NORTHWESTERN OHIO PLUMBERS & PIPEFITTERS
RETIREE HEALTH & WELFARE FUND
PLAN RESTATED AS OF APRIL 1, 2015

**WHEREAS**, by an Agreement and Declaration of Trust dated March 1, 2006, the Plan was established, pursuant to which the Board of Trustees serving thereunder formulated and adopted this Health & Welfare Plan; and

**NOW THEREFORE**, the Board of Trustees hereby establish the Northwestern Ohio Plumbers & Pipefitters Retiree Health & Welfare Plan effective January 1, 2011 revised and restated as of April 1, 2015, to contain the provisions of all prior Plan documents which became a part of this Plan, including all amendments which have been adopted by such Plans as of the effective date.

## ARTICLE I
## DEFINITIONS

**1.1 Active Plan**. Shall mean the Northwestern Ohio Plumbers & Pipefitters Active Health and Welfare Plan, or any successor thereto.

**1.2 Association**. Shall mean those Associations that have executed a Collective Bargaining Agreement with the Union, requiring contributions hereto. The term Association includes any new or successor Employer Association that becomes a party to the Trust Agreement by virtue of its execution of an adoption agreement, by which such Association agrees to be bound to the terms and conditions of the Trust Agreement, as amended from time to time.

**1.3 Beneficiary**. The term "Beneficiary" shall mean any person who, because of relationship to a person entitled to benefits under this Plan, may be entitled to benefits from the Plan. The term "Designated Beneficiary" shall mean the person or persons designated by a Participant to receive a death benefit from the Plan in the event of his/her death, or, in the absence of an effective designation, or if such designated person or persons shall have died, the first of the following classes of beneficiaries, in successive preference, then surviving: the Participant's (a) spouse; (b) children; (c) parents; (d) brothers and sisters; (e) estate, pursuant to Section 3.2. The term "children" shall include legally adopted children. Following the entry of a divorce decree, it is presumed that the Participant intended to revoke any designation of his former spouse as the Participant's Designated Beneficiary unless:

(a) The Judgment of Divorce affirmatively states that the divorced spouse will remain Designated Beneficiary, or

(b) A Qualified Domestic Relations Order affirmatively states that the divorced spouse remains the Designated Beneficiary, or

(c) The Participant completes a new designation of Beneficiary form after entry of the Judgment of Divorce, which named the divorced spouse as the Participant's Designated Beneficiary.

**1.4 Benefit Year**. Shall mean the calendar year.

**1.5 Child**. Shall mean any Child of the Participant under the age of 26, including any stepchild, adopted child, or child placed with the Participant or Spouse for guardianship or foster care. In case of divorce, proof of the Participant's obligation to provide coverage for a child or stepchild shall be required, such as a judgment of divorce, qualified medical child support order, or such other order of a court of competent jurisdiction. Illegitimate children shall be included within this definition, so long as the Participant provides the Plan Administrator proof of paternity, by presenting a registered birth certificate, naming the Participant as the father, order of filiation or adoption order.

1.6 **Claim**. Shall mean a request for a Plan benefit by an eligible Participant or his Dependent.

1.7 **Collective Bargaining Agreement**. Shall mean any contract, or participation agreement, entered into between the Union and the Association, or any Employer, pursuant to which the Employer has agreed to contribute to this Trust Plan, as well as any renewal or extension thereof.

1.8 **Contribution Hours**. Shall mean those hours worked in Covered Employment, for which an Employer, pursuant to a Collective Bargaining Agreement, or other written agreement, has actually made fringe benefit contributions. Only contributions for hours that the Active Plan or Retiree Plan, as applicable, has received will be deemed Contribution Hours.

1.9 **Covered Employment**. Shall mean employment with an Employer, for which the Employer agreed, through a written Collective Bargaining Agreement, or other written agreement, to make contributions to the Plan.

1.10 **Credit Account**. Shall mean the method of crediting Contribution Hours received on behalf of each Employee to the Employees' individual Credit Account. The cost of benefits plus Plan expenses is deducted from the Employees individual Credit Account.

1.11 **Custodial Care**. Shall mean a service provided to a Participant or Dependent when all of the following are true:

(a) The service is aimed at providing personal care and assistance for activities of daily living;

(b) The service does not seek to cure a medical condition or is provided during a period where the patient's medical condition is not changing; and

(c) The service is not required to be administered by a trained or licensed Medical Provider in order to be administered safely and effectively.

1.12 **Dependent**. Shall mean a Participant's eligible Spouse, and/or child. An eligible Dependent child includes the Participant's son, daughter, stepchild, adopted child, child lawfully placed for adoption or guardianship, or child meeting the definition of a "foster child" under applicable law that is lawfully placed with the Participant by an authorizing placing agency or by court order, and is under the age of 26.

1.13 **Experimental or Investigational Treatment**. Shall mean any health service, health device, or drug for use in the diagnosis or treatment of a health condition that meets any of the following conditions:

(a) The device or drug cannot be marketed lawfully without the approval of the United States Food and Drug Administration (FDA) and final approval has not been given by the FDA;

(b) The health service is described as experimental, investigational, unproven or under study in the written informed consent document provided to the patient by the medical provider providing the service;

(c) Authoritative evidence does not permit conclusions concerning the effect of the health service, device or drug on health outcomes; or

(d) There is insufficient authoritative evidence that the health service, device or drug does not improve the net health outcome as much or more than any other established alternative.

**1.14 Hour Bank**. Shall mean a notional account existing in the Active Plan where Contribution Hours in excess of those needed to establish or maintain eligibility are stored.

**1.15 Effective Date**. Shall mean the effective date of this Plan, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits. The Effective Date of this Plan shall be April 1, 2015.

**1.16 Employee**. Shall mean any person who was employed by an Employer in Covered Employment, or such other employment for which the Employer is obligated by a Collective Bargaining Agreement, or any other written agreement, to contribute to the Active Plan.

**1.17 Employer**. Shall mean any of the following:

(a) Any member of an Employer Association and any other individual, partnership, corporation or business entity which is employing the services of individuals performing work that is within the trade jurisdiction of the Union and which has a Collective Bargaining Agreement, or any other written agreement in effect, requiring contributions to this Plan;

(b) Any other Employer, including a sole proprietor or partnership, engaged in work coming within the trade, craft and geographical jurisdiction of the Union, who is obligated by a Collective Bargaining Agreement, or such other written agreement, to make contributions to this Plan on behalf of its Employees;

(c) The Union, its affiliated Locals or related International bodies, solely to the extent that it acts in the capacity of an Employer of its business representative or its Employees, provided it agrees to make contributions to the Plan on behalf of such Employees;

(d) Any training or other similar program operated in whole or in part by the Union, or with its approval, or in which the Union participates;

(e) Any board of Board of Trustees, committee or other agency established to administer or be responsible for fringe benefit Plans, educational or other programs established through collective bargaining by the Union, the members of which maintain a collective bargaining relationship with the Union or one of its constituent Locals;

(f) Any council, committee, or other body composed of representatives of one or more labor organizations of which the Union or one of its constituent Locals is a member and agrees in writing to participate herein; or

(g) Any sponsoring Employer Association, whose members maintain a collective bargaining relationship with the Union, solely in its capacity as an Employer of Employees, on whose behalf it has agreed in writing to make contributions to this Plan.

In the case of an Employer electing to contribute pursuant to the provisions of subsection (d), (e), (f) or (g), contributions must be uniformly made with respect to all Employees of that Employer.

**1.18 Employer Contributions**. Shall mean those sums required to be paid to the Active Plan pursuant to the governing Collective Bargaining Agreement between an Employer and the Union. Employer Contributions are Plan assets within the meaning of the Employee Retirement Income Security Act ("ERISA") and are assets of this Plan the moment they become due.

**1.19 Medical Necessity**. Shall mean a health service that a Medical Provider, while exercising prudent clinical judgment, provides to a Participant or Dependent to evaluate, diagnose or treat an illness, injury, disease or its symptoms, if all of the following are true:

(a) The evaluation, diagnosis or treatment is in accordance with generally accepted standards of medical practice;

(b) The evaluation, diagnosis or treatment is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

(c) The evaluation, diagnosis or treatment is not primarily for the convenience of the patient or medical provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

**1.20 Medical Provider**. Shall mean a doctor of medicine, osteopathy, chiropractic, podiatry or optometry, legally qualified and licensed to practice medicine or perform surgery or provide services at the time and place services are performed. The term "Physician" shall also mean a person who is licensed or certified as a psychologist. It shall also mean a person who is a Member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service. This definition shall include a Physician's assistant, nurse or person of a similar position working under the direction of the treating Physician. The Plan will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a Physician, however, the Plan reserves the right to seek verification from the treating Physician prior to approving payment for any claims or benefits.

**1.21 Participant**. Shall mean a former Employee who has met the requirements established by the Board of Trustees to be eligible for benefits under this Plan.

**1.22 Permanently and Totally Disabled**. Shall mean a physical or mental condition of a Participant, which the Trustees find, on the basis of medical evidence, to permanently and totally prevent the Participant from engaging in any work within the jurisdiction claimed by the United Association (UA) for remuneration or profit. The disability must be, on the basis of medical evidence, expected to continue during the remainder of his or her life or which will be expected to continue for at least one year. To be considered Permanently and Totally Disabled, such disability cannot have resulted from the use of illegal narcotics, illegal activity or resulted from a self-inflicted injury that is not the result of a medical condition.

**1.23 Plan Year**. Shall be January 1st through December 31st. The Plan Year shall also be known as the Fiscal Year.

**1.24 Qualified Medical Child Support Order (QMCSO)**. Shall mean a medical support order:

(a) Which creates or recognizes the existence of an alternate recipient's right to receive benefits as a dependent under this Plan, and

(b) Includes:

(1) The name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

(2) A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the Plan);

(3) The period to which such order applies, and;

(4) The legal name of this Plan.

**1.25 Reasonable and Customary or Reasonable Charge**. Shall mean charges that do not exceed charges normally made by other hospitals, physicians or service providers in this geographic area. For purposes of foregoing covered charges shall mean the actual cost or charge to an eligible Participant or Dependent, but only to the extent they shall be deemed Reasonable and Customary Charges for necessary medical care and services which are ordered by a legally qualified Physician, but not to exceed the maximums provided in the schedule of benefits.

**1.26 Retiree**. Shall mean an individual who has retired under a pension program sponsored by the Union and who has established and/or maintained eligibility for benefits under this Plan.

**1.27 Service**. Shall mean services rendered to the eligible Participant or the eligible Dependent by a Medical Provider subsequent to the effective date of the Plan and prior to the termination of eligibility as provided in the eligibility section of the Plan, to the extent and subject to the terms and conditions and definitions set forth in this Plan, except as otherwise limited or excluded herein. "Service" shall also mean all care and procedures rendered by Medical Providers for diagnosis and/or treatment of disease or injury based on valid medical need, according to accepted standards of medical practice.

**1.28 Sickness**. Shall include disease, mental, emotional or nervous disorders, and covered pregnancy. A recurrent sickness shall be considered as one sickness. All related sicknesses shall be considered as one sickness. Concurrent sickness shall be deemed to be one sickness unless such sicknesses are totally unrelated.

**1.29 Spouse**. Shall mean the individual to whom a Retiree is legally married. A marriage certificate shall be required as proof of spousal relationship subject to government approval. This definition includes persons of the same-sex who were married in state or foreign jurisdiction where same-sex marriage is legal, but is residing in state or countries where such marriage is not legal.

**1.30 State Benefits**. Shall mean the full amount of unemployment compensation benefits payable to an Employee for a full or partial week of unemployment under the Ohio Unemployment Compensation Act or similar act of any State.

**1.31 Supplemental Credit Reserve Account**. A form of health reimbursement account existing under the Active Plan.

**1.32 Union**. Shall mean the UA Local 50 Plumbers, Steamfitters and Service Mechanics, its affiliated Local Unions, or any successor thereto.

## ARTICLE II
## ELIGIBILITY

**2.1 Participation**. Every former Employee on whose behalf an Employer was required, by a Collective Bargaining Agreement, or such other written agreement to make contributions on behalf of that Employee, shall be eligible to become a Participant in this Plan upon satisfying the applicable eligibility requirements, including completing all requested enrollment forms. Participation in any predecessor plan(s) shall not grant any right, title or interest in this Plan, unless specifically provided herein.

**2.2 Retired Employees**.

(a) **Initial Eligibility**. To establish Initial Eligibility, the Retiree must meet the following conditions:

(1) Attain the age of 65;

(2) Is no longer working in Covered Employment;

(3) Was a Participant in the Active Plan for at least ten (10) years prior to retirement from Covered Employment, and have been a Participant in in the Active Plan for twelve (12) of the previous twenty-four (24) months immediately preceding retirement from Covered Employment;

(4) Exhaust the balance of the Hour Bank in the Active Plan; and

(5) Remit timely self-payments to the Plan.

(b) **Continuing Eligibility**. Upon establishing Initial Eligibility for benefits, a Retired Participant remains eligible by making timely self-payments at rates and under conditions established from time to time by the Board of Trustees.

(c) **Retirees Returning to Work**. Retirees who come out of retirement and return to work in Covered Employment will be placed back into the Active Plan. Retirees returning to work on temporary assignment due to a lifting of benefit suspension rules will remain in the Retiree Plan.

(d) **Reinstatement of Eligibility**. A Retired Participant's eligibility will not be reinstated. A Retiree who comes out of retirement to return to Covered Employment, and then reenters retirement must meet the requirements of Section 2.2(a) for coverage to be reinstated under this Plan.

## 2.3 Early Retirees

(a) **Initial Eligibility**. To establish Initial Eligibility, the early Retiree must meet the following conditions:

(1) Attain the age of 55;

(2) Is no longer working in Covered Employment;

(3) Was a Participant in the Active Plan for at least ten (10) years prior to retirement from Covered Employment, and have been a Participant in in the Active Plan for twelve (12) of the previous twenty-four (24) months immediately preceding retirement from Covered Employment;

(4) Exhaust the balance in the Hour Bank in the Active Plan;

(5) Remit timely self-payments to the Plan.

(b) **Continuing Eligibility**. Upon establishing initial eligibility for benefits, Early Retirees maintain eligibility by timely remitting self-payments at the rates established by the Board of Trustees.

(c) **Early Retirees Returning to Work**. Early Retirees who come out of retirement and return to work in Covered Employment, the Participant will be placed back into the Active Plan. Early Retirees returning to work on temporary assignment due to a lifting of benefit suspension rules will remain in the Retiree Plan, and must continue to make self-payments.

(d) **Reinstatement of Eligibility**. An Early Retiree's eligibility will not be reinstated. An Early Retiree who returns to Covered Employment and then reenters retirement must meet the requirements of Section 2.3(a) for coverage to be reinstated under this Plan.

## 2.4 Class II Employees

(a) **Initial Eligibility**. To establish Initial Eligibility a Class II Employee must meet the following conditions:

(1) Attain the age of 65;

(2) Is no longer working in Covered Employment;

(3) Was a Participant in the Active Plan for at least ten (10) years prior to retirement from Covered Employment, and have been a Participant in in the Active Plan for twelve (12) of the previous twenty-four (24) months immediately preceding retirement from Covered Employment;

(4) Exhaust the balance in the Hour Bank of the Active Plan, if applicable; and

(4) Remit timely self-payments to the Plan.

(b) **Continuing Eligibility**. Upon establishing Initial Eligibility for benefits, a Retired Participant remains eligible by making timely self-payments at rates and under conditions established from time to time by the Board of Trustees.

(c) **Retirees Returning to Work**. Upon coming out of retirement to return to work in Covered Employment, the Participant will be placed back into the Active Plan.

(d) **Reinstatement of Eligibility**. A retired Class II Participant's eligibility will not be reinstated. A Class II Participant who come out of retirement to return to Covered Employment, and then later reenters retirement, must meet the requirements of Section 2.4(a) for coverage to be reinstated under this Plan.

## 2.5 Surviving Spouses

(a) **Initial Eligibility – Class I or Class II Participants in the Active Plan**. Surviving Spouses of Class I and Class II Participants are eligible for benefits from this Plan provided the Participant maintained eligibility in the Active Plan immediately prior to the date of death and provided that the Spouse does not have other group healthcare coverage available to them. Eligible Surviving Spouses and their Dependents will not be moved into this Plan until the balance, if any, of the deceased Participant's Hour Bank in the Active Plan has been exhausted.

(b) **Initial Eligibility – Early Retiree or Retired Participants**. Surviving Spouses of Retired Participants or Participants who retire early are eligible provided the Participant was eligible for benefits from this Plan on the date of death.

(c) **Continuing Eligibility**. Self-payments to the Plan will be required at established rates from the Surviving Spouse as of the first day after the last of the following occurs:

(1) The month following the month in which the death of the Class I, Class II, Early Retiree or Retiree occurs; or

(2) The month following the month in which any balance in the Hour Bank is exhausted under the Active Plan; or

(3) In case of a Disabled Participant, when any disability credits are exhausted and any balance in the Hour Bank is exhausted under the Active Plan.

(d) **Dependents of Surviving Spouse**. Dependents of an eligible Surviving Spouse must have self-payments made on their behalf to receive benefits under this Plan.

(e) **Termination**. Coverage for Surviving Spouses and their Dependents terminates upon the earlier of the following events:

(1) The remarriage of the Surviving Spouse; or

(2) The eligibility of the Surviving Spouse for coverage by another group health insurance plan as an Employee; or

(3) The last day of the month for which a timely self-payment was remitted; or

(4) The last day of the month in which a Dependent child turns age 26.

2.6 **Eligibility for Dependents**. An eligible Dependent shall mean a Participant's:

(a) Spouse. Provided, however, that a Spouse who is eligible to enroll in coverage from his or her employer must enroll in such coverage as soon as such coverage becomes available, at which this Plan's coordination of benefit provisions shall apply. The cost of the working Spouse's coverage may be reimbursed from the Participant's Supplemental Credit Reserve Account.

(b) Son, daughter, stepchild, adopted child, child lawfully placed for adoption or guardianship, or child meeting the definition of a "foster child" under applicable law that is lawfully placed with the Participant by an authorizing placing agency or by court order, and is under the age of 26. A copy of the order of adoption, guardianship or placement order must be provided to the Plan Administrator.

(c) A handicapped Child, who is incapable of self-sustaining employment because of mental or physical handicap, and who is dependent upon the Participant for support and maintenance, shall remain a dependent so long as such incapacity commenced prior to the child reaching age 26, and the Participant's coverage remains in force. Proof of the Child's incapacity must be submitted to the Board of Trustees within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated;

(d) The Plan shall provide benefits otherwise available hereunder, in accordance with any valid order of a court, determined by the Board of Trustees to be a Qualified Medical Child Support Order (QMCSO) under applicable federal law, which creates or recognizes the right of an alternate recipient to benefits as an eligible Dependent under the Plan. A QMCSO must create or recognize an alternative recipient's right to receive benefits for which a Participant or Beneficiary is eligible to receive under this Plan, provide a reasonable description of the benefits of this Plan and the period to which the QMCSO applies is specified. The administrator of this Plan will establish reasonable methods to notify individuals affected by the order, segregate any amounts payable under the order, determine whether the order is qualified and distribute the benefits under the QMCSO. Any payment made by the Plan under a QMCSO or reimbursement for expenses paid by the Child or the Child's custodial parent or legal guardian must be made either to the Child or the Child's custodial parent or legal guardian.

2.7 **Disabled Employees**.

(a) **Initial Eligibility**. A Class I or II Participant in the Active Plan who becomes Permanently and Totally Disabled will become eligible for benefits in this Plan upon exhaustion of Short Term Disability Benefits along with any balance in the Hour Bank under the Active Plan and provided he or she meets the requirements of one of the following categories:

(1) **Class I and Class II Participants age 55 and older**: A Class I or Class II Participant in the Active Plan who becomes Permanently and Totally Disabled must meet the requirements for Initial Eligibility in Section 2.2(a), 2.3(a), or 2.4(a), as applicable.

(2) **Class I and Class II Participants age 54 and under**: With the exception of the requirement of attaining a specific age, a Class I or Class II Participant in the Active Plan who becomes Permanently and Totally Disabled must meet the requirements for Initial Eligibility in Section 2.2(a), 2.3(a), or 2.4(a), as applicable.

(b) **Continuing Eligibility**. Upon establishing Initial Eligibility for benefits, a Disabled Participant remains eligible by making timely self-payments at rates and under conditions established from time to time by the Board of Trustees.

(c) **Return to Covered Employment**. If a Disabled Participant returns to Covered Employment, he or she will return to the Active Plan.

(d) **Reinstatement of Eligibility**. A Disabled Participant who returns to Covered Employment and later applies for coverage under this Plan upon retirement must meet the requirements of Section 2.2(a), 2.3(a), or 2.4(a), as applicable, to reestablish Initial Eligibility for benefits under this Plan.

**2.8 Continuation of Coverage Under the Family and Medical Leave Act (FMLA)**. A contributing Employer which is a "covered employer" as that term is defined by the FMLA shall, in order to provide or continue coverage for an eligible Participant, is required to notify the Plan when such "eligible employee" has been granted family or medical leave, in accordance with the terms and conditions established by the Board of Trustees. Both the Employer and the Participant shall be required to provide such notices, information and documentation as may be required by the Board of Trustees and by law. The Plan will continue coverage during the period of any leave for which a Participant is eligible under the provisions of the FMLA. The Employer must remit to the Plan the required amount of Contribution Hours required for eligibility. The Employer and the Participant must fully comply with all other requirements established by the Board of Trustees.

**2.9 Continuation of Coverage Under USERRA**. If a Participant leaves Covered Employment to enter service in the Armed Forces, or certain other uniformed services of the United States, any balance in the Hour Bank will be frozen, and he may elect to continue coverage for all benefits under this Plan, for a period that is the lesser of:

(a) The twenty-four (24) month period beginning on the last day of Covered Employment; or

(b) The day the Participant fails to apply for or return to Covered Employment.

If a Participant elects to continue coverage, he shall be charged the monthly COBRA premium rate, as described herein, unless his period of service is less than 31 days, in which case coverage shall be provided at no additional cost to the Participant.

The Participant must return to Covered Employment or register on the Union's out-of-work list within ninety (90) days of his discharge under honorable conditions from the services or within twenty-four (24) months of discharge if he is recovering from an illness or injury incurred during or aggravated by his services. Upon his return to Covered Employment or registration on the Union's out-of-work list, the Participant's Hour Bank, if any, shall be restored. He shall be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds five (5) years, the Participant must again establish initial eligibility before his coverage will be reinstated. Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code, as amended from time to time.

**2.10 Continuation of Coverage Under Consolidated Omnibus Budget & Reconciliation Act of 1986 (COBRA)**. COBRA offers Employees and their Dependents the opportunity to temporarily extend their health care coverage at group rates, in certain instances, after coverage under the Plan would normally end. Within the first ninety (90) days of a Participant or Dependent receiving coverage under this Plan, the Plan Administrator will provide each Participant and Dependent a general notice describing COBRA rights. If a qualifying event occurs, the Plan Administrator will provide an election notice to the Participant and his or her Dependents. The election notice describes their COBRA rights and how to elect COBRA coverage. The Plan Administrator must provide this election notice to the Participant and his or her Dependents within 14 days after receiving notice of the qualifying event.

(a) **Participant Eligibility for COBRA Coverage**: A Participant who suffers either a reduction in his hours of employment or is terminated from employment, for reasons other than gross misconduct, is eligible for COBRA continuation coverage.

(b) **Dependent's Eligibility for COBRA Coverage**: A Dependent child or Spouse has the right to elect continuation coverage under COBRA if he or she loses coverage as a result of any of the following qualifying events:

(1) The death of the Participant; or

(2) The termination of the Participant's employment, for reasons other than gross misconduct, or reduction in Participant's hours of employment; or

(3) The Participant's divorce or legal separation; or

(4) Upon the Participant's eligibility for Medicare; or

(5) For a Dependent child, ceases to be an eligible Dependent under this Plan.

(i) A Child born to or placed for adoption with a covered Participant during the COBRA coverage period shall be considered a qualified Beneficiary, entitled to coverage under this Plan.

(c) **Notice Requirements**: A Participant or Dependent who has lost coverage due to divorce, separation or loss of dependency status, must notify the Benefits Office of the qualifying event within sixty days (60) of the occurrence of such event to qualify for COBRA continuation coverage. In all other cases, the Participant's Employer must notify the Benefits Office within thirty days (30) of the qualified events. Failure to elect COBRA continuation coverage within the time specified will result in termination of the Participant or Dependent's group health care coverage, as of the date of the qualifying event.

(d) **Duration of COBRA Continuation Coverage**:

(1) **Participant**. A Participant who experiences a reduction in hours worked, or is terminated from employment for reasons other than gross misconduct, shall be entitled to maintain COBRA Continuation Coverage for a maximum of eighteen (18 months).

(2) **Spouse or Dependent Child**. Where the qualifying event is a loss of dependency status, i.e. death of an employee, divorce, legal separation, or eligibility for Medicare, the Spouse or Dependent children shall be entitled to coverage to maintain Continuation Coverage for a maximum of thirty-six (36) months.

(e) **Extension of COBRA Continuation Coverage**:

(1) **Disabled Employee**: A Disabled Participant's continuation coverage may be extended to a total period of twenty-nine (29) months if:

(i) The Social Security Administration ("SSA") determines that the Participant was disabled prior to beginning COBRA coverage; or it determines that before the first eighteen (18) months of COBRA coverage have expired, the Participant was disabled within sixty-days (60) of the date that the Participant first began COBRA coverage; and

(ii) The Disabled Participant notifies the Plan Administrator in writing of a Social Security Disability ("SSD") award within the first eighteen months (18) of the COBRA continuation coverage and within sixty days (60) of (a) the date on which SSA issues the disability determination; (b) the date on which the qualifying event occurs; or (c) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, whichever is later.

(iii) **Loss of SSD Status**. A Disabled Participant must notify the Plan Administrator in writing within thirty-days (30) of a determination by the SSA that the Disabled Participant is no longer disabled.

(2) **Second Qualifying Event**: If a second qualifying event occurs during the first eighteen (18) months of COBRA continuation coverage, the continuation coverage period can be extended an additional eighteen (18) months, for a total coverage period of thirty-six (36) months.

(i) **Notice Required**. The Participant must notify the Plan Administrator in writing of a second qualifying event within sixty days (60) from when the second qualifying event occurred or within sixty days (60) of the date the Participant would lose coverage under the Plan due to the qualifying event, whichever is later.

(f) **Cost of Continuation Coverage**: The Board of Trustees shall determine the cost of COBRA continuation coverage, excluding weekly disability benefits, but shall not exceed 102% of the applicable health insurance premium. The Board of Trustees may charge up to 150% of the applicable health insurance premium to Participants who receive the eleven (11) month extension of COBRA coverage as a result of a disability

**2.11 Termination of Eligibility**. A Participant's eligibility for benefits shall terminate on the last day of the month for which he has failed to meet the requirement for continuing eligibility under the Plan, unless he makes self-payments, when permitted, in accordance with the provisions of this Plan. If the Participant elects to make self-payments, his eligibility for benefits hereunder shall terminate on the last day of the month that falls within Participant's COBRA coverage period for which timely payment was received.

## ARTICLE III
## BENEFITS

This Plan provides coverage to you and your eligible dependents for various benefits that are summarized here and in the schedule of benefits. For some benefits, you must also pay a portion of the expense, known as a co-pay or deductible. For a summary of the benefits provided by the Plan, see:

- Appendix A for non-Medicare eligible Participants or
- Appendix B for Participants eligible for the Medicare Supplement.

**3.1. Major Medical, Surgical, and Prescription Drug Benefits**. The Plan has contracted with various service providers to furnish medical, hospital, surgical, and prescription drug benefits. A description of these benefits is set forth in the Schedule of Benefits, found in Appendix A for non-Medicare eligible Participants or Appendix B for Participants eligible for the Medicare Supplement. The Plan may provide certain benefits through specific benefit managers, and some benefits may be subject to specific requirements, such as preauthorization. Different coverage options may be offered with different eligibility and qualification requirements.

**3.2. Death Benefit**. The Plan provides death benefits to the appropriate Beneficiary upon proof of the eligible Participant's or his eligible Dependent's death. The amount of death benefit is specified in the Schedule of Benefits, attached as Appendices A and B, and is subject to the provisions thereof. The Plan may purchase such coverage from a life insurance company, which may impose additional requirements for such coverage.

(a) **Beneficiary**. A Participant may, in his application for a death benefit, designate a Beneficiary or Beneficiaries to receive his death benefits.

(b) **Change in Beneficiary**. Subject to any legal restrictions, or to the rights of any irrevocably appointed Beneficiary, the Participant may from time to time change the Beneficiary. Designations of Beneficiary and any changes thereto, must be made in writing, signed by the Participant and filed with the Plan. In the absence of a subsequent appointment or change in Beneficiary, the Beneficiary who is named at the time of the Participant's termination of service, shall remain the Beneficiary for purposes of receiving the death benefit described in the Schedule of Benefits.

(c) **Failure to Designate a Beneficiary**. In the absence of any statutory provision to the contrary, and if the Participant has not designated a Beneficiary or Beneficiaries, the death benefit proceeds shall pass in descending order to the following individuals:

(1) The Participant's surviving Spouse, then to

(2) The Participant's surviving Child or Children, in equal shares; but if there are no survivors, then to

(3) The Participant's surviving Parent or Parents, in equal shares; but if there are no survivors, then to

(4) The Participant's surviving Siblings, in equal shares; but if there are no survivors, then to

(5) The Participant's estate.

(d) **Division of Death Benefit Proceeds**. If a Participant has named two or more Beneficiaries but has not specified a method of sharing the death benefit proceeds, the Beneficiaries who survive the Participant shall be entitled to receive equal shares of the benefit.

(e) **Payment If Beneficiary is Minor**. If any Beneficiary is a minor or otherwise incapable of giving a valid release for any payment due, death benefit proceeds payable to such Beneficiary shall be paid to his duly appointed guardian. Any such payment shall constitute a full discharge of the liability of the Plan or any insurance company.

(f) **Beneficiary Predeceases Participant.** Should any legally designated Beneficiary predecease the Participant, the insurance proceeds so designated shall, unless otherwise specified by the Participant, and in the absence of any statutory provisions to the contrary, be payable equally to the remaining legally designated Beneficiary or Beneficiaries, if any, who survive the Participant.

**3.3 Use of SCRA balance from Active Plan**. Participants in this Plan who accumulated a balance in the Supplemental Credit Reserve Account (SCRA) may continue to use the balance for such purposes permitted by law and by the Board of Board of Trustees.

(a) **Covered Expenses**. Medical expenses eligible for reimbursement from the SCRA include medical, dental, and optical insurance deductibles, co-pays, and medical services otherwise not covered by the Plan, if these expenses meet Internal Revenue Code guidelines for deductibility and are included in the schedule of benefits set forth in Schedule A to this Plan. SCRA balances may also be used to make self-payments of insurance premiums owing under the terms of this Plan.

(b) **Reimbursements**.

(1) Distributions from the SCRA will only be made to reimburse expenditures upon submission of proper documentation to the Plan Administrator. Proper documentation is required for consideration of requests for reimbursement. SCRA cash distributions will not be paid in advance of the covered expenditures. Covered expenses will only be paid from a participant's SCRA to the extent of the balance remaining in that participant's SCRA at the time of the claim.

(2) PrePaid Benefits Card: The Board of Trustees may, within their discretion, provide a pre-paid benefits card to electronically access the balance in the participant's medical reimbursement account for reimbursement at pharmacies and other health care providers that participate in the prepaid benefits program.

(c) **SCRA Transferable**. When a participant is deceased, the SCRA balance is transferable to an eligible Surviving Spouse. The balance is not transferable to Dependent children.

(d) **Balance Forfeitable**. If there is no activity with respect to the SCRA for a period of five (5) or more years after termination of coverage, then the balance of the SCRA is forfeited to the Active Plan.

(e) **Option to Opt-Out**. A Participant may opt-out of the SCRA account and waive all rights to future reimbursements from the SCRA. The Plan shall offer the opt-out opportunity once annually. Upon loss of eligibility, the Participant who has not previously opted out may permanently opt-out and waive the right to future reimbursements from the SCRA.

## ARTICLE IV
## EXCLUSIONS AND GENERAL LIMITATIONS

**4.1 Exclusions**. To the extent the exclusions listed below are not the result of an otherwise covered benefit, each exclusion listed below applies to all benefits under this Plan, except life insurance, irrespective of whether the exclusion is repeated in a provision of this Plan describing such benefits. Accordingly, except where required by law, this Plan **will not provide** benefits, as follows:

1. For injury received while working for pay or profit by any Participant or any Dependent including any extra side job, weekend job, a job being performed by a friend or relative on which the Participant or Dependent is assisting (working or viewing).

2. For loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law.

3. For pre-employment or insurance exams.

4. For treatment of injury or illness caused by war.

5. For any hospital confinement, surgery, treatment, service or supply for which the Participant or Dependent is not legally obligated to pay.

6. For any period of hospital confinements that occur before the effective date of eligibility, upon becoming eligible however, the Plan will assume coverage.

7. For treatment of injury, resulting from causes other than sickness, accidental injury or disease. Injuries incurred in a "fight", however, injuries sustained in the context of domestic violence will be covered. In case of questionable claims of this type, the Trustees will require a copy of the police report and full details describing the altercation. However, coverage will be extended to victims of domestic violence or where the injury is related to an otherwise covered benefit.

8. For educational or self-help therapy, other than diabetic self-management in a hospital setting.

9. For expense incurred for any type of family planning (other than those associated with contraceptive management).

10. For weight loss or diet control treatment, unless Medically Necessary; comprehensive nutritional programs; visits with specialists in endocrinology; visits when required solely for the purpose of weight loss; treatment of obesity only; dietary supplements; nutritional lectures; and quick weight loss programs and clinics.

11. For sterilization reversals.

12. For payment of surcharge or nonresident tax levied by community hospitals.

13. For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a Medical Provider, including ergometers and exercycles, bicycles, etc.

14. For elective surgery, including cosmetic surgeries that are not necessary by reason of sickness, injury or disease or for the protection of the health of the individual, including services or supplies for treating hair loss or to restore hair growth.

15. For medical treatment or services, if any, that are not recommended and approved or prescribed by a legally qualified Medical Provider.

16. For treatment of injuries sustained in an automobile accident or motorcycle or other motor vehicle accident or complications resulting from such injuries or accident, unless a subrogation agreement is executed in favor of the Plan.

17. For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies.

18. For expense incurred if the Participant is engaged in any unlawful act.

19. For immunization injections, unless required under the Patient Protection and Affordable Care Act (PPACA) or other applicable law;

20. Any deductible required by the Plan or reimbursement of deductibles under the Plan or prescription deductible, if any.

21. For expense incurred (or from complications resulting from) for cosmetic surgery or experimental surgery, except as specifically covered by this Plan.

22. For court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any eligible Participant or any of his eligible Dependents, even when prescribed by a Medical Provider, unless required under the Mental Health Parity and Addiction Equity Act (MHPAEA).

23. For the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

24. For hospitalization for dental care other than when concurrent hazardous medical condition necessitates hospitalization.

25. For voluntary abortions, except in those cases where such surgery is performed to protect the health of the Participant or eligible Spouse.

26. For radial keratotomies (and/or for Lasik), except as covered under the dental/vision benefit.

27. For purchase of sun lamps required for any cause.

28. For Experimental or Investigational Treatment, supplies and devices, unless required under the Patient Protection and Affordable Care Act.

29. For temporomandibular joint (TMJ) services, except for surgery and except as covered under the dental/vision benefit. Pre-certification may be required.

30. For Custodial Care.

31. For prescription drugs that are primarily for elective or cosmetic purpose (i.e., Retin-A).

32. For donor expenses.

33. For maternity and obstetrical benefits for Dependent children, unless required by the Patient Protection and Affordable Care Act (PPACA).

34. For charges in excess of Reasonable and Customary Charges.

35. For travel, even if prescribed by a Medical Provider.

36. For fees related to telephone consultations, failure to keep a scheduled visit or complete a claim form.

37. For services or supplies for artificial insemination, in-vitro fertilization or gamete intra fallopian transfer (GIFT).

38. For chelation therapy, except for acute arsenic, gold mercury and lead poisoning.

39. For coverage for services related to gender dysphoria.

40. For over-the-counter drugs, unless specifically provided as a covered benefit or required by the Patient Protection and Affordable Care Act (PPACA).

41. For food supplements or augmentation, unless specifically provided as a covered benefit or required by the Patient Protection and Affordable Care Act (PPACA).

42. For vitamins, unless injectable, specifically provided as a covered benefit or required by the Patient Protection and Affordable Care Act (PPACA).

43. For appetite suppressants, unless Medically Necessary to treat attention deficit disorders or narcolepsy.

44. For diabetic supplies or disposable medical supplies, unless specifically provided as a covered benefit.

45. For any medical services provided by or paid for by the United States government, state government, local government, or any instrumentality of the foregoing.

46. For vision and dental services

**4.2 Modifications**. The amount of benefits offered by this Plan and the Board of Trustees therefore can modify the eligibility requirements at any time, or such benefits can be eliminated entirely, as the Board of Trustees deem appropriate. No retroactive claim to benefits will be recognized in case of such modification or elimination of coverage.

**4.3 Coordination of Benefits**. In general, benefits from this Plan are subject to amounts payable in accordance with coordination of benefits (COB) rules. The purpose of these rules is to avoid duplicate or overlapping payments of benefits resulting in unjust overpayments. The COB rules apply generally to all benefits payable from this Plan other than the Death Benefit and Short Term Disability Benefits.

(a) **Employment**. COB rules are in effect whenever any individual has coverage under this Plan and any other group insurance program, health and welfare Plan, Blue Cross/Blue Shield, Medicare, or other health care plan. If a Participant becomes employed by an employer that provides a health care plan other than this Plan, then that employer's health insurance program will become the primary insurance carrier once the Participant's eligibility for benefits under this Plan expires.

(b) **Birthday Rule for Dependents**. If both the Participant and his Spouse are entitled to benefits under separate group health insurance programs, and both plans cover the couple's Dependent Children, the Plan which covers the Spouse with the birthday earliest in the year, shall be considered the primary payor for the Dependent Children. If the birthdays of the two policyholders are on the same date, the policy of plan that has been in effect for the longer time will be primary. This Plan will pay benefits in accordance with its applicable schedule of benefits if it is considered to be primary. Otherwise, the other plan will be required to pay the benefits up to the maximum amount payable in accordance with its schedule of benefits and this Plan will then pay any remaining amounts not covered by such other plan up to, and in accordance with, its Schedule of Benefits so that, in the aggregate, no more than 100% of the "covered charges" will be paid.

(c) **Order of Coverage**. This Plan determines its order of coverage using the following rules:

(1) If a person is covered as an insured or as an employee under one policy and a dependent under another, the policy or plan under which he is the insured or employee is primary.

(2) In case of Dependent Children of divorced parents, the plan of the parent on whom the Judgment of Divorce places the health care responsibility will be the primary insurer. If this is not stated in the judgment, then the following COB rules shall apply:

(i) The plan of the parent with physical custody of the Child/ren shall be primary; then

(ii) The plan of the Spouse of the parent with physical custody of the Child.

(iii) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child(ren) will follow the order of benefit determination rules set forth in this subsection.

(d) **Out-of-State Policy**. If one of the policies or plans is issued in another state that does not use birthdays for coordination of benefits and each policy or plan by its terms is secondary, then the out-of-state policy or plan shall be secondary. Each policy or plan will then be responsible for a maximum of fifty percent (50%) of their allowed expense or allowed benefit.

(e) **Coordination of Benefits - Medicare**. The Plan will provide identical benefits to all Participants regardless of Medicare coverage that may otherwise be available; except, in the following circumstances then Medicare shall be primary: (a) a Participant is a Retiree over age 65; (b) a Spouse of a Participant over age 65 for whom Medicare would otherwise be secondary is determined to be a Participant of an Employer with less than twenty (20) employees; (c) a Participant is under age 65 and has received Social Security Disability benefits for 24 months or longer; (d) a Participant is under age 65 and qualifies as an eligible person who requires hemodialysis treatment or a kidney transplant because of chronic kidney disease.

(f) **Coordination of Benefits – Auto Accidents**. If medical, surgical, or prescription drug coverage is available from other provider of insurance, the Plan will provide coverage only on a secondary basis and only if the Participant signs a reimbursement agreement in a form acceptable to the Board of Board of Trustees.

(g) **Duty to Comply with Plan Requirements**. If a Participant and/or Beneficiary is eligible for benefits under a health maintenance organization, preferred provider organization, or similar type of plan, which requires that health care services be obtained only from certain designated health care providers and/or organizations, and if such individual fails to comply with the requirements of such policy or plan, then he shall not be eligible for benefits hereunder, pursuant to the coordination of benefits provision. Only if a Participant and/or a Beneficiary is denied benefits under another health care plan, after complying with all its requirements for eligibility and/or coverage, will he become eligible for coverage under the Plan, pursuant to the coordination of benefits provision.

## ARTICLE V
## ADMINISTRATION

**5.1. Discretionary Authority, Interpretation, and Administration**. The Plan shall be administered solely by the Board of Trustees and employees or agents of the Trustees, acting for them as authorized agents. The Board of Trustees shall have the fullest possible discretionary authority to administer all aspects of the Plan's operations, including but not limited to the exclusive right and discretion to interpret all terms and provisions of governing documents, which include, but are not limited to this Plan Document, the Trust Agreement, Summary Plan Description, any Summary of Material Modification or Summary of Benefits and Coverage, or any document, instrument, or record used in the administration of the Fund, as well as any amendments or modifications thereof and apply same as they deem appropriate. The Board of Trustees' original intent is and continues to be that the exercise of such discretionary authority and all Trustee determinations made pursuant thereto, whether prospectively or retroactively, shall be entitled to the highest possible deference allowed by law, in case of review by any court or governmental authority of competent jurisdiction. Without limiting the foregoing, it is the explicit intent of the Board of Trustees

that their decisions shall not be subject to *de novo* review, but shall instead be construed under the arbitrary and capricious standard, or any higher standard permitted by applicable law. The foregoing clarification of the Board of Trustees' powers shall not be interpreted as a limitation on those powers as they existed prior to this restatement or hereafter may be exercised, but as a clarification of same and expression of the Board of Trustees' original intent regarding such powers and applied retroactively, to the fullest extent possible. Trustee determination shall be final and binding on all concerned parties.

**5.2. Records and Reports**. The Board of Trustees shall keep such records and other data as may be necessary for the proper administration of the Plan. Upon receipt of a written request, the Board of Trustees shall furnish any Participant or Beneficiary with a copy of the Plan, Trust Agreement, or latest annual report, subject to a reasonable charge where permitted be law not to exceed the lesser of:

(a) The actual cost of reproduction; or

(b) $.25 per page.

**5.3 Claims Filing and Initial Benefit Determination**.

(a) **Definitions**. The following defined terms will be used in this section:

(1) **Adverse Benefit Determination**. A denial, reduction, termination of, or failure by the Plan to provide or make payment for, a benefit available under the Plan. A retroactive cancellation of coverage is also included in this definition.

(2) **Urgent Care Claims**. An "Urgent Care" claim is any claim for medical care or treatment which cannot be decided under normal time frames because: (A) it can 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. Any Claim that a physician with knowledge of the claimant's medical condition determines in an 'Urgent Care" claim shall be treated as an "Urgent Care" claim by the Plan. Otherwise, the determination regarding whether a claim involves "Urgent Care" shall be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

(3) **Pre-Service Claims**. A "Pre-Service" claim is any claim that, under the terms of the Plan, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(4) **Concurrent Care Claims**. A "Concurrent Care" claim is any claim regarding an on-going course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the Plan.

(5) **Post-Service Claims**. A "Post-Service" claim is any claim that is not a "Pre-service", "Urgent Care", or "Concurrent Care" claim.

(b) **Claims Filing and Determinations**

(1) **General One-Year Filing Deadline**. Unless another time period is provided by this Plan, claims for benefits must be filed with the Plan Administrator within one-year (1) of their occurrence. The Board of Board of Trustees may, in their sole and absolute discretion, waive this requirement.

(2) **Urgent Care Claims**. The Plan shall notify the claimant of its decision as soon as possible but no later than seventy-two (72) hours after receipt of a properly submitted claim. In the event the claimant failed to submit sufficient information to process the claim or failed to follow the Plan's procedures, then the claimant shall be notified of the defect within twenty-four (24) hours, and shall have forty-eight (48) hours to provide the information. The Plan shall then notify the claimant of its decision either within forty-eight (48) hours of its receipt of the requested information, or at the end of the initial forty-eight (48) hours given to the claimant to provide it. Oral notice of the decision may be provided, but written notice will be provided within three (3) days of the oral notification.

(3) **Pre-Service Care Claims**. The Plan shall notify the claimant within fifteen days (15) of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period by an additional fifteen days (15). The Plan may only exercise the fifteen-day (15) extension if, prior to the end of the initial fifteen-day (15) period, the claimant is provided with a notice that provides the reasons for the delay and the date by which the plan expects to render a decision. In the event the extension is due to the failure of the claimant to submit information necessary to reach a decision on the claim, then the claimant shall be given forty-five (45) days to provide the necessary information. The claim will then be decided within fifteen days (15) of receiving the requested information or within the initial forty-five day (45) extension to provide the information, whichever occurs first.

(4) **Post-Service Care Claims**. The Plan shall notify the claimant within thirty days (30) of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period by an additional fifteen days (15). The Plan may only exercise the fifteen-day (15) extension if, prior to the end of the initial thirty-day (30) period, the claimant is provided with a notice that provides the reasons for the delay and the date by which the plan expects to render a decision. In the event the extension is due to the failure of the claimant to submit information necessary to reach a decision on the claim, then the claimant shall be notified within five days (5) and given forty-five days (45) to provide the necessary information. The claim will then be decided within fifteen days (15) of receiving the requested information or within the initial forty-five day (45) extension to provide the information, whichever occurs first.

(5) **Disability Claims**. The Plan shall notify the claimant within forty-five days (45) of receipt of the claim. If the Plan is not able to make a decision due to circumstances beyond the Plan's control, then it may extend the period for thirty days (30). The Plan may only exercise the thirty-day (30) extension if, prior to the end of the initial forty-day (45) period, claimant is provided with a notice that provides the reasons for the delay, the standards on which entitlement to the benefit is based, and the date by which the Plan expected to render a decision. If additional time is still needed, then the Plan may extend the timeframe an additional thirty days (30), and shall notify the claimant of the second extension prior to the expiration of the first thirty-day (30) extension. The Plan may not exercise the second thirty-day (30) extension without again providing notice to the claimant of the reasons for the delay, the standards on which the benefit is based, and the date by which the Plan expects to render a decision. If any extension is based upon the need for the claimant to provide additional information, the claimant shall be given forty-five days (45) to provide it.

(6) **Concurrent Care Claims**. An adverse determination regarding a Concurrent Care Claim is any reduction or termination by the Plan of the course of treatment before the end of the period of time or the full number of treatments, unless the reduction or termination occurs as the result of a Plan amendment or termination of the Plan. The Plan will notify the claimant of the adverse benefit determination regarding a Concurrent Care Claim at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Additionally, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Plan shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four hours (24) after receipt of the claim by the Plan, provided that the claim was submitted to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(7) **Time**. For purposes of claims reviews and Step 1 and Step 2 appeals, the period for review shall begin when the claim or appeal is filed in accordance with the Plan's procedures. If an extension of time occurs due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the one that the notification of the extension is sent to the claimant until the claimant responds to the request for additional information.

(c) **Claim Denial Notices**.

(1) Claim Denial Notice include:

(i) The specific reason(s) for denying the claim;

(ii) Specific reference(s) to pertinent Plan provisions on which the denial is based;

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

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

(v) If applicable, a copy of the internal rule, guideline or protocol that was relied upon, and a statement that such rule will be provided free of charge to the claimant upon request;

(vi) If the adverse determination is based on the issues of medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for determination, or a statement that such explanation will be provided free of charge to the claimant upon request; and

(vii) A description of the expedited review process applicable to "Urgent Care" claims.

**5.4 Internal Appeals Procedures.**

(a) **Step 1 Appeal.** If the claimant disagrees with the action taken on his/her claim by the Plan, then the claimant may submit a written request for review. The claimant may either submit the claim personally, or may have the claim submitted by the claimant's duly authorized representative. The Plan Administrator will review the claim in accordance with the following rules listed below. The decision of the Plan Administrator in a Step 1 Appeal is not a final adverse benefit determination.

(1) A request for review of the Plan's action must be submitted in writing to the Administrator within 180 days after mailing of the notice of the adverse benefit determination.

(2) Claimant may have an opportunity to review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the claim for benefits.

(3) Claimant shall be provided, 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. A document is considered relevant to the claim if the document (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit decision, or (3) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

(4) The Plan shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination by the Plan.

(5) The Plan shall not afford deference to the initial adverse benefit determination.

(6) The review will not be conducted by the individual who made the initial adverse determination, nor by the subordinate of such individual.

(7) If the appeal is from an adverse benefit determination that was 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, then the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purposes of a consultation under this section shall be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the review, nor the subordinate of any such individual. The claimant shall be informed of the identity of each medical or vocational expert 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.

(8) If the request for review involves an Urgent Care claim, then the claimant shall be offered an expedited review process pursuant to which (A) the request for appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and (B) 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.

(9) The Plan Administrator shall notify the claimant of its decision of an Urgent Care benefit claim within 72 hours, a Non-Urgent Pre-Service benefit claim within fifteen 15 days and a Non-Urgent Care Post-Service benefit claim or Disability claim within 30 days of receipt of the appeal.

(10) If the determination is adverse, the notice shall include the following information:

(i) The specific reason(s) for the adverse determination;

(ii) Reference(s) to the specific Plan provisions on which the determination is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim. A document is considered relevant to the claim if the document (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit decision, or (3) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants;

(iv) If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request;

(v) If the adverse determination is based on 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;

(vi) A statement regarding the claimant's right to bring a civil action under ERISA section 502(a) following the adverse benefit determination on appeal;

(vii) 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" and;

(viii) Any other information required by law.

(b) **Step 2 Appeal**.

(1) The claimant or his or her authorized representative may appeal the final decision by the Plan Administrator, by written notice received by the Board of Board of Trustees within one hundred (180) days of the mailing of the notice of an adverse benefit determination. The written notice only needs to state the claimant's name, address, and the fact that the claimant is appealing from the decision of the Plan Administrator, giving the date of the decision appealed from.

(2) The Board of Board of Trustees shall review the claim and advise the claimant of any adverse benefit determination in accordance with the notice content and timing requirements set forth in Step 1 of the Appeals Procedure, as set forth above. In addition, the Board of Board of Trustees shall provide the claimant

with any new evidence considered, relied upon, or generated by the Plan free of charge. This information shall be provided as soon as possible and sufficiently in advance of the deadline for making the final adverse determination so that the claimant has a reasonable opportunity to respond. With respect to any and all claims, the Board of Board of Trustees shall not issue a final adverse benefit determination unless the information described above has been provided in the manner specified and the claimant has been afforded a reasonable opportunity to respond.

**5.5 External Reviews.**

(a) **Request for External Review**. A claimant will have 4 months from receipt of an adverse benefit or final adverse benefit determination to file a request for an external review. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(b) **Preliminary review**. Within 5 business days following the receipt of the request for an external review, the Plan will complete a preliminary review of the request to determine the following:

(1) Whether the claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

(2) Whether the adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(3) Whether the claimant has exhausted the plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process;

(4) Whether the claimant has provided all the information and forms required to process an external review.

(c) **Post Preliminary Review**. Within 1 business day after completion of the preliminary review, the Plan will issue a written notice to the claimant noting the reasons, if the claim is not eligible for external review, along with contact information for the Employee Benefits Security Administration (EBSA), or, the information needed if the application for the review is not compete. The claimant shall have the latter of (a) the four-month filing period, or (b) the 48-hour period following the claimant's receipt of the notification to provide any additional information that is needed.

(d) **Referral to Independent Review Organization (IRO)**. At the conclusion of the Preliminary Review, the Plan will then refer eligible claims to a randomly selected IRO and immediately provide coverage if the decision of the Plan is overturned. The Plan shall adhere to all terms of the contract with the IRO.

5.6 **Expedited External Reviews**.

(a) **Option for Expedited Review**. A claimant may request an expedited external review at the time the claimant receives either of the following:

(1) An adverse benefit determination that involves a medical condition where delay would jeopardize the claimant's health or ability to regain maximum function and the claimant has made a request for an expedited internal appeal;

(2) A final internal adverse benefit determination where the claimant has a medical condition where the timeframe for a normal external review would jeopardize the claimants health or ability to regain maximum function, or, if the determination involves an admission, availability of care, continued stay, or a health care or service for which the claimant received emergency services but has not yet been discharged.

(b) **Preliminary Review**. Immediately upon receipt of the request for an expedited review, the Plan shall determine whether the request meets the requirements for external review. This determination is made by applying the criteria for a standard external preliminary review set forth set Section 5.5(b).

(c) **Post Preliminary Review**. Issue a written notice to the claimant noting the reasons, if the claim is not eligible for external review, along with contact information for the Employee Benefits Security Administration (EBSA), or, the information needed if the application for the review is not compete. The claimant shall have the latter of (a) the four-month filing period, or (b) the 48-hour period following the claimant's receipt of the notification to provide any additional information that is needed.

(d) **Referral to IRO**. If the Plan determines the request is eligible for external review, then an IRO must be assigned the claim in the same manner as for a standard external review. The Plan shall provide the IRO with all the information used in making the benefit determination in the most expeditious manner available.

5.7 **Misstatement in Application for Benefits**. If any person in his application for benefits, or in response to any request of the Board of Trustees for information, makes any statement which is erroneous or omits any material fact or fails before receiving his first payment to correct any information he previously incorrectly furnished to the Board of Trustees for their records, the amount of the benefit shall be adjusted on the basis of the true facts, and the amount of any overpayment theretofore made to such person shall be deducted from the next payments as the Board of Trustees shall direct. Retroactive rescission of coverage shall only occur in the event of fraud or material misrepresentation to the Plan. The Plan Administrator shall provide at least 30 days written notice in advance of any retroactive rescission of coverage.

5.8 **Contributions to the Plan**. Pursuant to certain Collective Bargaining Agreements, the Board of Trustees, the Union and the Associations have executed a Trust Agreement. The terms of the Trust Agreement provide for receipt and holding of contributions payable by the Employers along with interest and other income. The contributions and income from interest and investments are to pay benefits and provide funds for its operation. The Employers shall have no rights, title or interest in the contributions made to the Plan and no part of the Plan shall revert to the Employers.

5.9 **Funding and Payment of Benefits**. The amount of Employer Contributions shall be determined by the terms of the Collective Bargaining Agreement between each such Employer and the Union. All benefit payments will be paid by the Board of Trustees and all contributions available for investment will be invested by the Board of Trustees in such manner as serves the best interests of the Plan and its

Participants. Prior to the termination of the Plan, no part of the Plan assets may be applied other than for the exclusive benefit of Participants and their Beneficiaries.

**5.10** **Duty to Notify the Plan of Changes**. The Benefits Office must be notified of any changes regarding the following:

(a) **Marriage** - To add a Spouse or Child to coverage, the marriage must be reported within thirty (30) days of the marriage and a copy of the certificate of marriage must be filed in the Fund Office. If notification occurs after the date of the marriage, coverage will begin on the date the notification is received, not the date of the marriage.

(b) **Guardianship/Foster/Adopted Child** – To add a foster Child or Child placed for guardianship to coverage, the Participant must provide the Fund Office with a true copy of the applicable court order within thirty (30) days of the entry of the order. If notification does not occur within thirty (30) days of the order, coverage will be being upon receipt of the notification by the Fund Office, not the effective date of the order. Upon the foster Child or Child placed for guardianship leaving the care of the Participant, either by attaining the age of majority or by other court order, the Participant shall notify the Fund Office within 30 days of the triggering event and coverage shall end on the last day of the month in which the triggering event occurs.

(c) **New Children** - To add a Participant's Child to coverage, the birth must be reported within thirty (30) days. A copy of the birth certificate must be filed in the Benefits Office. The Child will be covered from the moment of birth, as provided herein.

(d) **Adoptions** - Adoption or placement of a Child must be reported within thirty (30) days to add the Child as an eligible Dependent and a copy of the legal adoption papers or court order for placement must be filed in the Benefits Office.

(e) **Change of Address** - Any change of address shall be reported immediately.

(f) **Name Change** - Any name change shall be reported immediately.

(g) **Deaths** - Deaths should be reported immediately. A certified copy of the death certificate is required.

(h) **Divorce** - Divorce must be reported immediately and a full copy of the judgment of divorce must be filed in the Benefits Office. A former spouse is not eligible for benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provisions outlined herein. Eligible Dependent Children will continue to be covered if they continue to be legal Dependents.

(i) **26th Birthday** - Dependent children attaining the age of twenty-six (26) or foster children who no longer meet the definition of a "foster child" under applicable law are no longer eligible for coverage. Once no longer eligible for coverage, such dependent may elect continuation of coverage under the COBRA provision of the Plan.

**5.11** **HIPAA and HITECH Privacy Requirements**.

(a) **Use and Disclosure of Protected Health Information (PHI)**. The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act

(HITECH). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations, as those terms are defined in 45 C.F.R. § 164.501.

(b) **The Plan will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary**. With an authorization, the Plan will disclose PHI to constituent plans affiliated with the Union for purposes related to administration of these plans.

(c) **Trustee Certification**. The Plan will disclose PHI to the Board of Trustees, subject to the conditions set forth in subsection D.

(d) With Respect to PHI, the Board of Trustees agree to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Board of Trustees provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized herein or by an individual;

(4) Not use or disclose PHI in connection with any other benefit or plan of the Board of Trustees unless authorized by an individual;

(5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA and HITECH;

(7) Make available the information required to provide an accounting of disclosures;

(8) 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 HITECH; and

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

(e) In order to maintain adequate separation between the Plan and the Plan Sponsor, only the following employees or classes of employees may be given access to PHI:

(1) Any Plan employees;

(2) The Plan administrator;

(3) Staff designated by the Plan administrator; and

(4) Third-party providers who have executed a business associate agreement.

(f) **Limitations of PHI Access and Disclosure**. The persons described in subsection 5.9(e) may only have access to and use and disclose PHI for plan administration functions that the Board of Trustees perform for the Plan.

(g) **Noncompliance**. If the persons described in subsection 5.9(e) do not comply with this Plan document, the Board of Trustees shall resolve any issues of non-compliance in accordance with the provisions of HIPAA, HITECH and regulations thereunder.

(h) **Notification Upon Breach**. Following the discovery of a breach of unsecured PHI, the Plan will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, inappropriately accessed, acquired or disclosed in the breach. Notice will be provided in plain language and include:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(2) A description of the types of unsecured PHI that were involved in the breach (e.g., full name, Social Security number, date of birth, home address, account number, disability code);

(3) The steps individuals should take to protect themselves from potential harm resulting from the breach;

(4) A brief description of the steps the Plan is taking to investigate the breach, mitigate losses, and to protect against further breaches; and

(5) Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, an e-mail address, website, or postal address.

## ARTICLE VI
## MISCELLANEOUS

**6.1 Right to Receive and Release Necessary Information**. For the purposes of determining the applicability of and implementing the terms of this Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

**6.2 Facility of Payment**. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of its provisions, and amounts so paid shall be deemed to be benefits paid under this Plan. To the extent of such payments, the Plan shall be fully discharged from further liability under this Plan.

**6.3 Right of Recovery**. Whenever payments have been made by the Plan with respect to Covered Charges in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments to the extent of such excess, from any person to, or for whom such payments were made, any other insurance companies, or any other service providers.

6.4 **Automatic Subrogation**. In the event of any payments of services under this Plan, the Plan shall, to the extent of such payments, be automatically subrogated to all rights of recovery of the Participant or Dependant arising out of any claim or cause of action which may accrue against a third party. Any such Participant or Dependant hereby agrees, by virtue of accepting coverage hereunder, (regardless of whether a specific reimbursement agreement is executed), to reimburse the Plan for any benefits so paid hereunder, out of monies recovered from such third party as the result of judgment, settlement or otherwise, regardless of whether such Participant or Dependant has been made whole by such recovery from a third party. Such Participant or Dependant hereby agrees to take such actions, to furnish such information and assistance, and to execute and deliver all necessary instruments, or other documents as the Board of Trustees may require in order to facilitate the security and enforcement of their rights. Participant or Dependant hereby agree to cooperate with the Plan and its representatives in completing all appropriate forms in order to provide such information surrounding any accident as the Plan or its representatives deem essential to fully investigate the incident.

The Plan, by payment of any proceeds, shall automatically be granted a lien on any settlement, judgment or other payment or recovery received by the Participant or Dependant. In addition to consenting to said liens, the Participant or Dependant pledges to take any necessary steps to assist the Plan in securing any such lien. The Plan's right of recovery shall be a first priority lien against any proceeds recovered by the Participant or Dependant, which right shall not be reduced or compromised by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's priority recovery rights by allocating the proceeds exclusively to non-medical expense damages.

A Participant or Dependant may not incur any expenses or costs on behalf of the Plan, attributable to any rights of the Plan under this Section; specifically, neither court costs nor attorney's fees shall be deducted from the Plan's recovery without the prior written consent of the Plan, such costs and expenses being the sole responsibility of the Participant or Dependant. Any so-called "Plan Doctrine," "Common Plan Doctrine," "Attorney's Plan Doctrine" or other equitable remedy shall not defeat the Plan's right to unconditional full reimbursement granted hereunder.

6.5 **Workers' Compensation (Work Related Illness or Injury)**. Benefits will not be paid under this Plan for any illness or injury if the Participant is entitled to Workers' Compensation benefits for that illness or injury. If the Board of Trustees are unable to determine whether the illness or injury is work related and covered by Workers' Compensation, the Board of Trustees may, but shall not be required to, provide benefits until such a determination is made. If the Board of Trustees determine that the Plan will provide benefits, those benefits will only be provided if the Participant agrees in writing to indemnify and reimburse the Plan for all such benefits paid hereunder out of any money recovered by the Participant in the form of Workers' Compensation benefits, damages, compensation or settlement of any claims against his Employer or any third party arising out of that illness or injury. The Participant hereby agrees to take all actions to furnish all such information and assistance and to execute and deliver all necessary instruments as the Plan may require to facilitate the enforcement of the provision of this paragraph. The term "Participant" referred to in this Section shall also mean all Spouses and Dependents of any Participant.

"Work-Related" and/or "Occupational Claim" - shall mean a claim arising out of work-related illnesses and injuries which are generally paid by Workers' Compensation Insurance and not by the Plan. In case it is difficult to determine whether it is work related, the Board of Trustees may, but shall not be required, to make voluntary payments from the Plan for Medical, Hospital and related expenses resulting from such illness or injury, but no such payments will be made in any case unless such work-related claim or occupational-related claim has first been filed with the Workers' Compensation Bureau and in the event the claim is denied/disputed. Benefits for such claims will be paid pursuant to an assignment, in accordance with the provisions of the Plan, subject to reimbursement in the event benefits are, at a later

date, received from Workers' Compensation or any third party, regardless of whether the Participant is made whole by such recovery.

6.6 **Assignments**. The agreement for assignment of medical claims for work related injuries, asbestosis or asbestosis related claims, or similar claims may be required prior to payment of benefits hereunder.

6.7 **Release of Participant Records**. Information regarding a Participant or Dependent or the records of a Participant or Dependent may be furnished or released upon receipt of an authorization properly executed by the Participant or Dependent upon receipt of a Court Order or Subpoena served upon the Board of Trustees or the Administrative Manager.

6.8 **Right to Amend and Terminate**. The Board of Trustees may amend, by majority vote, any or all provisions of this Plan at any time, without obtaining the approval or consent of any Union, Association, Employer, Employee, Participant or Beneficiary, provided that no amendment shall divert Plan assets to an Employer. This Plan may be terminated by an instrument, in writing, executed by the Board of Trustees, as provided in the Trust Agreement.

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

6.10 **Construction**. In the construction of the Plan, the feminine shall include the masculine, and the singular, the plural, in all cases where such meanings would be appropriate.

6.11 **Effect of Invalidity of Provision**. If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provision had not been included.

6.12 **Approval of Internal Revenue Service**. This Plan is adopted, subject to the approval by the Internal Revenue Service as meeting the requirements of the Code and Regulations thereunder with respect to the deductibility of contributions to the Plan and expenses thereof and with respect to the tax exemption of such Plan. In the event that such approval is not secured for the Plan, as adopted, it may be amended for purposes of securing qualification under the Code, as may be necessary to secure such approval.

6.13 **Choice of Law & Venue**. To the extent not preempted by federal law, this Plan shall be governed and controlled by the laws of the State of Michigan as to interpretation, enforcement, validity, construction, and effect and in all other respects. Any and all disputes regarding the terms and conditions of this Plan will be heard in the United States District Court for the Eastern District of Michigan.

6.14 **Employer Contributions, Title**. Employer Contributions become Plan assets at the time they are due and owing to the Plan. Title to all Employer Contributions paid into and/or due and owing to this Plan shall be vested in and remain exclusively in the Board of Trustees of the Plan. An Employer shall have no right, title or interest in the Employer Contributions owing to the Plan. The Board of Trustees may exercise all available remedies provided by law to collect delinquent Employer Contributions.

**6.15. Provider Non-Discrimination**. The Plan shall not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's licensee or certification under applicable state law.

IN WITNESS WHEREOF, the Board of Trustees of the Northwestern Ohio Plumbers & Pipefitters Retiree Health and Welfare Fund, hereby execute this Plan on the 8th day of October, 2015.

**UNION TRUSTEES**

Eric Osborn

Scott Lopez

Timothy Pollauf

**EMPLOYER TRUSTEES**

Shaun M. Murray

Michael Schabel

Jeff Earl

**ALTERNATE TRUSTEES**

Bob Lynn, Jr.

Don Lee

Paul Cordell

**ALTERNATE TRUSTEES**

Pete Vavrinek

Stephen Dunbar

Kevin E. Gray

## APPENDIX A
## SCHEDULE OF BENEFITS FOR EARLY RETIREE PARTICIPANTS AND DEPENDENTS IN THE NORTHWESTERN OHIO PLUMBERS & PIPEFITTERS HEALTH AND WELFARE PLAN

**Effective: September 1, 2014**
(changes effective **April 1, 2015** are in **bold**)

This Plan offers coverage for various benefits, some of which require the satisfaction of applicable deductibles, co-pays, limitations, exclusions or separate eligibility requirements. Full credit will be given for deductibles and co-pays satisfied under the terms of the Predecessor Plan in the current benefit year. The following benefit levels currently apply:

| Benefit Item | In-Network | Out-of-Network |
|---|---|---|
| Lifetime or Annual Plan Maximums | None | |
| Participant Responsibility | Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from the out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts. | |
| Prior Authorization Requirement – Medical and Surgical | Coverage will be denied if your Medical Provider does not obtain prior authorization from the Plan's utilization review vendor for certain medical and surgical services, which are noted throughout this Schedule of Benefits. Services requiring prior authorization are as follows:<br>• Non-emergency in-patient care<br>• In-patient mental health & substance abuse treatment<br>• Certain maternity services<br>• Skilled nursing care<br>• Hospice<br>• Home infusion therapy<br>• Home health care<br>• Private duty nursing<br>• Outpatient surgeries requiring general anesthesia<br>• Medically necessary cosmetic surgery<br>• Tempo-mandibular joint repair<br>• Physical therapy after the 24th visit | |
| Prior Authorization Requirement – Prescription Drugs | Coverage will be denied if your prescribing Medical Provider does not obtain prior authorization from the Plan's Pharmacy Benefit Manager (PBM) for *all* specialty drugs, compound drugs costing $100 or more, and any non-specialty or non-compound drugs costing $5,000 or more **(effective 4-1-15)**. | |
| Calendar Year Deductible | $400 per individual; $1,200 per family | |
| Calendar Year Out-of-Pocket Maximum (Excludes deductibles and copays) | $1,500 Individual<br>$3,000 Family | |

| | | |
|---|---|---|
| Co-Insurance | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **PREVENTIVE SERVICES**<br>Preventive health benefits include regular periodic health evaluation for adults and children, well baby care from birth, and routine adult and child immunizations. All preventive health benefits required by the Patient Protection and Affordable Care Act of 2010 (PPACA) and its implementing regulations will be covered without cost-sharing when received from an in-network provider. | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Health Evaluation Visit - Children<br>Regular and periodic well-baby and well-child check-ups from birth. | Covered 100%<br>No deductible | Covered at 70% after deductible; up to out-of-pocket maximum; 100% thereafter |
| Health Evaluation Visit – Adults<br>(Chest x-ray, EKG, cholesterol screening, and other select lab procedures) - once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Immunizations – routine immunizations for adults and children | Covered 100%<br>No deductible | Covered at 70% after deductible; up to out-of-pocket maximum; 100% thereafter |
| Gynecological Exam - once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Pap smear screening - once every other calendar year up to age 50, then once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Voluntary sterilization for females | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Routine Fecal occult blood screening - once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Routine Flexible sigmoidoscopy exam- once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Prostate specific antigen (PSA) screening- once per calendar year | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Routine mammogram and related reading - once per calendar year (Subsequent medically necessary mammograms performed in the same calendar year are subject to deductibles and coinsurance) | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Sports physical exam –once per calendar year | Covered 80% after deductible up to the out-of-pocket maximum; 100% thereafter | Covered at 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Colonoscopy – over age 50 once every five years. Otherwise, medically necessary colonoscopies are subject to your deductible and coinsurance | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Smoking cessation - up to two cessation attempts per calendar year (includes four cessation counseling sessions and FDA-approved cessation medications for a 90-day treatment prescribed by a Medical Provider) | Covered 100%<br>No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **PHYSICIAN OFFICE SERVICES** | | |
| Outpatient Physician consultations & office visits | Covered 80% after deductible up to out-of-pocket maximum; 100% | Covered 70% after deductible up to out-of-pocket maximum; 100% |

| | | |
|---|---|---|
| | thereafter | thereafter |
| **URGENT AND EMERGENCY MEDICAL CARE** | | |
| Emergency Room (Copay waived if admitted at in-network or out-of-network hospital) | $100 copay per visit. Covered 80% up to out-of-pocket maximum; 100% thereafter | $100 copay per visit. Covered 70% up to out-of-pocket maximum; 100% thereafter |
| Ambulance/Transportation | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Urgent care | Covered at 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered at 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **DIAGNOSTIC SERVICES** | | |
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Diagnostic Test (X-Ray, blood work) | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Imaging (CT/PET scans, MRIs) | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **MATERNITY SERVICES** Covered maternity services also include those provided by a certified nurse midwife, in which the nurse midwife is legally authorized to perform. | | |
| Prenatal and postnatal care visits | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Delivery and nursery care – Prior authorization required for in-patient delivery in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Lactation counseling, breast pumps and supplies | Covered 100% No deductible | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **HOSPITAL CARE** | | |
| Unlimited days in a semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – Prior authorization required for non-emergency in-patient care | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Inpatient consultations | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Chemotherapy | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **ALTERNATIVES TO HOSPITAL CARE** | | |
| Skilled Nursing care - Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Hospice Care - Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Home Infusion Therapy - Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |

| | | |
|---|---|---|
| Home Health Care & Medically Necessary Private Duty Nursing – Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Rehabilitation Services | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Habilitation Services | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **SURGICAL SERVICES** | | |
| Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by an assisting physician or surgeon may not exceed one third (1/3) the cost of the primary physician. - Prior authorization required for non-emergency in-patient surgery | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Pre-surgical consultations | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Voluntary sterilization for males | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| **HUMAN ORGAN TRANSPLANTS** | | |
| Organ & tissue transplants – Case management may be required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |

| **MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT** | | |
|---|---|---|
| **Benefit Item** | **In-Network** | **Out-of-Network** |
| Mental health outpatient services | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum |
| Substance abuse outpatient service | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum |
| Mental health inpatient services – Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum |
| Substance abuse inpatient services – Prior authorization required | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum |
| Employee assistance program | 8 visits per incident | Not covered |
| **HEARING BENEFITS** | | |
| Audiometric exam – once per calendar year | If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 80% after deductible up to the out-of-pocket maximum | If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 70% after deductible up to the out-of-pocket maximum |
| Hearing aids – once per calendar year | Up to $1,000 per year | |
| **OTHER COVERED SERVICES** | | |
| Allergy testing & treatment | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |

| | | |
|---|---|---|
| Chiropractic -- Up to 12 visits per calendar year | Covered 80% after deductible up to annual benefit maximum. Includes X-rays | Covered 70% after deductible up to annual benefit maximum. Includes X-rays |
| Durable Medical Equipment; Prosthetics & Orthotics – Prescription must be sent with claim | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter |
| Oral Surgery related to:<br>• Accidents<br>• Tempo-mandibular joint repair up to $1,000 – Prior authorization required<br>• Bruxism<br>• Root Canal<br>• Crown within 6 months after Root Canal<br>• Osseous Surgery | Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter | |
| **PRESCRIPTION DRUG BENEFITS ADMINISTERED BY AmWinsRx** | | |
| **Note: Effective 4-1-15**, EZ Scripts will no longer be the Plan's 90-day mail order pharmacy provider. Drug Source may be used for 90-day mail order ***only*** if you are currently using Drug Source. If you are currently not filling any 90-day prescription mail orders through the Plan or are using EZ Scripts as your mail order pharmacy, you ***must*** now use MedVantx. | | |
| Prior authorization | Prior authorization must be obtained for all specialty drugs, compound drugs costing $100 or more, and all non-specialty and non-compound drugs costing $5,000 or more **(effective 4-1-15)** | |
| Day Supply Limits | Up to 34, or 90 day supply for non-specialty drugs. 30 day supply only for specialty drugs **(effective 4-1-15)** | |
| One copay per 34 day supply for non-specialty drugs. **Effective 4-1-15**, only a 30 day supply will be available for specialty drugs. | $10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; Covered 80% of cost up to $210 copay-Specialty Drugs | $10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; 20% coinsurance up to $210-Tier 4 Name Brand; (Must submit a claim for reimbursement when using a non-network pharmacy; **Effective 4-1-15**, specialty drugs not covered out-of-network, unless not available at an in-network pharmacy |
| Mail Order 90 day supply | $20-Generic; $70-Tier 2 Name Brand; $140-Tier 3 Name Brand; N/A - Specialty Drugs **(effective 4-1-15)** | Not Covered **(effective 4-1-15)** |
| Contraceptive coverage, including oral contraceptives, injections, IUD insertion and devices. | No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent); Covered 80%-Specialty Contraceptives | No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent). Must submit a claim for reimbursement when using a out-of-network pharmacy; Specialty contraceptives not covered out-of-network |
| Specialty Drugs - Prior authorization required and limited to 30 day supply **(effective 4-1-15)** | Covered 80% of cost up to $210 copay | Not Covered **(effective 4-1-15)** |
| Over the Counter Drugs (OTC) - Covered | **Allergy Drugs** | **Heartburn Drugs** |

| | | |
|---|---|---|
| with $0 Copay only if prescribed by a Medical Provider. | • Claritin (syrup, tablets, reditabs)<br>• Claritin D (12 & 24 hr tabs)<br>• Zyrtec<br>• Zyrtec-D<br>• Alavert (syrup, tablets<br>• Tavist ND tablets<br>• Store brand Loratadine<br>• Store brand Loratadine-D | • Prilosec OTC<br>• Zegerid OTC<br>• Prevacid OTC<br>**Cholesterol Drugs**<br>• Sio-Niacin OTC<br>**Cold Sores**<br>• Abreva |
| Compound Drugs - Prior authorization required for compound drugs costing $100 or more **(effective 4-1-15)** | Copays vary | |
| **DEATH BENEFIT** | | |
| Death Benefit | $1,000 | |

APPENDIX B
MEDICARE SUPPLEMENT SCHEDULE OF BENEFITS

The Plan requires you to take Medicare Parts A and B once you are eligible. When you become eligible for Medicare because of attained age, the Plan generally will continue to offset employer contributions against retiree self-payments. However, if you return to work and receive sufficient employer contributions to establish initial eligibility as an active participant, you will be treated as an active participant. The Plan will become primary payor for your claims, and Medicare will be the secondary payor. When employer contributions and hour bank credits become inadequate to maintain your eligibility, you will be automatically re-enrolled in the retiree program and Medicare again will become your primary payor and you will be enrolled in the Plan's retiree Medicare Supplement. The chart below is intended to show how Medicare and the Medicare Supplement Plan interact when Medicare is your primary coverage. If you have questions please contact the Benefits Office.

| Covered Service | NWOPP MEDICARE SUPPLEMENT | | |
|---|---|---|---|
| | Medicare pays+ | Plan pays | You pay |
| **Medicare Part A Hospital Coverage-** includes semi-private room & board, general nursing care, miscellaneous services and supplies* | | | |
| Deductible | Nothing | A portion of the Part A Deductible | Up to $200 per calendar year per Medicare beneficiary in combined Part A & Part B deductible related expenses. |
| First 60 days of care | All but the Part A deductible | A portion of the Part A Deductible | Up to $200 per calendar year per Medicare beneficiary in combined Part A & Part B deductible related expenses. |
| Days 61-90 | All but the daily copayment | Daily copay | Nothing |
| Days 91-150 (Lifetime Reserve Days) | All but the daily copayment | Daily copay | Nothing |
| Day 151 and beyond (additional 365 days after Lifetime Reserve Days used) | Nothing | 100% of Medicare-eligible expenses | Nothing |
| **Blood received during hospital admission*** | All but the first three pints | Your first three pints | Nothing |
| **Skilled Nursing Facility Care-** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital* | | | |
| First 20 days of care | 100% | Nothing (Medicare covers in full) | |
| Days 21-100 | All but daily skilled nursing facility copayment | Daily copay | Nothing |
| **Hospice Care** | | | |
| | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | Nothing |
| **Emergency care outside the U.S.** | | | |
| | No benefit for care outside U.S. | No benefit for care outside U.S. | All costs for services |
| **Medicare Part B Physician and Outpatient Services-** In or out of the hospital and outpatient physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic treatment, such as tests, durable medical equipment, per calendar year** | | | |
| **Deductible (annual)** | Nothing | Part B Deductible | Up to $200 per calendar year per Medicare beneficiary in combined Part A & Part B deductible related expenses. |
| **Coinsurance** | 80% of the approved amount after Part B deductible is met | 20% coinsurance after deductible is met | Nothing |
| **Blood benefit** | All but the first three pints | Your first three pints | Nothing |
| **Clinical laboratory services – tests for diagnostic services** | Medicare-approved services | Nothing (Medicare covers in full) | |
| **Home Health Care Services –** Medicare-approved services | | | |
| Medicare-approved medically necessary skilled care services and medical supplies | 100% | Nothing (Medicare covers in full) | |
| Durable medical equipment | 80% of the approved amount after deductible is met | 20% coinsurance after deductible is met | Nothing |
| **Excess benefits** | Nothing | Nothing | All costs |

| PRESCRIPTION DRUG BENEFITS ADMINISTERED BY AmWinsRx | | |
|---|---|---|
| **Note: Effective 4-1-15**, EZ Scripts will no longer be the Plan's 90-day mail order pharmacy provider. Drug Source may be used for 90-day mail order ***only*** if you are currently using Drug Source. If you are currently not filling any 90-day prescription mail orders through the Plan or are using EZ Scripts as your mail order pharmacy, you ***must*** now use MedVantx. | | |
| Prior authorization | Prior authorization must be obtained for all specialty drugs, compound drugs costing $100 or more, and all non-specialty and non-compound drugs costing $5,000 or more **(effective 4-1-15)** | |
| Day Supply Limits | Up to 34, or 90 day supply for non-specialty drugs. 30 day supply only for specialty drugs **(effective 4-1-15)** | |
| One copay per 34 day supply for non-specialty drugs. **Effective 4-1-15**, only a 30 day supply will be available for specialty drugs. | $10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; Covered 80% of cost up to $210 copay-Specialty Drugs | $10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; 20% coinsurance up to $210-Tier 4 Name Brand; (Must submit a claim for reimbursement when using a non-network pharmacy; **Effective 4-1-15**, specialty drugs not covered out-of-network, unless not available at an in-network pharmacy |
| Mail Order 90 day supply | $20-Generic; $70-Tier 2 Name Brand; $140-Tier 3 Name Brand; N/A - Specialty Drugs **(effective 4-1-15)** | Not Covered **(effective 4-1-15)** |
| Contraceptive coverage, including oral contraceptives, injections, IUD insertion and devices. | No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent); Covered 80%-Specialty Contraceptives | No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent). Must submit a claim for reimbursement when using a out-of-network pharmacy; Specialty contraceptives not covered out-of-network |
| Specialty Drugs - Prior authorization required and limited to 30 day supply **(effective 4-1-15)** | Covered 80% of cost up to $210 copay | Not Covered **(effective 4-1-15)** |
| Over the Counter Drugs (OTC) - Covered with $0 Copay only if prescribed by a Medical Provider. | **Allergy Drugs**<br>• Claritin (syrup, tablets, reditabs)<br>• Claritin D (12 & 24 hr tabs)<br>• Zyrtec<br>• Zyrtec-D<br>• Alavert (syrup, tablets<br>• Tavist ND tablets<br>• Store brand Loratadine<br>• Store brand Loratadine-D | **Heartburn Drugs**<br>• Prilosec OTC<br>• Zegerid OTC<br>• Prevacid OTC<br>**Cholesterol Drugs**<br>• Sio-Niacin OTC<br>**Cold Sores**<br>• Abreva |
| Compound Drugs - Prior authorization required for compound drugs costing $100 or more **(effective 4-1-15)** | Copays vary | |

| DEATH BENEFIT | |
|---|---|
| Death Benefit | $1,000 |