within 60 days of the determination of assistance.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

II. Qualified Medical Child Support Orders (QMCSO)

Federal law requires that this Plan extend health care coverage directly to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "Qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). Any judgment, decree, or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under State law (such as a State child support enforcement agency) that provides for medical support of a child is a medical child support order. In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. A medical child support order must contain the following information in order to be Qualified:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- The period to which the order applies.

All requests for enrollment and/or claims for benefits pursuant to a medical child support order shall be submitted, in writing, to the Administrative Manager along with a copy of the medical child support order. The Administrative Manager can be reached at: National Employee Benefits Administrators, Inc., 2010 N.W. 150th Avenue, Suite 100, Pembroke Pines, Florida 33028, 1-800-822-5899.

Upon receipt of a medical child support order the Administrative Manager shall notify the Employee and each Alternate Recipient named in the order that the medical child support order was received and shall provide each with a written copy of the procedures for determining whether the order is Qualified. Notices shall be sent to the addresses shown in the medical child support order. Alternate Recipients may designate an attorney or other representative to receive copies of notices and communications sent to them relating to a medical child support order by submitting a written and signed authorization to the Third Party Administrator.

The Board of Trustees shall consult with legal counsel and shall determine whether an order is a Qualified Medical Child Support Order no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of the medical child support order, unless it is submitted within 30 days preceding the date of such meeting. If a medical child support order is submitted less than 30 days before the next meeting, the Board of Trustees shall determine whether it is a QMCSO no later than the date of the second meeting following the Plan's receipt of the order. If special circumstances require a further extension of time, the Board of Trustees shall make the determination not later than the date of the third meeting following the Plan's receipt of the order.

The Trustees will provide notice of their decision to the Employee and to the Alternate Recipient as soon as possible, but not later than 5 days after the determination is made. The Trustees will notify the

Employee and each Alternate Recipient of a denial of benefits based on a determination that a medical child support order is not qualified following the procedures established under this Plan for notification of benefit claim denials. The decision can be appealed by filing a notice of appeal within sixty (60) days after receipt of the Trustees' decision.

If the Administrative Manager receives an appropriately completed National Medical Support Notice that meets the requirements for a QMCSO set forth above, the Notice shall be deemed to be a QMCSO.

Pending a decision by the Board of Trustees as to whether a medical child support order is a QMCSO any amount which would be payable for benefits on behalf of such Alternate Recipient may be withheld.

III. Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Covered Employees and/or their Dependents may be entitled to temporarily extend their coverage under this Plan by electing COBRA continuation coverage after their eligibility for coverage under the Plan has terminated.

The following sets forth important information about your right to COBRA continuation coverage. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

A dependent child will become a qualified beneficiary if he/she loses coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

An employer filing a proceeding in bankruptcy under title 11 of the United States Code can also be a qualifying event for retired employees with Plan coverage. If a proceeding in bankruptcy is filed with respect to a participating employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary as a result of the bankruptcy, if the bankruptcy results in loss of coverage under the Plan. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the employer's bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Third Party Administrator has been notified that a qualifying event has occurred. The employer must notify the Third Party Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- The commencement of bankruptcy proceedings;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or the occurrence of an event that qualifies as a Second Qualifying Event that entitles you to an extension of your COBRA coverage), you must notify the Third Party Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Third Party Administrator at

National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

How is COBRA Coverage Provided?

Once the Third Party Administrator receives notice that a qualifying event has occurred, the TPA will notify you or your Dependent of the right to elect continuation coverage. The Third Party Administrator will also tell you how much such coverage will cost, and will provide an election form and instructions for electing the coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. To elect continuation coverage, you or your Dependent must complete the election form and timely submit it to the Third Party Administrator.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Third Party Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Paying for COBRA continuation coverage

A person who elects continuation coverage must pay the required premium in order to remain covered. The COBRA notice will provide all necessary information regarding the premium and required due dates for payment. The Board of Trustees annually determines the monthly premium amount due for COBRA continuation coverage. It cannot be more than 102% of the cost of coverage provided to similarly situated Participants and Dependents unless a higher charge is permitted by law.

When does COBRA Coverage End?

COBRA coverage ends on the first to occur of the following:

- The end of the maximum continuation period;
- The date on which all coverage offered by the Plan terminates;
- The date on which you or your Dependent becomes covered by another group health plan provided this occurs on a date after COBRA continuation coverage is elected;
- The date you or your Dependent become entitled to Medicare coverage, provided this occurs on a date after COBRA continuation coverage is elected; or
- The last day of the month preceding the month for which the COBRA premium was not timely.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Third Party Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Third Party Administrator.

Plan Contact Information

Plumbers and Pipefitters Local Union No. 630 Welfare Fund
c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, Florida 33028
1-800-822-5899

IV. Continuation Coverage under USERRA

The right to continuation coverage when you leave work to perform military service is provided under a federal law called the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"). If you leave your employment to perform services in the uniformed services you may elect to continue coverage under the Plan for yourself and your dependents up to a maximum period of time that is the lesser of:

(a) the 24-month period beginning on the date on which the absence for the purpose of performing military service begins; or

(b) the period beginning on the date upon which the absence for the purpose of performing military service begins, and ending on the day after the date on which the Covered Employee fails to apply for or return to a position of employment, as defined in USERRA.

If your service in the uniformed services continues for fewer than 31 days you will not be required to pay more than any regular employee share for continuing health plan coverage.

If your service in the uniformed services continues for more than 31 days and you elect continuation coverage you may be required to pay no more than 102 percent of the full premium under the Plan, representing the employer's share plus the employee's share plus 2% for administrative costs.

If you enter military service lasting more than 31 days; your eligibility is based on your reserve account; you elect continuation coverage; and you have a positive balance in your reserve account at the time you leave employment, you may either:

(a) use your reserve account balance instead of paying for continuation coverage, with the opportunity to continue coverage by paying no more than 102% of the full premium under the Plan if your reserve account balance is depleted; or

(b) pay for continuation coverage as provided above in order to maintain your reserve account balance intact as of the beginning date of your military service.

If you leave employment for military service without giving advance notice or with notice but without electing continuation coverage then your coverage may be terminated under the terms of the Plan. Depending on the circumstances you may be eligible for retroactive reinstatement of coverage. You may also lose coverage if you fail to make required payments.

If your coverage is terminated as a result of your service in the uniformed services your coverage under the Plan will be re-instated immediately upon re-employment after military service. You will not be subject to any exclusions or waiting periods if exclusions or waiting periods would not have been imposed if your coverage had not been terminated as a result of military service, unless you have an injury or illness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If your eligibility for coverage is based on maintaining required numbers of hours or weeks in a reserve account your coverage will be re-instated immediately, even if you do not have sufficient hours or weeks in your reserve account to establish coverage. The Plan may require that you pay the cost of coverage until the time that your reserve account contains sufficient hours or weeks to sustain coverage.

V. FMLA Authorized Leave

Employees receiving benefits under this Plan may be eligible to take Authorized Leave under the Family and Medical Leave Act ("FMLA") if an Employee is granted Authorized Leave under FMLA by his or her Employer.

An Employee's Employer has all responsibilities and obligations under FMLA to determine whether and when an Employee is eligible for Authorized Leave under FMLA. The Trustees have no responsibilities or obligations relating to such determination, except to the extent that the Plan is the Employer of any Employees receiving benefits.

An Employer who grants Authorized Leave under FMLA to an Employee is required to notify the Third Party Administrator at the time the Authorized Leave period begins and provide all relevant information regarding the Employee's Authorized Leave.

FMLA Authorized Leave

Pursuant to FMLA, Authorized Leave may be granted to an Employee by an Employer for a period of up to 12 workweeks during a 12 month period, or, in the case of Authorized Leave to care for a servicemember, up to 26 workweeks during a 12 month period.

Pursuant to FMLA, Authorized Leave means leave from employment granted for the following specified reasons:

(a) For the birth of an Employee's child, and to care for such child;

(b) For the placement with the Employee of a child for adoption or foster care;

(c) To care for the Employee's spouse, child or parent with a serious health condition;

(d) Because of a serious health condition that makes the Employee unable to perform the function of the Employee's job;

(e) Because of a qualifying exigency arising out of the fact that an Employee's spouse, child or parent is on active duty in the Armed Forces in support of a contingency operation; or

(f) To care for the Employee's spouse, child, parent or next of kin who is a covered service member, as defined in the Family and Medical Leave Act.

Employer Obligations during FMLA Authorized Leave

Pursuant to FMLA, an Employer who grants FMLA Authorized Leave to an Employee is required to maintain group health insurance coverage for the Employee during the period of Authorized Leave on the same conditions as if the Employee had been continuously employed. An Employer must therefore continue to make contributions to the Plan in the amount and manner as would otherwise be required if the Employee was not on Authorized Leave.

An Employer is required to maintain group coverage for an Employee on Authorized FMLA Leave until:

(a) the Employee's FMLA Leave entitlement is exhausted;

(b) the Employer can show that the Employee would have been laid off and the employment relationship terminated; or

(c) the Employee provides unequivocal notice of intent not to return to work.

Employee Rights and Obligations during FMLA Authorized Leave

An Employee may not be required to use any hours in his reserve account during a period of FMLA Authorized Leave, and may not be required to pay a greater premium than the Employee would have been required to pay if the Employee had been continuously employed.

An Employee remains obligated to make payment of any copayments or other financial obligations which are due to be paid by the Employee in order to maintain continuing coverage during the period of Authorized Leave.

Failure by Employee to Make Required Contributions

The Plan will not terminate an Employee's eligibility for failure to make required contributions during a period of FMLA leave until and unless the Plan receives certification from the Employer that notice was properly given to the Employee that coverage would be terminated if payment was not received, as required under 29 CFR §825.212(a)(1). Nothing in this section shall be construed to prohibit an Employer from making payment of any co-contributions on behalf of an Employee.

If an Employee's eligibility for coverage during Authorized FMLA Leave is terminated due to the Employee's failure to make required contributions, then the Employer's contribution obligation may be suspended for the duration of the Employee's Authorized Leave.

Reinstatement after FMLA Authorized Leave

If an Employee's coverage during FMLA Authorized Leave lapses for failure to make required contributions, and the Employee returns to employment after FMLA Authorized Leave, the Employee's eligibility for coverage shall be restored upon re-employment under the same conditions as if the Employee had been continuously employed, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

If an Employee on Authorized FMLA Leave chooses not to retain coverage under the Plan during the period of leave, and returns to employment after FMLA Authorized Leave, the Employee is entitled to be reinstated upon re-employment on the same terms as prior to taking the leave, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

FMLA Authorized Leave and COBRA Continuation Coverage

Authorized Leave granted to an Employee by an Employer pursuant to FMLA is not a Qualifying Event for the purpose of eligibility for COBRA continuation coverage. If an Employee fails to return to work at the end of a period of Authorized Leave, however, such failure to return to work terminates an

Employer's obligation to continue coverage, and may constitute a Qualifying Event for the purpose of eligibility for COBRA continuation coverage.

CLAIMS PROCEDURES

The Plan is required by law to follow certain procedures in processing, reviewing and paying claims. The following procedures apply for the filing and processing of benefit claims; the notification of benefit determinations; and the appeal of adverse benefit determinations.

The Board of Trustees has delegated responsibility for deciding claims to a Claims Administrator for each type of benefit claim. The Claims Administrator for each benefit type is listed above in the descriptions of the benefits offered under the Plan, and identified below.

I. Time for Filing Claims

Either you or your health care provider must submit your claims for benefits to the Claims Administrator for each type of claim. **Please note and follow any time limits for filing claims and for appealing adverse benefit determinations.**

All claims for self-funded benefits under this Plan must be made within one year of the date the claim was incurred. Claims for benefits may be made by a medical care service provider, such as a doctor, hospital, pharmacy or clinic, on your behalf at or near the time services were provided if allowed by the Claims Administrator. You may also submit claims on your own behalf. **Whether a claim is submitted by you or by your medical care provider, the claim must be submitted within one year of the date it was incurred or it will be deemed to be untimely.**

II. Submitting Claims

Submitting Medical Benefit Claims

If you receive benefits under Schedule of Benefits A, your medical benefits claims must be submitted to Cigna using the submission information on your ID card, following Cigna's rules and procedures. Cigna will subsequently transfer claims to NEBA, which shall serve as the Claims Administrator and will make initial claims determinations.

If you receive benefits under Schedule of Benefits B, medical benefit claims for Medicare eligible retirees must be submitted to Medicare in the first instance for claims adjudication and payment, following procedures established by Medicare for submitting claims. After any payment by Medicare your provider can submit your claim via the Medicare Crossover (COBA) Program, or you can submit your claim to NEBA, following NEBA's procedures for submitting claims. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. *All claims for benefits must be made within one year of the date the claim was incurred.* NEBA will serve as the Claims Administrator and will make claims determinations for secondary payer benefits.

If you receive benefits under Schedule of Benefits C, your medical benefit claims must be submitted to NEBA, following NEBA's rules and procedures. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. *All claims for benefits must be made within one year of the date the claim was incurred.* NEBA will serve as the Claims Administrator and make initial claims determinations.

Submitting Prescription Drug Claims

If you receive benefits under Schedules of Benefits A or B, you will typically not have to submit prescription drug claims, as most benefits are determined at the pharmacy when you received your prescription drugs. If you need to submit a prescription drug claim outside of this typical process, it must be submitted to CVS/Caremark, following CVS/Caremark's rules and procedures. *All claims for benefits must be made within one year of the date the claim was incurred.* CVS/Caremark will serve as the Claims Administrator and will make initial claims determinations.

If you receive benefits under Schedule of Benefits C, your prescription drug claims must be submitted to NEBA, following NEBA's rules and procedures. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. *All claims for benefits must be made within one year of the date the claim was incurred.* NEBA will serve as the Claims Administrator and make initial claims determinations.

Submitting Dental Benefit Claims

Claims for dental benefits must be submitted to NEBA, following NEBA's rules and procedures. You don't need to file a claim if your dentist submits it on your behalf. If you have to submit a claim yourself, please contact NEBA at 1-800-822-5899 to obtain a copy of the required form. You must send your completed claim form to the claims address listed on the claim form. *All claims for benefits must be made within one year of the date the claim was incurred.* NEBA will serve as the Claims Administrator and will make initial claims determinations.

Submitting Vision Benefit Claims

There are no claims submissions for in-network vision benefits. Claims for out of network vision benefits must be submitted to Superior Vision, following Superior Vision's rules and procedures. Superior Vision will serve as the Claims Administrator and will make initial claims determinations. *Claims must be submitted within 90 days or as soon as reasonably possible, not to exceed one year.* You can contact Superior Vision customer service at 800-507-3800 or visiting the Superior Vision website at www.superiorvision.com. Superior Vision's address for claims administration is:

National Guardian Life Insurance Co.
c/o Superior Vision Services
P.O. Box 967
Rancho Cordova, CA 95741

Submitting Loss of Time, Death, and Accidental Death or Dismemberment Benefit Claims

Claims for Loss of Time, Death, and Accidental Death or Dismemberment benefits must be filed with NEBA following NEBA's rules and procedures. Please contact NEBA at 1-800-822-5899 to obtain a copy of the required form to submit your claim. You must send your completed claim form to the claims address listed on the claim form. *All claims for benefits must be made within one year of the date the claim was incurred.* NEBA serves as the Claims Administrator for these benefits and will make initial claims determinations. Loss of Time benefits are also referred to in this section as "Disability Benefits".

III. Claims Determination Procedures

Once a benefit claim is filed the appropriate Claims Administrator follows set procedures to evaluate the claim and determine the benefits available under the terms of the Plan. The time periods for benefit claim determinations are different depending on the type of claim, as described below. All benefit claim

determinations are made following governing plan documents and will be applied consistently with respect to similarly situated claimants.

A. Time Periods for Claims Determinations

All benefit claim determinations will be made within the time periods specified herein. The applicable time period begins at the time you file a claim under the procedures provided, whether or not you have provided all of the information necessary to make a benefit determination.

If you fail to submit information necessary to decide a claim, however, the Claims Administrator will need more time before making a determination. If the time period for making a determination is extended for any of the reasons described below, then the period for making the benefit determination is frozen from the date on which you are notified of the need for an extension of time until the date on which you respond to the request for additional information.

B. Time Periods for Determinations of Medical, Prescription Drug, Vision and Dental Claims

The Claims Administrator will process claims for Medical, Prescription Drug, Vision or Dental benefits upon receipt of each claim and will subsequently notify you of the benefit determination. Claims will be processed based on procedures and within the time period allowed for each type of claim, as follows:

1. Urgent Care Claims

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—(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim is to be made by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

If you submit an Urgent Care Claim then the Claims Administrator will notify you of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless you failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If you failed to provide sufficient information, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Following such notification the Claims Administrator will notify you of the benefit determination as soon as possible, but in no case later than 48 hours after (i) the Plan receives the specified information, or (ii) the end of the period afforded to provide the specified additional information, whichever is earlier.

2. Concurrent Care Claims

A Concurrent Care Claim is a claim for benefits for an approved ongoing course of treatment to be provided over a period of time or number of treatments.

It will be considered as an "adverse benefit determination" if, after approval of a course of treatment, there is a reduction or termination of the benefits (other than by plan amendment or termination) before the end of the approved time period or number of treatments. The Claims Administrator shall notify you of such a change in benefits at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

A request to extend an approved ongoing course of treatment beyond the approved time period or number of treatments may also be an Urgent Care Claim depending on the circumstances. An Urgent Care Claim for extension of an approved ongoing course of treatment shall be decided as soon as possible, taking into account the medical exigencies. If such a claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Administrator shall notify the Participant of the benefit determination within 24 hours after receipt of the claim.

3. Pre-Service Claims

A "Pre-Service Claim" is any claim for a benefit that requires, in whole or in part, approval of the benefit in advance of obtaining medical care. ***Some benefits under the Plan require pre-approval before the benefit is provided, and you must be sure to submit a Pre-Service Claim in order to obtain coverage for such benefits.***

The Claims Administrator will notify you that your Pre-Service Claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This time period may be extended once by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information.

If you or your authorized representative fail to follow the Plan's procedures for filing a Pre-Service Claim, then you or your authorized representative will be notified of the failure and of the proper procedures to be followed, provided that the failure to follow procedures is a communication as described in 29 C.F.R. §2560.503-1(c) (1)(ii). This notification shall be made as soon as possible, but no later than 24 hours following a failure to properly file a Pre-Service Claim involving Urgent Care, or 5 days following a failure to properly file any other type of Pre-Service Claim. This notification may be made orally, unless you or your authorized representative requests written notification.

4. Post-Service Claims

A "Post-Service Claim" is a claim for a benefit that is filed after the services have been provided. The Claims Administrator shall notify you of an adverse benefit determination of a Post-Service Claim within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because you failed to submit the information necessary to decide the claim, then the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

C. Time Period for Determination of Loss of Time Claims

The Claims Administrator will process a claim for Loss of Time benefits and notify you of the determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

This period may be extended by the Claims Administrator, for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain 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 those issues, and you shall have at least 45 days within which to provide the specified information.

D. Time Period for Determination of Death, Accidental Death or Dismemberment Claims

After you submit a claim for Death, Accidental Death or Dismemberment Benefits, the Claims Administrator will process the claim and notify you of its determination within a reasonable period of time not exceeding 90 days. The Claims Administrator may extend the 90-day limitation if special circumstances so require.

IV. Adverse Benefit Determinations

An "adverse benefit determination" is any decision on a claim that is a denial, reduction, or termination of benefits. More specifically, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is

based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

A. Time Period for Notification of Adverse Benefit Determinations

Except as otherwise described below, if a claim is wholly or partially denied, the Claims Administrator shall notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

B. Manner and Content of Notification of Adverse Benefit Determinations

Except as otherwise described below, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination.

In the case of an adverse benefit determination on an Urgent Care Claim, notification may be given orally within the time frame described above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

The notification of an adverse benefit determination shall set forth the following information:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the determination based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) If the adverse benefit determination relates to a claim involving urgent care, a description of the expedited review process applicable to such claims.

V. Appeals of Adverse Benefit Determinations

A. Time Period for Appeal

You have a right to appeal an adverse benefit determination relating to any claim for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination. Unless otherwise provided herein, you will have *at least 60 days* following receipt of an adverse benefit determination to appeal the determination. Appeals of adverse benefit determinations must be brought by you or by your authorized representative.

B. Opportunity to Review and Submit Material Relevant to Your Claim

You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Claims Administrator will provide, free of charge and upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

A document, record, or other information shall be considered "relevant" to your claim for benefits if such document, record, or other information, (i) was relied upon in making the benefit determination, (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the benefit determination, or (iv) in the case of disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The review shall take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

C. Additional Time Period and Procedures for Appeals of Claims for Medical, Prescription Drug, Vision, Dental and Loss of Time/Disability Benefits

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, Vision, Dental and Loss of Time/Disability benefits must be submitted in writing within 180 days of your receipt of an adverse benefit determination.

The Board of Trustees will consider and decide all appeals of adverse benefit determinations for claims for Medical, Prescription Drug, Vision, Dental and Loss of Time/Disability benefits taking into account all comments, documents, records and other information submitted by the claimant relating to the claims, without regard to whether such information was submitted or considered in the initial benefit determination. The Board will not afford deference to the initial adverse benefit determination, and the review will be conducted by a fiduciary who did not make the initial adverse benefit determination and who is not a subordinate of the person who did.

If an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The professional so consulted will not be a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and will not be a subordinate of any expert consulted in connection with the adverse determination under appeal.

If medical or vocational experts were consulted on behalf of the Plan in connection with an adverse benefit determination, such experts will be identified, whether or not the advice obtained was relied upon in making the benefit determination.

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, Vision or Dental benefits involving urgent care will include an expedited review process. Under the expedited review process a request for an expedited appeal may be submitted orally or in writing by the claimant, and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

D. Time for Determination and Notification of Decision after Appeal

All appeals of adverse benefit claim determinations will be made within the time periods described below. The applicable time period begins at the time a request for an appeal is received by the Plan in accordance with the procedures for filing appeals, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. *If you fail to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.*

The Board of Trustees shall make a benefit determination no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If a request for review is filed less than 30 days before the next meeting, the Board shall make a determination no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of the request for review.

If an extension of time for review is required because of special circumstances, the Plan Administrator shall provide written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will be made.

The Plan Administrator shall notify you of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

E. Time for Determination and Notification of Decision after Appeal of Certain Types of Health Care Claims

1. Urgent Care Claims

If you appealed an adverse benefit determination of an Urgent Care Claim the Plan Administrator will notify you of the Plan's decision on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

2. Pre-Service Claims

If you appealed an adverse benefit determination of a Pre-Service Claim the Plan Administrator will notify you of the Plan's decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claimant's request for review of an adverse benefit determination.

F. Manner and Content of Notification of Decision after Appeal

The Plan Administrator shall provide written or electronic notification to the claimant of the Board's decision on a claim after appeal and review.

In the case of an adverse benefit determination, the notification shall set forth the following information—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(4) A statement of the claimant's right to bring an action under section 502(a) of ERISA;

(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

G. Submission of Additional Information

This Plan allows for you to re-submit a claim that was denied on the basis of insufficient information if certain conditions are met. If your medical benefit claim is denied because the Claims Administrator received insufficient information on which to adjudicate a claim, you may submit such additional information within one year of receiving notice that the claim was denied on this basis. If sufficient information is submitted within one year of the denial, the Claims Administrator will re-consider adjudication of the claim. *This review is only available if a claim was denied because the Claims Administrator did not have sufficient information and if sufficient information is submitted within one year of the claim denial.* The Claims Administrator will not consider information submitted more than one year after a claim is denied. There will be no further notification to a Covered Person after notice is given that a medical claim was denied because the Claims Administrator received insufficient information.

OTHER IMPORTANT INFORMATION ABOUT YOUR BENEFITS

I. Circumstances That Could Affect Your Receipt of Benefits

Fraud or Misrepresentation: The Plan shall have the right to recover whatever benefits are paid on behalf of any person when the basis of such claim is misrepresented or fraudulently presented to the Plan, whether by a Participant or by any medical service provider(s). If fraud or misrepresentation is established the Plan shall have the right to recover all benefits paid by either: (1) a direct recovery from the Participant and/or the medical service provider(s) responsible for the fraud or misrepresentation; or (2) by reducing or off-setting all subsequent benefits for such Participant and members of the Participant's family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts. Such recovery may also include medical investigation charges, auditors' fees and attorney fees, as necessary.

Coordination of Benefits: If you are enrolled in more than one health care plan, one plan is treated as the primary plan and the others are treated as secondary or tertiary. Coordination of Benefits ("COB") ensures that the combined payments of all coverage under different plans will not exceed the Allowable Expense approved for the medical or dental services provided. This Plan coordinates benefits with other group benefit plans that provide medical and/or dental benefits; governmental programs providing benefits required by statute; and individual liability policies such as motor vehicle and homeowners'. This Plan does not coordinate benefits with HMOs or individual health insurance policies and does not coordinate benefits for prescription drug benefits. The Plan coordinates benefits with Medicare following Medicare rules and regulations therefore this section does not apply to coordination of benefits with Medicare.

The Third Party Administrator shall determine whether this Plan is the primary plan or secondary plan, using rules and procedures established for this Plan. If this Plan is the primary plan it will pay full benefits, without regard to any Other Coverage. If this Plan is the secondary plan it will provide payments toward the balance of the cost of covered services after the Other Coverage, up to the Allowable Expense. When acting as the secondary plan, this Plan will apply its standard Coinsurance, Deductibles and Copayments to calculate the benefit payable and pay the balance of the covered expenses not paid by the primary plan. Under no circumstance will this Plan pay more as the secondary plan than it would have paid had this Plan been the primary payer.

You are required to provide the Third Party Administrator with updated information regarding your other coverage. The Third Party Administrator is not required to determine the existence of or the amount of benefits payable under any other group health plan, insurance program or government program. The payment of benefits under this Plan shall be affected by the benefits payable under Other Coverage only if this Plan is furnished with information concerning the existence of such other source of benefit payments.

Please contact the Third Party Administrator for more information about Coordination of Benefits with Other Coverage, including the rules and procedures that apply.

Reimbursement and Subrogation: If you receive benefits under this Plan for Injuries or Illnesses that were caused by a third party, the Plan has a right of reimbursement to recover the amount of benefits paid if you later obtain recovery from the responsible party. The Plan also has a subrogation right to assert any clams that you may have against such responsible party. This is a condition precedent, which means that you have to agree to the Plan's rights in order to receive benefits under the Plan for Injuries or Illnesses caused by a third party. These important rules are described in more detail below.

Plan's Rights: By receiving benefits under the Plan for Injuries or Illness caused by a third party you agree that the Plan has the right of subrogation against any third party tortfeasor who caused the Injuries or Illness or against any insurance carrier providing coverage related to the Injuries or Illness. You further agree that the Plan has a separate and independent right to reimbursement, in the amount of the benefits paid under this Plan, from any amounts recovered on your behalf from a third party relating to the Injuries or Illness, whether or not recovered amounts are designated as medical expenses, and whether or not recovered amounts are in your custody or control.

Reimbursement and Subrogation Agreement: By receiving benefits under the Plan related to Injuries or Illnesses caused by a third party, you agree to execute a Reimbursement and Subrogation Agreement and any other required documents, as provided by the Plan Administrator, describing in further detail the Plan's reimbursement and subrogation rights.

Your Responsibilities: You are also required to notify the Plan Administrator of any claim or legal action asserted against any party or insurance carrier in connection with such Injuries or Illness; to promptly

provide the name and address of such party and any insurance carrier to the Plan Administrator; and to notify the Plan Administrator and seek consent of the Trustees before settling any such claim.

Plan's Lien: By receiving benefits you also agree that the Plan has a lien, for the amount of benefits paid under the terms of the Plan, on any amounts recovered on your behalf, whether or not such amounts are designated as payment for medical expenses. This lien attaches to any recovery, settlement, or judgment obtained from or against any party at fault, or from any other source, relating to Injuries or Illness caused by a third party. The lien shall remain in effect until the Plan is reimbursed in the amount of all benefits paid in connection with your Injuries or Illness. The lien applies to any such amounts recovered, whether in your possession or in someone else's possession, such as a lawyer, trustee, guardian or conservator.

Right to Full Recovery: The Plan's reimbursement and subrogation rights are not subject to equitable distribution or to any reduction for costs or attorneys' fees incurred in pursuit of your claim against a third party tortfeasor, insurance carrier or other responsible party. The Plan shall be entitled to reimbursement from the first dollars recovered from any party or insurance carrier. The Plan has the right to full recovery, which shall not be subject to reduction regardless of whether you recover the full value of your claim against a third party and/or insurance carrier.

Failure to Comply: In the event that you fail to execute a Reimbursement and Subrogation Agreement, or otherwise fail to comply with the terms of this section, then such shall be considered a breach of this Plan and benefits may be denied by the Trustees.

Plan's Right to Recover Excess Payments: Whenever payments have been made by the Plan in excess of the maximum amount of payment allowed under the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine: (a) any persons to whom, for whom or with respect to whom such payments were made or (b) any insurance companies, service plans or any other organizations to whom such payments were made.

No Reliance on Oral Representation: All decisions relating to eligibility, coverage and benefits will be made in writing. No oral representation, confirmation, description or explanation of coverage and/or benefits is binding upon the Plan.

II. Other Important Information

Assignment of Claims: Benefits which are not based on expenses incurred may not be assigned. Benefits payable for expenses incurred in connection with a specified period of disability, hospital care or surgical or medical treatment resulting from one injury or illness may be assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable. The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payments and the Plan will not be required to see to the application of the payment.

Time Limitations for Legal Actions: No action may be brought under ERISA in court prior to exhaustion of these administrative remedies. Any action brought in court must be initiated within two years of the date that a claim was denied after exhaustion of all administrative remedies.

Physician Review: A physician designated by the Plan shall have the right and opportunity to examine any person whose illness or injury is the basis of any claim when and as often as reasonably required and, in the event of such person's death, to make an autopsy unless prohibited by law.

Applicable Law: This Plan is created and accepted in the State of Florida. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Florida except as to matters governed by federal law.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, *all documents governing the plan,* including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Benefit from reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Information can also be obtained at the DOL's website, www.dol.gov.

GLOSSARY

All capitalized terms used in this Summary Plan Description are used in the same manner as they are used and defined in the Plan Document, including the following:

A. Available for Work - Being registered on the out-of-work list with the Union's hiring hall and otherwise being unemployed. An employee shall not be considered available for work, if (i) he is working for an employer that is located within the geographic jurisdiction of the Plan, but which is not obligated to make contributions to the Fund on the employee's behalf; or, (ii) he is working for an employer that is located outside of the geographic jurisdiction covered by the Plan, and which is not covered by a Reciprocal Agreement.

B. Board of Trustees - The Board of Trustees of the Welfare Plan of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund. Also referred to as the "Trustees."

C. Bargaining Unit Employee - A person who is employed by an Employer under the terms of a Collective Bargaining Agreement doing work in any job classification. Bargaining Unit Employees may be eligible for benefits under Schedule of Benefits A or C, as determined by the Plan's Trustees based on the negotiated contribution rate in the applicable Collective Bargaining Agreement.

D. Claims Administrator - The person or entity designated by the Board of Trustees to adjudicate benefit claims on behalf of the Plan.

E. Collective Bargaining Agreement – An agreement between an Employer and a Union under which the Employer has agreed to make contributions to the Trust Fund on behalf of its Employees. Also referred to as "CBA."

F. Complete Coverage Employee - A person who is employed by an Employer under the terms of a Collective Bargaining Agreement doing work in any job classification other than Helper or Pre-Apprentice and on whose behalf the Employer is required to make contributions to the Fund at rates for job classifications other than Helper or Pre-Apprentice. Also referred to as "Journeyman Employee". Complete Coverage Employees are eligible for benefits under Schedule of Benefits A.

G. Covered Employee - An Employee who is eligible for benefits under this Plan as a Bargaining Unit Employee or a Non-Bargaining Unit Employee.

H. Covered Person - A Covered Employee, a covered Retiree, and/or a covered Dependent.

I. Employee - Each person who is employed by an Employer and on whose behalf the Employer is required to make contributions to the Fund under the terms of a Collective Bargaining Agreement or a Participation Agreement.

J. Employer –

(a) An employer who is bound by a Collective Bargaining Agreement with a Union or by a Participation Agreement with the Trustees, to make payments to the Trust Fund with respect to Employees covered by said Collective Bargaining Agreement or Participation Agreement.

(b) A Union required to contribute to the Trust Fund on behalf of its employees, as agreed to by the Trustees and as set forth in a Participation Agreement.

(c) The Trustees of the Trust Fund who contribute on behalf of Trust Fund employees, as set forth in a Participation Agreement.

(d) The trustees of any other trust fund established pursuant to a collective bargaining agreement who contribute on behalf of trust fund employees or trust fund participants, as agreed to by the Trustees and as set forth in a Participation Agreement.

K. Fee Schedule - The schedule of maximum allowable expenses for services and supplies, as determined by the Board of Trustees. The Fee Schedule for in-network charges will be based on the negotiated schedule provided by the contracted PPO network. The Fee Schedule for out-of-network charges will be the 25th percentile of the ADP Context fee schedule, except that a special fee schedule may be used for out-of-network charges for Non-PPO radiologists, anesthesiologists, pathologists, and emergency room physician providers if there are no PPO providers available at the hospital and the charges are incurred at an In-Network hospital or out-patient facility. The special fee schedule will also be used for Ambulance charges and Out-of-Network Non-PPO emergency and urgent care facility and ancillary charges as well as Non-PPO emergency room or urgent care physician charges. The special fee schedule will be the 85th percentile of the ADP Context fee schedule.

L. Helper Employee - A person who is employed by an Employer under the terms of a Collective Bargaining Agreement doing work in the Helper or Pre-Apprentice job classifications and on whose behalf the Employer is required to make contributions to the Fund under wage/benefit schedules for Helper Employees. Helper Employees are eligible for benefits under either Schedule A or Schedule C, as determined by the Plan's Trustees based on the negotiated contribution rate in the applicable Collective Bargaining Agreement.

M. Illness - A disease, disorder or condition which requires treatment by a Physician. Illness also includes pregnancy, childbirth, miscarriages, non-elective abortion or complication resulting thereof, or any related condition. Also referred to as Sickness.

N. Injury - A non-occupational accidental physical harm which is the result of a specific unexpected incident caused by an outside force. Injury does not include Illness.

O. Non-Bargaining Unit Employee – Any employee of a contributing Employer or of the Union who is a full-time salaried employee, officer or director of the contributing Employer or of the Union and upon whose behalf the Trustees have agreed to accept contributions pursuant to a written Participation Agreement.

P. Participant - A Covered Employee and/or a covered Dependent. The term "Participant" includes Retirees unless indicated otherwise. Also referred to as a Covered Person.

Q. Participation Agreement – An agreement between an Employer, a Union or the trustees of a trust fund, and the Board of Trustees, under which the Employer, Union or the trustees of a trust fund have agreed to make contributions to the Trust Fund on behalf of non-bargaining unit employees.

R. Plan – This Welfare Plan of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund, as amended.

S. Plan Administrator – The Board of Trustees of the Plan.

T. Reciprocal Agreement - An agreement between or among the Union and unions in other geographical locations which provides for the transfer of contributions to a traveling Employee's home local union Fund when a traveling Employee is working outside of such Employee's home local's jurisdiction.

U. Retiree - A person who meets the eligibility criterion for coverage under this Plan as a Retiree.

V. Schedule of Benefits – The Schedule that sets forth the levels of benefits and payment requirements, including Copayments, Coinsurance, Deductible amounts and maximum benefit and payment limitations.

W. Sickness - A disease, disorder or condition which requires treatment by a Physician. Sickness also includes pregnancy, childbirth, miscarriages, non-elective abortion or complication, or any related condition. Also referred to as Illness.

X. Third Party Administrator – The person or entity designated by the Board of Trustees to perform plan administration functions for the Plan.

Y. Totally Disabled - A disability resulting from bodily Injury or Illness which completely and continuously prevents the Employee from performing any and every duty pertaining to his occupation or employment.

Z. Trust Fund or Fund - The entire trust estate of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund, as it may from time to time be constituted, including but not limited to, all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), earnings and profits therefrom, and any and all other property or funds received and held by the Trustees by reason of their acceptance of this Plan.

AA. Union – Plumbers and Pipefitters Local Union No. 630, and any of its successors.

Additional Definitions can be found in the Plan Document.

Non-Discrimination Statement:

The Welfare Plan of the Plumbers and Pipefitters Local Union No. 630 Welfare Fund ("the Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

The Plan also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services please contact the Plan's Third Party Administrator at 1-561-478-0095 (TTY: 1-800-822-5899).

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019 | (800) 537-7697 (TDD)

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

ATENCIÓN: si hablas español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-561-478-0095 (TTY: 1-800-822-5899).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-561-478-0095 (TTY: 1-800-822-5899).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-561-478-0095 (TTY: 1-800-822-5899).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-561-478-0095 (TTY: 1-800-822-5899).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-561-478-0095 (TTY: 1-800-822-5899).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-561-478-0095 (TTY: 1-800-822-5899).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-561-478-0095 (TTY: 1-800-822-5899).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-561-478-0095 (TTY: 1-800-822-5899).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-561-478-0095 (TTY: 1-800-822-5899) (0095-478-561-1: رقم هاتف الصم والبكم (TTY: 1-800-822-5899)..

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-561-478-0095 (TTY: 1-800-822-5899).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-561-478-0095 (TTY: 1-800-822-5899).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-1-561-478-0095 (TTY: 1-800-822-5899). 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-561-478-0095 (TTY: 1-800-822-5899).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-561-478-0095 (TTY: 1-800-822-5899).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-561-478-0095 (TTY: 1-800-822-5899).