ARIZONA PIPE TRADES HEALTH *and* WELFARE TRUST FUND

Summary Plan Description

Plan Rules and Regulations for the Retiree Only Health Reimbursement Arrangement (HRA)

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January 2018

ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND

Summary Plan Description (SPD)/Plan Rules and Regulations for the

Retiree Only Health Reimbursement Arrangement (HRA)

Amended, restated and effective January 1, 2017 and including Amendment #1

ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND

To All Eligible Plan Participants:

We are pleased to provide you with this document describing the Health Reimbursement Arrangement (HRA) Plan benefits for Retirees provided by your Health and Welfare Trust Fund. This document describes the **Retiree Only HRA Plan** and this document is called the Summary Plan Description (SPD)/Plan Rules and Regulations.

Inside this document is a description of the benefits to which you and your family are entitled, the rules governing these benefits and the procedures that should be followed when making a claim. It will help you understand and use the benefits provided by the Fund. You should review it and also show it to those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. **Remember, not every expense you incur is reimbursable by the Plan.**

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in the front of this document.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Also included in this document is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act (ERISA).

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Board of Trustees information regarding change of name, change of address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child (such as reached the limiting age for eligibility), Medicare enrollment or disenrollment or the existence of other coverage.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan.

Please familiarize yourself with the benefits described in this document in order to fully understand the extent of the benefits to which you are entitled. Any questions you have should be directed to the Administrative Office where the staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

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AUTHORIZED SOURCE OF INFORMATION

The only source of authorized information on the Retiree Only HRA Plan is this document that is the Summary Plan Description/Plan Rules and Regulations, and the written statements of the Fund. Statements or representations made by individuals other than designated personnel are not authoritative sources of information.

Questions about eligibility, benefits and other matters should be submitted to the Administrative Office at their address listed on the Quick Reference Chart in the front of this document.

DISCLAIMER

NOTE: The benefits described in this document are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and beyond the amount of the funds collected and available for such purpose.

The Board of Trustees shall have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Board of Trustees has full power to construe the provisions of the Agreement and Declaration of Trust for the Fund and the Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Board of Trustees in good faith shall be binding on all of the parties and beneficiaries of this Fund.

The provisions contained in the Rules and Regulations of this Health and Welfare Plan will govern all claim payments.

Nothing in the SPD portion of this document is meant to interpret or extend or change in any way the provisions expressed in the Rules and Regulations of the Health and Welfare plan.

The Board of Trustees reserves the right to amend, modify or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant as determined in the Board's sole and exclusive discretion.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed:	**Contact the following:**
Administrative Office (Administrative Office) HRA Claims Administrator • Eligibility and Plan Benefit information • HRA Plan benefits, claims and appeals • COBRA Administration	**BeneSys, Inc.** 3109 N. 24th Street, Suite 105 Phoenix, AZ 85016 **Toll Free Phone:** **1-877-429-7473** Fax: 1-303-429-1359 Website: www.azpipe.org Email address: staff@azpipe.org
Plan Administrator (Board of Trustees) • Claim Appeals	**Board of Trustees for the Arizona Pipe Trades Health and Welfare Trust Fund** 3109 N. 24th Street, Suite 105 Phoenix, AZ 85016 Toll Free Phone: 1-877-429-7473 Website: www.azpipe.org Email address: staff@azpipe.org
Privacy Officer and Security Officer	**Arizona Pipe Trades Health and Welfare Trust Fund** 3109 N. 24th Street, Suite 105 Phoenix, AZ 85016 Toll Free Phone: 1-877-429-7473 Website: www.azpipe.org Email address: staff@azpipe.org

ARTICLE I: INTRODUCTION

1.01 **Establishment of Plan.** Effective June 1, 2014, and restated on January 1, 2017, the Arizona Pipe Trades Health and Welfare Trust Fund (the Fund) hereby establishes this Health Reimbursement Arrangement (HRA) Plan for Retirees only (the Plan).

1.02 **Purpose.** The Plan is intended to qualify as an employer-provided Retiree Only medical reimbursement plan under Internal Revenue Code sections 105 and 106 and regulations issued thereunder in the form of a health reimbursement arrangement in accordance with Internal Revenue Service Notice 2002-45. The Plan is intended to comply with the requirements of IRS Notice 2013-54 and shall be interpreted to accomplish that objective.

This Retiree Only HRA Plan is established for the sole benefit of retired employees of the Arizona Pipe Trades Health and Welfare Trust Fund. The Retiree's HRA Account shall be funded from the rollover of the HRA Account balance accumulated while the Retiree was an Active Employee in the Active Employee Plan. Effective March 1, 2016, the HRA Account is also comprised of the certain Fund contributions on behalf of Medicare-Eligible Retirees as explained in section 4.02.

HRA Plan reimbursements to Retirees are provided tax-free.

1.03 **Rights.** This Plan does not give any Participant or any other person any legal or equitable right against the Fund, or the corpus or income of the Fund unless the right is specifically provided for in this Plan. No Participant shall have the right to anticipate, hypothecate or otherwise alienate or assign any benefits from this Plan.

ARTICLE II: DEFINITIONS

The following words and phrases shall, when used herein with initial capitalization, have the following meanings unless the context clearly indicates otherwise. Some of the words and phrases used in this Plan are defined, for convenience, as they are introduced into the text, rather than in this Article II.

2.01 **Code.** The Internal Revenue Code of 1986, as amended or replaced from time to time.

2.02 **Dependent.** Any individual who is a tax dependent of an Eligible Retiree, as defined in Code section 152, and any child to whom Code section 152(e) applies. Notwithstanding the foregoing, this Plan will provide benefits in accordance with the applicable requirements of any national medical support notice (NMSN), defined in section 401(e) of the Child Support Performance and Incentive Act of 1998 (PL 105-200), even if the child is not a tax dependent.

2.03 **Eligible Retiree.** An Eligible Retiree includes both a Non-Medicare Retiree (also called an Early Retiree) and a Medicare-Eligible Retiree. An Eligible Retiree is a Plan Participant.

a. A **Non-Medicare Retiree** means a Former Active Employee of the Arizona Pipe Trades Health and Welfare Trust Fund who is receiving an Early Regular or Disability Pension from the Arizona Pipe Trades Pension Trust Fund and who is not entitled to Medicare. A Non-Medicare Retiree is also called an Early Retiree in this document.

b. The term **Medicare-Eligible Retiree** means a former Active Participant of the Arizona Pipe Trades Health and Welfare Trust Fund who is entitled to benefits under Medicare part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) and who has been awarded a pension under the Arizona Pipe Trades Pension Trust Fund.

2.04 **Fund.** Arizona Pipe Trades Health and Welfare Trust Fund.

2.05 **HRA Account.** The recordkeeping account established and maintained for each Plan Participant, which is comprised of the rollover of the HRA Account balance from the Active Employee Plan, less fees, expenses and/or benefit payments. Effective March 1, 2016, the HRA Account is also comprised of the certain Fund contributions on behalf of Medicare-Eligible Retirees as explained in section 4.02.

2.06 **Medical Care Expenses.** The Plan will reimburse HRA Plan Participants for Medical Care Expenses, under IRC Section 213, except those expenses excluded from the Plan in accordance with Section 5.13.

"Medical Care Expenses" include, but are not limited to COBRA premiums, premiums for individual or group health insurance coverage whether purchased in the individual insurance marketplace or on a private exchange (including a Retiree Medicare exchange), or public state or federal Health Insurance Marketplace, premiums for Long Term Care insurance, and Medicare premiums up to the unused amount in the HRA Plan Participant's HRA Account , and Retiree self-payments provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees. See also section 5.08 for more information.

2.07 **Participant/HRA Participant.** Each Eligible Retiree is a Participant immediately upon retirement. If an Eligible Retiree has a Spouse at the time the HRA account is established, that Spouse will also be considered to be a Participant.

2.08 **Plan.** This Health Reimbursement Arrangement (HRA) Plan, as set forth herein, and any modification, amendment, extension or renewal thereof. This Plan is intended to provide nontaxable benefits under Code sections 105 and 106.

2.09 **Plan Administrator.** The Board of Trustees of the Arizona Pipe Trades Health and Welfare Trust Fund, with the powers and duties described in Article VI to administer the Plan for the benefit of the Participants.

2.10 **Plan Year.** A 12 consecutive month period beginning each June 1st and ending the following May 31st.

2.11 **Spouse.** An individual who is legally married to an Eligible Retiree. An unmarried Domestic Partner or civil union partner is not a Spouse under this Plan.

2.12 **Trustee.** The Board of Trustees or any successor Trustee, in accordance with the terms of this Plan.

2.13 **You or Your**. Refers to the Eligible Retiree.

ARTICLE III: ELIGIBILITY AND VESTING

3.01 **Eligibility for Participation.** An individual shall be eligible to participate in the Plan immediately upon becoming an Eligible Retiree as defined in this Plan. If the Eligible Retiree has a Spouse at the time the HRA Account is started in this Retiree Only HRA Plan, a joint HRA account will be established.

3.02 **Termination of Participation.** A Participant will cease to be a Participant in this Plan upon the earliest of:

a. the date the Participant's HRA Account is depleted;

b. the effective date of the Participant's election to permanently opt out of coverage under this Plan;

c. the death of the Participant,

d. the date the account is forfeited; or

e. the date of termination of this Plan.

3.03 **Vesting.** Benefits are not vested. The Trustees reserve the right to terminate the Plan at any time.

ARTICLE IV: CONTRIBUTIONS

4.01 **Participant Contributions.** Participant contributions are neither required nor permitted under this Plan.

4.02 **HRA Contributions.** Upon a Retiree's participation in this Retiree Only HRA Plan, an Eligible Retiree's HRA Account is automatically funded with the HRA Account balance that existed upon termination from the Active Employee HRA Plan (as a result of the funds accumulated when the Retiree was an Active Employee under the Active Employee Plan).

No further contributions accumulate in a Retiree Only HRA Account under this Plan, except as explained below:

(a) Effective March 1, 2016, the Fund will make contributions to an HRA Account on behalf of a Medicare-Eligible Retiree and/or a Medicare-eligible Spouse that participated under the terminated Arizona Pipe Trades Health and Welfare Medicare Retiree Plan. The amount of the contribution to the HRA Account will depend on the date the individual retired. The HRA contributions are intended to help reimburse the premium that a Medicare-Eligible Retiree or Spouse pays for the purchase of an individual supplemental Medicare plan, as well as other Medical care expenses.

If the Eligible Retiree and Spouse are currently married, a joint HRA Account will be established. Questions about HRA contributions should be directed to the Administrative Office.

(b) **A Medicare-Eligible Retiree (and each Medicare-eligible Spouse) with a retirement date <u>prior to</u> August 1, 2009,** will have a $1,000 contribution made by the Fund to their HRA Account to be available for use during the period March 1, 2016 through December 31, 2016. An additional $1,000 contribution will be made available for use during the period January 1, 2017 through December 31, 2017. An additional $1,000 contribution will be made available for use for each subsequent calendar year. These additional contributions are not made to a Medicare-Eligible Retiree and Medicare eligible Spouse that did not participate in the terminated Arizona Pipe Trades Health and Welfare Medicare Retiree Plan.

The unused portion of the HRA will rollover to be able to be used in following years.

(c) **A Medicare-Eligible Retiree (and each Medicare-eligible Spouse) with a retirement date <u>on or after</u> August 1, 2009,** will have a $500 contribution made by the Fund to their HRA Account to be available for use during the period March 1, 2016 through December 31, 2016. An additional $500 contribution will be made available for use during the period January 1, 2017 through December 31, 2017. A third contribution of $500 will be made available for use during the period January 1, 2018 through December 31, 2018. No additional HRA contribution will be made after December 31, 2018; however, any unused portions of the HRA will rollover to be used in following years. These additional contributions are not made to a Medicare Eligible Retiree and Medicare eligible Spouse that did not participate in the terminated Arizona Pipe Trades Health and Welfare Medicare Retiree Plan.

For Medicare-Eligible Retirees who return to work for a Contributing Employer, all contributions that are required to be made under the terms of the collective bargaining agreement and which are designated as Health and Welfare or HRA contributions will be credited to their HRA Account in this Retiree Only HRA Plan.

The Trustees may make an HRA contribution to the HRA Account of those Participants who have been unable to transition to an affordable Medicare supplement plan because of the Participant's disability or serious illness.

The Trustees may also make additional HRA contributions from Fund reserves.

For Non-Medicare Eligible Retirees who return to work for a contributing employer, HRA contributions made on their behalf to the Active Employee HRA Plan will automatically be transitioned to their HRA Account in this Retiree Only Plan.

ARTICLE V: BENEFITS

5.01 **Benefit Eligibility.** An Eligible Retiree shall be eligible to receive benefits under the Plan immediately upon becoming eligible to participate in the Plan in accordance with Section 3.01, and shall continue to be eligible to receive benefits until participation terminates under the Plan in accordance with Section 3.02.

5.02 **Payment of Benefits.** Benefits under this Plan shall be limited to reimbursement of Medical Care Expenses incurred by a Participant after the eligibility requirements have been satisfied, up to the unused amount of the Participant's HRA Account. The Board of Trustees shall require evidence that Medical Care Expenses have been incurred by a Participant before benefit payments under this Plan may be made to a Participant.

In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Medical Care Expenses can only be reimbursed under this Plan once, to the extent not reimbursed through insurance or any other accident or health plan.

If Medical Care Expenses of a Participant are covered by both this Plan and a health care flexible spending account, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the health care flexible spending account have been exhausted.

Time Limit For Initial Filing Of Claims for Reimbursement under the Plan:
All claims must be submitted to the Plan within two (2) years from the date of service.

5.03 **Statement of HRA Account Balance.** Upon initial establishment of an HRA Account in accordance with Section 5.02 and at least annually thereafter, the Board of Trustees will provide each Participant with a statement of his or her HRA Account balance, and all payments made from the HRA Account for that Plan Year.

5.04 **Death of Eligible Retiree.** If an Eligible Retiree had a Spouse at the time the HRA Account was started in this Retiree Only HRA Plan, that HRA account was set up as a joint HRA account. If an Eligible Retiree dies, the surviving Spouse will continue to be eligible as a Participant. If there is no surviving Participant, surviving Dependent children may submit claims incurred by the Participant prior to the date of the Spouse's death. Remaining HRA Account balances will be forfeited. Remaining HRA Account balances will revert to general reserve assets of the Arizona Pipe Trades Health and Welfare Fund.

5.05 **Forfeitures.** Amounts forfeited in accordance with Section 5.04 and Section 5.11(c) shall be utilized to offset administrative expenses of the Plan as directed by the Board of Trustees.

5.06 **Compliance with Federal Laws.** Benefits under this Plan shall be provided in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and other applicable group health plan laws, as such are amended and to the extent required by such laws. In addition, benefits under this Plan shall be provided in compliance with the Patient Protections and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA) to the extent applicable.

5.07 **COBRA.** Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Spouse or Dependent Child of a Retiree who participates in this Plan (a qualified beneficiary) and whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis. The self-pay coverage shall be the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by COBRA, subject to all conditions and limitations under COBRA. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, such a qualified beneficiary shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants.

Qualified beneficiaries under COBRA shall be eligible to withdraw from the Retiree's remaining HRA Account. A premium for COBRA continuation coverage shall be charged to the qualified beneficiary in such amounts and shall be payable at such times as are established by the Board of Trustees and permitted by COBRA.

For more information on COBRA contact the Administrative Office.

5.08 **HRA Account Claims Administration**.

(a) **Benefits.** The Plan will reimburse HRA Participants for Medical Care Expenses, under IRC Section 213, except those expenses excluded from the Plan in accordance with Section 5.13. "**Medical Care Expenses**" include, but are not limited to, COBRA premiums, premiums for individual or group health insurance coverage whether purchased in the individual insurance marketplace or on a private exchange (including a Retiree Medicare exchange), or public state or federal Health Insurance Marketplace, premiums for Long Term Care insurance, and Medicare premiums up to the unused amount in the HRA Participant's HRA Account , provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

(b) **Medical Care Expenses**. An HRA Participant may receive reimbursement for eligible Medical Care Expenses provided a claim for such benefits is submitted in the form prescribed the Board of Trustees and there are adequate funds in the HRA to reimburse part or all of such claim.

(1) **Incurred**. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an HRA Participant first becomes covered by the Plan are not eligible.

However, a Medical Care Expense incurred during one Plan Year may be paid during a later Plan Year, provided that the HRA Participant was an HRA Participant in the Plan during both Plan Years.

(2) **Medical Care Expenses**. "Medical Care Expenses" is defined in Article II.

(3) **Medical Care Expenses Exclusions.** "Medical Care Expenses" shall not include the expenses listed as exclusions under Section 5.13 of this Article.

(4) **Cannot Be Reimbursed or Reimbursable from Another Source**. Medical Care Expenses can only be reimbursed to the extent that the HRA Participant or other person incurring the expense is not reimbursed for the expense through the Medical Plan, other insurance, or any other accident or health plan (if the other health plan is a Health Flexible Spending Account (FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Plan imposes Copayment or Deductible limitations), the HRA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein.

(c) **Maximum Benefits**. Unused amounts in the HRA may be carried over to the next year, as provided hereafter.

(d) **Nondiscrimination**. Internal Revenue Code §105(h) applies to this Plan.

(e) **Establishment of Account**. The Administrative Office will establish and maintain an HRA Account with respect to each HRA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping of account balances and available reimbursement amounts.

(1) **Crediting of Accounts**. For Medicare-Eligible Retirees who return to work for a contributing employer, all contributions made on their behalf will automatically be transitioned to their HRA Account in this Retiree Only HRA Plan.

The Trustees may also make additional HRA contributions from Fund reserves.

For Non-Medicare Eligible Retirees who return to work for a contributing employer, all HRA contributions made on their behalf will automatically be transitioned to their HRA Account in this Retiree Only Plan.

There is no interest or investment income credited to an HRA Account.

(2) **Debiting of Accounts**. An HRA Participant's HRA Account will be debited for any reimbursement of Medical Care Expenses, including premiums for health insurance coverage and COBRA premiums incurred during the Plan Year.

Administrative expenses incurred by the Plan to administer the HRA are not debited from a Participant's HRA Account.

(3) **Available Amount**. The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account as described above reduced by prior reimbursements debited as described above.

(f) **Carryover of Accounts.** If any balance remains in the HRA Participant's HRA Account at the end of the Plan Year after all reimbursements have been made, such balance shall be carried over to reimburse the HRA Participant for Medical Care Expenses incurred during a subsequent Plan Year.

(g) **Opt Out or Freeze Permitted**.

(1) **Opt Out**. An HRA Participant is permitted to permanently opt out of the HRA which will forfeit the unused HRA Account balance. By opting out of HRA coverage (which is considered to be group coverage), an individual may preserve his/her eligibility to qualify for a federal premium assistance tax credit (a subsidy) to buy insurance coverage in the Health Insurance Marketplace. Participants who permanently opt out of the HRA plan will:

a) Waive all rights to future Plan reimbursements

b) Not be eligible for reinstatement in this Plan at any time in the future

c) Will not be eligible for COBRA continuation coverage.

This opt out election is available at least annually and upon termination of coverage under the Plan. For the process to opt out, contact the Administrative Office.

(2) **Freeze Unused HRA Account Balance For Use at a Later Date:** An HRA Participant is permitted to request to freeze their unused HRA Account balance once per calendar year, in a time and manner determined by the Trustees. By freezing the unused HRA balance (which is considered to be group coverage), an individual may preserve his/her eligibility to qualify for a federal premium assistance tax credit (a subsidy) to buy insurance coverage in the Health Insurance Marketplace.

A frozen HRA Account balance can be reinstated upon the Participant's requested date or the Participant's date of death.

a) An election must be made prior to the effective date of the freeze and is irrevocable until a reinstatement event occurs.

b) Reinstatement Event. You may be reinstated in your HRA, and the balance unfrozen, upon the earlier of the following events:

i. The first day of the calendar year following the year for which a Participant elected to freeze their unused HRA Account balance and the Participant notifies the Fund of this request;

ii. The date upon which the Participant becomes eligible for and enrolled in Medicare parts A and B; or

iii. The Participant's date of death.

c) Contact the Administrative Office for the form to request that an HRA Account balance be frozen on a selected date, or the form to request that the HRA Account balance be reinstated on a selected date.

d) Participants, eligible Spouses and eligible Dependents may not have access to the HRA Account balance after the effective date of the freeze. Upon reinstatement, the Plan cannot reimburse any Medical Care Expenses incurred after the effective date of the freeze and before the reinstatement. However, after the reinstatement event, access to the HRA Account balance is available for Medical Care Expenses incurred after the reinstatement event and which are submitted to the Administrative Office in a timely manner.

(3) Non-Medicare eligible individuals with certain household income levels who purchase individual coverage through a Health Insurance Marketplace may be eligible for federal subsidies to help them pay the insurance premiums. Individuals who are covered under a group health plan, including an HRA, are not eligible for these subsidies. Therefore, some individuals may request to permanently opt out of or temporarily freeze their HRA Account balance in order to qualify for a subsidy.

5.09 <u>Reimbursement Procedure</u>.

(a) **Timing**. Within thirty (30) days after receipt by the Administrative Office of a reimbursement claim from an HRA Participant, the Administrative Office will reimburse the HRA Participant for appropriate Medical Care Expenses, or the Administrative Office will notify the HRA Participant that his/her claim has been denied. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Administrative Office, including in cases where a reimbursement claim is incomplete. The Administrative Office will provide written notice of any extension, including the reasons for the extension, and will allow the HRA Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

(b) **Claims Substantiation**. An HRA Participant who seeks benefits may apply for reimbursement by submitting an application, called an HRA Reimbursement Request, in writing to the Administrative Office in such form as the Board of Trustees may prescribe, but **no later than two (2) years from the date of service** on the claim, setting forth:

(1) the person or persons on whose behalf Medical Care Expenses have been incurred;

(2) the nature and date of the Medical Care Expenses so incurred;

(3) the amount of the requested reimbursement; and

(4) a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third-party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. Except for the final reimbursement from the HRA Account, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least **$25**.

The Board of Trustees may waive the time deadline of two (2) years from the date of service on the claim for good cause.

(c) **Claims Denied**. For reimbursement claims that are denied, see the appeals procedure in section 5.14 on Claim Appeals.

5.10. Reimbursements After Termination and COBRA/Self-Payment.

(a) When an HRA Participant ceases to be an HRA Participant hereunder, the HRA Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates. Such HRA Participant (or the HRA Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Plan Year prior to termination of participation, provided that the HRA Participant (or the HRA Participant's estate) files a claim within **two (2) years** from the date of service on the claim. Reimbursement is only permitted if:

(1) the claim is an eligible Medical Care Expense;

(2) there are funds in the HRA Account;

(3) the Participant was HRA-eligible when the claim was incurred; and

(4) the Participant has not submitted the claimed Medical Care Expenses as a deduction on any federal income tax return.

(b) A Retiree whose coverage terminates under this Section shall not be entitled to continue coverage under COBRA Self-Payment Provisions.

(c) A COBRA-eligible HRA Participant shall not be eligible for reimbursement after COBRA coverage terminates.

(d) Note that an HRA Participant may exercise an annual or post-termination opt-out right, as described in this Article.

5.11 Recordkeeping and Administration.

(a) **Inability to Locate Payee**. If the Administrative Office is unable to make payment to any HRA Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such HRA Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such HRA Participant or other person shall be subject to the provisions set forth in Section 5.11 (c).

(b) **Effect of Mistake**. In the event of a mistake as to the eligibility or participation, or the allocations made to any HRA Participant's HRA Account , or the amount of benefits paid or to be paid to an HRA Participant or other person, the Administrative Office shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such HRA Participant or other person the credits to the HRA or distributions to which he/she is properly entitled under the Plan. Such action by the Administrative Office may include withholding of any amounts due to the Plan from any future benefits.

(c) **Account Forfeiture.**

Automatic Forfeiture: Any HRA Account with less than $1,000 that remains inactive (no money coming in or money going out) for twenty-four (24) consecutive months, will be forfeited and the HRA Account will be closed. An Eligible Retiree who elects to temporarily freeze an HRA Account balance will not be subject to this forfeiture provision.

Prohibited Work Forfeiture: Any HRA Account of a Participant that:

(1) takes employment in Arizona in any capacity or continues employment in Arizona in any capacity with any employer in the plumbing and pipefitting industry not obligated to contribute to the Arizona Pipe Trades Health and Welfare Trust Fund; or

(2) engages in any kind of commercial business activity in the plumbing and pipefitting industry in Arizona as a sole proprietor, partner, contractor or commission agent without being signatory to a labor agreement with Local 469 requiring contributions to the Arizona Pipe Trades Health and Welfare Trust Fund;

will be immediately forfeited and the HRA Account will be closed.

(d) **Reinstatement of Account Balance**: If an individual ceases to be an Eligible Retiree and returns to work through Local 469 within five years of his/her automatic HRA Account forfeiture date, his/her HRA Account balance will be reinstated at the level that existed at the time of forfeiture. HRA contributions on behalf of this Active Employee will be credited to the Retiree Only HRA Account. This HRA reinstatement provision is not permitted if the individual permanently opted out.

(e) **Termination of Account**.

A Participant's HRA Account will terminate upon the earlier of:

(1) the date on which this Plan is terminated; or

(2) the date the Account is forfeited as outlined above; or

(3) the effective date of the election to permanently opt out of coverage under this Plan; or

(4) the date on which the Participant's HRA Account reaches a zero balance.

The balance in a Retiree Only HRA cannot be transferred to an HRA Account in the Active Employee HRA Plan.

(f) **Participation Following Death of a Participant.**

In the event of a Participant's death, Spouses and tax-qualified Dependents may continue to submit eligible Medical Care Expenses to the HRA until the earlier of:

(1) such time as the balance in the Participant's HRA Account reaches zero; or

(2) the date the HRA Account is otherwise terminated as outlined above.

5.12 No Guarantee of Tax Consequences.

(a) Neither the Administrative Office nor the Board of Trustees makes any commitment or guarantee that any amounts paid to or for the benefit of an HRA Participant under this portion of the Plan will be excludable from the HRA Participant's taxable income for federal, state, or local income tax purposes.

It shall be the obligation of each HRA Participant to determine whether each payment under this portion of the Plan is excludable from the HRA Participant's gross income for federal, state, and local income tax purposes, and to notify the Administrative Office if the HRA Participant has any reason to believe that such payment is not so excludable.

5.13 Exclusions - Medical Expenses That Are Not Reimbursable from an HRA Account.

(a) This Section specifies certain expenses that **are not reimbursable** from the HRA Account because they do not meet the definition of "medical care" under Internal Revenue Code §213. The following expenses are not reimbursable:

(1) Health insurance premiums for coverage that has been reimbursed under a Spouse's plan (e.g. coverage subject to the "double-dip" prohibitions of Revenue Ruling 2002-3).

(2) Long-term care expenses for a person who has not been certified as chronically ill.

(3) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(4) Cosmetic dental services.

(5) The salary expense of a nurse to care for a healthy newborn at home.

(6) Funeral and burial expenses.

(7) Household and domestic help (even though recommended by a qualified Physician due to a Retiree's or Dependent's inability to perform physical housework).

(8) Massage therapy (unless qualifies as a medical expense).

(9) Home or automobile improvements. (These are potentially qualifying expenses if they are done to accommodate a disability.)

(10) Custodial care.

(11) Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods (unless it is a residential school or program to treat behavioral, emotional and/or addictive conditions and the primary purpose of the program is medical care).

(12) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity (unless the expense would not have been incurred but for the disease).

(13) Social activities, such as dance lessons (even though recommended by a Physician for general health improvement). These are potentially qualifying expenses if they are recommended by a Physician to treat a medical condition such as rehabilitation after surgery.

(14) Bottled water.

(15) Diaper service or diapers.

(16) Cosmetics, toiletries, toothpaste, etc.

(17) Vitamins and food supplements, even if prescribed by a Physician. (Potentially a qualifying expense if recommended by a Physician for a specific medical condition).

(18) Uniforms or special clothing, such as maternity clothing.

(19) Automobile insurance premiums.

(20) Transportation expenses of any sort, including transportation expenses to receive medical care. (This is potentially a qualifying expense if the expense is primarily for and essential to medical care).

(21) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.

(22) Any item that does not constitute "medical care" as defined under Code §213.

(23) Expenses not submitted to the Plan within two (2) years from the date of service.

5.14 Claim Appeals.

(a) This section describes the Plan's procedures for appealing Adverse Benefit Determinations in connection with HRA claims. The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan Participants. The claim appeal procedures outlined in this Article **are designed to afford you a full, fair and fast review of the claim to which it applies**.

(b) **Definitions**.

1. **Days:** For the purpose of the claim filing and appeal procedures outlined in this Article, "days" refers to calendar days, not business days.

2. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination is defined as:
   - a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; or
   - a reduction in a benefit resulting from the application of any utilization review decision, exclusion or limitation on an otherwise covered benefit or 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; or
   - a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

3. **Claim:** For purposes of benefits covered by these procedures, a claim is a post-service request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter in this section referred to as "you") or that individual's authorized representative (as defined later in this Article) in accordance with the Plan's HRA claim administration procedures, described in this Article.

   A claim must include the following elements to trigger the Plan's claim filing procedures:

   a) be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),

   b) be **received by the HRA Claims Administrator**,

   c) **name a specific individual**,

   d) **name a specific medical condition or symptom**,

   e) **name a specific treatment, service or product** for which approval or payment is requested, and

   f) **made in accordance with the Plan's claim administration procedures** described in this Article.

   A claim is NOT:

   a) a request made by **someone other than** the individual or his/her authorized representative;

   b) a request made by a **person who will not identify himself/herself** (anonymous);

   c) a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated reimbursement for a service;

   d) a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;

   e) an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal.

4. **Post-Service Claim**: A post–service claim is a claim for benefits under the HRA Plan. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A claim regarding Eligibility or Rescission of coverage will be treated as a post-service claim.

5. **Health Care Professional**: A Health Care Professional is a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

6. **Tolled**: Tolled means stopped or suspended, particularly as it refers to timeperiods during the claims process.

7. **Rescission:** Rescission is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform

an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

(c) **Review Of A Matter That Is Not A Claim (as defined in this Article)**

A Plan Participant may request review of a matter that is not a claim (as defined in this Article) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document.

(d) **Authorized Representative**

This Plan recognizes an authorized representative as any person at least 18 years old whom you have so designated in writing as the person who can act on your behalf to file a claim under this Plan (because of your death, disability or other reason acceptable to the Board of Trustees or its designee) and to appeal an Adverse Benefit Determination. An authorized representative under this Plan includes a Health Care Professional.

The Plan requires a written statement from the individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form available from the Appropriate Claims Administrator. If the individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has a notarized power of attorney for health care purposes, a Court order of guardianship/conservatorship, or is the individual's legal Spouse, parent, grandparent or child over the age of 18.

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A designated authorized representative may be revoked by submitting a completed change of authorized representative form available from and to be returned to the Administrative Office.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

(e) **Appeal Of A Denial Of A Post-Service Claim**

Appeals must be in writing to the Board of Trustees (whose address is on the Quick Reference Chart in the front of this document). You will be provided with:

1. the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
2. the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

3. a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
4. free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
5. a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, the Board of Trustees, who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
6. in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the Board of Trustees will:
    a. consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
    b. provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

    There is **no extension permitted** to the Plan in the appeal review process.
7. The Board of Trustees will make a determination on the appeal as follows:
    a. **If your request is submitted more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.
    b. **If your request is submitted within 30 days of the next Board meeting**, the review will occur no later than the second Board meeting following the Board's receipt of the appeal.

    If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made not later than the third meeting of the Board following the Plans' receipt of the request for review.

    If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
8. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the

denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

9. If the claim was denied due to a medical judgment (not Medically Necessary, Experimental or Investigational) the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

10. You will receive a notice of the Board's appeal determination no later than 5 calendar days after the benefit determination is made. If that determination is adverse, it will include:
    a. information that is sufficient to identify the claim involved (e.g. date of service, Health Care Facility or Health Care Practitioner, claim amount if applicable);
    b. the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided;
    c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
    d. reference the specific Plan provision(s) on which the determination is based;
    e. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    f. a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
    g. an explanation of the Plan's time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
    h. if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
    i. if the denial was based on a medical judgment (not Medically Necessary, Experimental or Investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
    j. the statement that "You and your Plan may have other voluntary 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;" and
    k. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals processes.

11. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) for assistance.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-877-429-7473.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-429-7473.

12. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process or external review process.

(f.) **Limitation On When A Lawsuit May Be Started**

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

(g.) **Discretionary Authority Of Board Of Trustees And Designees**

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(h.) **Facility Of Payment**

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, Claims Administrator nor any other designee of the Board of Trustees will be required to see to the application of the money so paid.

(i.) **Elimination Of Conflict Of Interest**

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those person's employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

ARTICLE VI: PLAN ADMINISTRATOR

6.01 **Plan Administrator.** The Board of Trustees is the Plan Administrator and has the authority to appoint any other person or entity as the Plan's Claims Administrator for any or all of the duties and responsibilities described in this Article VII. The Board of Trustees shall have the

authority to remove a Claims Administrator and appoint a successor from time to time as the Board of Trustees deems necessary.

6.02 **Duties of Plan Administrator.** The Plan Administrator has the duty and full power to administer this Plan.

a. General Powers and Duties. The Plan Administrator's primary responsibility is to administer the Plan for the exclusive benefit of the Participants, in accordance with the terms of the Plan. The Plan Administrator shall have full and exclusive discretionary authority to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including full and exclusive discretionary authority to determine eligibility for contributions and benefits and to construe the terms of the Plan. Any such determination by the Plan Administrator made in exercise of its full and exclusive discretionary authority shall be conclusive and binding upon all persons. The Plan Administrator may establish such procedures as such shall deem necessary or advisable to carry out the purpose of the Plan; provided, however, that any procedure, discretionary act, interpretation or construction shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and in compliance with the terms of State law and all regulations issued pursuant to the Code and State law. The Plan Administrator shall have all discretionary authority necessary to accomplish his or her duties under this Plan.

b. **Specific Duties**. The Plan Administrator shall be charged with the duties of the general administration of the Plan, including, but not limited to, the following:

1. Determine questions submitted to the Plan Administrator in connection with the administration of the Plan;

2. Provide a periodic report indicating the balance of the HRA Account s, at least annually or more frequently as directed by the Plan Administrator;

3. Direct the Claims Administrator with respect to the amount, timing and manner of benefits payable to any Participant under the Plan;

4. Maintain all necessary records for the administration of the Plan;

5. Interpret and enforce the provisions of the Plan and to make and publish such rules for regulation of the Plan as is consistent with the terms hereof.

6.03 **Records and Reports.** The Plan Administrator or its designee shall keep a record of all actions taken and all other books of accounts, records, and other data that may be necessary for proper administration of the Plan, and shall be responsible for supplying all information and reports to the Internal Revenue Service and others as required by law, to the extent applicable to the Plan.

In addition, the Plan Administrator shall furnish a written statement of Plan status periodically, which shall include the following:

a. The HRA Account of each Eligible Retiree.

b. The payment of administrative expenses and other expenses, including as pro-rated among the HRA Account of each Participant.

c. All payment of benefits made from the HRA Account of each Participant.

d. Such further information as the Plan Administrator may deem appropriate.

6.04 **Appointment of Advisors.** The Plan Administrator may appoint counsel, actuaries, specialists, advisors, claims administrators and other persons as the Plan Administrator deems necessary or desirable in connection with the administration of the Plan.

6.05 **Information from the Claims Administrator.** The Claims Administrator shall supply full and timely information to the Plan Administrator on all matters relating to the eligibility of all reimbursements of Medical Care Expenses to Participants, and such other pertinent facts as the Plan Administrator may require, and as may be pertinent to the Trustee's duties under the Plan.

ARTICLE VII: PROTECTED HEALTH INFORMATION

7.01 **Use of Protected Health Information.** The Plan will use and disclose "Protected Health Information" (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to payment for health care and health care operations as defined in the Plan's HIPAA privacy notice.

For purposes of this Article VII, the "Plan Sponsor" is the Board of Trustees. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions of Section 7.02 below.

7.02 **Plan Sponsor Obligations.** With respect to PHI, the Plan Sponsor agrees to:

a. Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c. Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

d. Not use or disclose PHI in connection with any other benefit or benefit plan of the Trust Fund or Plan Administrator unless authorized by an individual;

e. Report to the Plan any PHI use or disclosure of information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

f. Make PHI available to an individual in accordance with HIPAA's access requirements;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

h. Make available the information required to provide an accounting of disclosures;

i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

k. Appoint one or more individuals to act as Privacy Official on matters regarding the Plan in accordance with Section 7.04, and may remove such Privacy Official as the Plan Sponsor deems appropriate from time to time.

l. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

m. Not use PHI that is genetic information for underwriting purposes. Underwriting purposes includes eligibility, enrollment, cost sharing, computation of premium as well as activities related to the creation, renewal or replacement of health insurance or health benefits.

7.03 **Plan Sponsor's Access to PHI.** Adequate separation will be maintained between the Plan and the Plan Sponsor. Therefore, in accordance with HIPAA, only the Plan Administrator may be given access to PHI, and such person or entity may use and disclose PHI only for Plan

administration functions that the Plan Sponsor performs. If the persons described herein do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Plan to correct and mitigate any such noncompliance.

7.04 **Privacy Official.** The Privacy Official shall be responsible for compliance with the Plan Sponsor's and the Plan's obligations under this Article IX and HIPAA, including but not limited to the following:

a. The Privacy Official shall from time to time formulate and issue to Participants and the Plan Sponsor such policies and procedures as he or she deems necessary for compliance with this Article IX and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Plan.

b. The Privacy Official shall be responsible for arranging with the Plan, Plan Sponsor and any third-party administrator for the issuance of, and any changes to, the privacy notice under the Plan.

c. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Plan's HIPAA privacy notice.

7.05 **Security of Electronic PHI.** The Plan Sponsor will:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI (ePHI) that it creates, receives, maintains, or transmits on behalf of the group health plan;

b. Ensure that the adequate separation discussed above, specific to ePHI, is supported by reasonable and appropriate security measures;

c. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

d. Report to the Plan any security incident of which it becomes aware concerning ePHI.

ARTICLE VIII: GENERAL PROVISIONS AND ERISA INFORMATION

8.01 **Restriction on Alienation.** No benefit which shall be payable under this Plan to any person shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, either voluntarily or involuntarily, and any attempt to anticipate,

alienate, sell, transfer, assign, pledge, encumber or charge the same shall be void. No such benefit shall be subject to garnishment, attachment, execution or levy of any kind, or legal process for or against such person, and the same shall not be recognized by the Plan Administrator, except to such extent as may be required by law.

8.02 **Severability.** If any provision or provisions of the Plan shall be for any reason invalid or unenforceable, this will not affect any other provision of this Plan. In the event of any such holding, the Board of Trustees will immediately amend the Plan provisions to remedy the defect to the extent possible.

8.03 **Reliance on Participant Information.** If a Participant makes any erroneous statement, omits any material fact, or fails to correct any information previously furnished incorrect to the Plan Administrator for its records, the Plan Administrator has the right to maintain an action to recover any amounts improperly paid to any person.

8.04 **Inability to Locate Payee.** If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment shall be forfeited following 12 months after the date that any such payment first became due.

8.05 **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Eligible Retiree or his/her dependent, or the allocation made to the HRA Account of any Participant, or the amount of benefits paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code section 105 or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan.

8.06 **Gender/Number.** Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in this Plan in the singular form, they should be construed as though they were also used in the plural form in all situations where they would so apply, and vice versa.

8.07 **Applicable Laws.** This Plan shall be governed in all respects by applicable laws of the State of Arizona, unless superseded by federal law. This Plan is intended to comply with the requirements of Code sections 105 and 106 and all regulations thereunder, and is to be interpreted and applied consistent with that intent.

8.08 **Headings.** The headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

8.09 **ERISA Information.** The following information concerning the Plan is being provided in accordance with government regulations:

1. The **name and type of administration of the Plan**:

   The Arizona Pipe Trades Health and Welfare Trust Fund is liable for all Health Reimbursement Arrangement (HRA) benefits under this group health plan. These HRA Plan benefits are administered by an independent Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.

   The Plan is administered by a joint Board of Trustees, consisting of four Union representatives and four Employer representatives.

2. The **name and address of the Plan Administrator/Plan Sponsor** is:

   Board of Trustees
   Arizona Pipe Trades Health and Welfare Trust Fund
   7010 N Broadway, Suite 106
   P.O. Box 21240
   Denver, CO 80221-0240
   Toll Free Phone: 1-877-429-7473

3. The **names and business addresses of Board of Trustees** as of January 1, 2017 are:

Union Trustees	**Employer Trustees**
Mel Ingwaldson United Association Local 469 3109 N. 24th St. Phoenix, AZ 85016	Darrell Fox Dynamic Systems, Inc. 331 S. Price Rd Chandler, AZ 85224
Aaron Butler United Association Local 469 3109 N. 24th St. Phoenix, AZ 85016	Bryan DeWitt W.D. Manor Co. 1838 N. 23rd Avenue Phoenix, AZ 85009
Larry Savage, Jr. United Association Local 469 3109 N. 24th St. Phoenix, AZ 85016	Drew Schroder Bel-Aire Mechanical, Inc. 4201 N. 47th Ave Phoenix, AZ 85031
Mike VanKirk United Association Local 469 3109 N. 24th St. Phoenix, AZ 85016	Ron Hudson Hudson Services P.O. Box 6657 Peoria, AZ 85385

4. In addition to the Board of Trustees, the following persons have been designated as agents for the **service of legal process**:

Gerald Barrett, Esq. Ward, Keenan and Barrett, Ltd. 3838 N Central, Suite 1720 Phoenix, Arizona 85012-1994	Keith F. Overholt, Esq. Jennings, Strouss & Salmon, P.L.C. One East Washington Street, Suite 1900 Phoenix, AZ 85004-2554

5. The **Employer Identification Number** assigned by Internal Revenue Service to the Board of Trustees is 86-0104344.

   The **Plan Number** assigned by the Board of Trustees is 501.

6. For purposes of maintaining the Fund's **fiscal records**, the year-end date is May 31.

7. **Funding Medium**: Benefits are provided from the Fund's assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

   Financial Information:

8. **Contribution Source:**

   All contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements with Local Union No. 469 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada. The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour per month.

   The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement. See the Section entitled "Plan Documents and Reports" later in this Article if you wish to obtain additional information about the Collective Bargaining Agreements.

9. **Organizations Accumulating Fund Assets:**

   The Fund's assets and reserves are held in custody by **Wells Fargo Bank.** See the Section entitled "Plan Documents and Reports" in this Article if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

10. **Plan Information:**

    The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described under Article III on Eligibility in this Plan's Rules and Regulations.

11. **Plan Regulations:**

    All of the types of benefits provided by the Plan and the complete terms of the benefits are set forth under the Articles of this Plan's Rules and Regulations.

12. **Statement of ERISA Rights:**

As a Participant in the Arizona Pipe Trades Health and Welfare Trust Fund's Retiree Only HRA 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 The Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office whose address is listed on the Quick Reference Chart in the front of this document, and at 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 US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. 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 Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage:

1. 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, as described in the COBRA section of the Active Employee Summary Plan Description. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights. The Administrative Office has additional information about COBRA and can answer your questions.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing 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 insurer 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 Pre-Existing Condition exclusion for 12 months after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries:

1. 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.

2. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

1. If your claim for a welfare 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.
2. 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.
3. 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.
4. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.
5. 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:

1. If you have any questions about the 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 (formerly known as the Pension and Welfare Benefit Administration), US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), US Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

13. **Claim Filing and Appeals:**

To file a claim or to appeal a denied claim, refer to Article 6 on Claim Filing and Claim Appeals Procedures of this Plan. The name and address of the Administrative Office to whom claims and appeals are to be directed is listed on the Quick Reference Chart in the front of this document.

14. **Plan Documents and Reports:**

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

A. Trust Agreement

B. Collective Bargaining Agreements

C. Plan Documents and all amendments

D. Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor

E. List of Contributing Employers

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charge will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your Union Office. To make such arrangements, call or write the Administrative Office. A summary of the Annual Report which gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

15. **Spanish Language Assistance:**

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero 1-877-429-7473.

This document contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this document, contact the Administrative Office at their phone number or address listed on the Quick Reference Chart in the front of this document.

Nothing in this document is meant to interpret or extend or change in any way the provisions expressed in the rules and regulations of the health and welfare plan.

The Board of Trustees reserve the right to amend, modify or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant.

ARTICLE IX: AMENDMENT AND TERMINATION

9.01 **Discontinuance of the Plan.** It is the intention of the Board of Trustees that is Plan shall be maintained indefinitely. However, the Board of Trustees reserves the right at any time or times to amend or discontinue the Plan.

9.02 **Amendment.** It is the intention of the Board of Trustees that this Plan shall be maintained indefinitely. However, the Board of Trustees reserves the right at any time or times to amend

the Plan or Trust, in accordance with the provisions of this Article IX. Any such amendment shall be by written instrument approved by the Board of Trustees.

All Participants and any persons claiming any interest in the Plan will be bound by such amendment, provided that no amendment causes any of the Trust Fund assets to be diverted to purposes other than the exclusive benefit of Participants.

9.03 **Termination.** The Board of Trustees specifically reserves the right to discontinue or terminate this Plan and the Trust Fund in whole or in part. Upon a termination of the Plan and/or Trust Fund, the Board of Trustees shall take such steps as determined to be necessary or desirable to comply with applicable laws, and such steps as necessary to ensure that the assets remain dedicated to the payment of benefits for Participants of the Plan in another tax-exempt vehicle.