United Association of Journeymen and Apprentices
Of The Plumbing and Pipefitting Industry
Of The
United States and Canada

PLUMBERS & PIPEFITTERS LOCAL 219
HEALTH & WELFARE FUND
Akron, Ohio

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective September 1, 2019

PLUMBERS & PIPEFITTERS LOCAL 219

HEALTH & WELFARE FUND

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Effective January 1, 2019

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SPECIAL NOTICE

It is extremely important that you keep the Fund Office informed of any change in address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits. The importance of a current, correct address ON FILE AT THE FUND OFFICE cannot be overstated. It is the ONLY WAY the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan. Likewise, it is also important that you notify the Fund Office of any changes in your personal status, including, but not limited to: (i) marriages; (ii) divorces; (iii) births; and (iv) deaths. As outlined herein, it is your sole and exclusive responsibility to keep the Fund Office apprised of life changes. If you fail to provide the Fund Office with notice of familial changes, your benefits and/or the benefits of your dependents and/beneficiaries could be jeopardized. In addition, if your failure to provide the Fund Office with timely notification of a life change causes the Fund to incur expenses (such as expenses related to health insurance benefits for an ineligible dependent), the Fund may take action to recoup such costs, including suspending benefits, retracting payments, and/or taking other legal action to collect.

TO: ALL PARTICIPANTS AND BENEFICIARIES OF THE
PLUMBERS & PIPEFITTERS LOCAL 219 HEALTH & WELFARE FUND

We are pleased to distribute this revised Summary Plan Description as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and Plan Document (collectively referred to as the "Plan" or "Health & Welfare Plan") detailing the benefits provided by the Plumbers & Pipefitters Local 219 Health & Welfare Fund. This booklet replaces and supersedes in entirety your previous booklet.

This booklet summarizes the eligibility rules for participation in the Plan, the benefits provided to those of you who are eligible and the procedures which must be followed in filing a claim. In addition, important information is included in the booklet concerning the administration of the Plan and your rights as a Participant.

A number of changes have occurred in the Plan since the previous distribution of your booklet. **We urge you to review this booklet carefully so you are informed of the financial protection provided for those individuals who are eligible for benefits under the Plan.**

Please note the receipt of this booklet does not automatically mean that you are eligible for benefits. Your eligibility will be determined in accordance with the Plan's Rules of Eligibility, which are set forth in this booklet.

Only the Board of Trustees is authorized to interpret the Plan. No employer or union, nor any representative of any employer or union, is authorized to interpret the Plan, nor does any such person act as an agent of the Board of Trustees. The Board of Trustees shall be the sole judge of the standard of proof required in any case. In the application and interpretation of any of the provisions of the Plan, decisions of the Board shall be final and binding on all parties or persons affected. Such decisions shall receive judicial deference to the extent they do not constitute an abuse of discretion.

The Trustees reserve the right and shall have full authority to amend, alter, modify and interpret all questions of nature, amount and duration of benefits to be provided under this Plan. The Board of Trustees reserves the right to determine eligibility for benefits and all other questions arising under the Plan. The Board of Trustees reserves the right to terminate the Plan. Plan amendments will be communicated to all parties as required by law.

Any retiree or surviving dependent benefits that have been made available by this Plan are a privilege, not a right. No person acquires a vested right to such benefits, either before or after his retirement. The Trustees may expand, reduce or cancel coverage for retirees, change eligibility requirements or the amount of self-payment and otherwise exercise prudent discretion at any time without legal right or recourse by a retiree or any other person.

This document and the benefits provided hereunder are not guarantees for employment or otherwise a contract for employment. The Trustees, by their signature at the end of this document, intend that this document shall serve as both the Plan Document and Summary Plan Description for this Fund.

If you have questions concerning your eligibility, schedule of benefits or general provisions of the Plan, please write or call the Fund Office.

Sincerely,

Board of Trustees
PLUMBERS & PIPEFITTERS LOCAL 219
HEALTH & WELFARE FUND

GENERAL INFORMATION

Your Responsibilities as a Participant

The primary purpose of this Plan is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation.

There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable.

A list of your responsibilities under the Plan follows. As you read this list, you will note that none of these responsibilities is extremely burdensome. In fact, just a little time and effort on your part will assist in protecting your best interests under the Plan.

Take Time to Read This Booklet

This booklet is the primary source of information about your Health & Welfare Plan. It contains information you need to know about how to qualify for benefits, the benefits which are available and how to file a claim for benefits.

We have tried to organize the booklet into sections dealing with specific provisions of your benefit program and to simplify the language whenever possible. Please note the masculine gender, as stated herein, shall also include the feminine gender, wherever applicable.

REMEMBER: No one can read this booklet for you. You owe it to yourself and your family to become familiar with the details of this Plan, this booklet provides that information. Of course, if you have any questions about your Plan which are not answered in this booklet, be sure to contact the Fund Office for additional assistance.

If You Haven't Filed Enrollment Cards – Do It Now!

When you first became eligible for benefits under the Plan, you should have received from the Fund Office enrollment cards for your completion and return to the Fund Office. These cards request certain basic information that is needed for your records at the Fund Office, such as your Social Security Number, address, date of birth, names, ages and Social Security Numbers of your dependents and the name of your beneficiary. *This information is vital!* Without it, the Fund Office will have difficulty keeping you informed about Plan changes if your correct address is not on file. *In addition, you run the risk of not having a permanent record of your participation in the Plan.* **IF YOU HAVEN'T COMPLETED AN ENROLLMENT CARD, DO IT NOW!** If you are not certain whether you have an enrollment card on file at the Fund Office, contact the Fund Office. The staff will advise you whether your card is on file. If not, a card will be sent to you for your completion.

Notify The Fund Office Promptly Regarding Any Change in Address, Beneficiary Or Dependents.

We advise you by first-class mail when there are Plan changes or benefit improvements. If you move, be sure the Fund Office has your new address in order that you receive all current information concerning your Plan.

Also, if your marital status changes (i.e., you marry, divorce, or in the unfortunate circumstance that your spouse becomes deceased) or if, for some other reason, you wish to change the name of your beneficiary, don't forget to send the change in writing to the Fund Office. Unless you do, the latest beneficiary card on file will generally determine who receives any benefit which may be payable in the event of your death. Failure to change your beneficiary is often just an oversight, but such an oversight could be costly to your survivors.

Finally, if you add any Eligible Dependents to your household (whether by birth, marriage, adoption, etc.), the Fund Office should be notified regarding the name and age of the new Dependent(s). Since this Plan does provide certain benefits for Eligible Dependents, the Fund Office must know who your Dependents are. Failure to notify the Fund Office could result in the delay and/or denial of benefits on behalf of your Dependents.

Unless you provide notice, the Fund Office has no way of knowing if there have been changes in your address, beneficiary, dependents, and other such status. If your failure to provide the Fund Office with timely notice of these types of life changes results in the Fund incurring uncovered expenses (such as the payment of medical claims on behalf of an ineligible dependent or excess premiums charged on behalf of a deceased dependent) you may be responsible for such costs.

Medical Examination

No medical examination shall be required of any covered Participant or Eligible Dependent to secure this coverage initially. However, the Trustees shall have the right through their medical examiner to examine the covered Participant or Eligible Dependent as often as they may reasonably require during the pendency of a claim hereunder and the right and opportunity to order an autopsy in case of death where it is not forbidden by law.

The Trustees Interpret the Plan

Any interpretation of the Plan's provisions rests with the Board of Trustees. No Employer or Union, nor any representative of any Employer or Union, is authorized to interpret this Plan on behalf of the Board, nor can an Employer or Union act as an agent of the Board of Trustees. However, the Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from participants regarding eligibility rules, benefits and claims procedures. If there are questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination. The Board of Trustees shall be the sole judge of the standard of proof required in any case. In the application and interpretation of any of the provisions of this Plan, decisions of the Board of Trustees shall

be final and binding on all parties or persons affected. Such decisions shall receive judicial deference to the extent they do not constitute an abuse of discretion.

The Board of Trustees reserves the right and shall have full authority to amend, alter, modify, and interpret all questions of nature, amount, and duration of benefits to be provided through the Fund. The Board of Trustees reserves the right to determine eligibility for benefits and all other questions arising under this Plan (with the exception to those determinations that have been delegated to the Fund Administrator). The Board of Trustees reserves the right to terminate the Plan.

Any benefits that have been made available by the Fund are a privilege, not a right. No person acquires a vested right to such benefits, either before, during, or after his retirement. The Board of Trustees may expand, reduce, or cancel coverage, change eligibility requirements, and otherwise exercise prudent discretion at any time without legal right or recourse by a Participant or any other person.

This document and the benefits provided hereunder are not guarantees for employment or otherwise a contract for employment. Wherever used in this document, the masculine pronoun includes the masculine and the feminine gender, unless the context clearly indicates otherwise.

The Plan Can Be Changed

The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it. Although the Trustees hope to maintain the present level of benefits and to improve upon them, if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. Therefore, benefits provided by the Plan are not guaranteed to the Participants, Retirees, and/or Dependents covered by the Plan. The Board of Trustees reserves the right to terminate the Plan or make any changes, modifications or amendments to the benefits which the Fund provides and to interpret the Plan.

Any amendment to the Plan will be made by a written resolution of a majority of the Trustees and will be effective as of the date specified in the resolution. The Plan Administrator will notify all eligible Participants of any amendment modifying substantive terms of the Plan as soon as administratively possible after its adoption, but in no event later than 210 days after the close of the plan year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications (within the meaning of ERISA Section 102(a)(1) and Labor Reg. Section 2520.104(b)(3) unless incorporated in an updated Summary Plan Description.

Your Plan Is Tax-Exempt

Your Health & Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust. This means the Employer's contributions to the Trust are tax-deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income.

Investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to Participants and their Eligible Dependents. Such tax-exemption works to the benefit of both the Employer and the Employee. In effect, it means that money that otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses. The Trustees are well aware of these advantages and will take whatever measures are necessary to keep your Plan qualified as a tax-exempt trust under Internal Revenue Service rules.

About Your Plan

The Plumbers & Pipefitters Local 219 Health & Welfare Plan is maintained as a result of a collective bargaining agreement between Participating Employers and Plumbers & Pipefitters Local Union No. 219. Your Health & Welfare Plan receives contributions from participating Employers on dates and in amounts called for by the labor contract negotiated with the Employers by your Union.

For Participants in the Office & Salaried Program, the Employer contributions are in accordance with the levels established by the Board of Trustees and are subject to change, as required by the Board of Trustees.

Decisions on Plan operations and benefits are made by a Board of Trustees on which labor and management are equally represented.

Working together, the Board of Trustees establishes rules of eligibility, strives constantly to improve benefits, supervises the investments of the Fund's assets and sees that the Fund is in compliance with all applicable federal and state laws. In carrying out these responsibilities, the Trustees are assisted by a team of professionals, including:

A. ***The Administrative Manager,*** who handles the day-to-day business activities of the Fund, such as collecting Employer contributions, keeping records of money received, crediting each Participant's account with the correct contributions received and answering inquiries from Participants about their eligibility for benefits.

B. ***The Claims Administrator,*** who processes the payment of claims and answers questions concerning benefits. The Consultant assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on many other matters important to the Fund's operations. The largest part of the money that the Fund receives is returned directly to Participants in the form of health and welfare benefits. However, after expenses, a certain portion of each contribution is set aside for

reserves. The Fund's reserves can be drawn on in emergencies when, due to unforeseen circumstances, the Fund's claims expenses temporarily exceed its income.

C. ***An Independent Auditor,*** as required by law, examines the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This summary provides a brief description of how your Plan was established, what its purpose is and how it operates. The following pages describe how you and your family become eligible for benefits, the benefits which are available and your responsibilities under the Plan.

In the Event of Plan Termination

In the event the Plan, in the opinion of the Trustees, is inadequate to carry out the intent and purpose under the Agreement and Declaration of Trust, or to meet the payments due or to become due to Participants, the Plan may be terminated by the Trustees. Upon termination of the Plan, providing there are funds remaining, the Trustees shall:

A. First pay the unpaid expenses and the expenses involved in terminating the Plan;

B. Pay premiums on any policies existing at the time to provide one or more of the benefits authorized by the Trust Agreement, as the Trustees determine; and

C. Provide one or more of the benefits on a fully or partially self-funded basis authorized by the Trust Agreement, as the Trustees determine.

The Participants shall continue to receive such benefits as may be provided in the policies then in force and in such additional or substitute policies as the Trustees are able to secure by the assets then in the Fund. In the event of self-funding, the Participants shall continue to receive such benefits as the Trustees in their discretion are able to secure by use of the assets then in the Fund.

If at any time there are insufficient funds to pay premiums on such policies or to provide self-funded benefits, the Trustees shall transfer such balance to charitable organizations, as they may select. No portion of the assets of the Plan, directly or indirectly, shall revert or accrue to the benefit of any Employer or Union.

GENERAL DEFINITIONS

Wherever used in this Summary Plan Description, the following terms shall be deemed to have the meanings described below:

Alcoholism/Substance Abuse Treatment Facility **–** A facility which primarily provides detoxification treatment and rehabilitative services for alcoholism and/or substance abuse.

Ambulatory Surgical Center - means a place approved or licensed as such by an agency of the governing jurisdiction.

Amendments **–** The provisions of the Trust Agreement and the Plan Document may be amended from time to time by the Trustees and such amendments shall be effective when voted upon by the majority of such Trustees provided that such amendments shall be made consistent with the objectives and purposes of the Trust.

Birthing Center **–** means a facility licensed as such by an agency of the State in which it operates. If the State does not have any license requirements, the facility must meet all of the following tests:

A. It is primarily engaged in providing birthing services for low-risk pregnancies;

B. It is operated under the supervision of a licensed physician;

C. It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;

D. It has a written agreement with a licensed ambulance service to provide immediate transportation of the covered person to an accredited hospital, as defined herein, if an emergency arises;

E. It has a written agreement with an accredited hospital located in the immediate geographical area of the birthing center to provide emergency admission of the covered person.

Calendar Year **–** As used herein, "calendar year" means that period commencing on the effective date the eligible person's coverage begins and shall continue until the next following January 1st. Each subsequent "calendar year" shall be from January 1st through December 31st.

Co-payment **–** means an out-of-pocket charge paid by the Participant to the Provider at the time the services are rendered. A co-payment does not apply to the Plan's Calendar Year Deductible.

Cosmetic Surgery – Cosmetic surgery means surgery which is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Charges – the Billed Charges for Covered Services except that Anthem reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Institutional Provided to the Non-Contracting Amount determined as payable by Anthem.

Covered Person – means any individual eligible for benefits under this Plan, such as an eligible Participant, Retiree, Spouse, or dependent child, as applicable.

Custodial Care – Custodial care means care given solely to assist a person in the routine activities of housekeeping, eating, bathing and other activities of daily living.

Date Claim Incurred – The incurred date of a claim shall be the first date on which the Participant or the Eligible Dependent is under the care of a Physician and/or had an expense which would be payable by the Fund for services rendered.

Effective Date – The Effective Date means the date your coverage under the Plan begins.

Eligible Dependent – The term "Eligible Dependent" or "Dependent" shall mean the following members of the Eligible Participant's family:

A. Your legal spouse;

B. Your children:

- From birth until their twenty-sixth (26^{th}) birthday, including children who are eligible for other employer sponsored health coverage;

- Who are living with you and are incapable of self-sustaining employment due to mental retardation or physical handicap prior to attainment of the maximum age and who are dependent on you for over one half of their support and maintenance, providing that you furnish due proof of such incapacity within thirty-one (31) days of your children's attainment of such maximum age. Such children must legally reside with you.

- The children of the Eligible Participant, as defined above, shall include:

    1. Natural children;

    2. Legally adopted children of the Eligible Participant from the date the child is placed in the home of the Eligible Participant by a state agency or order of a court of competent jurisdiction, and not from the date of birth;

3. Stepchildren. If such stepchildren are eligible for coverage through another plan, eligible charges shall be subject to the Coordination of Benefits Provisions of the Plan. Coverage for the stepchild shall not be effective unless and until the Fund has been given written notice that the stepchild is not covered by under another plan. Coverage through the Fund shall not be provided until and unless the Eligible Participant furnishes to the Fund certified copies of Qualified Medical Child Support Orders (QMCSO), pertinent divorce orders and/or death certificates to aid the Fund in the determination of the stepchild's eligibility.

   If the natural parents of the eligible stepchild are divorced, the Fund shall be subrogated to the rights of reimbursement pursuant to the court order and/or separation agreement through which the stepchild's natural parents were divorced. No coverage shall be effective for the stepchild by the Fund until a subrogation agreement acceptable to the Fund has been provided.

If one of the Eligible Participant's Dependents (other than a newborn child) is confined to a hospital on the date on which benefits for that Dependent would otherwise become effective, benefits for that Dependent will not become effective until the day immediately following his/her discharge from the hospital.

Eligible Participant – The term Eligible Participant shall mean a person eligible for benefits under the Eligibility Rules adopted by the Trustees.

Employer or Participating Employer – The term Employer or Participating Employer means an employer who is, or has been, obligated under a collective bargaining agreement with the Union to make payments for benefits provided by the Health & Welfare Fund, or any other individual, firm, association, partnership or corporation who has an assent agreement with the Union and/or the Trustees and contributes to the Fund as herein provided for in accordance with terms established by the Trustees in their absolute discretion.

Excess Charges – the amount of Billed Charges in excess of the covered Traditional Amount or Non-Contracting Amount determined as payable by Anthem for a Non-Contracting Institutional Provider, a Non-Participating Physician or Other Professional Provider.

Expense Incurred – The term Expense Incurred includes only those charges made for services and supplies which a prudent person would consider to be reasonably priced and necessary in light of the injury or sickness being treated.

Experimental Or Investigative Drug, Device, Medical Treatment Or Procedure – A drug, device, medical treatment or procedure is experimental or investigative if:

A. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

B. The drug, device, medical treatment or procedure, or the patient-informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

C. Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis; or

D. Reliable evidence shows the prevailing opinion among experts regarding the drug, service, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extension of Benefits – If an Eligible person is totally disabled on the date of termination of coverage, covered expenses incurred for services directly related to the disabling condition will be payable during the continuance of the weekly disability benefits, but in no event beyond one year after the date of the coverage termination.

Fiscal Year – As used herein Fiscal Year means that period between January 1st and December 31st for purposes of maintaining the Plan's financial records.

Home Health Care Agency – means a public or private agency which:

A. Is certified as a home health agency under Medicare or is licensed as a home health agency by the state in which it operates;

B. Is primarily engaged in providing skilled nursing and other therapeutic services;

C. Has its policies set by a professional group which governs the services provided;

D. Maintains records for each patient.

Hospice – means a public or private entity, or part thereof, which is licensed or certified as a Hospice by Medicare and by the state in which it operates.

Hospital – means any institution which meets one of the following requirements:

A. Is an approved and accredited hospital recognized by the Joint Commission of the Accreditation of Hospitals (JCAH) and is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, unless:

    1. such confinement is for purposes other than convalescence; and

    2. the eligible person is not ambulatory during such confinement, or

B. Any institution which meets all of the following requirements:

    1. maintains permanent and full-time facilities for bed care of five (5) or more resident patients;

    2. has a licensed physician in regular attendance;

    3. continuously provides 24-hour per day nursing services by registered nurses;

    4. is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; and

    5. is operating lawfully in the jurisdiction where it is located.

Illness - An illness is defined to mean:

A. Bodily injury or sickness; or

B. Pregnancy, childbirth, or a condition which arises from either; or

C. Congenital defects or birth abnormalities, including premature births for which more than routine nursery care is required, and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the condition, when such ambulance transportation is certified by the attending physician as necessary to protect the health and safety of the newborn child.

Lesser Amount - for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the lesser of the Billed Charges or Traditional Amount. For Non-Contracting Institutional Providers, the Lesser Amount means the Non-Contracting Amount.

Medically Necessary **–** means the services, treatment and confinement must be generally recognized in the physician's profession as effective and essential for treatment of the injury or illness for which it is ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on generally recognized and accepted standards of medical practice in the United States; and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies or confinement shall not be considered "medically necessary" if they are an Experimental Procedure, or if investigational or primarily limited to research in their application to the injury or illness; or if primarily for scholastic, educational, vocational or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his/her family or caretaker.

Medicare **–** means the Part A and Part B Plans described in Title XVIII of the United States Social Security Act, as amended.

Mental/Nervous Disorder **–** means mental illness or functional nervous disorder.

Non-Contracting Amount – the maximum amount determined as payable and allowed by a Anthem for a Covered Service provided by a Non-Contracting Institutional Provider.

Nursing Home **–** means a licensed facility which is operating within the confines of the law to provide room and board for sick or injured persons under the supervision of a registered nurse or a physician 24 hours per day and meets all of the following tests:

A. It has available at all times the services of a licensed physician who is on the staff of an accredited hospital;

B. It maintains a daily medical record for each patient; and

C. It is not primarily a place for rest or custodial care, a place for the aged, a place for alcoholics or drug addicts or a hotel.

Physician or Surgeon **–** shall mean a person who is duly licensed to prescribe and administer all drugs and/or to perform all surgery. Included are osteopaths, chiropractors, optometrists, podiatrists, dentists, psychologists and physical therapists when operating within the scope of their license, but not including the Participant, the Spouse of the Participant or persons of the immediate family of the Participant or Spouse of the Participant.

Practitioner **–** means a person, other than one defined above as a Physician or Surgeon, who:

A. Upon referral by a Physician or Surgeon of Medicine or Doctor of Osteopathy, provides services which are covered by the Plan; and

B. Is practicing within the scope of his/her license. Referral by a Doctor of Medicine or a Doctor of Osteopathy is not required for the services of a certified nurse, midwife or a licensed midwife.

Qualified Medical Child Support Order (QMCSO) **–** means a domestic relations court order that is issued as part of a child support proceeding which creates or recognizes the existence of the right of such child as an Alternate Recipient to receive benefits under a group health plan. The Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO), as defined in ERISA.

Reconstructive Surgery **–** means surgery which is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. Reconstructive surgery includes breast reconstruction following a mastectomy which has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Specialty Drug – is a prescription drug or medication that is designed to target and treat medical conditions and includes bioengineered proteins, blood-driven products, and complex molecules. Specialty drugs generally require special handling or ongoing monitoring and assessment by a health care professional and/or they may be relatively difficult to dispense when compared to traditional prescription drugs or medications.

Total Disability – Totally Disabled **–** Total Disability and Totally Disabled with respect to Participants mean the inability to perform work for pay, profit or gain at any job for which the individual is suited, by reason of education, training or experience as a result of accidental bodily injury or sickness. For a Dependent, Total Disability and Totally Disabled mean the inability to perform the usual and customary duties or activities of an individual in good health and of the same age and sex.

Traditional Amount – the maximum amount determined as payable and allowed by Anthem for a Covered Service provided by a Physician or Other Professional Provider based on factors, including the following:

A. The actual amount billed by a Provider for a given service;

B. Center for Medicare and Medicaid Services (CMS)'s Resource Based Value Scale (RBVS);

C. Other fee schedules;

D. Input from Participating Physicians and wholesale prices (where applicable);

E. Geographic considerations; and

F. Other economic and statistical indicators and applicable conversion factors

Trust Fund – Trust Agreement – The term Trust Fund means the Plumbers & Pipefitters Local 219 Health & Welfare Fund, as established by the Trust Agreement. The Trust Agreement shall mean the Agreement and Declaration of Trust establishing the Plumbers & Pipefitters Local 219 Health & Welfare Fund, and as the Fund is from time to time amended.

Trustees – The Trustees are those Trustees of the Plumbers & Pipefitters Local 219 Health & Welfare Fund, as appointed in accordance with the Trust Agreement. The Trustees shall hold all property, income and assets in trust for the purposes of the Trust Fund for the benefit of the Participants. The Trustees shall have the sole authority to administer and manage the Fund and any decisions made by them shall be final and binding on all Eligible Participants and Eligible Dependents.

Union – shall mean the Plumbers & Pipefitters Local Union No. 219, Akron, Ohio.

Usual, Customary And Reasonable (UCR) Criteria – The criteria are based on the following factors in the locality where the services are rendered:

A. Usual means the charge most consistently made by an individual physician or provider to patients for a given service.

B. Customary is the amount ordinarily charged by most providers for comparable services and supplies.

C. Reasonable means a payment that may be made, although it differs from the Usual or Customary criteria if, in the opinion of the Plan, it merits special consideration based on the circumstances of a particular case.

Work-related Illness – an illness which arises from or is sustained in the course of work for pay, profit or gain.

GENERAL PROVISIONS AND LIMITATIONS

The Fund's plan of benefits is self-funded. This means that the Fund leases a health insurance network allowing access to Contracting Institutional Providers and Participating Physicians and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, the Fund pays for benefits based on the Non-Contracting Amount that is determined payable by the health insurance network. For Non-Participating Physicians and Other Professional Providers, the Fund pays for benefits based on Traditional Amounts.

No Guarantee of Benefits

All benefits under the Plan shall be payable through Employees or Agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Therefore, benefits offered by the Plumbers & Pipefitters Local 219 Health & Welfare Fund are not guaranteed to the Employees,

Participants, Retirees and/or Dependents covered by the Fund. The Board of Trustees reserves the right to terminate or make any changes, modifications or amendments to the benefits that the Fund provides. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claims for benefits against the participating Union, any Employer or the Trustees. The Trustees, the Employers and the participating Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the participating Union.

Delinquent Contributions

In the event that a claim arises for an Eligible Participant or Eligible Dependent and contributions have not been received by the Fund Office on behalf of said individual, the claim shall not be payable until such contributions are received by the Fund Office. In this instance, the Participant should notify the Fund Office of his/her employment. The Fund Office will make every effort to collect the delinquency and pursue the collection of the cost of the claim from the Employer. Upon failure to obtain these items, the Participant may then appeal to the Board of Trustees for coverage of the claim in accord with the appeals procedures set forth below.

Exclusion For All Benefits Except For Life And Accidental Dismemberment Benefits

This Plan will not pay for any charges received as a result of an injury or illness sustained or arising out of work performed for remuneration, profit, or gain for which benefits are payable under the State Workers' Compensation Program or other similar laws, except for diagnostic-related charges which have been incurred in determining if the injury or illness is work-related.

Medical Examination

The Trustees reserve the right through a medical examiner to examine an Eligible Participant or Dependent as often as may reasonably be required during the pendency of a claim.

Preferred Provider Organization

Your Plan has been attached to a Preferred Provider Organization (PPO). The network groups of hospitals and physicians have agreed to provide their services at discounted fees to Plan Participants and their Dependents who utilize their services. ***Your failure to utilize the Network will result in a reduction in benefits paid by the Plan on your behalf. However, you will not be penalized if there are no Network Providers available to you in your immediate area or in case of emergency treatment.*** The cost savings which are experienced by the Fund through the utilization of the Network providers will assist in maintaining current benefit costs.

Please Contact The Fund Office To Verify Coverage And Benefit Levels

Only the Fund Office can verify eligibility for coverage and the benefit levels applicable to a covered service. Accordingly, if you have any questions about whether a service, procedure, treatment, or prescription is covered under your plan of benefits through the Fund, or if you

have a question regarding the amount of benefits that the Fund will pay for same, you must direct your questions to the Fund Office. Please be aware that the Fund may engage outside service providers to certify medical necessity for a service. These service providers cannot certify coverage for the service under the Fund's plan of benefits, nor can they certify the amount of benefits that will be payable for a covered service. If you do not confirm coverage and benefit levels with the Fund Office, you may incur expenses that are not payable by the Fund. In such a case, you will be required to pay for the excess charges. Accordingly, the Trustees strongly urge you to contact the Fund Office to address your questions regarding coverage or benefit levels prior to undertaking new treatments.

RULES OF ELIGIBILITY

ACTIVE EMPLOYEE PROGRAM
(Active Employees Working Under The Terms Of A Collective Bargaining Agreement)

An employee who is covered under the collective bargaining agreement between the Plumbers & Pipefitters Local 219 and Employers signatory to the Plumbers & Pipefitters Local 219 Health & Welfare Fund will be eligible for benefits subject to the following conditions.

Initial Eligibility

You will be eligible for benefits on the first day of the month following the month in which contributions are received and you accumulate a total of two-hundred-twenty (220) hours of employment with one or more contributing Employers within a period of twelve (12) consecutive months. Notwithstanding the preceding sentence regarding the qualification requirements for initial eligibility, please note that in order to be eligible to make self-contributions in the event that you deplete your Fund Bank (as discussed in more detail below), you must accumulate a total of four-hundred-forty (440) hours of employment with one or more contributing Employers within a period of twelve (12) consecutive months.

Continuation of Eligibility

Once having become eligible, you will remain eligible provided you are credited with a minimum of 140 hours of employment with one or more contributing employers per calendar month. Hours of employment will be used to determine eligibility during the second month following the month in which the hours were worked.

Credited Reserve Hours

For each calendar month in which you are credited with less than the required number of hours, you will lose one month of eligibility for benefits unless you have sufficient credited hours in reserve to satisfy the minimum number of required hours. You may accumulate credited reserve hours as follows:

A. All hours credited during the initial eligibility period (this only applies to those employees who first commence work on or after March 1, 2007, for which contributions are paid to the Fund on behalf of such employees (i.e., covered work); on the other hand, if you first commenced covered work prior to that time, you will receive credit for all hours in excess of four-hundred-forty (440) credited during the initial eligibility period); and

B. All hours in excess of 140 credited during any one calendar month;

C. With a maximum accumulation of six (6) months of coverage in reserve.

Termination of Eligibility

If you have used your initial three (3) months of eligibility credit, you have not met the credited hours requirements (as set forth above) to continue your eligibility and you do not have sufficient credited hours in reserve to meet the minimum eligibility requirement, your eligibility for benefits will terminate.

Self-contributions

Active Participants who have depleted their Fund Bank may continue to preserve eligibility by making a subsidized self-payment as follows:

A. If you are credited with less than 140 hours for any month, you may make self-payments representing the difference between the amount of hours paid on your behalf by contributing Employers and the minimum amount of hours required to maintain your eligibility, with a maximum monthly premium of $250.00 and a maximum of nine (9) full self-pays.

B. You may preserve your eligibility, as set forth in (a) above if you are actively seeking work through Plumbers & Pipefitters Local #219, subject to the following:

    1. Effective June 1, 2003, you must have at least 160 credited hours of Covered Employment during any continuous 6-month period, unless you are disabled from work during such period and receiving short-term disability benefits through the Fund. If you fail to have at least 160 credited hours of Covered Employment during this period (unless you are disabled from work during such period and receiving short-term disability benefits through the Fund) your eligibility to make self-payments will terminate on the last day of the 6-month period in which less than 160 hours are credited and you will be required to pay the active COBRA rate. For example, if 120 hours of Covered Employment were credited to you during the period of June 1, 2012 through November 30, 2012, your last day of eligibility to make subsidized self-payments would be November 30, 2012.

2. If you are laid off and have accepted employment with an employer not affiliated with the Plumbing & Pipefitting Industry, you may preserve your eligibility for up to nine (9) months during which time you will be eligible to continue coverage at 100% of the active Participant rate.

3. If you are on an authorized leave of absence by reason of union activities or governmental service or activity related to the construction industry, you may petition the Board of Trustees to request your reserve bank be frozen during your leave of absence period.

Covered Employment – The term "Covered Employment" shall mean any employment accepted with an employer signatory to an agreement with Local Union #219 or any Local Union within the jurisdiction of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry.

To be "actively seeking work", you must:

1. Maintain membership in the Plumbers & Pipefitters Local Union 219 and register for work by signing the daily roster, in person, at least once every thirty (30) days, or evidence your availability for work by acceptance of a referral.

2. If you are on application with the Plumbers & Pipefitters Local Union 219, you must register for work by signing the daily roster, in person, at least once every two weeks, or evidence your availability for work by acceptance of a referral.

Reinstatement of Eligibility

If you fail to maintain your eligibility for benefits by meeting the hourly requirements and do not make self-payments, you will re-qualify for eligibility for benefits on the first (1st) day of the month in which contributions are received and you accumulate a total of two-hundred-twenty (220) hours of employment with one or more contributing Employers within a period of twelve (12) consecutive months.

Termination of Coverage

In addition to the previous provisions, your eligibility for benefits will automatically terminate if any of the following should occur:

A. Termination of the Plan;

B. Plan modification which terminates coverage for the class to which you belong;

C. Plan modification to terminate a particular type of benefit under the Plan; or

D. The last day of the eligibility period for which your Participating Employer pays contributions to the Fund on your behalf.

OFFICE & SALARIED PROGRAM

Initial Eligibility

Any Contributing Employer may enroll its Office and Salaried employees in the Plan, provided that certain requirements are met. A Contributing Employer seeking to enroll its Office and Salaried employees in the Plan must sign a participation agreement with the Fund.

Office and Salaried employees must work at least 30 hours per week to be eligible for benefits under the Plan. Office and Salaried employees will become eligible for benefits on the first day of the month following the month in which the Fund receives monthly contributions from the signatory Employer on behalf of the employee. Employers must contribute on behalf of all employees in order to receive benefits. For example, in an office of five (5) employees, contributions must be received for all five (5) employees (assuming they work a minimum of 30 hours per week) in order for any one of the five (5) employees to participate in the Plan.

Employers seeking to enroll their Office and Salaried employees in the Plan must make contributions on behalf of each Office and Salaried employee equal to 140 hours at the applicable Union Health and Welfare contribution rate.

Termination of Eligibility For Benefits

Your eligibility will automatically terminate if any of the following occurs:

A. Termination of the Plan;

B. Plan modification to terminate coverage for the class to which you belong;

C. Plan modification to terminate a particular type of benefit under the Plan;

D. When no additional contributions have been made on your behalf.

Self-contributions

If your eligibility for benefits terminates due to a reduction in the number of hours worked or termination of employment for any reason (except gross misconduct), you may arrange with the Trustees to continue your eligibility at your own expense, subject to the conditions included under the Plan's COBRA provisions.

RETIREE PROGRAM

Eligibility

If an Employee has reached age 65, unless employed full-time by an employer that contributes to the Fund, or has been placed in retirement or accepted voluntary retirement on receiving a pension or Social Security benefits, he may within thirty-one (31) days arrange at his expense for continuation of eligibility for reduced benefits as set forth in the Schedule of Benefits for Retired Employees.

If an Employee has retired under the age of 65, either on early retirement or disability retirement, as evidenced by receiving a pension benefit from Social Security or another qualified plan, the Employee may within thirty-one (31) days arrange at his own expense for the continuation of eligibility for benefits under the Plumbers & Pipefitters Local 219 Health & Welfare Fund.

On a one-time basis only, a retired Employee may elect not to make self-payments for coverage for himself and his spouse (if applicable) and later re-enroll in this Plan, provided that he can submit evidence to the Fund Office that he and his spouse (if applicable) had credible health insurance coverage through another employer-sponsored group health insurance plan (including continuing coverage through COBRA), or are entitled to a benefit through the Veterans Administration (VA), for, at least, the thirty-six (36) months prior to his application for re-enrollment in this Plan. To be eligible for this one-time re-enrollment option, the retired Employee must elect to waive coverage for himself and his spouse (if applicable) as of the first (1st) day for which he would have been eligible for coverage through the Plumbers & Pipefitters Local 219 Health and Welfare Fund's Retiree Program. On a one (1) time basis only, if coverage under the other employer sponsored group health plan (including COBRA continuation coverage) or VA plan is terminated (other than for the non-payment of premiums), the retired Employee may elect to make self-payments for coverage in this Plan for himself and his spouse, provided that self-payments begin as of the first (1st) day for which coverage has been terminated under the other employer-sponsored group health plan, VA plan, or COBRA. In other words, the Fund Office must receive proof that there has been credible health insurance coverage for, at least, the thirty-six (36) months prior to the date on which the retired Employee submits his application for reenrollment in the Plumbers & Pipefitters Local 219 Health & Welfare Fund. Furthermore, in order to qualify for this one (1) time re-enrollment right, if the retired Employee was the owner and/or a principal officer of a contributing employer, said contributing employer must be current with all dues and fringe benefit contributions (including interest and other such penalties) prior to re-enrollment. Likewise, the retired Employee must be a member in good standing with Plumbers & Pipefitters Local Union No. 219 (as defined in the Union's Constitution and/or Bylaws) in order to re-enroll under this provision. The Board of Trustees, in its sole and absolute discretion, shall determine the appropriate self-payment rate applicable to retired Employees electing this one (1) time re-enrollment option, which is subject to revision as deemed necessary by the Board of Trustees.

Payment Of Contributions

Retiree Program contributions are determined in accordance with the levels established by the Board of Trustees and are subject to change, as required by the Board of Trustees.

Termination Of Eligibility For Benefits Of Retired Participants

The benefits of a Retired Participant covered under the Retiree Program will terminate on whichever of the following dates occurs first:

A. The date the coverage terminates;

B. The date of expiration of the period for which the last contribution is made to the Trustees, as required, on account of the Retired Participant;

C. The date the Retired Participant ceases to be within the classes of persons eligible for coverage under the Program;

D. The date on which the Retired Participant's death occurs.

Reemployment Of Retired Participants

If a Retired Participant returns to work for a Participating Employer and contributions are received on his behalf, the hours worked will be credited towards the Initial Eligibility requirements under the Active Program. No credit will be given under the Retiree Program for those contributions received. Should sufficient hours be received to satisfy the Initial Eligibility requirements of the Plan under the Active Program, the Retired Participant's coverage will be transferred to the Active Program. The Retired Participant will then be entitled to the benefits available under the Active Program. The eligibility rules of the Active Program will apply to the Retired Participant until he becomes eligible once again to participate in the Retiree Program.

SURVIVING SPOUSE PROGRAM

Eligibility

If the deceased individual was an Eligible Participant or Eligible Retired Participant upon death, his Spouse shall be eligible to participate in the Surviving Spouse Program until the Surviving Spouse is covered under another group program, excluding Medicare; or, if remarried until she becomes eligible under the new spouse's program. The Surviving Spouse shall have the right to elect to join the Surviving Spouse Program within sixty (60) days after the date of termination of coverage as a Dependent of the deceased Participant or Retired Participant by making application and remitting timely monthly contributions established by the Trustees.

No newly acquired dependents of the Surviving Spouse shall be eligible for benefits under this Plan.

Payment of Contributions

Surviving Spouse Program contributions are determined in accordance with the levels established by the Board of Trustees and are subject to change, as required by the Board of Trustees.

Termination Of Eligibility For Benefits

If the Surviving Spouse fails to join the Surviving Spouse Program by making application within sixty (60) days following the death of the Eligible Participant or Eligible Retired Participant, or fails to make contributions required by the Trustees, eligibility for benefits shall terminate and the Surviving Spouse shall not be able to be reinstated to the Surviving Spouse Program in the future.

CONTINUATION OF COVERAGE (COBRA)

Under certain circumstances, covered person whose coverage under this Plan would otherwise terminate, may elect to continue medical coverage under this Plan for a limited period of time. Under appropriate circumstances, this right extends to Eligible Participants and their Eligible Dependents.

Your Rights

If you are a Participant covered by this Plan, you have the right to choose continuation coverage if you lose your eligibility for coverage under this Plan due to a reduction in the number of hours worked or termination of employment for any reason, unless termination is due to gross misconduct on your part.

If you qualify for continuation coverage due to a reduction of hours or termination of employment but do not elect such coverage for your entire family, your eligible Spouse or Dependent Children are still entitled to elect continuation coverage.

If you are the Spouse of a Participant covered under this Plan, you have the right to choose continuation coverage for yourself if you lose your group health care coverage under this Plan for any of the following reasons:

A. Termination of employment (for reasons other than gross misconduct), or a reduction in the hours worked by your Spouse (i.e., the Plan Participant);

B. Death of your Spouse (i.e., the Plan Participant);

C. Divorce or legal separation from your Spouse (i.e., the Plan Participant); or

D. Your Spouse (i.e., the Plan Participant) becomes enrolled in Medicare following the date of the Qualifying Event.

If you are a Dependent Child of a Covered Participant covered under this Plan, you have the right to continuation coverage if you lose your eligibility for coverage under this Plan for any of the following reasons:

A. Termination of the Covered Participant's employment (for reasons other than gross misconduct) or a reduction in the number of hours worked by your parent, who is the Covered Participant under this Plan;

B. Death of your parent, who is the Covered Participant under this Plan;

C. Your parents' divorce or legal separation;

D. Your parent who is the Covered Participant under this Plan becomes enrolled in Medicare following the date of the Qualifying Event; or

E. You cease to satisfy this Plan's definition of a "Dependent Child".

Newborn And Adopted Children

A child who is born to or placed for adoption with an individual under COBRA during a period of COBRA coverage will also be eligible to become a Qualified Beneficiary. These Qualified Beneficiaries can be added to COBRA coverage upon proper notification to the Fund Office within thirty-one (31) days of the birth or adoption. In addition, COBRA coverage may be elected on behalf of a newborn or adopted child if the parent is no longer entitled to COBRA.

Type of Coverage to be Continued

The coverage that will be provided to a qualified beneficiary is the same medical coverage that is provided to other similarly situated non-COBRA beneficiaries in this Plan. This will include the right to add dependents.

Your Obligations

Under the law, the Covered Participant or a family member has a responsibility to notify the Fund Office about a divorce, legal separation or a child losing Dependent status under the Plan. Such notification should take place immediately after any of these three events occurs. If such an event is not reported to the Fund Office within sixty (60) days after it occurs, continuation coverage will not be provided.

It is the responsibility of the individuals to notify the Fund Office regarding any of the following events:

A. Death;

B. Divorce/legal separation;

C. Termination of employment;

D. Reduction in hours;

E. Medicare enrollment; and

F. Disability, as determined by the Social Security Administration

It would be advisable, however, for the Spouse of a deceased Participant to contact the Fund Office as soon as possible after the Participant's death so that continuation of coverage can be made available to the Surviving Spouse and any dependent Children at the earliest possible date.
It is also extremely important that the Covered Participant, Spouse or Dependent notify the Fund Office immediately about any changes in address so that if any qualify for continuation coverage, the election notice will be mailed to the correct address. This is critical because the election of continuation coverage must be made within a 60-day time limit. If the notice is sent to the wrong address, the time limit may be exceeded, in which case no continuation coverage would be extended.

Procedures For Obtaining Continuation Coverage – Other Requirements

Once the Fund Office knows that an event has occurred which qualifies you or other family members for continuation coverage, the Fund Office will notify you about your right to elect continuation coverage. Once you receive this election notice from the Fund Office, you have sixty (60) days from to notify the Fund Office that you are electing continuation coverage.

This sixty (60) day period begins to run on the later of: (i) the date that your coverage will terminate; or (ii) the date of the election notice (which is provided to you by the Fund Ofiice). If you do not elect the coverage within the sixty (60) day time period, your group health coverage through this Plan will end.

You do not have to show that you are insurable to choose continuation coverage; however, under the law, you may have to pay for all or part of the amount required for continuation coverage. If a charge is made it will be shown on the election notice. If you elect continuation coverage, this Plan is required to give coverage which, as of the time such coverage is provided, is identical to the coverage provided other similarly situated beneficiaries and for which you were eligible prior to the Qualifying Event.

The law requires that you be given an opportunity to maintain continuation coverage for a maximum of thirty-six (36) months unless you lost your coverage due to a termination of employment or due to a reduction in hours worked, in which case the required continuation period is eighteen (18) months. In the case of employees who lose their coverage due to service in the military, the required continuation period is twenty-four (24) months. If you are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of continuation coverage and provide notice to the Plan Administrator of the disability determination within sixty (60) days after the date the determination is issued and before the end of the initial coverage period, the maximum coverage for you and other members of your family who have elected COBRA coverage may be extended for an additional eleven (11) months, for a total of twenty-nine (29) months.

Self-Payment for Continuation

A person electing to continue coverage must pay the entire self-payment to the Fund on a monthly basis. The self-payment is adjusted by the Board of Trustees from time to time, but it may not exceed 102% of the full cost to the Fund, except that for a qualified beneficiary whose coverage is being extended from eighteen (18) to twenty-nine (29) months, the self-payment will be no more than one-hundred-fifty (150%) of the full cost. Your first payment for continuation coverage must be made to the Fund Office within forty-five (45) days of the election. Thereafter, monthly payments must be made to the Fund Office no later than thirty (30) days from the due date of the payment.

Termination of COBRA Coverage

Your continuation coverage will terminate on the earliest of the following dates:

A. the end of eighteen (18) months, in a case where the coverage originally terminated because of termination of employment or reduction in hours, except that:

    1. if another qualifying event occurs during the eighteen (18) month continuation, continuation coverage will terminate thirty-six (36) months after the first qualifying event;

2. if the Plan Participant becomes entitled to eighteen (18) months of continuation coverage and then becomes entitled to Medicare coverage before the expiration of the eighteen (18) months, the continuation for qualified beneficiaries (other than the Plan Participant) can be continued for a length of time equal to but not to exceed thirty-six (36) months from the date of the Plan Participant's first qualifying event;

3. if a qualified beneficiary is determined to have been disabled under Title II or Title XVI of the Social Security Act at the time of the qualifying event or within sixty (60) days thereafter, the eighteen (18) month continuation will be extended to the earlier of twenty-nine (29) months after the qualifying event or the first (1st) of the month that begins thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

B. thirty-six (36) months for other qualifying events;

C. the date that your Employer or the Fund ceases to provide group health care coverage;

D. the date that you fail to pay the required premium for your continuation coverage;

E. the date that you become covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any pre-existing condition (if applicable) of such beneficiary or at the point when the new plan may no longer exclude coverage for any such beneficiary's pre-existing conditions (if applicable) as a result of HIPAA; or

F. that date that you become enrolled in Medicare after the date of your election of COBRA coverage.

Continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plumbers & Pipefitters Local 219 Health & Welfare Fund reserves the right to terminate your COBRA coverage if you are determined to be ineligible.

It is recommended that you contact the Fund Office if you should have any questions concerning COBRA.

Application of Deductible and Plan Limits

Applicable deductible and benefit limits imposed by this Plan will be considered met for qualified beneficiaries to the extent they had been met while the person was covered under this Plan as Covered Participant or Eligible Dependent. Upon division of a covered family into separate units due to the election of continuation coverage, the continuation coverage unit will be charged or credited with the amount of deductibles and benefit limits already met by members of the continuation unit, and each unit will be considered separately with regard to the charges incurred from that date forward.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment Rights

If you were eligible to enroll in this plan and declined this plan's coverage because you were covered under a group health plan, Medicaid, or under other health insurance coverage, and lose the other coverage you and your Eligible Dependent(s) will be permitted to enroll in this plan during a special enrollment period. However, you must notify the Fund Office of your request for special enrollment within thirty (30) days after the other coverage ends. The Fund Office may require you to provide written documentation of the termination of the other coverage. In addition, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your Eligible Dependent(s) in this plan. However, you must provide the Fund Office with notice of your intent to enroll yourself and your Eligible Dependents in this plan within thirty (30) days of the event (having or becoming a new Eligible Dependent). Coverage under these special enrollment provisions will be effective no later than the first (1st) day of the first (1st) calendar month beginning after the date the completed request for enrollment is received by the Fund Office.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	***FLORIDA – Medicaid***
Website: http://myalhipp.com/ *Phone: 1-855-692-5447*	*Website: http://flmedicaidtplrecovery.com/hipp/* *Phone: 1-877-357-3268*
ALASKA – Medicaid	***GEORGIA – Medicaid***
The AK Health Insurance Premium Payment Program *Website: http://myakhipp.com/* *Phone: 1-866-251-4861* *Email: CustomerService@MyAKHIPP.com* *Medicaid Eligibility:* *http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx*	*Website: Medicaid* *www.medicaid.georgia.gov* *- Click on Health Insurance Premium Payment (HIPP)* *Phone: 404-656-4507*
ARKANSAS – Medicaid	***INDIANA – Medicaid***
Website: http://myarhipp.com/ *Phone: 1-855-MyARHIPP (855-692-7447)*	*Healthy Indiana Plan for low-income adults 19-64* *Website: http://www.in.gov/fssa/hip/* *Phone: 1-877-438-4479* *All other Medicaid* *Website: http://www.indianamedicaid.com* *Phone 1-800-403-0864*
IOWA – Medicaid	***KANSAS – Medicaid***
Website: http://dhs.iowa.gov/hawk-i *Phone: 1-800-257-8563*	*Website: http://www.kdheks.gov/hcf/* *Phone: 1-785-296-3512*
KENTUCKY – Medicaid	***NEW HAMPSHIRE – Medicaid***
Website: https://chfs.ky.gov *Phone: 1-800-635-2570*	*Website: https://www.dhhs.nh.gov/oii/hipp.htm* *Phone: 603-271-5218* *Toll-Free: 1-800-852-3345, ext 5218*

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov *Phone: 1-888-549-0820*	*Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm* *Medicaid Phone: 1-800-432-5924* *CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm* *CHIP Phone: 1-855-242-8282*
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov *Phone: 1-888-828-0059*	*Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program* *Phone: 1-800-562-3022 ext. 15473*
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ *Phone: 1-800-440-0493*	*Website: http://mywvhipp.com/* *Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)*
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ *CHIP Website: http://health.utah.gov/chip* *Phone: 1-877-543-7669*	*Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf* *Phone: 1-800-362-3002*
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ *Phone: 1-800-250-8427*	*Website: https://health.wyo.gov/healthcarefin/medicaid/* *Phone: 307-777-7531*

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Extension of Benefits

If you or your Eligible Dependents are totally disabled as a result of an illness or accident on the date coverage under the Plan would otherwise terminate, benefits will be paid to the same extent as if the coverage were still in effect for eligible expenses for only that specific illness/accident and will terminate on the earlier of:

A. the date the person ceases to be disabled;

B. the date on which coverage with respect to such illness/accident takes effect under any other group medical plan; or

C. three (3) months from the date the coverage ceased.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) guarantees certain employees a minimum of twelve (12) weeks of coverage under this Plan based on premium payment provisions in effect immediately prior to such leave. The FMLA applies to employers who employ 50 or more employees within 75 miles of the employee's worksite for each working day during each of 20 or more calendar work weeks in the current or preceding calendar year.

Notwithstanding any provision in this Plan to the contrary, the following provisions shall apply to an Eligible Participant who requests from his Employer and receives a leave of absence pursuant to the FMLA:

A. An Eligible Employee must have been employed by the Employer (i) for at least 12 months; and (ii) for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave.

B. If the Eligible Participant is covered by the collective bargaining agreement negotiated by the Union, the Fund shall continue eligibility for the Participant and credit contributions on behalf of the Participant who is using FMLA leave as though the Participant had been continuously employed for a maximum of 12 weeks as allowed by law.

C. For the duration of the Participant's FMLA leave, coverage by the Plan and benefits provided pursuant to the Plan shall continue at the level coverage would have continued if the Participant had remained actively employed.

D. A Participant using FMLA leave shall not be required to utilize his Reserve Bank hours or pay any greater premiums than the Participant would have been required to pay if the Participant had been continuously employed.

E. A Participant, upon returning from FMLA leave, shall be reinstated in the Plan to the same status as provided when the leave began, subject to benefit changes that affect all Participants in the Plan. The Participant shall not be subjected to any restrictions, waiting periods, physical examinations or other pre-existing condition (if applicable) exclusions that would not have been imposed upon the Participant had he not taken the FMLA leave.

F. The Employer shall remit to the Fund the normal contributions on behalf of such Participant during the period of FMLA leave.

When taking a FMLA leave, you need to inform the Fund Office, in writing, so that your rights to health care coverage are protected during the leave.

If you return to work within twelve (12) weeks, you will not lose health care coverage. If you do not return to work within twelve (12) weeks, you may then qualify to continue your coverage under COBRA (as set forth in the section on COBRA continuation coverage).

In the event that you seek to exercise your rights to FMLA leave, you should adhere to your employer's policies and procedures with regard to taking such leave. The provisions under this Section only set forth this Plan's requirements and do not address any additional requirements that may be required by your employer.

Participants Serving In Armed Forces

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires your employer to continue your medical coverage if you go into active military service for no more than thirty (30) days. If you go into military service for more than thirty (30) days, you and your Eligible Dependents may be able to continue your medical coverage at your own expense for up to twenty-four (24) months. See the section on COBRA continuation coverage for more details. In addition, this Plan provides as follows with respect to participants serving in the Armed Forces:

A. A Participant who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his Reserve Bank, if any, until discharged from active full-time military duty; or utilizing his Reserve Bank, if any, to continue coverage under the Plan, as provided hereafter.

B. In the event a Participant who enters into full-time military duty of the United States has no Reserve Bank, has an insufficient Reserve Bank to maintain coverage while serving in the military service, or does not elect to utilize his Reserve Bank to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan for the Participant and his Eligible Dependents can be continued for twenty-four (24) months upon receipt of a timely application and required contributions established by the Board of Trustees.

C. If a Participant enters the Armed Forces on a short-term basis of 31 days or less of continuous military service, coverage under the Plan will be continued for the Participant and Eligible Dependents at the Plan's expense. For military service which exceeds 31 days, the Participant shall be responsible for contributions for those months of service subsequent to the initial service of 31 days.

D. A Participant shall notify the Fund Office as soon as he knows or understands that he will be entering the military service of his desire to purchase continuation health care coverage for that period of time when he is in active military service, not to exceed 24 months. This notice requirement shall be adhered to by the Participant unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.

E. Upon a Participant's honorable discharge from military service, the Participant's eligibility status under the Plan will be restored to the status that existed when he entered military service, with the exception of any Reserve Bank Dollars that the Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Participant must notify the Fund Office, in writing, within 60 days of his discharge of his intent to return to covered employment. In addition to such written notice, the Participant shall also supply the Fund Office with copies of his discharge papers showing the date of his education or enlistment in military service and the date of his discharge. Failure on the part of the Participant to file such notice and documentation with the Fund Office may be deemed an indication that the Participant does not wish to restore his eligibility status under the Plan.

Effective Date of Dependent Coverage

Your Dependents become eligible for coverage at the same time you become eligible for your coverage, or on a date when you first acquire a Dependent, whichever is later. The coverage for any Dependent will not become effective unless your coverage is also in effect on such date.

If a Dependent is confined in a hospital on the date such Dependent would otherwise become covered, the coverage with respect to that particular Dependent will be deferred until final discharge from the hospital. This requirement, however, will not apply to a newborn child confined in a hospital at birth.

Termination of Dependent Coverage

The benefits of any Dependent will terminate on whichever of the following dates occurs first:

A. The date the Eligible Participant's coverage under this Plan terminates;

B. The first date following the date such Dependent ceases to be an Eligible Dependent;

C. The date the Plan is discontinued.

Extension Of Dependent Coverage For A Handicapped Child

If the coverage of an Eligible Dependent child would terminate solely due to attainment of the maximum age, and if:

A. Such Dependent child becomes incapable of self-support due to mental retardation or physical handicap prior to the attainment of such age; and

B. Such Dependent child is dependent upon the Eligible Participant for over one half of his/her support and maintenance; and

C. Such Eligible Participant furnishes to the Board of Trustees satisfactory proof of all of the foregoing within 31 days of such Dependent child's attainment of such maximum age. Coverage of such Dependent child will terminate during the continuation of his/her qualifications under (a) and (b) above unless satisfactory proof of the continuance is furnished by the Eligible Participant as the Board of Trustees may reasonably require or unless the Dependent's coverage is terminated in accordance with any other termination provisions of the Plan.

The Board of Trustees may reasonably require the Dependent child be examined by a medical examiner designated by the Board of Trustees, at the Plan's expense, prior to this extension. In addition, during the two years following the Dependent child's attainment of the maximum age, the Board of Trustees may require satisfactory proof at reasonable intervals, including medical examination at the Plan's expense. However, after the two-year period, such proof, including medical examinations, may not be required more than once per calendar year.

SCHEDULE OF BENEFITS

ACTIVE PROGRAM
(Participating Members of Plumbers & Pipefitters Local 219 And Their Eligible Dependents)

And

(Office & Salaried Program Participants And Their Eligible Dependents)

Subject To The Provisions Described In The Plan

The following is a summary of the Schedule of Benefits provided by the Plan.

LIFE, ACCIDENTAL DISMEMBERMENT AND ACCIDENT & SICKNESS WEEKLY BENEFITS (PARTICIPANTS ONLY - DEPENDENTS EXCLUDED)

Life Benefit	$10,000.00
Accidental Dismemberment	$ 5,000.00
Accident & Sickness Weekly Benefits **(Active Program only)**	$275.00/week
(1st Day – Accident; 8th Day – Illness)	26-week maximum

Two or more periods of disability are considered as one unless between periods of disability you have returned to active full-time work or normal employment for sixty (60) consecutive days, or unless the disabilities are due to causes entirely unrelated.

COMPREHENSIVE MEDICAL BENEFITS (PREFERRED PROVIDER ORGANIZATION PROGRAM) – FOR ELIGIBLE PARTICIPANTS AND ELIGIBLE DEPENDENTS

	In-Network	**Non-Network**
Annual Deductible	**$250 Individual** **$500 Family**	**$500 Individual** **$1,000 Family**
Coinsurance You Must Pay	**10%**	**40%**
Coinsurance Limit (your out-of-pocket maximum)	**$2,500 Individual** **$5,000 Family**	**$5,000 Individual** **$10,000 Family**
Deductible Applies to Out-of-Pocket Maximum?	**No**	**No**

Covered Services (Subject to your Deductible, Coinsurance and Co-Payment responsibilities~~)~~

Hospital Room & Board Benefit	Semi-private Room Rate
Hospital Miscellaneous Benefit	UCR
In-Hospital Medical Expense Benefit	UCR
Surgical Expense Benefit –	UCR
Outpatient Hospital Expense Benefit	UCR
Anesthesia Benefit	UCR
Pre-admission Testing – Same-day Surgery Benefit	UCR
Second Surgical Opinion Benefit	UCR
Organ Transplant Benefit	UCR
Maternity Benefit (for female Participant or Spouse of Male Participant only) Ultrasound-limit of three (3) per pregnancy unless medically necessary	UCR

Nervous/Mental Disorders Benefit - Inpatient & Outpatient	UCR
Inpatient	UCR
Outpatient	UCR
Treatment of Chemical, Alcohol & Drug Abuse Benefit - Inpatient & Outpatient	UCR
Outpatient Diagnostic X-ray & Laboratory Benefit	UCR
Emergency Hospital Benefit	UCR
Radiation Therapy Benefit	UCR
Annual Physical Examinations (Participant & Spouse only) - One examination per calendar year (including related office visit and other accompanying expenses)	UCR Benefit is paid only <u>after</u> the deductible is satisfied
Influenza/pneumonia Vaccines	UCR
Well-child Care (Birth to age twenty-six)	UCR
Treatment of Neuromusculoskeletal Conditions – Chiropractic Benefits –Excludes Dependent children under age 10.	UCR Maximum chiropractic benefit of twelve (12) visits per calendar year
Physicians' Office Visits	UCR
Home Health Care Visits	UCR
Ambulance Benefit	UCR
Skilled Nursing Facility Benefit (Medicare-approved)	UCR
Hospice Care Benefit	UCR
Asbestosis Testing (Participant Only) - X-ray Benefit (No Deductible or Copayment Requirement)	$50.00/maximum - Per Calendar Year

Physical Therapy-Per Calendar Year	UCR Maximum yearly benefit of twenty-four (24) visits, with the last 12 visits paid at only 50% UCR
Preventative Services	100% *

** In accordance with the Patient Protection and Affordable Care Act of 2010, as amended, the Plan covers certain preventative services without charge of a copayment or coinsurance, even if you have not met your yearly deductible. For more information regarding preventative services or how such services are covered under the Plan, please contact the Fund Office.*

AN IMPORTANT NOTE ABOUT IN-NETWORK/OUT-OF-NETWORK SERVICES

The Fund pays significantly higher benefits on behalf of participants and dependents who use "in-network" medical service providers. And while you are free to engage the services of an out of network service provider, please be aware that you will be responsible for excess costs incurred out-of-network.

Please consider the following example as an illustration of the difference in benefits paid for the use of in-network/out-of-network services:

IN-NETWORK FEE FOR SERVICES ILLUSTRATION					
Total Billed	**Usual/Customary/Reasonable ("UCR") Amount For Service Determined By Anthem**	**In-Network Deductible (Family) Paid By Participant**	**In-Network Co-Insurance Limit (Family) Paid by Participant**	**Fund Pays**	**Participant Pays**
$100,000	$50,000	$500	$5,000	$44,550	$5,450

OUT-OF-NETWORK FEE FOR SERVICES ILLUSTRATION					
Total Billed	**Usual/Customary/Reasonable ("UCR") Amount For Service Determined By Anthem**	**Out-Of-Network Deductible (Family) Paid By Participant**	**Out-Of-Network Co-Insurance Limit (Family) Paid by Participant**	**Fund Pays**	**Participant Pays**
$100,000	$50,000	$1,000	$10,000	$39,000	$61,000

As you can see from the illustrations above, which has been produced as a representation only, there are significant cost savings available to participants who use in-network providers. Please contact the Fund Office if you have any questions about whether your service provider is in-network, or to locate an in-network service provider.

PRESCRIPTION DRUG BENEFIT

The prescription drug coverage program provides a 4-tier plan for generic, preferred brand, non-preferred brand, and specialty prescription drugs as shown in the following table:

Type of Prescription	**Your Payment Responsibility**
Generic Retail Drug Co-pay	$10
Brand Name Retail Drug Co-pay	See Below*
Generic Mail Order Drug Co-pay	$20
Brand Name Mail Order Drug Co-pay	See Below*
Preferred Brand – Retail: Mail Order:	Greater of 20% or $20. Greater of 20% or $40.
Non-Preferred – Retail: Mail Order:	Greater of 30% or $35. Greater of 30% or $70.
All Specialty drugs** – Retail Mail Order	Greater of 30% or $35 Greater of 30% or $70
Prescription Drug Out-Of-Pocket Maximum (Per Plan Year)	$4,600 single / $9,200 family

*Since a generic drug substitute is the same chemically and usually costs less than the brand name drug, if you choose a brand name (preferred or non-preferred) when a generic is available, you will pay the greater of 20% or $20 for preferred brands at retail (and the greater of 20% or $40 for mail order prescriptions), and the greater of 30% or $35 for non-preferred brands at retail (and 30% or $70 for mail order prescriptions).

** Please contact the Fund Office if you have any questions regarding specialty drugs, including whether a prescription drug constitutes a "specialty drug."

With respect to the Plan's Smoking Cessation Benefit, there is a maximum lifetime benefit of five (5), ninety (90) day supplies.

NOTE: There is a mandatory mail-order requirement with respect to all maintenance medications (e.g., blood pressure medication, etc.) which means maintenance drugs must be obtained by mail order only.

SPECIAL NOTE REGARDING CERTAIN COMPOUND MEDICATIONS

(prior-authorization required)

A Prior authorization will be required for all compound medications over $300. A compound medication is created when a licensed pharmacist combines, mixes, or alters ingredients, in response to a prescription, to create a medication tailored to the medical needs of a patient. Prior authorization can be obtained through CVS Caremark at a cost of $35.00 per authorization. A prior authorization on a compound prescription drug claim will be considered valid for ninety (90) days, marked from the date of the authorization. Compound prescription drugs are limited to one (1) medication each twenty-five (25) day period. If you fail to follow this requirement, your claim may be denied. If you have any questions about this requirement, please contact the Fund Office.

DENTAL BENEFITS
FOR ELIGIBLE PARTICIPANTS AND DEPENDENTS

The Fund has entered into a separate fully insured arrangement with Delta Dental of Ohio ("Delta Dental") whereby, in return for the required premium paid to it, Delta Dental will provide eligible Participants and Dependents with dental benefits as provided in the schedule of benefits below. Delta Dental or the Fund will also issue to the Participants a separate certificate describing these benefits. That certificate is incorporated herein by reference. Should the Participant need another copy of the certificate, he or she should contact Delta Dental.

Benefit Year- January 1 through December 31

Maximum Payment- $500 per person total per Benefit Year on all services.

Deductible- None.

Covered Services-

	PPO Dentist	**Premier Dentist**	**Non-participating Dentist**
	Plan Pays	**Plan Pays***	**Plan Pays***
Diagnostic & Preventative			
Diagnostic and Preventive Services- exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment- to temporarily relieve pain	100%	100%	100%
Sealants- to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy- to detect oral cancer	100%	100%	100%
Radiographs- X-rays	100%	100%	100%
Basic Services			
Simple Extractions – non-surgical removal of teeth	80%**	80%**	80%**
Minor Restorative Services - fillings	80%**	80%**	80%**

When services are received from a Premier or Non-participating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

****Coinsurance applies after a deductible of $50 (single) and $150 (family).***

COVERED DENTAL SERVICES PAYABLE AS DESCRIBED ABOVE INCLUDE:

Covered Service	Limitations
Oral exams (including evaluations by a specialist).	Payable twice per calendar year.
Prophylaxes (cleanings).	Payable twice per calendar year.
People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment.	The patient should talk to his or her dentist about such treatments and contact Delta Dental with any coverage questions.
Fluoride treatments for eligible persons up to age nineteen (19)	Payable twice per calendar year.
Bitewing X-rays.	Payable once per calendar year.
Full mouth X-rays, which include bitewing X-rays.	Payable once in any five-year period.
Sealants.	Payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine, and second permanent molars up to age 14. The surface must be free from decay and restorations.
Minor Restorative Service – fillings	Composite resin (white) restorations are Covered Services on posterior teeth.

Appeals. Participants should follow the appeals process provided by Delta Dental, as set forth in the Delta Dental certificate. In the event of an adverse benefit decision from Delta Dental, a Participant may appeal to the Board of Trustees following the procedures set forth in the Second Level of Review explained in the SPD's Section titled REVIEW PROCEDURE FOR CLAIMS UNDER THE FUND.

Claims Subject to ERISA. (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, the Plan Participant or Beneficiary must exhaust available administrative remedies. Under the policy, the claimant must first seek two administrative reviews of the adverse claim decision. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews. Delta Dental will waive any right to assert that he or she failed to exhaust his or her required administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to Delta Dental is required. If reimbursement is not made; then Delta Dental has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from the Participant, or from his or her Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, Delta Dental's error in processing a claim, or any other reason.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in the SPD. Additionally, no legal action relating to dental benefits may be brought more than three (3) years after the date written proof of claim is required.

Any decision Delta Dental makes, in the exercise of its authority, shall be conclusive and binding; subject to the Participant's and/or Dependent's rights to:

(1) request a state insurance department review; or
(2) bring legal action.

NOTICE: A person is guilty of insurance fraud, if he or she submits an application or files a claim containing a false or deceptive statement:

(1) with intent to defraud an insurance company; or
(2) knowing that he or she is aiding a fraud against an insurance company.

Please Note That Separate Claims And Appeals Procedures Apply To Benefits Administered By The Fund's Board Of Trustees Through The Fund Office. Please Contact The Fund Office If You Have Any Questions About The Claims And Appeals Procedures Applicable To Your Situation.

SCHEDULE OF BENEFITS

RETIREE PROGRAM AND SURVIVING SPOUSE PROGRAM

LIFE INSURANCE BENEFIT (RETIRED PARTICIPANT ONLY) $5,000.00

MEDICAL BENEFITS

Retired Participants, Eligible Dependents & Surviving Spouses

A. **Not yet eligible for Medicare:**	The benefits are the same as the benefits provided under the Active Program (except for the exclusion of Accident & Sickness Weekly Benefits and Accidental Dismemberment Benefits and a $5,000.00 Life Insurance benefit), and you are subject to the same coinsurance, deductibles, co-pays and maximums. Please refer to the Schedule of Benefits for the Active Program for specific details.
B. **Eligible for Medicare**:	Retired Participants, Dependents & Surviving Spouses eligible for Medicare - Parts A & B should see their Certificate of Coverage for their specific benefits and coverages.

BENEFITS FOR ELIGIBLE PARTICIPANTS AND DEPENDENTS

LIFE INSURANCE AND ACCIDENTAL DISMEMBERMENT BENEFITS

Life Insurance Benefits

In the event of an Eligible Participant's death while covered under this Plan, the Plan will provide a payment of ten thousand dollars ($10,000) to the person who has been designated as the Active and Office & Salaried Participant's Beneficiary. A death benefit of five thousand dollars ($5,000) is provided under the Plan on behalf of Retired Participants.

Accidental Dismemberment Benefits (excludes Retired Participants)

The Fund will provide a benefit of five thousand dollars ($5,000) on behalf of Active and Office & Salaried Participants resulting from injuries described below, sustained in an accident, provided: (a) the loss occurs within 90 days following the date of the accident and (b) the loss is a direct and exclusive result of the injuries, independent of all other causes. If the Eligible Participant suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Schedule of Benefits Payable:

Both Hands or Both Feet	Principal Sum
Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
One Hand or One Foot	One-half of Principal Sum
Sight of One Eye	One-half of Principal Sum

Loss of hand or foot means severance of entire hand or foot at or above the wrist or ankle joint respectively.

Loss of sight means the total and irrecoverable loss of sight.

Principal Sum is the amount shown in the Schedule of Benefits.

Exclusions/Limitations:

Benefits will not be payable under the Accidental Dismemberment provisions for any loss which is caused directly or indirectly as a result of: (a) intentionally self-inflicted injury; (b) disease or infection, except an infection resulting from an accidental cut or wound; (c) declared or undeclared war or an act of war; participation in the commission of an assault or a felony.

Designation of Beneficiary – Life and Accidental Dismemberment Benefits

The Eligible Participant's Beneficiary shall be the person who has been designated by the Participant on a form satisfactory to the Fund. The Participant may change his Beneficiary at

any time by filing a written notice satisfactory to the Fund. The new designation shall take effect on the date the Eligible Participant signs the notice of change. When a new Beneficiary is designated, the interest of any previously designated Beneficiary shall cease.

If, at the death of the Eligible Participant, no named Beneficiary is surviving, the amount of the benefit will be paid in a single sum, to the Eligible Participant's Estate. All other benefits provided by the Fund shall be payable to the Eligible Participant or Eligible Retired Participant as the eligible person.

ACCIDENT & SICKNESS WEEKLY BENEFITS
(Active and Office & Salaried Participants)

When you are disabled due to an accident or sickness and under the care of a legally qualified physician, the Weekly Benefit will be paid to you beginning on the date shown in the Schedule of Benefits, up to the maximum number of weeks payable during any disability, as specified in the Schedule of Benefits.

During partial weeks of disability, you will be paid at the daily rate of one-seventh of the Weekly Benefit.

Maximum Benefit

A maximum benefit of 26 weeks shall be applied for each Period of Disability.

Period of Disability

Two or more periods of disability are considered as one unless between the periods of disability, you have returned to active full-time work or normal employment for sixty (60) consecutive days, or unless the disabilities are due to causes entirely unrelated.

Exceptions/Limitations

Payment under this Plan shall not be made for the following:

A. Disabilities resulting from the Participant's occupation or employment and which are considered eligible for payment under any Workers' Compensation or similar law;

B. Disabilities for which the Participant is not under the care of a legally qualified physician and for which there is no acceptable certification of the illness/accident provided to the Administrator by the physician.

C. Disabilities for which the Participant has or had a right to payment under the temporary disability laws of any state.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
(Active and Office & Salaried Participants)

The Plan includes a Health Reimbursement Arrangement ("HRA") benefit. Active Participants (including those who are eligible for Plan benefits under the Office & Salaried Program) (hereinafter "HRA Participants") whose employers make contributions to the Plan under a collective bargaining agreement or other agreement requiring the payment of HRA contributions to the Plan will have an HRA account established in their name. HRA Participants' HRA accounts will be limited to the HRA contributions received by the Plan from their contributing employer on such HRA Participants' behalf. If you are eligible for the HRA, you and your eligible Dependents can use your HRA to get reimbursed for allowable health care expenses or to maintain eligibility under the Plan after retirement through Retiree self-pay contributions (but only to the extent your coverage includes Retiree coverage through the Plan). This is not a vested benefit and the Trustees can modify or eliminate it at any time.

The benefit under this Section is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. The Trustees will interpret this benefit to accomplish that objective. The Medical Care Expenses reimbursement under the Plan are intended to those eligible for exclusion from the Participant's gross income under Section §105(b) of the Internal Revenue Code.

HRA ELIGIBILITY

HRA Participants are those individuals who are eligible for coverage as Active Participants (including those who are eligible for Plan benefits under the Office & Salaried Program) and whose employers make contributions to the Plan under a collective bargaining or other agreement requiring the payment of HRA contributions to the Plan. To be an HRA Participant, the Participant must otherwise be eligible for coverage through the Plan and his or her employer must remit contributions to the Plan with an amount designated for the HRA, as provided for in a collective bargaining agreement and/or other participation agreement.

The Trustees may require HRA Participants to accumulate a minimum amount of HRA credit prior to submitting eligible claims for reimbursement. Presently, an HRA participant is not eligible for HRA disbursements for one (1) year, after the date on which he or she first receives an HRA contribution. The Trustees will notify HRA Participants of any applicable account balance rule, including any changes to same.

Contributions

If you are an HRA Participant, a portion of the contributions that your Employer makes to the Plan on your behalf will be credited to your HRA account each month in accordance with the applicable collective bargaining agreement or participation agreement. The amount of the HRA contribution made on your behalf may be adjusted from time to time by the Trustees, or as a

result to changes in your collective bargaining agreement (or participation agreement). Your right to receive HRA contributions is not a vested right. This means that your right to receive HRA contributions may be forfeited under certain circumstances. As well, all HRA contributions are general assets of the Plan.

No contributions will be made to your HRA if you are granted extended eligibility due to periods of disability, qualified military service, or other non-work periods. Stated another way, HRA contributions are only made when you are actively working.

No contributions will be made to a Retiree's HRA and no contributions will be made by a Retiree.

No contributions will be made to an HRA established on behalf of a surviving spouse or surviving Dependents. As described below, in such a case, the surviving spouse and/or surviving Dependents may have the right to utilize the deceased HRA Participant's HRA, but they are not entitled to receive (or to make) additional HRA contributions.

Participant Contributions

HRA Participants cannot self-pay HRA contributions. Only employer contributions will be accepted or allocated to the HRA.

Reciprocal Contributions

If you travel outside of the Union's work jurisdiction and work under a reciprocal agreement between the Plan and another health and welfare fund, the following rules apply with respect to HRA contributions.

Full HRA Contribution. You will receive the full HRA contribution if the hourly health and welfare contribution rate paid on your behalf for such outside work and reciprocated back to this Plan is equal to or more than the total hourly contribution rate required to be paid to this Plan under the Union's collective bargaining agreements. In such case, the amount of contribution to your HRA will be the same as the amount contributed to your HRA when you work within the Union's jurisdiction.

- For illustration purposes only: if the total hourly contribution rate required to be paid to the Plan under the Union's collective bargaining agreements is $7.81 per hour, and $0.25 of this $7.81 is the normal allocation to the HRA, then Plan's base contribution rate is $7.56. Thus, if the reciprocal contribution is $7.81 or more, the HRA Participant would receive HRA contributions of $0.25 per reciprocal hour. So, for example only, if the reciprocal contribution is $7.81 or more, $0.25 goes to the HRA.

Partial HRA Contribution. You will receive a partial HRA contribution if the hourly health and welfare contribution rate paid on your behalf for such outside work and reciprocated back to this Plan is less than the full total hourly contribution rate required to be paid to this Plan under the Union's collective bargaining agreements, but more than the base rate determined by the Trustees, which excludes the full HRA contribution. In such a case, the amount of contributions made to your HRA will be the amount received by the Plan in excess of the base contribution rate determined by the Trustees.

- For illustration purposes only: if the total hourly contribution rate required to be paid to the Plan under the Union's collective bargaining agreement is $7.81 per hour, and $0.25 of this $7.81 is the normal allocation to the HRA, then the Plan's base contribution rate is $7.56. Thus, if the reciprocal contribution is, at least, $7.56 per hour (but less than $7.81 per hour), the amount in excess of $7.56 will be credited to your HRA. For instance, if the reciprocal amount is $7.76 per hour, $0.20 will be credited to your HRA.

In addition to the foregoing, pursuant to a reciprocal agreement, the Plan will reciprocate HRA contributions made on his or her behalf under the Union's collective bargaining agreement to a bargaining unit member's home health and welfare fund as well.

Funding this Benefit

All of the amounts payable under this Section shall be paid from the Plan's general assets. Nothing herein will be construed to require the Trustees to maintain any fund or to segregate any amount for the benefit of any Participant. No Participant or other person shall have any claim against, right to, or security or other interest in any account or asset of the Fund from which any payment under this Section may be made. There is no other trust or other fund from which benefits are paid under the Plan. No Participant has a dedicated separate account. All of the assets of the Trust Fund are available to reimburse Participants' or Eligible Retirees' eligible claims.

HOW TO USE YOUR HRA

You may use your HRA to pay for eligible health care expenses. If you retire and have a balance remaining in your HRA from contributions made while you were an Active Participant, you are entitled to use the balance in your HRA to pay your retiree coverage contributions or receive reimbursement for eligible health care expenses, as described in the following subsection.

Once you lose your eligibility and are no longer covered under the Plan, you may generally continue to use the money in your HRA to pay for eligible health care expenses until the money runs out, subject to the forfeiture provisions below.

In the event of your death, your surviving eligible spouse or surviving eligible dependents will be given the same opportunity to receive reimbursement for out of pocket health care expenses or to pay retiree contributions that you had as an Active Participant or Retiree. Alternatively, if you have no surviving eligible spouse or surviving eligible Dependents, your estate will be given the opportunity to receive reimbursement for out of pocket health care expenses that you incurred prior to your death, subject to the twelve (12) month limitation below. Once your surviving eligible spouse or surviving eligible dependents are no longer covered under the Plan, they may continue to use the money in your HRA to pay for eligible health care expenses until the money runs out.

You will receive a periodic statement that identifies the credits made to your HRA, as well as a summary of claims paid, and the net balance in your account that is available for future use. Any unused balanced in your HRA at the end of a calendar year will be carried over into the next year. The unused balance can be carried over year after year until it is used or forfeited. Your HRA has no cash value and cannot be cashed out at any time.

The Trustees may contract with a separate service provider to track and pay eligible claims from your HRA. In the event of such an arrangement, the Trustees and/or the service provider will provide detailed instructions relating to the applicable processes and procedures for reimbursement.

FORFEITURE AS A RESULT OF DISQUALIFYING EMPLOYMENT

Be advised that your full HRA balance will be immediately and irrevocably forfeited if: (i) you cease working in covered employment (i.e., you stop working for an employer that has an obligation to make contributions to the Plan on your behalf either directly or through a reciprocal agreement); and (ii) you resume working for an employer that has no obligation to contribute to this Plan on your behalf (either directly or through a reciprocal agreement).

Your HRA balance will not be forfeited if you retire from covered employment and are receiving a pension benefit from the Plan's related defined benefit pension fund. Notwithstanding this, your HRA balance will be forfeited if your pension benefit is suspended as a result of disqualifying employment, as set forth in the Pension Plan's governing plan documents.

ALLOWABLE HEALTH CARE EXPENSES

Generally, any Medical, Prescription Drug, Dental, Vision, and Hearing Aid expenses for which you are not reimbursed and which are allowable deductions on your income tax returns (*IRS Publication 502*) are allowable health care expenses for the HRA. Expenses must have been incurred during the period of time that you and/or your eligible Dependents are eligible for the HRA under the Plan. Medical expenses that are eligible for reimbursement include:

- Out-of-pocket expenses such as the Deductibles, Copayments and Coinsurances under the Plan;
- Out-of-pocket expenses such as the Deductibles, Copayments and Coinsurances under your Dependent's medical, prescription, dental or vision plan (other than the Plan);
- Expenses that are not Covered Benefits under the Plan or the eligible Dependent's plan;
- Expenses that are over the maximum covered amount for that service under the Plan or the eligible Dependent's plan;
- COBRA premium payments for up to 18 months; and
- Active or Retiree self-payment premiums through the Plan.

The Trustees or their delegate/designee will determine whether a request for distribution from the HRA is for a covered health care expense, based on the relevant facts and circumstances.

CLAIMS AND REIMBURSEMENT PROCEDURES

You can use your HRA to reimburse yourself for eligible health care expenses, including Active and Retiree self-payment premiums through the Plan.

Reimbursement of Eligible Health Care Expenses

As described above, you can use your HRA to reimburse yourself for eligible health care expenses as detailed in the preceding section.

Claim forms, along with detail filing instructions, are available from the Fund Office (and/or through the Trustees' designee, as applicable). The general rules for filing a claim for reimbursement of eligible health care expenses are as follows:

- Claims must be filed within twelve (12) months of the date the eligible health care expenses were incurred.
- You must request the reimbursement of eligible health care expenses that were incurred only on your own behalf or on the behalf of one of your eligible Dependents. These expenses have to have been incurred during the time you were eligible for the HRA benefit.
- You must have already received the products or services.
- You must include a receipt for every eligible health care expense. A cancelled check is not an acceptable form of receipt.
- You cannot have received – nor will you receive – payment or reimbursement of the expense from any other plan or party.
- You must certify that the information on the claim form is complete and accurate.
- As the HRA Participant, you are the only person authorized to file a claim form, so ***you*** must sign/submit the claim form. In the event of your death, the Dependent(s) to whom your HRA was assigned can sign the form.
- The Plan's Fund Office and/or designee may establish rules related to claims processing, HRA account suspension, and other reasonable rules that the Trustees deem necessary to administer and enforce these provisions. You will be advised of any such rules, as amended from time to time.

If the claim form is not properly completed or you do not provide the required documentation to substantiate the claim, for reimbursement, the Fund's HRA claims processor may issue a notice requesting the additional information. If the additional information is not received within the given time frame, the claim may be denied in full.

Once the properly completed claim form is received with all required documentation, the Fund's HRA claims processor (or the Fund Office, as applicable) will reimburse your claim as follows:

- If the balance in your HRA is greater than the claim, you will be reimbursed in full.
- If the balance in your HRA is less than the total requested reimbursement, you will be reimbursed up to the amount remaining in your HRA (or not at all, if the balance is zero).

Any claim for reimbursement that is denied in whole or in part due to a lack of sufficient funds in the HRA must be refiled if you want to receive reimbursement in the future. Claims will ***not*** be automatically reprocessed.

Authorizing Payment of Premiums

As described before, you can use your HRA to receive reimbursement for Active and Retiree self-payment premiums through the Plan. Your entitlement to HRA reimbursement is limited to the total HRA balance that is credited to you by the Plan.

The general rules for filing a reimbursement claim for self-payment premiums are as follows:

- Please contact the Fund Office for details on what you need to submit for proof of payment.
- You must certify that the information on the claim form is complete and accurate.
- As the Retiree, you are the only person authorized to file a claim form, so ***you*** must sign/submit the claim form. In the event of your death, the Dependents to whom your HRA was assigned can sign the form.

Once the properly completed claim form is received with all required documentation, the Fund's HRA claims processor will reimburse your self-payment premium claim as follows:

- If the balance in your HRA is greater than the claim, you will be reimbursed in full.
- If the balance in your HRA is less than the total requested reimbursement, you will be reimbursed up to the amount remaining in your HRA (or not at all, if the balance is zero).

RUN-OUT OF HRA CLAIMS

Run-Out of HRA claims works as follows:

Active Termination Run-out.

Once you lose your eligibility and are no longer covered under the Plan, you may generally continue to use the money in your HRA to pay for eligible health care expenses

until the money runs out, whichever comes first, subject to the forfeiture provisions above.

Eligible Retiree Run-out.

In the event you become eligible for coverage under the Retiree Plan, you will continue to have access to any remaining HRA balance that existed at the time of your retirement.

Transfer Upon Death Run-out.

In the event of your death, your surviving eligible spouse (or if none, then your surviving eligible Dependents) will be given the opportunity to use your unused HRA balance to receive reimbursement for eligible out-of-pocket health care expenses or to make self-payments. Once your surviving eligible spouse or surviving eligible Dependents are no longer covered under the Plan, they may generally continue to use any unused portion of your HRA balance to pay for eligible health care expenses until the HRA balance is exhausted.

Alternatively, if you have no surviving eligible spouse or surviving eligible Dependents, your estate will be given the opportunity to receive reimbursement for your out-of-pocket health care expenses that you incurred prior to your death, subject to the twelve (12) month limitation below. (Example: You incur a claim on March 1, 2018. In the event of *your* death (meaning you, the Active Member or Retiree), your estate would have until February 28, 2019 to file an HRA claim).

However, in all cases, reimbursement is only available if you or they were otherwise eligible during the period the expenses were incurred and they timely file for reimbursement within twelve (12) months of the date the eligible health care expenses were incurred.

OTHER PROVISIONS RELATING TO THE HRA

Reimbursements are Limited to the Amounts Credited to Your HRA

Your entitlement to HRA reimbursement is limited to the amount that has been credited to your HRA account. You have no right to make a reimbursement claim based on amounts credited to anyone else's HRA account.

Forfeiture of Accounts

Any amount in an HRA Account that is forfeited will be used to pay administrative expenses of the Plan.

Claims Denied

If your claim for HRA reimbursement is denied, you will be notified of the Plan's claims and appeals procedures.

Conflicting Claimants

The Trustees have the sole and absolute discretion to resolve disputes over reimbursement filed by multiple claimants in the event of an eligible person's death.

Inability to Locate Payee

If the Trustees (or their designee) are unable to make payment to any Participant or other person to whom a HRA payment is due because they cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of a HRA Participant, or the allocation made to the account of any HRA Participant, or the amount of benefits paid or to be paid to a HRA Participant or other person, the Trustees (or their designee) shall, to the extent that they deem it administratively possible and otherwise permissible under Section 105 of the Internal Revenue Code105, the regulations issued thereunder, or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as they will in their judgment accord to such HRA Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan.

HOSPITAL, MEDICAL AND SURGICAL BENEFITS FOR ELIGIBLE PARTICIPANTS AND DEPENDENTS

(Excludes Retired Participants, Dependents and Surviving Spouses Eligible For Medicare)

If a Covered Person incurs expenses as a result of non-occupational sickness or injury, the Plumbers & Pipefitters Local 219 Health & Welfare Fund will provide the benefits described below, subject to the applicable maximums, coinsurance, co-payments and deductibles, as set forth in the Plan's Schedule of Benefits, and in accordance with the Plan's Usual, Customary and Reasonable allowances.

INPATIENT HOSPITAL EXPENSE BENEFITS:

Deductible Amount – The Deductible will be applied only once during a calendar year to each individual's Covered Expenses. Any expenses incurred by an individual in October, November or December, which are used to satisfy that individual's Deductible (in full or in part) will also be used to reduce that individual's Deductible for the following calendar year by the same amount.

If any two or more family members are injured in the same accident, the Deductible will apply only once and there will be a separate maximum amount payable for each individual. When two or more family members incur Covered Expenses during the same calendar year and the total expenses used towards satisfying their individual Deductible amounts exceed the Family Deductible Amount, no further Deductible amounts are required for the remainder of the calendar year for that family.

Deductible amounts applied under other coverage will also be applied towards the Deductible amount required by this Plan.

Co-payment Amounts

If you or your family members incur Covered Expenses after the effective date of your coverage under this Plan, payment will be made based on the Preferred Network provisions, as set forth in the Plan's Schedule of Benefits, after the Deductible amount has been met.

Coinsurance

This amount represents the percentage you are responsible to pay for Covered Services after you have met your Deductible. The Coinsurance Limit is a specified dollar amount of Coinsurance expense incurred in a Benefit Period by a Covered Person for Covered Services.

Hospital Room & Board

Benefits will be payable up to the semi-private room rate during any one period of confinement. Benefits will be provided for special care units for critically ill persons.

Hospital Miscellaneous Benefits

Benefits will be payable during any one period of confinement for the cost of miscellaneous items needed for inpatient treatment or evaluation when ordered by a physician and necessary for diagnosis or treatment. These items include operating, recovery, delivery and other treatment rooms; diagnostic tests, such as x-rays, scans, laboratory tests, electrocardiograms and electroencephalograms; bandages, dressings, oxygen, anesthesia and drugs; radiation therapy; and physical therapy. Hospital miscellaneous benefits will also be provided for a newborn baby's nursery charge during the time the mother is confined.

Gender Dysphoria Treatment

Gender dysphoria is generally defined as the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. Medical treatment includes feminization (male-to-female or MtF) or masculinization (female-to-male or FtM) of the body through hormone therapy and/or surgery, and psychotherapy including counseling and support. Gender reassignment surgery (transsexual surgery or sex reassignment surgery) refers to surgical procedures for the treatment of gender dysphoria. Surgery may include several staged procedures.

The Fund has generally suspended coverage for benefits associated with Gender Dysphoria (i.e. transgender services). If you are seeking benefits for gender dysphoria treatment, please contact the Fund Office for further details about the benefits available under through the Fund.

Medical Expense Benefits (In-hospital)

Medical expense benefits, while confined, shall be paid for physicians' charges for medical treatment during the period of hospital confinement.

Surgical Benefits

Benefits will be payable for surgery performed by a legally qualified Physician or Surgeon. Surgical benefits will be paid regardless of where the procedure is performed in a hospital, physician's office or approved ambulatory surgical facility. Outpatient surgery performed in the outpatient department of a hospital, or at an approved ambulatory surgical facility, will be payable at a higher benefit, as indicated in the Schedule of Benefits.

Your surgical benefits include the following dental procedures: (a) excision of tumors (epulides) of the jaw; (b) excision of unerupted, impacted teeth, including removal of alveolar bone and sectioning of the tooth; (c) removal of residual root (only when performed by a dentist other than the dentist who extracted the tooth); (d) drainage of acute alveolar abscesses; (e) alveolectomy; and (f) gingivectomy (for gingivitis or periodontitis).

Voluntary sterilization procedures will be payable in accordance with the Plan's established surgical rates. Expenses relating to a reverse sterilization procedure will not be considered eligible for payment under the Plan.

Voluntary abortions for female Participants or spouses of male Participants will be considered as an Eligible Expense under the Plan only in the event it is medically necessary as a life-sustaining measure on behalf of the mother, or if it is a result of a criminal act, as verified by a legally qualified physician.

Women's Health and Cancer Rights Act of 1998:

The Plan's Schedule of Benefits shall include benefits for: (a) reconstruction of the breast on which a mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and treatment for physical complications of all stages of mastectomies, including lymphedemas.

Anesthesia Benefits

When surgery is performed and payable in accordance with the Schedule of Benefits, either as an outpatient or while confined, the charge is payable based on the Schedule of Benefits.

Pre-admission Testing/Same-day Surgery

If the physician orders pre-admission testing in a hospital or same-day surgery performed in an operating room and such services are in lieu of being provided on an inpatient basis, the Plan will provide for payment of these services.

Second Surgical Opinion

The Plan does not require that you receive a second surgical opinion. However, if you or your dependents request one, it will be considered an allowable expense under the Plan's Schedule of Benefits.

Maternity Benefits

Maternity benefits will be payable as any other illness for female Participants and legal spouses of male Participants only.

Mothers' and Newborns' Health Protection Act:

Benefits for female Participants or spouses of male Participants for any hospital confinement in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. It is permissible for a mother and her newborn to be voluntarily discharged before the 48-hour or 96-hour minimum has elapsed with the physician's consent.

No benefits will be provided for surrogate pregnancies.

Nervous/Mental Disorders Benefits

Inpatient and outpatient expenses for the treatment of nervous and mental disorders will be payable in accordance with the Plan's Schedule of Benefits.

Chemical, Alcohol & Drug Abuse Benefits

Benefits provided by the Plan relating to treatment of chemical, alcohol and drug abuse, on an inpatient or out-patient basis, are payable in accordance with the Plan's Schedule of Benefits.

Outpatient Diagnostic X-ray and Laboratory Benefits

Benefits for outpatient diagnostic and laboratory services and outpatient radiation therapy services prescribed by a Physician or Surgeon will be covered up to the amount indicated in the Schedule of Benefits. No benefits will be payable under this provision for expenses relating to hearing and speech tests, eye refractions or dental-related services.

Emergency Hospital Benefits

The Plan will provide benefits for outpatient emergency hospital treatment rendered within 48 hours after and as a result of accidental bodily injury. In addition, Emergency Hospital Treatment will be payable when emergency hospital treatment is received for reasons due to a medical emergency, the symptoms of which occur suddenly and unexpectedly, requiring the immediate care of a physician.

Payment will be made for treatment at a state-accredited medical center or emergency treatment center in lieu of treatment in the hospital's emergency room.

Organ Transplant Benefits

The Fund will cover all expenses related to the transplantation of an organ, including patient screening, organ procurement and transportation, surgery for the patient and a live legally obtained human donor, follow-up care in the home or a hospital and immunosuppressant drugs, during a transplant benefit period if the following conditions are met:

A. The transplantation is not considered experimental or investigational by the American Medical Association; and

B. The patient is admitted to a transplant center program in a major medical center approved either by the federal government or the appropriate state agency of the state in which the center is located.

A transplant benefit period is a period of time which begins five (5) days before the date the first covered transplant is received and ends twelve (12) months later. A new transplant benefit period starts only if the next covered transplant occurs more than twelve (12) months after the last covered transplant was performed.

Obtaining Donor Organs:

The following services will be covered when they are necessary in order to acquire a legally obtained human organ:

A. evaluation of the organ;

B. removal of the organ from the donor; and

C. transportation of the organ to the transplant center.

Donor Benefits:

Benefits necessary for obtaining an organ from a living donor or cadaver are provided. Organ donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions, but only to the extent the donor is not covered by the donor's own insurance or health care plan. If donor coverage exists, this Plan will be considered as the secondary payer.

Genetic Testing

The Plan will provide benefits for certain medically necessary genetic tests, provided that preauthorization is obtained. To meet medical necessity standards for a genetic test, a person must:

a. Submit to genetic counseling;
b. Display clinical features OR have a strong family history for a specific genetically linked disorder; and
c. The result must directly impact treatment.

Any Covered Person seeking to obtain preauthorization for a genetic test should contact the Fund Office.

Annual Physical Examinations – Eligible Participants and Spouses Only

One annual physical examination, including related office visits and other accompanying expenses, is provided under the Plan's Schedule of Benefits, after your deductible is satisfied.

Influenza and pneumonia vaccines are payable under the Plan's Schedule of Benefits.

Treatment of Neuromusculoskeletal Conditions - Chiropractic Benefits

The following conditions and limitations are included under the Plan for treatment for neuromusculoskeletal conditions:

The Plan will consider eligible charges incurred only for active therapeutic treatment for an acute or chronic condition which is directed towards the correction of the condition within an anticipated reasonable and predictable period of time.

Diagnostic tests and/or therapeutic treatments must be considered to be scientifically valid and clinically accepted in accordance with established medical review mechanisms and standards.

Treatments using manipulation or adjustment which are performed by hand only shall be considered as an Eligible Expense under the Plan.

X-ray expenses will be considered for payment under the Plan providing they are considered to be medically necessary. Full spine x-rays will not be considered for payment under the Plan.

Manipulation, mobilization, adjustment, massage and/or physical therapy charges which are incurred by a Dependent child who is under the age of ten will not be considered for payment.

Treatment will be limited to a maximum number of twelve (12) visits per calendar year.

No coverage will be provided for the following:

Experimental drugs and medicines which are not commercially available and approved for general use by the United States Food & Drug Administration as effective for the treatment or diagnosis of the injury or illness.

Services and procedures which are not considered effective for the treatment or diagnosis of the injury or illness at the time they are performed or provided.

Home Health Care Benefits

Home health care benefits are provided to an Eligible Person for non-occupational injury or non-occupational disease following a period of hospital confinement. Home health care benefits are payable when each of the following qualifications is met:

Certification is received from a physician or surgeon that continued hospitalization would have been required if the home health care was not provided;

Home health care commences within seven days following discharge from a covered hospital and where such confinement was also covered under the Plan;

Home Health care is provided by a state-licensed or certified Home Health Agency and shall include the following services: (a) part-time or intermittent nursing care of a registered nurse

or a licensed practical nurse, other than a member of the Eligible Person's family; (b) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature; (c) physical, occupational or speech therapy services; and (d) medical supplies, drugs, medicines and laboratory services prescribed by a licensed physician to the extent that such charges would have been covered under the Plan had the Eligible Person received those same services while confined to a hospital.

Skilled Nursing Facility Benefits

Following a hospital stay of at least three days, your coverage includes inpatient and medical care services in a Medicare-approved Skilled Nursing Facility. Admission to a Medicare-approved Skilled Nursing Facility must occur within 30 days of the prior hospital stay and must be for Medicare-approved treatment of the same injury or illness (other than mental illness, alcoholism or drug addiction). No benefits are payable once a patient can no longer improve from the treatment for the current condition, nor are benefits payable for custodial care at any time. Benefits are payable for up to 100 days during a benefit period.

Hospice Care Benefits

Hospice care expenses will be payable if it is certified by a physician that the individual has a life expectancy of six months or less. The individual must submit a statement electing Hospice care in lieu of all other Plan benefits. However, expenses for any illness or injury which is not related to the terminal illness will be considered under the Plan's regular schedule of benefits.

A plan of care must be developed and submitted for approval by the individual's physician and the provider of the Hospice care services. All covered services must be provided by a licensed Hospice organization or a Hospice program sponsored by a hospital or home health care agency.

The Plan will pay for the following services, up to the amount of the allowance permitted for Hospice care:

A. Confinement room charges, up to 150% of the average semi-private daily room rate in the area;

B. Professional services of a registered or licensed practical nurse;

C. Treatment by physical means, occupational therapy and speech therapy;

D. Medical and surgical supplies;

E. Oxygen and its administration;

F. Medical social services, such as counseling of patient;

G. Acute inpatient Hospice care;

H. Respite care;

I. Dietary guidance;

J. Durable medical equipment; and

K. Home health aide visits;

Bereavement counseling for family members, limited to two visits (Family members shall include spouse, parents and children.)

Exclusions under this benefit include, but are not limited to: spiritual counseling; homemaker services; food or home-delivered meals; chemotherapy or radiation therapy, if other than to relieve symptoms of a condition; and custodial care, rest care or care which is only for another individual's convenience.

Physical Therapy Benefit

Physical therapy benefits are payable as specified in the Plan's Schedule of Benefits.

Clinical Trial Benefits

Pursuant to 42 U.S.C. § 300gg–8, the Plan will not deny an Eligible Participant the opportunity to participate in an FDA approved clinical trial for cancer or a life-threatening disease or condition, to the extent that it will not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, to the extent that such costs are not covered by the trial sponsor.

Other Covered Services:

A. Charges of a physician or clinical psychologist for professional services;

B. Physicians' office visits;

C. Routine pap/mammogram exams, prostatic specific antigen (PSA) exams, including corresponding office visit and other accompanying expenses;

D. Drugs and medicines requiring a physician's prescription;

E. Pre-natal vitamins;

F. Blood transfusions and cost of blood not donated or replaced;

G. Oxygen and other gases and their administration;

H. Crutches, braces and artificial limbs; prosthetic appliances;

I. Colostomy and ileostomy bags;

J. Private duty nursing services by a registered nurse or a licensed practical nurse;

K. Rental, up to the purchase price, of durable medical equipment;

L. Well-child examinations and related expenses for dependent children, up to age 26;

M. Influenza and pneumonia immunizations;

N. Vitamin B-12 shots, if necessary for treatment of an illness;

O. Oral contraceptives;

P. Contraceptive patches;

Q. Intrauterine devices;

R. Charges relating to impotency, if relating to medical diagnosis;

S. Allergy testing and injections; and

T. Ambulance services by a licensed professional ambulance service;

PLAN EXCLUSIONS/LIMITATIONS

In addition to exclusions and limitations which are noted in other sections of this Plan, no benefits will be provided under the Plan for the following expenses:

A. Hospitalization, medical or surgical treatment and/or supplies provided by the United States Government or any instrumentality therefore; except as required by law;

B. Any loss caused by war or act of war, whether or not declared;

C. Any loss incurred while engaged in services with the military, naval or air forces;

D. Any loss incurred in the commission of a felony;

E. Any services for which Workers' Compensation benefits are available;

F. Services which are rendered by the Eligible Person's immediate family members;

G. Services or supplies for which you have no legal obligation to pay;

H. Charges for telephone consultations, missed appointments or fees charged for the completion of a claim form;

I. Personal services and supplies (including telephone rentals, convenience items, etc.);

J. Custodial care, such as sitters, homemaker services or care in a place which serves you primarily as a residence when you do not require skilled nursing care;

K. Cosmetic surgery, including breast augmentation and face-lifting, except for the repair of accidental injuries sustained while covered under this Plan or for the reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses required due to such mastectomy, including lymphedemas;

L. Charges incurred where limited under the Office & Salaried Program;

M. Non-prescription items, including vitamins, nutritional supplements and other non-prescription items, except where specifically included herein;

N. Travel, whether or not recommended by a physician, except for local ambulance service;

O. Routine foot care;

P. Pregnancy-related charges for a Dependent child;

Q. Abortions which are not medically necessary as a life-sustaining measure for the mother, or which are not the result of a criminal act;

R. Reverse sterilization;

S. Charges relating to infertility studies or charges relating to restoration or enhancement of fertility or the ability to conceive by artificial means, including but not limited to in-vitro fertilization or embryo transfer;

T. Charges relating to the treatment of infertility (except for initial diagnostic evaluation);

U. For Gender Dysphoria Treatment, except as specified;

V. Treatment of obesity, including any care that is primarily for dieting or exercise for weight loss. However, certain necessary medical and surgical care required for the treatment of morbid obesity may be covered. Contact the Fund Office for further details on coverage;

W. Marital counseling;

X. Hospitalization for environmental change;

Y. Services or supplies primarily for educational, vocational or training purposes;

Z. Orthopedic shoes, corrective shoes, arch supports;

AA. Temporomandibular joint dysfunction (TMJ), except if specifically provided;

BB. Massotherapy;

CC. Charges for air conditioners, purifiers, humidifiers, dehumidifiers, heating pads;

DD. Hearing aids, including fittings and examinations;

EE. Services not recommended or prescribed by a physician or other provider while acting within the scope of their license;

FF. Speech therapy, except for purposes of rehabilitative treatment, prescribed by a physician;

GG. Acupuncture;

HH. Charges which are in excess of Usual, Customary and Reasonable (UCR) fees (participants will be responsible for such excess charges);

II. Charges which exceed the annual benefit provisions established under the Plan;

JJ. Charges incurred after the termination date of coverage under the Plan.

COORDINATION OF BENEFITS PROVISIONS

This Plan contains a provision coordinating it with other plans under which an Eligible Participant or Dependent is covered so that total available benefits will not exceed 100% of the allowable expense for services. The Coordination of Benefits (COB) may limit benefits when an Eligible Participant or Dependent is covered for benefits under more than one plan. The benefits payable under this Plan may be reduced in accordance with the following rules in order that an Eligible Person will not receive payment for more than 100% of Covered Charges from all plans.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan (be it this Plan or some other plan) may reduce the benefits that it pays so that payments from all plans to not exceed 100% of the total allowable expense.

Definition - The term *"plan"* shall be considered separately for each plan and also between that part of any plan which applies to anti-duplication provisions and that part which does not.

Allowable Expenses – "Allowable Expenses" are any necessary, reasonable and customary expenses at least a portion of which are covered by one of the plans covering the Eligible Participant or Dependent for whom a claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered both an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Eligible Participant or Dependent is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

A. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

B. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

C. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

D. If a person is covered by one (1) plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or a payment shall be the allowable expense used by the secondary plan to determine the benefits.

E. The amount of any benefit reduction by the primary plan because an Eligible Participant or Dependent has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

The following is a list of *plans* with which this Fund coordinates its benefits or services for medical or dental care or treatment. The following is a non-exclusive list of *plans* that the Plan coordinates with:

A. Group, nongroup, blanket, or franchise insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insurance or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (uninsured/underinsured, no-fault, medical payment and similar policies or coverage); group practices and other group pre-payment coverage; and Medicare (inclusive of Parts A and/or B) or any other federal governmental plan, as permitted by law (as set forth more fully below);

B. Group Blue Shield and other pre-payment coverage provided on a group basis;

C. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group;

D. School sponsored insurance and casualty and liability insurance;

E. Any other plan which has a Coordination of Benefits (COB) provision within that plan;

F. Any other plan which provides coverage arising out of any claim or cause of action which might accrue because of the alleged negligent conduct of a third party;

Any governmental plan or program created by federal or state statute or regulations for the purpose of providing some or all of the benefits as set forth in this Plan, including but not limited to Medicare, whether enrolled in or applied for;

G. Individual no-fault auto insurance, by whatever name called.

Effect on benefits: Primary v. Secondary Plans

The order of benefit determination rules determines whether this Plan is a primary plan or a secondary plan with the person has health insurance coverage under more than one (1) plan. When a claim is made, the primary plan plays its benefits without regard to any other plan. Vehicle insurance coverage including, uninsured/underinsured, medical payment coverage, no-fault, and similar policies or coverage as well as casualty and liability insurance coverage are always primary. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expense. No plan pays more than it would without the coordinating provision.

Order of Benefit Determination

When an Eligible Participant or Dependent is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

Any plan that does not have Coordination of Benefits provisions is always the primary plan and always pays first.

If all plans have a Coordination of Benefits provision then the order of benefits shall be determined as follows (*Please note that special rules, as set forth below, may apply in cases where the Eligible Person or Dependent is a Medicare beneficiary):

A. The Plan that covers the Eligible Person as a Dependent (as opposed to direct coverage as an employee, member, policyholder, subscriber, or retiree) will be considered the secondary plan and pay after any other plan.

B. If an Eligible Participant is covered as an Eligible Participant (direct coverage as an employee, member, policyholder, subscriber, or retiree) under another plan, this Plan will pay initially one-half of the allowable expense. After the other plan has paid a share equal to this Plan's initial payment, this Plan shall then pay remaining allowable expenses, if any.

C. If a Dependent of an Eligible Participant is covered as an Eligible Participant (directly covered as an employee, member, policyholder, subscriber, or retiree) under another plan, this Plan will not pay any benefits towards the Dependent's claim until that person's benefits under the other plan are exhausted. Then, if there are additional expenses payable towards that claim, this Plan will pay any remaining allowable expenses, if any. If the Dependent, as a Participant in the other plan, fails to comply with the requirements of the other plan, or fails to utilize a Health Maintenance Organization (HMO) that has been selected by that person under the other plan that would have been the primary payer, this Plan will not pay any portion of the allowable expenses incurred by that person.

D. For Dependent Children

1. If a Dependent Child is covered under both parents' plans, the plan covering the parent whose birthday, excluding the year of birth, occurs earlier in the calendar year shall be the primary plan, and the plan covering the parent whose birthday is later in the calendar year shall be the secondary plan. (The word "*birthday"* refers to only the month and day in a calendar year, not the year in which the person was born).

2. If both parents have the same birthday, plan covering the parent longest will be primary and the plan covering the parent for the shorter period of time will be secondary.

3. If the other plan does not have the "*Birthday Rule"* described above, but instead has a rule based on the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based on the birthday of the parent will determine the order of benefits.

4. If a claim is made for a Dependent Child whose parents are separated or divorced, the following order of benefit determination will apply:

- when the Dependent Child's parents are separated or divorced and the custodial parent has not remarried, the benefits of a plan that covers the Dependent Child as the custodial parent's dependent will be primary over the benefits of a plan that covers the Dependent Child as a dependent of the non-custodial parent;

- when the Dependent Child's parents are separated or divorced and the custodial parent has remarried, the plan that covers the Dependent Child as a dependent of the custodial parent will be primary over a plan that covers the Dependent Child as a dependent of the step-parent, and a plan that covers the Dependent Child as a dependent of the step-parent will be primary over a plan that covers the Dependent Child of the non-custodial parent.

- if there is a court decree that establishes financial responsibility for the health care, vision care, and dental care expenses with respect to the Dependent Child, the plan that covers the child as a Dependent of the parent with such financial responsibility will be considered primary over any other plan and in accordance with any Qualified Medical Child Support Order (QMCSO).

E. Plans that provide benefits for a Retired Participant will pay as the secondary plan.

Coordination With Governmental Programs And Programs Required By Statute

Benefits payable under this Plan for allowable expenses incurred during a claims determination period will be paid from the Plan, subject to the following limitations and in accordance with federal and state mandates:

Medicare: This Plan will pay its benefits *before* Medicare ONLY for:

A. An actively employed Eligible Participant who is age sixty-five (65) or older;

B. A disabled Eligible Participant who is under age sixty-five (65) and who has a relationship with an employer indicative of an employee status, or the actively employed Eligible Participant's disabled Spouse or Dependent who is under age sixty-five (65) and who is eligible for benefits under Medicare; and

C. The first thirty (30) months of treatment for end-stage renal disease received by any covered person;

When the rules above do not apply, the Plan will pay its benefits only *after* Medicare has paid its benefits.

IMPORTANT: Medicare benefits will be taken into account for any individual while he is eligible for Medicare (inclusive of Medicare Parts A and/or B) whether or not he is enrolled in Medicare.

Other Governmental Programs. For all other Eligible Participants, Eligible Retired Participants or Eligible Dependents who are eligible for benefits under a governmental program or eligible for benefits as a result of any state or federal statute or regulation (other than Medicare), this Plan will pay its benefits in accordance with the requirements of any relevant regulatory requirements.

Liability of the Fund

In the event benefits are reduced as provided above, each benefit otherwise payable shall be reduced proportionately, and only the reduced amount shall be charged against any applicable benefit limit under this Plan. If benefits have been paid under any other plan that should have been reduced in accordance with an anti-duplication provision, this Plan may pay at its option, to such other plan to the extent required to offset the deduction required by the existence of this Plan. Such payment shall reduce the liability of this Plan to the extent of such payment. If payment has been made by this Plan in excess of that permitted by this provision, this Plan shall have the right to recover such excess from any party acquiring same.

Right to Receive

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. This Plan and or its service providers may get the facts needed from other organizations or persons (or give such facts to other organizations or persons) for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the persons claiming benefits. This Plan and its service providers need not tell, or to get consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan and/or its service providers any facts needed to apply these COB rules and determine benefits payable.

Facility of Payment

Whenever payments, which should have been made under this Plan in accordance with this provision, have been made under any other plan, this Plan will have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments, any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid will be determined to be benefits paid under this Plan and to the extent of such payment for covered services, this Plan will be fully discharged from liability.

Right of Recovery

If this Plan pays for more covered services than this provision requires, this Plan has the right to recover the excess from anyone to or for whom the payment was made, or from any other person or organization that may have been responsible for the benefits or services provided for

the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of the payments made. You agree to do whatever necessary to secure this Plan's right to recover excess payment.

RIGHT OF SUBROGATION AND RECOVERY

The Fund's right of subrogation and recovery arises and will be exercised when any benefits, including short-term disability, hospital, surgical and/or medical benefits, are paid to or on behalf of a Participant Retiree or Dependent (hereinafter referred to as the "Covered Person") due to a loss, injury or illness for which another person or entity is our may be legally responsible. This would include but not be limited to a loss, injury or illness compensable under the workers' compensation system, and/or due to medical malpractice, negligence, tortious and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's advancement of benefits in this context, the Covered Person agrees to the terms set forth herein.

The Fund shall be fully reimbursed when recovery occurs or is available from any source, including but not limited to the person or entity that is or may be responsible for such loss, injury or illness, the insurer of such person or entity, the Covered Person's insurer including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance the workers' compensation system, or any other source (each of the aforementioned hereinafter collectively referred to as "Responsible Person(s)"). Such recovery includes but is not limited to court judgments, administrative or agency orders, private settlements, any and all monies however characterized, or any other payments. No settlement shall be made or release given for claims arising out of the Covered Person's loss, injury or illness without prior written consent of the Fund. In consideration for the Fund's advancement of benefits in this context, the Responsible Person(s) agrees to the terms set forth herein.

In connection with the above paragraphs, the Fund shall be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Fund. The Fund shall receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the Covered Person, payment of attorneys' fees and/or expenses. The Fund's right to full reimbursement shall not be subject to reduction for reasons including but not limited to the Covered Person's failure to recover the perceived full or actual value of his or her claim for whatever reason, attorneys' fees, expenses or other costs, and/or the Fund's failure to actively participate in the claim and/or recovery. Further, the Fund expressly rejects, disclaims and otherwise prohibits application of the "make-whole" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights. Additionally, the Fund expressly rejects, disclaims and otherwise prohibits application of the "common fund" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights.

The Covered Person shall complete all paperwork deemed necessary by the Fund to protect its subrogation interests, including the signing of the Fund's subrogation and reimbursement agreement; failure to do so entitles the Fund to deny coverage for the subject loss, injury or illness. The Covered Person will do nothing to impair or negate the Fund's right of subrogation

and will fully cooperate with the Fund. If the Covered Person performs any act or fails to act, or otherwise compromises the Fund's rights, the Fund may immediately seek recovery of all benefit amounts paid by any available means, including legal action. The Fund shall also have the right to offset any future benefit payments that would otherwise be payable to or on behalf of the Covered Person, to the extent of its lien. These offset benefits shall be permanently forfeited by the Covered Person and the Covered Person shall be legally responsible for any unpaid amounts.

The Covered Person assigns to the Fund any and all claims, demands and contractual rights the Covered Person has or may have against Responsible Person(s) arising from or related in any way to the Covered Person's loss, injury or illness, and agrees that the Fund is substituted in the place of the Covered Person against such Responsible Person(s) to the extent of the amount paid by the Fund as a result of such loss, injury or illness. This entitles the Fund to make claim or file suit in the name of the Covered Person. The Covered Person agrees that the Fund shall hold a lien against any amounts the Covered Person receives, will receive or has available from any source as a result of the loss, injury or illness to the extent of benefits paid by the Fund. The Covered Person agrees that the Fund may at any time notify or otherwise communicate with the Responsible Person(s) and the Covered Person's attorney and release information relative to the loss, injury or illness. The Covered Person agrees to promptly make claims against the Responsible Person(s), and, if necessary, to commence and prosecute a lawsuit against such Responsible Person(s) with all due diligence. Any recipient of settlement proceeds or assets collected from judgments are subject to the imposition of a constructive trust.

CONSTRUCTIVE TRUST

A Covered Person or his attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision and otherwise make restitution to the Plan. A Participant or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has received restitution.

RECOUPMENT

If the Plan should provide any form of benefit under the Plan to you and/or your dependent(s) and, for whatever reason, such benefit was not required under the terms of the Plan or otherwise mistakenly paid, the Plan shall have the right to offset future benefits to the extent of the overpayment. This provision does not limit the Plan's right to recover such amount by any other lawful means.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order made pursuant to a state domestic relations law (including community property law) that relates to the provision of support for a child of a Participant (Alternate Recipient) and which:

A. Creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under this Plan; and

B. Specifies (a) the name and last known mailing address (if any) of the Participant and each Alternate Recipient covered by the Order, and (b) a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

C. Does not require the Plan to:

1. Provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support, as described in Section 1908 of the Social Security Act.

2. Upon receipt of any judgment, decree or order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to an Alternate Recipient pursuant to a state domestic relations law, the Trustees shall promptly notify the affected Participant and any Alternate Recipient of the receipt of such judgment, decree or order and shall notify the affected Participant and Alternate Recipient of the Trustees' procedures for determining whether or not the judgment, decree or order is a Qualified Medical Child Support Order (QMCSO).

   The Trustees shall establish procedures to determine the status of judgment, decree or order as a QMCSO and to administer Plan benefits in accordance with Qualified Medical Child Support Orders. Such procedures shall be in writing, shall include a provision specifying the notification requirements enumerated in the preceding paragraph, shall permit an Alternate Recipient to designate a representative for receipt of communications from the Trustees and shall include such other provisions as the Trustees shall determine, including provisions required under regulations promulgated by the Secretary of the Treasury. A Participant or Alternate Recipient, and/or representatives of either or both parties may obtain a copy of the QMCSO procedures established by the Trustees, upon written request made to the Fund Office. A Participant or Alternate Recipient may sue the Fund with respect to the enforcement of a QMCSO.

STATEMENT OF YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5000 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5000 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ERISA requires that certain information be furnished to each participant in an Employee Benefit Plan. This book is the Plan document and Summary Plan Description for purposes of ERISA.

ADDITIONAL INFORMATION REQUIRED BY ERISA

1. ***Name of Plan:***

   Plumbers & Pipefitters Local 219 Health & Welfare Plan

2. ***Plan Established and Maintained by:***

Board of Trustees
Plumbers & Pipefitters Local 219 Health & Welfare Fund
c/o Timothy Myers, Administrator
33 Fitch Boulevard
Austintown, Ohio 44515
(330) 779-8859
(330) 270-3582 (facsimile)

3. ***Participating Employers:***

Upon written request to the Fund Office, you may receive information as to whether a particular employer is a sponsor of the Plan. If he is, the Fund Office will furnish his address.

4. ***Employer Identification Number (EIN):***

34-1374275

5. ***Plan Number:*** 501

6. ***Type of Plan:***

This Plan is maintained for the purpose of providing dismemberment, disability, hospitalization, surgical, medical, dental, vision and other related benefits.

7. ***Type of Administration of the Welfare Plan:***

Although this plan technically is administered and maintained by the joint Board of Trustees of the Plumbers & Pipefitters Local 219 Health & Welfare Fund, the Trustees have delegated certain claims administration functions to a professional benefits administrator: Timothy Myers, Administrator, BeneSys, Inc. Address all communications with the Board of Trustees to:

Board of Trustees
Plumbers & Pipefitters Local 219 Health & Welfare Fund
c/o Timothy Myers, Administrator
33 Fitch Boulevard
Austintown, Ohio 44515
(330) 779-8859
(330) 270-3582 (facsimile)

Hospital, surgical, medical, dental, vision, life, accidental dismemberment and weekly accident and sickness benefits are self-funded and administered by the Plumbers & Pipefitters Local 219 Health & Welfare Fund, through Timothy Myers, Administrator, BeneSys, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

Prescription drug benefits are provided through Caremark, Inc., 2211 Sanders Road, Northbrook, Illinois 60062.

The Hospital (facility), Medical and Surgical benefits are self-insured through a provider network operated by Anthem. The provider lists are furnished automatically, without charge, as a separate document.

As of the publication of this Summary Plan Description, Stop Loss coverage is insured through Ullico Insurance Service Company, 1625 Eye Street, NW, Washington, D.C. 20006.

8. ***Agent for Service of Legal Process:***

The Board of Trustees serves as the agent for service of legal process. Service of legal process may also be made upon any individual Trustee.

9. ***Name, Title and Address of Principal Place of Business of each Trustee:***

MANAGEMENT

Aaron R. Hall
MCA of Akron
2181 Akron Peninsula Rd.
Akron, OH 44313

Joseph Stella
MCA of Akron
2181 Akron Peninsula Rd.
Akron, OH 44313

Tony Cline
594 Hudson Run Rd.
Barberton, OH 44203

UNION

Timothy R. Stem
Plumbers & Pipefitters Local Union No. 219
1655 Brittain Rd.
Akron, Ohio 44310

Brett Bozak
Plumbers & Pipefitters Local Union No. 219
1655 Brittain Rd.
Akron, Ohio 44310

Dan Hatcher
Plumbers & Pipefitters Local Union No. 219
1655 Brittain Rd.
Akron, Ohio 44310

10. ***Collective Bargaining Agreements:***

This plan is maintained pursuant to a collective bargaining agreement between Plumbers & Pipefitters Local Union No. 219 and the various participating employers. You may obtain a copy of the collective bargaining agreements by writing to the Plan Administrator, or you may examine it at the Fund Office.

11. ***Sources of Contributions:***

The Plan is funded through contributions by the employers on behalf of their employees under the terms of a collective bargaining agreement, and by investment income earned on a portion of the Fund's assets.

The Plan is subject to periodic actuarial review to assure the relationship between income and benefit costs meets the funding standards.

12. ***Funding Medium for the Accumulation of Plan Assets:***

Assets are accumulated and benefits are provided by the Trust Fund. Some Plan assets are invested.

13. ***Date of the Plan's Fiscal Year End:*** December 31.

14. ***Maternity Or Newborn Infant Coverage:***

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

15. ***Women's Health and Cancer Rights Act:***

This Plan, when providing medical and surgical benefits with respect to a mastectomy will provide, in the case of a Participant or Eligible Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, and coverage for prostheses and physical complications at all stages of the mastectomy, including lymphedemas. Such coverage is subject to this Plan's annual deductibles and coinsurance provisions.

16. ***Mental Health Parity and Addiction Equity Act of 2008***

To the extent the applicable medical plan provides mental health and substance abuse benefits, it will not place financial requirements, such as co-pays and deductibles, and treatment limitations, such as visit limits, on mental health or substance use disorder benefits that are more restrictive than the predominant requirements or limitations applied

to substantially all medical and/or surgical benefits. Such coverage shall be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

17. ***Genetic Information Nondiscrimination Act of 2008***

The Fund shall not request or require an individual Participant or family member to undergo a genetic test provided, however this prohibition shall not limit the Plan from adjusting the employer's contributions based on the manifested disease of an individual covered under the policy. However, the Plan will not use the manifested disease to further increase the employer's contributions since, it also constitutes genetic information about family members covered under the Plan.

The Plan shall not request or require a Participant or family member to undergo a genetic test. Provided that such prohibition does not: (1) limit the authority of a health care professional to request an individual to undergo a genetic test; or (2) preclude the Plan from obtaining or using the results of a genetic test to make a determination regarding payment. The Plan shall request only the minimum amount of information necessary to accomplish the intended purpose.

18. ***Notice of Nondiscrimination on the basis of race, color, national origin, age, disability, or sex (including gender identity).***

The Plan does <u>not</u> exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including gender identity).

The Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact the Plan's Administrator by mail or phone as follows: BeneSys, Inc., 33 Fitch Avenue, Austintown, Ohio 44515, Telephone: (330) 779-8859.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including

gender identity), you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

If you need help or speak a non-English language, call 1 (330) 779-8859 and you will be connected to an interpreter who will assist you at no cost.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (330) 779-8859

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (330) 779-8859

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (330) 779-8859

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (330) 779-8859

PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga libreng serbisyo para sa tulong sa wika na maaari mong gamitin. Tumawag sa 1 (330) 779-8859

ВНИМАНИЕ! Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по номеру 1 (330) 779-8859

ATANSYON Si w pale Kreyòl, gen sèvis èd pou lang gratis ki disponib pou ou. Rele 1 (330) 779-8859

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (330) 779-8859

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1 (330) 779-8859

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Dzwoń pod numer 1 (330) 779-8859

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Call 1 (330) 779-8859

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (330) 779-8859

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie uns an unter 1 (330) 779-8859

توجه: اگر به زبان فارسی صحبت می کنید، خدمات یاری رسانی زبانی، بطور رایگان، در دسترس شما می باشد. با شماره 1 1 1 (330) 779-8859

19. ***Your Financial Responsibilities***

Your financial responsibilities include the deductible amounts specified in the schedule of benefits. Coinsurance charges are also your responsibility. You are responsible for paying non-covered charges, billed charges for all services and supplies after benefit maximums have been reached, and for services and supplies rendered by non-contracting and non-participating providers, as well as for excess charges.

20. ***Rescission of Benefits***

In accordance with the Affordable Care Act, this Plan will only "rescind," or cancel, or discontinue coverage retroactively in cases where a participant or the participant's eligible dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of this Plan. If this Plan seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a covered person's failure to pay premiums is not a rescission.

21. Any action brought against the Fund or against the Fund's Board of Trustees must be brought in the United States Federal District Court for the Northern District of Ohio, or, to the extent that such an action is not preempted by ERISA, in the Summit County, Ohio Court of Common Pleas. Venue in any other jurisdiction is inappropriate.

HIPAA - PROTECTED HEALTH INFORMATION

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
  Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting:

  www.hhs.gov/ocr/privacy/hipaa/complaints/

- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when someone dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

The effective date of this Notice is January 1, 2018. We reserve the right to (1) change this notice, and (2) to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If any changes are made, we will mail the revised Notice to participants. The Plan has a legal duty to comply with the terms of any such Notice currently in effect.

CLAIMS AND APPEALS PROCEDURES

The procedures which you need to follow in order to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. The changes provided in this new Procedure apply to all claims filed. You will be provided with any future changes to the procedures in a separate document. Please make sure you review all correspondence about your Fund and keep these additional procedures with your Summary Plan Description.

FILING CLAIMS FOR MEDICAL BENEFITS

When you receive health care services:

A. Show your identification card to the service provider; and

B. Ask the provider to file a claim for you

If your provider of the medical service is a Participating Provider in the Anthem network, he/she will submit all necessary claim information on your behalf to Anthem. ("Anthem"). Anthem will forward the claims to the Fund's Administrative Office to be reviewed and paid. If you do not use a provider that is part of Anthem network, the Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Anthem, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

A. Obtain an itemized bill from the hospital, doctor, medical facility or other provider;

B. Obtain a claim form from the Fund's Administrative Office;

C. Complete the claim form and attach the itemized bill to the form;

D. Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

A. Participant's name and address;

B. Patient's name and address, if different;

C. Date of Service;

D. Type of Service and diagnosis;

E. Itemized charges;

F. Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by Anthem. The Fund's Administrative Office will process your claim within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least forty-five (45) days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or in part with an explanation of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

A. The specific reasons for the adverse benefit determination;

B. The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;

C. A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

D. The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

E. A notice of your right to a written explanation of any exclusion which affects your claim; and

F. A description of this Fund's Appeals Procedure set forth below.

NOTIFICATION OF PLAN'S BENEFIT DETERMINATION

Except as otherwise provided below, if a claim is wholly or partially denied, the Claimant shall be notified of such adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which to expect the benefit determination.

Urgent Care Claims.

In the case of a claim involving urgent care, the Claimant will be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with these procedures. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

A. The receipt of the specified information; or

B. The end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Decisions.

If we have approved an ongoing course of treatment to be provided over a period of time or number of treatments:

A. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claimant shall be notified, in accordance with these procedures, of the adverse benefit determination 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.

B. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with these procedures, and appeal shall be governed by these procedures, as appropriate.

Other Claims.

In the case of a claim not described above, the Claimant shall be notified of the benefit determination in accordance with the following provisions, as appropriate.

A. **Pre-Service Claims**. In the case of a pre-service claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than the period required by law after receipt of the claim. This period may be extended one time for up to 15 days, provided that it is determined that such an extension is necessary due to matters beyond control and the Claimant is notified, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which to expect a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with these procedures.

B. **Post-Service Claims**. In the case of a post-service claim, the Claimant shall be notified, in accordance with these procedures, of the adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that it is determined that such an extension is necessary due to matters beyond control and the Claimant is notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which to expect a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

C. **Disability Claims**. In the case of a claim for disability benefits, the Claimant shall be sent a Benefits Notice in accordance with these procedures, of the adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond control and

Claimant is notified, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which to expect a decision. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which to expect a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

If applicable, the Benefit Notice will provide a complete discussion of why the claim was denied and the standards it used in making the decision. If the Plan disagrees with a disability determination made by the Social Security Administration, the Benefit Notice will include an explanation as to why it disagrees.

Benefit Denials (including an initial denial) will also include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; they will also include the internal rules, guidelines, protocols, standards, and other criteria, on the basis of which the Plan denied the claim.

The Plan will not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact, will be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures.

Calculating Time Periods.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted by these procedures 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 date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

PRESCRIPTION CLAIMS UNDER CAREMARK PROGRAM

You will receive a personalized Caremark Prescription Benefits Identification Card with eligible dependents issued on the card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating Caremark pharmacy.

FILING A CLAIM FOR WEEKLY INDEMNITY BENEFITS

Claims must be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within forty-five (45) days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the forty-five (45) day period. A decision will be made within thirty (30) days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least forty-five (45) days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within thirty (30) days.

In the event that your claim for benefits is denied in whole or in part, the Fund's Administrative Office will provide you with a Notice of Adverse Benefit Determination in writing which contains the following:

A. The specific reasons for the adverse benefit determination;

B. The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;

C. A description of any additional materials or information necessary for you to perfect your claim and an explanation if why such materials or information is necessary;

D. The notice of any internal guidelines or protocol used in making this decision, if applicable, and your right to receive a copy;

E. A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

F. A description of this Fund's Appeals Procedure set forth below.

FILING CLAIMS FOR LIFE INSURANCE AND ACCIDENTAL DISMEMBERMENT BENEFITS AS A RESULT OF AN ACCIDENT

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims for Life Insurance, and Accidental Dismemberment benefits will be provided through the Fund's administrative office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify you or your beneficiary of the decision on the claim for benefits within ninety (90) days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial ninety (90) day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Fund's Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/she will receive a Notice of Adverse Benefit Determination in writing which contains the following:

A. The specific reasons for the adverse benefit determination;

B. The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;

C. A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;

D. The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;

E. A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and

F. A description of the Fund's Appeals Procedures set forth below.

PROOFS OF CLAIM

Written proofs of claim for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. ***All claims must be submitted by you or the Provider no later than ninety (90) days from the date on which the services were incurred.*** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. ***However, all claims must be filed within six (6) months from the date the claim was incurred and if they are not submitted, they will be denied as untimely.***

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

PHYSICAL EXAMINATION

The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

REVIEW PROCEDURE FOR CLAIMS UNDER THE FUND

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, weekly disability or life insurance/accidental dismemberment benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

FIRST LEVEL REVIEW

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within one hundred eighty (180) days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Administrative Manager
Plumbers and Pipefitters Local 219 Health and Welfare Fund
33 Fitch Boulevard
Austintown, OH 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Administrative Manager shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Administrative Manager will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of our request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

In the event the denial is upheld, you will receive a written Notice which includes the following:

A. The specific reason for the denial;

B. The sections of the Plan and/or Summary Plan Description upon which the denial was based;

C. A statement advising you of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

D. A notice of your right to a written explanation of any exclusion(s) that affects your claim, if applicable; and

E. A notice of your right to file a second level appeal to the Board of Trustees.

Special Rules Relating To Disability Claims. Disability Claim denial notices will contain the following additional information:

A. An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

B. If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

C. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

D. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

E. If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

F. Denial notices will be provided in a culturally and linguistically appropriate manner.

Additional Considerations Relating To Disability Claims:

A. A retroactive cancellation of disability coverage will be treated as a claim denial unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

B. Disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

SECOND LEVEL REVIEW

You may file a written notice of appeal to the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the notice. The Appeal should be addressed as follows:

Board of Trustees
Plumbers and Pipefitters Local 219 Health and Welfare Fund
33 Fitch Boulevard
Austintown, OH 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Board of Trustees shall consult the appropriate health professional and will disclose the identity of such individual to you upon request.

In those appeals to the Board of Trustees, the Board of Trustees shall make a benefit determination no later than the date of the regularly scheduled Board of Trustees' meeting that immediately follows the Fund's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination

may be made by no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the Fund's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund shall provide the Claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund shall notify the Claimant, in accordance with these procedures of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made. The Board of Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determination.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

A. The specific reason for the denial;

B. The sections of the Plan and/or Summary Plan Description upon which the denial was based;

C. A statement advising you of any internal guidelines or protocol used in making the decision, if applicable and your right to receive a copy;

D. A notice of your right to a written explanation of any exclusion that affects your claim, if applicable; and

E. A notice of your right to file a lawsuit under ERISA Section 502(a)

The decision of the Administrative Manager and/or the Board of Trustees, as applicable, is final and binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious. **The mandatory levels of appeal must be exhausted before any legal action is brought. Any legal action for benefits must be commenced within one (1) calendar year after these claims' review procedures have been exhausted.**

Special Rules Relating To Disability Claims (Second Level Review). Disability Claim denial notices will contain the following additional information:

A. An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

B. If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

C. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

D. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

E. If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

F. Denial notices will be provided in a culturally and linguistically appropriate manner.

Additional Considerations Relating To Disability Claims (Second Level Review):

A. A retroactive cancellation of disability coverage will be treated as a claim denial unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

B. Disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

EXTERNAL REVIEW

Following a Notice of Denial upon review by the Board of Trustees, you have the option of having your claim reviewed by an external reviewer. The following types of denials that can go to external review:

- Any denial that involves medical judgment where you or your provider disagree with the Plan;
- Any denial that involves a determination that a treatment is experimental or investigational; and,
- Cancellation of coverage under the Plan based on the Plan's claim that you gave false or incomplete information when you applied for coverage.

You must exhaust the Plan's internal review process before requesting an external review. You must file a written request for an external review within 60 days of receipt of the Notice of Denial upon review by the Board of Trustees.

The decision of third-party reviewer, as applicable, is final and binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious. **The mandatory levels of appeal must be exhausted**

before any legal action is brought. Any legal action for benefits must be commenced within one (1) calendar year after these claims' review procedures have been exhausted.

DEFINITIONS:

A. The term "**urgent care claim**" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or 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.

B. The term "**pre-service claim**" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

C. The term "**post-service claim**" means any claim for a benefit under the Plan that is not a pre-service claim or urgent care claim.

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

Lawsuits, Claims, And Causes Of Action Against The Fund Or Against The Fund's Board Of Trustees

Any action brought against the Fund or against the Fund's Board of Trustees must be brought in the United States Federal District Court for the Northern District of Ohio, or, to the extent that such an action is not preempted by ERISA, in the Summit County, Ohio Court of Common Pleas. Venue in any other jurisdiction is inappropriate.

Ohio Fraud Warning Notice

Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Approval And Effective Date

The Trustees have duly adopted and approved this summary plan description and plan document, effective September 1, 2019.