PLUMBERS & PIPEFITTERS LOCAL UNION NO. 396

HEALTH & WELFARE FUND

Plan Document and Summary Plan Description

Revised: April 1, 2022
and amended through
December 31, 2022

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1. Important 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. Tear-out forms are included at the end of the booklet for submission.

The importance of a current, correct address on file in 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.

Also, **you have the responsibility to inform the Fund Office within thirty (30) days of a divorce, legal separation, or a child losing Dependent status under the Plan.**

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is EIN 34-6545105. The Plan Number assigned to this Plan by the Board of Trustees is 501. The electronic payer identification number assigned the Plan is 34654.

Hospital and Medical Benefits are self-funded by the Trust through a contract with Medical Mutual, with a stop loss agreement underwritten by an insurance company.

From time to time you will receive supplemental notices about changes to this Plan. It is your responsibility to review those notices.

2. Introduction

We are pleased to present you with your new benefit booklet containing a summary of the current pertinent provisions of the Plumbers and Pipefitters Local Union No. 396 Health & Welfare Fund.

The Plan is financed through Employer Contributions into the Trust Fund. Employer Contributions are based on an hourly rate and are determined by the provision of the collective bargaining agreements in effect between the local union and participating signatory employers. On written request to the Plan Administrator, you may obtain a copy of your collective bargaining agreement, and you can receive information as to whether a particular employer participates in the Plan. Your Collective Bargaining Agreement and other documents under which the Plan is maintained are available for inspection at the Plan office.

The Plan is administered by the Board of Trustees consisting of an equal number of Trustees from Labor and Management. Under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Plan Administrator is the Board of Trustees and this Board has the authority to control and manage the operations and administration of the Plan and is the Agent for service of Legal Process.

The Board of Trustees, as the Administrator of your Plan has authorized the payment of the benefits of the Plan through BeneSys, Inc., currently located at 3660 Stutz Drive, Suite 101, Canfield, OH 44406.

The Board of Trustees is the Administrator of the Fund and has the full authority and control of the program. Thus, the Trustees, from time to time, may unilaterally modify the existing levels of benefits as they, in their sole judgement and discretion, deem proper for the Fund's maximum welfare and protection of the Funds' assets. The Trustees shall also have the sole power to interpret and determine the benefits payable under this Plan at all times and, if there is a controversy, the Board of Trustees' decision in all matters will be final, binding, and conclusive.

Changes in the Plan may also be required to preserve the Fund's tax-exempt status under the Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change the Plan provisions so that the Trust does not lose its tax-exempt status. In the event of a change that would result in the reduction of any benefit provided by the Plan, the Trustees will endeavor to review the change with the Participants prior to initiating such change.

All benefits under the Plan shall be payable through Participants or agents of the Trustees acting under their authority. Benefits as authorized under the Plan are <u>not</u> vested and will be paid as long as the Fund can operate on a sound financial basis. No benefits shall be payable except those which are provided under the Plan, and no person shall have any claim for benefits against any participating Union, the Association, any Employer, or the Trustees.

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan, and determine all questions arising in the administration of the Plan. The Board of Trustees has the power to determine the rights or eligibility of Participants and their Dependents, and benefits. This includes the authority and right to make findings of fact relating to these decisions.

No union or management representative, individual trustee, business agent, or other individual has the authority to answer questions or make decisions concerning the provisions of the Health and Welfare Fund unless such individual has been given the authority by the Board of Trustees and is acting on its behalf. This new booklet contains an outline of how you should

file claims, benefits provided in the Plan, and in the event an application for benefits is denied, a procedure in which you can file to appeal the denial is included.

This booklet supersedes and replaces any Plan Document and Summary Plan Description previously issued to you. Therefore, we ask that you read this booklet very carefully at this time and submit any questions you may have regarding it to the Fund Office listed in this booklet, to resolve any possible misunderstandings.

Sincerely,

THE BOARD OF TRUSTEES

3. Plan Administration

3.01 Identification of the Plan

Name of Plan: Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan

Type of Plan: The Plan is a welfare benefit plan that provides medical benefits, prescription drug benefits, death benefits, dental and vision benefits, and disability benefits.

Plan Number: 501

Date Plan Year Ends: March 31st

Type of Administration: The Administration of the Plan is carried out by:
BeneSys, Inc. (a Third Party Administrator)

Plan Sponsor and Plan Administrator:
Board of Trustees
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 270-0453, ext. 2784

Employer Identification Number: 34-6545105

Agent of Service of Legal Process:
Board of Trustees
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 270-0453, ext. 2784

3.02 Collective Bargaining Agreements

The Plan is maintained pursuant to several collective bargaining agreements between the Union and contributing Employers. To determine whether an employer is a contributing Employer, you may write to the Plan Administrator. Each collective bargaining agreement is available for examination at the Fund office. You may receive a copy of any such agreement from the Plan Administrator upon written request.

3.03 Source of Funding

Contributing Employers and employees share the costs of benefits provided through this Plan. Further, there are provisions for the self-payment of premiums made to the Plan, for example, by qualified beneficiaries who elect COBRA Continuation Coverage. The Board of Trustees are responsible for establishing and carrying out the Fund's funding policy.

3.04 Amending or Terminating the Plan

The Board of Trustees intends to continue the Plan indefinitely, although it reserves the right to change, discontinue, or end the Plan at any time. In the event of the termination of the Amended and Restated Agreement and Declaration of Trust ("Trust Agreement"), the Trustees shall apply the assets of the Fund to pay or to provide for the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in accordance with the provisions of ERISA and the provisions of the Plan. If the Trustees change or end

the Plan, you will be notified in writing. The Plan will end automatically if every contributing Employer withdraws from the Plan or as defined by law.

3.05 Board of Trustees

The Plan is administered by a Board of Trustees consisting of an equal number of Employer Trustees and Union Trustees. The Trustees are fiduciaries for the Plan and have the authority to control and manage the operation and administration of the Plan. At the present time, the Trustees are as follows:

UNION TRUSTEES

J. Brent Kelley (Chairman)
8790 Suncrest Dr.
Poland, OH 44514

Marty Loney
493 Bev Road, Bldg. 3
Boardman, OH 44512

Tim Morrison
10410 Youngstown-Salem Rd.
Salem, OH 44460

Joseph Longo
431 Pamela Ct.
Poland, OH 44514

EMPLOYER TRUSTEES

Wesley Prout (Secretary/Treasurer)
Prout Boiler, Heating & Welding, Inc.
3124 Temple St.
Youngstown, OH 44510

Matt Morrone
Morrone Mechanical
151 2nd Street
P.O. Box 103
Lowellville, OH 44436

Jeremy Smith
York Mahoning Mechanical Contractors
724 Canfield Rd.
PO Box 3077
Youngstown, OH 44511-3077

John Deraway
Alcon Mechanical
1932 Warren Ave.
Niles, OH 44446

3.06 Plan Professionals

Third Party Administrator

BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 270-0453, ext. 2784

Legal Counsel

Joseph C. Hoffman, Jr., Esq.
Faulkner, Hoffman & Phillips., LLC
20445 Emerald Parkway Dr., Suite 210
Cleveland, OH 44135

Benefits' Consultant

Segal Consulting
1300 East Ninth St., Suite 1900
Cleveland, OH 44114

4. Schedule of Benefits for Active and Early Retiree Members and Their Dependents

Participants and Beneficiaries will receive a free copy of detailed Schedules of Benefits upon request to the Plan Administrator.

All Medical benefits are provided through the Plans Preferred Provider Organization (PPO), Medical Mutual SuperMed Plus network. The SuperMed PPO service area includes the state of Ohio, as well as Boone, Campbell and Kenton counties in Kentucky. Medical Mutual members also have access to the Aetna® Open Choice® PPO network when they live, travel or spend significant time outside of the Medical Mutual SuperMed PPO service area. Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.[1] In-Network and Out-Of-Network Benefits are reimbursed based upon PPO contractual obligations. The Plan does not pay for charges over the Usual, Customary, and Reasonable ("UCR") fees.

	In Network*	**Out of Network***
Annual Deductible	$600 Single / $1,200 Family	$1,200 Single / $2,400 Family
Co-insurance	75% Plan - 25% Member	65% Plan - 35% Member
Out-of-Pocket Maximum	$3,000 Single/$6,000 Family	$6,000 Single / $12,000 Family
Dependent Age Limit	Age 26[2]	
Office visits (illness/injury) (including On Demand Virtual Telemedicine and Urgent Care Provider office visits)	75% after deductible	65% after deductible
Preventive Care Services	100%	Age 21+: Not covered Up to age 21: Vision exams covered 65% after deductible
EMERGENCY ROOM		
Emergency Room Care	75% after deductible	75% after deductible
Emergency Room Care for Non-Emergency	75% after deductible	65% after deductible
OUTPATIENT SERVICES		
Allergy Testing	75% after deductible	65% after deductible
Allergy Treatment	75% after deductible	65% after deductible
Home Health Care	75% after deductible	65% after deductible
OUTPATIENT THERAPY		
Cardiac Rehabilitation	75% after deductible	65% after deductible
Chemotherapy	75% after deductible	65% after deductible
Dialysis Treatment	75% after deductible	65% after deductible
Hyperbaric Therapy	75% after deductible	65% after deductible
Occupational Therapy	75% after deductible	65% after deductible
Physical Therapy	75% after deductible	65% after deductible
Pulmonary Therapy	75% after deductible	65% after deductible
Radiation Therapy	75% after deductible	65% after deductible

	In Network*	Out of Network*
Respiratory Therapy	75% after deductible	65% after deductible
Speech Therapy	75% after deductible	65% after deductible
ADDITIONAL SERVICES		
Abortions (for Participant and spouse only)	75% after deductible	65% after deductible
Blood, Blood Typing and Administration	75% after deductible	65% after deductible
Medical Supplies	75% after deductible	65% after deductible
Organ Transplant	75% after deductible	65% after deductible
Private Duty Nursing	75% after deductible	65% after deductible
Autism Spectrum Disorders (other than ABA)	75% after deductible	65% after deductible
Applied Behavior Analysis (ABA)	75% after deductible	65% after deductible
Disease Management (DM) Program	Limited Supplies - no cost share (includes syringes, pen needles, glucose strips, control solution, lancing device, glucose lancets and a glucose meter)	
Non-emergency care when traveling outside the United States	Not covered	Not covered

SUPPLEMENTAL BENEFITS	
Weekly Disability Benefits	Accident - 1st day Illness – 8th day $450 per week - Maximum 26 weeks (with a maximum 13-week extension as detailed in Section 10, where the treating provider certifies the same-cause disabling condition still exists and will likely continue to exist thereafter). Note: Both the $450 per week benefit and the 13-week extension are effective on a prospective basis only for weekly disability benefits paid on and after September 18, 2021.
Mental/Nervous disorder	Subject to deductible and co-insurance
Alcohol/substance abuse	Subject to deductible and co-insurance
Hospice Care	Services covered, subject to deductibles and co-insurance
Death Benefits	$10,000 (Active and Early Retirees only)
Dental/Vision Benefits	**Dental -** Effective January 1, 2023, the Plan offers Dental Benefits through a fully insured contract with Medical Mutual. Please refer to the separate certificate of coverage provided by Medical Mutual for full details. **Vision -** Effective January 1, 2023, the Plan offers Vision Benefits through a fully insured contract with VSP Vision Care. Please refer to the separate certificate of coverage provided by VSP for full details.

PRESCRIPTION DRUG BENEFITS		
	Retail	**Mail Order**
Out-of-Pocket Maximum	$3,850 Single / $7,700 Family combined with Mail Order	$3,600 Single / $7,200 Family combined with Retail
Generic	$15 copay	$30 copay
Preferred Brand[3]	20% coinsurance with $20 minimum	20% coinsurance with $40 minimum
Non-Preferred Brand	40% coinsurance with $35 minimum	40% coinsurance with $70 minimum
Specialty	40% coinsurance with $100 minimum and $150 maximum	40% coinsurance with $100 minimum and $150 maximum
Specialty via Prudent RX	30% coinsurance unless enrolled in program	30% coinsurance unless enrolled in program

Benefits Related to the Novel Coronavirus Disease (COVID-19) Outbreak, for Participants Enrolled in the Active and Non-Medicare Eligible Retirees Plan:

- **Diagnostic Testing**
  - Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, there shall be no cost-sharing for the following services:
    - Diagnostic tests to detect the virus that causes COVID-19, including serological tests for COVID-19 that are used to detect antibodies against the SARS-CoV-2 virus, that are approved or authorized by the FDA, including the administration of such tests; and
    - Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

- **Vaccination and Other Preventive Services**
  - Effective December 26, 2020 through the end of the Public Health Emergency regarding COVID-19 that the Secretary of Health and Human Services issued on January 31, 2020 ("Public Health Emergency"), the Plan will waive cost-sharing for any COVID-19 preventive service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force or any COVID-19 immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC, including the administration of any such vaccine by a Network or Non-Network Provider. This will be covered under the medical benefit and the outpatient prescription drug benefit within 15 days of such recommendation. The Plan will pay Non-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

- Effective after the Public Health Emergency ends, the Plan will cover any FDA-approved COVID-19 preventive service or vaccination as a Preventive Care Service.

- **Treatment and Additional Benefits**
  - Effective January 27, 2020 through December 31, 2020, there shall be no cost-sharing for COVID-19 treatment;
  - Effective March 18, 2020 through December 31, 2020, there shall be no cost-sharing for telehealth services provided by Express Care Online; and
  - Effective March 18, 2020 through June 14, 2020, there shall be no earlier refill limits on 30-day prescriptions for maintenance medications at any in-network pharmacy.

Footnotes:

1 Deductible and coinsurance expenses incurred for services by a non-network provider do not apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for service by a network provider will also not apply to the non-network deductible and coinsurance out-of-pocket limits.

2 If an unmarried Dependent Child is incapable of self-sustaining employment because of mental or physical disability, and (1) became incapable while he was a Dependent Child as defined herein, (2) is chiefly dependent upon the Eligible Participant for support and maintenance, and (3) if the Eligible Participant furnishes due proof of such incapacity, then such Dependent's eligibility for benefits shall be continued for as long as Participant remains eligible and such Dependent remains in such condition.

3 The Fund has a mandatory generic substitution policy. Members who elect to receive brand medications when a generic is available will be charged the difference between the cost of brand and generic plus the brand co-payment.

5. Medicare Coverage

5.01 Schedule of Benefits for Medicare Coverage for Retired Participants and/or Dependents Age 65 and Over and Eligible for Medicare Parts A & B

When you or your Dependents are eligible for Medicare, you may be eligible for the Fund's insured Retiree medical benefits. Medicare-eligible medical and prescription drug benefits are provided through the Humana Medicare Advantage Plan. Please refer to the Certificate of Coverage issued to you by Humana for full program details.

The coverage is provided to Retired Participants and their eligible Dependents who are enrolled in Medicare Parts A and B. The Board of Trustees has elected to provide these benefits on a fully-insured basis through an insurance contract with Humana for its Medicare Advantage Plan. These benefits are subject to any exclusions and/or restrictions.

Effective January 1, 2023, the Humana benefits will include **dental and vision** plans as well. Again, please refer to the Certificate of Coverage issued to you by Humana for full program details.

Medicare Retiree Plan medical and prescription benefits are insured through a contractual agreement between the Fund and Humana, Inc., presently located at 500 West Main Street, P.O. Box 143, Louisville, KY 40201-1438.

5.02 Death Benefit Under the Plan's Medicare Coverage

All Participants eligible for the Death Benefit under the Plan's Medicare Coverage will have a one-time opportunity to elect additional Death Benefits in the amount of $4,500. This election must be in writing and should be directed to the Fund Office. If the additional coverage is not elected during the 31-day period following their eligibility for Medicare, the option will expire and will not be available again to the Retiree. These Participants will remain eligible to receive the current benefit of $2,000. The cost of the additional coverage is $25 per month and must be self-paid by the Retired Employee.

6. Rules of Eligibility for Active Participants' Coverage

The eligibility rules now in effect are shown below. They may be changed from time to time as the Trustees, in their discretion, may deem necessary.

6.01 Initial Eligibility

A Participant shall become eligible to receive benefits on the first day of the month following the month in which Employer Contributions on his behalf total at least 480 hours, provided the hours have been worked within six consecutive months. Once a Participant meets this requirement, he or she will also be eligible for benefits the second month following the month in which he or she accumulated 480 hours.

6.02 Newly Organized Participants

In the case of a "newly-organized Participant," the Plan's "Rules of Eligibility for Participants' Coverage" are modified to permit Participants to make self-payments before the normal period of "initial eligibility." A "newly-organized Participant" is a Participant in a collective bargaining unit represented by the Union who has been certified as "newly-organized" by the Union in writing to the Fund. Upon receipt of that notice, the Fund shall notify the newly-organized Participant of the right to obtain coverage by making self-contributions in amounts determined by the Trustees.

The self-contributions will be funded by applying Employer Contributions made on the Participant's behalf for hours worked in excess of 160 in a month or, if the Participant works 160 hours or less in any month, by the Fund. However, if the Participant works less than 130 hours in any month, the Participant shall pay the difference between the self-contribution premium and the amount of the Employer Contributions made on the Participant's behalf in that month.

Coverage includes all Plan benefits except "Loss of Time" benefits. Coverage begins on the Participant's entry into the bargaining unit and may continue for up to nine (9) consecutive months, or until the Participant meets the "initial eligibility" requirements, whichever occurs sooner. Each month's contribution provides one month of coverage.

A Participant's failure to make a timely self-contribution for any month after electing this coverage will result in termination of coverage, with no option to resume this special eligibility. Participants may be considered "newly-organized" only once in their lifetime.

6.03 Continuation of Eligibility

A Participant will remain eligible to receive benefits so long as his or her Employer Contributions are received with a minimum of 140 hours 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.

6.04 Self-Contributions

Participants who accumulated less than the minimum required number of hours for continuation of eligibility may make self-contributions at a rate determined by the Trustees for the number of hours needed to meet the minimum eligibility requirements.

A Participant who is totally unemployed during an eligible accumulation period may continue to maintain his eligibility by paying the premium established by the Board of Trustees for a maximum of 12 consecutive months. Each such payment is subject to review and any changes as the Trustees deem necessary. A Participant who has exhausted the 12-month maximum self-pay allowance will be eligible to participate under COBRA.

Participants will be notified of the amount of self-contribution necessary to maintain eligibility. Failure to make a self-contribution by the due date will result in termination. Terminated Participants will have to meet the requirements of Initial Eligibility to become eligible again.

A Participant who has lost eligibility for benefits under this Fund due to a work assignment in a sister local union's territorial jurisdiction, and who subsequently acquired eligibility for benefits under that sister local's health and welfare fund, may regain eligibility in this Fund beginning with the month his or her eligibility in the sister local's welfare fund terminates. To regain eligibility to participate in this Fund, the Participant may pay, in advance, for a month's coverage in the amount the collective bargaining agreement requires. However, a Participant **may not** regain eligibility to participate in this Fund while he or she is eligible for benefits in a sister union's fund.

6.05 Self Employed

A self-employed individual **may not** make self-contributions to maintain eligibility, but may be eligible for COBRA Continuation Coverage.

6.06 Sick Credit

An eligible Participant will be credited with two hours per day for a period not to exceed 26 weeks for the purpose of maintaining eligibility while drawing weekly indemnity benefits from this fund or weekly compensation from the Industrial Commission.

6.07 Hour Bank

For the purpose of helping Participants maintain eligibility, hours credited to Participants' accounts in excess of 140 hours per month, for a maximum of 6 months, will automatically apply to reduce the amount of self-contribution required to maintain eligibility. All Participants' hour bank balances were recalculated on December 31, 2015 based on the excess of Contributions received per month over 140 hours from November 1, 2014 to October 31, 2015 with a maximum of 840 hours (6 months).

6.08 Reciprocal Agreements

In order to extend benefits to Participants who are required from time to time to work outside of this Fund's jurisdiction, the Fund has executed Reciprocal Agreements with numerous Welfare Funds in adjacent areas. These Reciprocal Agreements provide for the transfer of Contributions that Participants earn while temporarily working under other such Welfare Funds' jurisdiction, to this Fund.

Before leaving this Fund's jurisdiction area, check with the Fund Office to ensure that this Fund has a Reciprocal Agreement with the Welfare Fund in the area where you will be working.

If there is no Reciprocal Agreement in effect, you may be able to regain your coverage by making a self-payment. See Rules of Eligibility, Self-Contribution, in Section 6.04.

6.09 Disqualifying Employment

Any employment or self-employment by a Participant in any capacity for, or as, a non-signatory building or construction contractor anywhere will be deemed to be disqualifying employment that will result in the termination of coverage under the Plan. For this purpose, a non-signatory building or construction contractor is any such contractor who is not signatory to a collective bargaining agreement with the participating union. It shall also include any employment for or as a construction or project manager who subcontracts or permits to be subcontracted, directly or indirectly, building trades work to a non-signatory building or construction contractor.

The Plan Administrator will promptly notify the Participant if it determines that the Participant engaged in such disqualifying employment. **If, at *any* time after the 15th day following the**

date of such notice, the Participant engages in *any* disqualifying employment, the Participant's and his or her Dependents' coverage under the Plan will be terminated-including forfeiture of all accumulated hour bank credits and any self-payment rights other than COBRA continuation coverage rights. The Fund will offer the Participant and Dependents the COBRA continuation coverage rights otherwise available under the Plan for loss of coverage due to a reduction in hours in covered employment.

The Participant may appeal this termination of coverage under the Plan's claims appeal procedure. A Participant whose coverage has been terminated under these Plan provisions may resume his or her coverage by once again meeting the Plan's initial eligibility rules, but benefits previously forfeited under these termination provisions will not then be reinstated.

6.10 Retiree Subsidy Account

A certain amount per hour of all Contributions that the Plan collects from contributing Employers may be allocated to a Retiree Subsidy Account. The Board of Trustees will review the amount allocated to the Retiree Subsidy Account, annually. The Retiree Subsidy Account is set aside to offset the increasing costs of maintaining retiree participation in the Plan.

7. Rules of Eligibility for Dependent's Coverage

A Participant is eligible for Dependent's coverage on the day he becomes eligible for Participant coverage or on the day he acquires his first eligible Dependent, whichever is later.

Plan coverage is available to the Participant's biological and adopted children through the end of the month in which they reach the age of 26 years regardless of student status, marital status, support tests, or the availability of employer-based coverage to such children.

The Plan does not require that you specifically enroll in coverage for yourself once you become eligible. However, your Dependents must be enrolled with the Plan in order to have coverage. If you do not enroll any of the Eligible Dependents upon becoming initially eligible for coverage under this Plan, your Dependents may qualify for the Special Enrollment described in this Section. If you and your Dependents do not meet the Special Enrollment rules, then the Dependent will not become eligible for coverage under this Plan until the date that all of the enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility.

7.01 Special Enrollment Rules

If you decline enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be eligible to enroll yourself and your Dependents in the Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within thirty-one (31) days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

If you do not enroll your Spouse for coverage within thirty-one (31) days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption, or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than thirty-one (31) days after the date of your newly acquired Dependent Child's birth, or placement for adoption.

If your Spouse and/or Dependent Child(ren) did not enroll for coverage within the thirty-one (31) days after the date of their initial eligibility because they had other health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation coverage, individual insurance, Medicare, Medicaid, or other public program, and your Spouse and/or Dependent Child(ren) cease to be covered under that other health insurance policy or plan, you may enroll your Spouse and/or Dependent Child(ren) within thirty-one (31) days after the termination of their coverage under that other health care policy or plan. This applies only If the other coverage terminated because of:

- loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, death, divorce, or legal separation;
- termination of Employer Contributions toward that other coverage; or
- exhaustion of coverage, if that other coverage was COBRA Continuation Coverage.

COBRA Continuation Coverage is exhausted if it ceases for any reason other than failure of the individual to pay the applicable COBRA premium on time, or for cause (such as making a

fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). An individual is considered to have exhausted COBRA Continuation Coverage if such coverage ceases:

- Due to the failure of the employer or other responsible entity to remit
- premiums in a timely basis;
- When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- Because the 18-month or 36-month period of COBRA Continuation
- Coverage has expired.

However, you may not avail yourself of this opportunity for Special Enrollment for yourself or any Dependent unless, at the time of Initial or Special Enrollment, you indicated in writing that the reason your Spouse and/or Dependent Child(ren) were not enrolled was because they had coverage under another health insurance policy or plan.

To request special enrollment or obtain more information, contact the Fund Office. An enrollment form is provided in Section 20. You may also obtain an enrollment form from the Fund Office.

If the completed written enrollment form is submitted on a timely basis, coverage will be effective as follows:

- Your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren), except with respect to coverage of a newborn or newly adopted Dependent Child, will become effective on the date of the event that created the special enrollment opportunity.
- Coverage of a newborn for whom enrollment is requested within thirty-one (31) days after birth will become effective as of the date of the child's birth.
- Coverage of a newly adopted Dependent Child for whom enrollment is requested within thirty-one (31) days after adoption or placement for adoption will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

If you enroll Dependent Children **other than** the newly born or adopted child under this provision, coverage for the other Dependent Children will not become effective until all of the proper enrollment forms are completed, and claims will not be paid retroactively to the date of their initial eligibility.

7.01.01 COVID-19 Emergency Extension of Special Enrollment Deadlines

Effective March 1, 2020, when determining deadlines for Special Enrollment, the Plan will disregard the period beginning March 1, 2020 and ending on the earlier of:

- One year from the date the deadline would have been under normal, non-emergency Special Enrollment procedures; and
- The date that is 60 days after the announced end of the "National Emergency" or such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury.

"National Emergency" refers to the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the determination, under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, that a national

emergency exists beginning March 1, 2020, which the President issued on March 13, 2020.

Example: A Participant was eligible to participate in the Plan but declined to enroll. On March 31, 2021, the Participant gave birth and would like to enroll herself and her baby into the Plan. Under normal, non-emergency Special Enrollment procedures, she would have 31 days (until May 1, 2021) to request enrollment. With the Emergency Extension, the employee now has until the earlier of:

- May 1, 2022 (one year from the date the deadline would have been under normal, non-emergency Special Enrollment procedures); and
- 60 days after the end of the National Emergency.

7.02 Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

The Plan's Special Enrollment Provisions apply if:

- You, your Spouse or other Dependent had medical coverage under Medicaid or a State child health insurance plan (a "CHIP" plan) but lose eligibility for that Medicaid or CHIP coverage and request coverage under the Plan within 60 days after such coverage terminates; or
- You, your Spouse or other Dependent becomes eligible for state CHIP assistance or coverage under Medicaid and request coverage under the Plan within 60 days after you or your Dependent are determined to be eligible for such assistance.

7.03 Termination of Dependent's Coverage

A Participant will cease to be eligible for Dependents' coverage on the earlier of the following dates:

1. the date the Participant's coverage terminates;
2. the date the Participant ceases to be in a class of Participants eligible for Dependents' coverage;
3. the date Dependents' coverage is discontinued; or
4. the date the Dependent ceases to qualify as a Dependent.

7.04 Coverage for a Surviving Spouse and/or Surviving Dependent

Upon the death of a Participant, his or her Spouse will be eligible to participate in this Plan under the Surviving Spouse Program until the Spouse:

1. becomes eligible to participate in a group hospitalization program offered by his/her employer that provides substantially the same benefits as this Plan;
2. becomes covered by another group program, excluding Medicare; or
3. remarries.

To participate in the Surviving Spouse Program, the Spouse must submit a written application to continue coverage through the Surviving Spouse Program to the Fund Office within sixty (60) days of the Participant's death and pay timely monthly Contributions to the Fund Office in the amount and at the time established by the Board of Trustees.

Upon the death of a Participant, his or her Dependents will also be eligible to participate in the Plan under the Surviving Dependent Program until he or she fails to meet the definition of Eligible Dependent, so long as the Dependent submits a written application to continue coverage through the Surviving Dependent Program to the Fund Office within sixty (60) days of the Participant's death and pays the timely monthly Contributions to the Fund Office in the amount and at the time established by the Board of Trustees.

7.05 Qualified Medical Child Support Orders (QMCSOs)

Upon receipt of a QMCSO, the Plan Administrator will promptly notify the eligible Participant and each Alternate Recipient, as defined in ERISA Section 609(a), of the receipt of such order and, within a reasonable amount of time, notify you as to whether or not the order is qualified.

Participants and Beneficiaries can obtain, without charge, a copy of the Plan's written procedures governing QMCSO determinations.

In general, a QMCSO is a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law that requires a person to provide medical coverage for his or her children (called Alternate Recipients). Such orders are often issued in situations involving divorce, legal separation, or a paternity dispute. A properly completed National Medical Support Notice is treated as a QMCSO. A QMCSO may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. Once the Eligible Dependent Child is enrolled as an Alternate Recipient under a QMCSO, the child's custodial parent will receive a copy of this Benefit Booklet, as well as all other information needed to receive benefits under the Plan. If the QMCSO requires payments for services rendered to an Alternate Recipient to be paid to other than the Participant, payment will be issued to the Provider of service.

8. Rules of Eligibility for Early Retired and Permanently Disabled Participants and Dependents

8.01 Early Retirement

Participants who retire early, i.e., prior to their 65th birthday, may elect to continue receiving benefits under the active Participant program for which they were last eligible (however, they may not receive the weekly indemnity benefit and accidental death and dismemberment benefits) until they attain age 65, by paying the required monthly premium. Such Participants may also continue their Spouse's coverage by paying the specified additional monthly premium. The monthly premiums are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees.

Early Retirees must also meet the following criteria to continue receiving benefits under the active Participant program:

- he or she had at least 24 consecutive months of eligible participation in this Welfare Plan immediately before retirement;
- he or she retired from Covered Employment in the trade; and
- he or she is receiving retirement or Total and Permanent Disability benefits from a qualified pension or corporate retirement plan and/or is receiving disability or retirement benefits under the Social Security Act.

8.02 Permanently Disabled

If you are totally and permanently disabled, you are able to continue eligibility under the Disability Retiree Program for you and your Dependents through timely self-payments if:

- you were an active, eligible Participant in the Plan for a total of 24 months immediately preceding your disability; and
- you have received your Social Security Disability award**.**

Participants who qualify for extended life insurance coverage under the waiver-of- contribution coverage provided to Participants who become totally disabled while eligible for benefits under the active Participant program may elect to continue the active program exclusive of the weekly indemnity benefits and accidental death and dismemberment benefits by making the required monthly premium. The monthly premiums are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees. Upon attainment of age 65, coverage would then be provided pursuant to the terms of the retirees normal (Medicare entitled) Participant program.

8.03 Eligibility for Surviving Spouse

The Surviving Spouse of an Early Retiree and Permanently Disabled Participant Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within 60 days following the Participant's or Retiree's death.

9. Rules of Eligibility for Medicare-Entitled Retirees and Eligible Dependents (Age 65)

9.01 Eligibility for Normal Retirees

If you are a Normal Retiree, you may be eligible for the Medicare Advantage Plan currently offered through Humana on a fully insured basis, through timely self-payments if:

- you had at least 24 consecutive months' eligible participation in this Welfare Plan immediately before you retired;
- you are at least 65 years of age;
- you are retired from Covered Employment in the trade; and
- you are receiving retirement or Total and Permanent Disability benefits from a qualified pension and/or are receiving disability or retirement benefits under the Social Security Act.

You must notify the Fund Office in writing that you want to maintain your eligibility through the Normal Retirement Program within 31 days of the last month in which you were covered as an active Participant or Early or Disabled Retiree. You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost, and will run concurrently with (that is, will be counted toward) any required COBRA continuation coverage. If you fail to make a self-payment, you will lose your coverage and it cannot be reinstated.

Coverage for the Normal Retiree's Eligible Dependents may be continued for the same periods, as set forth above, upon timely self-payment.

9.02 Eligibility for Surviving Spouse

The Surviving Spouse of a Normal Retiree or Participant Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within 60 days following the Retiree's death.

10. Explanation of Your Benefits

As a Participant in this Plan, you and your family are entitled to certain benefits for Hospitalization, Physicians Services, and Other Benefits, as described more specifically below. All of these benefits are subject to the following limitations:

Each calendar year, you must pay all costs up to the "deductible" amount. If you have other family members on the Plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. For in-network providers, the individual deductible is $600 and the family deductible is $1,200. For out-of-network providers, the individual deductible is $1,200 and the family deductible is $2,400.

After you have satisfied the deductible portion, the Plan will generally pay 75% of in-network covered charges until you reach the out-of-pocket limit, and 65% of out-of-network covered charges. If you have other family members on the Plan, each family member must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is a separate out-of-pocket limit for in-network and out-of-network services. For in-network covered services, the individual out-of-pocket limit is $3,000 and the family out-of-pocket limit is $6,000. For out-of-network covered services, the individual out-of-pocket limit is $6,000 and the family out-of-pocket limit is $12,000.

The Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund has entered into an agreement with various organizations, which are preferred provider organizations ("PPOs"), to obtain discounts from hospitals and Physicians. A copy of the PPO Network Directory is available on line at http://www.medmutual.com/ualocal396 or by calling the Fund Office at 1-800-435-2388. When you and your Dependents use a Network Provider, the provider is required to charge a discounted rate. The Providers and Physicians in the Network have signed contracts with the PPO and may terminate or refuse to sign new contracts. To be assured of your Provider or Physician's current Network status, you should contact the PPO directly and inquire. Additionally, please be aware that even though a hospital is contracting with your PPO, each Provider and Physician who works with or in the hospital is not automatically part of the Network. You need to check on each Provider and Physician you use to ensure that they are part of the PPO.

The provider list will be furnished to you for free, as a separate document.

10.01 Hospital Expenses

10.01.01 Medical Expense Benefits

For each day of confinement to semi-private or ward accommodations, the Fund will cover room and board, subject to the current deductible and co-insurance amounts, and the following provisions. The deductible and co-coinsurance amounts for in-network providers and facilities are different than the deductible and co-insurance amounts for out-of-network providers and facilities. If you are confined in private room accommodations, the Fund will cover the hospital's most common rate for semi-private accommodations. The Fund will not cover room and board in excess of the hospital's most common semi-private room rate.

10.01.02 Maternity Services and the Newborns' and Mothers' Health Protection Act of 1996

Coverage for inpatient hospital maternity services is treated as any other illness or injury. Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered.

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

This Plan does not cover expenses incurred due to the pregnancy of a Dependent Child of any Participant, other than certain prenatal screenings for which the Affordable Care Act requires coverage as preventive services.

10.01.03 Medical Emergency Care Expense Benefit

This benefit covers treatment you or your Eligible Dependents receive in a hospital emergency room due to medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a person, who possesses an average knowledge of health and medicine, could reasonably expect that, in the absence of immediate medical attention, would result in the following:

1. Placing the individual's health (or, if the individual is pregnant, the individual's unborn child's health) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any body organ or part.

This benefit is processed as in-network claim regardless of the provider's network status.

10.01.04 Surgical Expense Benefit

The Surgical Expense Benefit covers the Physician's bill for surgery performed in a hospital, qualified outpatient surgical facility or a Physician's office up to the Usual, Customary and Reasonable charges for such surgery in the area in which the services are provided. The surgery must be the result of illness, injury, or pregnancy.

10.01.05 Sterilization Benefit

For female Participants and female Eligible Dependents, the Plan covers, in full, in-network, FDA-approved contraceptive methods prescribed by the individual's doctor, including FDA-approved sterilization procedures. In-network, FDA-approved contraceptive methods, including FDA-approved female sterilization procedures, are covered without cost-sharing—you will not be charged, even if you have not met your deductible.

For female Participants and Eligible Dependents, the Plan covers 100% of charges for in-network sterilizations and 65%, after deductible, of the Usual, Customary, and Reasonable ("UCR") charges for non-network sterilizations.

For male Participants and Eligible Dependents, the Plan covers 75%, after deductible, of charges for in-network sterilizations and 65%, after deductible, of the UCR charges for non-network sterilizations.

Reverse sterilizations are not covered and remain general exclusions under this plan.

10.01.06 Outpatient Laboratory Diagnostic and X-Ray Services

The following services are covered by the Plan at the level provided in the Summary of Benefits on an inpatient or outpatient basis:

- Radiology, ultrasound and nuclear medicine;

- Laboratory and pathology services; and
- EKG, EEG and other electronic diagnostic medical procedures.

The Outpatient Diagnostic X-ray and Laboratory Expense Benefit covers charges for X-ray and/or Laboratory work done at your Physician's request, on an outpatient basis, because of illness, injury, or pregnancy.

The Plan covers certain in-network diagnostic tests as Preventive Care Services, and these are provided without cost sharing.

10.01.07 Anesthesia Benefit

Anesthesia is administered to allow medical procedures (usually surgery) to be performed without the patient experiencing too much discomfort. This service is covered by the Fund when rendered in connection with a covered service. The kind of anesthesia selected depends on the type of service performed and by the instructions of the Physician or Surgeon performing the procedure. Anesthesia may be administered only by a Physician, a certified registered nurse anesthetist, or other licensed provider acting within the scope of his or her license. This benefit is paid according to the level provided in the Summary of Benefits.

10.01.08 Physician and Nursing Charges

Charges for a Physician, Surgeon, Clinical Psychologist, or other licensed provider acting within the scope of his or her license rendering professional services are covered for medically necessary services.

10.01.09 Chiropractic Benefits:

The chiropractic expense benefit covers all services provided or supervised by a chiropractor or other licensed provider acting within the scope of his or her license. The Plan covers 75%, after the deductible, of the UCR charges for in-network chiropractic treatment and 65%, after deductible, of the UCR charges for out-of-network chiropractic treatment, for up to twenty-six (26) treatments per person per calendar year. However, any chiropractic treatments are subject to review for Medical Necessity after twenty-six (26) treatments. The Plan will not pay for any treatments that are not Medically Necessary.

10.01.10 Durable Medical Equipment

Reimbursement will be made at the Usual, Customary and Reasonable cost under the Plan on the purchase of durable medical equipment which meets all of the following criteria:

1. It can stand repeated use;
2. It is used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is not useful to a person in the absence of illness or injury;
4. It is appropriate for home use;
5. It is certified in writing by a Physician as being medically necessary;
6. It is related to the patient's physical disorder;
7. The anticipated length of time the equipment will be required for therapeutic use must be certified in writing; AND
8. It is for the exclusive use of the covered person for whom the Physician has certified that it is medically necessary.

10.01.11 Immunizations

The Plan covers routine immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as Preventative Care Services. Immunizations will also be covered based upon Physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

In addition to covering immunizations as mandated by law, the Plan covers:

- For members up to age 21: All preventive immunizations at 100% (in-network) and 65 after deductible (out-of-network);
- For members of all ages, the Plan covers 75%, after deductible, of in-network charges (not covered for non-network) for:
    - Rabies immunization; and
    - Meningococcal conjugate serogroups C & Y, influenza B, tetanus toxoid (Hib-MenCY-TT).

Effective December 26, 2020 through the end of the Public Health Emergency regarding COVID-19 that the Secretary of Health and Human Services issued on January 31, 2020 ("Public Health Emergency"), the Plan will waive cost-sharing for any COVID-19 preventive service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force or any COVID-19 immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC, including the administration of any such vaccine by a Network or Non-Network Provider. This will be covered under the medical benefit and the outpatient prescription drug benefit within 15 days of such recommendation. The Plan will pay Non-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

Effective after the Public Health Emergency ends, the Plan will cover any FDA-approved COVID-19 preventive service or vaccination as a Preventive Care Service.

10.01.12 Ambulance Benefits

The Fund will pay the Usual, Customary and Reasonable ("UCR") covered charges for professional licensed ambulance service under this benefit.

The Ambulance Service Benefit covers transportation charges for professional licensed ambulance service that is needed only for medical treatment. In addition, the Usual, Customary and Reasonable charges for air ambulance will also be covered, provided **all** of the following conditions are met:

- The transportation is by a vehicle designed and equipped and used only to transport the sick and injured;
- The transportation is from the scene of an accident or medical emergency to a hospital or between hospitals;
- The trip is to the closest facility that can give the appropriate services for the condition; and
- Certification by an attending Physician must be received indicating the transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

10.01.13 Clinical Trials Coverage

The Plan will cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial if the Plan would provide those items and services to patients not participating in a trial.

10.02 Mental and Nervous Disorders Treatment

The Plan will cover medically necessary inpatient treatment (admission to a hospital or approved Rehabilitative Facility) and outpatient treatment for mental disorder(s) and/or nervous disorder(s), subject to the Plan's deductible and co-insurance.

The following services provided by or under the direct supervision of a Physician, licensed psychologist, or other licensed provider acting within the scope of his or her license are

covered: individual, group, and family psychotherapeutic counseling, electro-shock treatment, psychological testing, and psychiatric consultation for treatment of mental disorders.

Gender Affirming Surgery

The Plan, through Medical Mutual, will cover Medically Necessary services for gender affirming Surgery, subject to accepted medical clinical guidelines and corporate medical policies.

Autism Spectrum Disorders

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders, subject to accepted medical clinical guidelines and corporate medical policies.

Covered Services include:

- Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist or other licensed provider acting within the scope of his or her license.
- Clinical therapeutic intervention which includes, but is not limited to, applied behavior analysis. The intervention must be provided by, or be under the supervision of, a Professional who is licensed, certified, or registered by an appropriate state agency to perform such services in accordance with a treatment plan.
- Mental/behavioral health Outpatient services performed by a licensed Psychologist, psychiatrist, Physician, or other licensed provider acting within the scope of his or her license providing consultation, assessment, development, or oversight treatment plans.
- Prescription Drugs.

Treatment for autism spectrum disorders means evidence-based care and related equipment prescribed or ordered for a Covered Person diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary.

All Covered Services must be prescribed or ordered by either a developmental pediatrician, a Psychologist, or other licensed provider acting within the scope of his or her license, trained in autism spectrum disorders and require Preauthorization.

10.03 Alcohol and Substance Abuse Treatment

If you are admitted to a drug and/or alcoholism treatment facility, the Plan will pay, subject to the Plan's deductible and co-insurance amounts, the facility's actual charge for room and board, up to the cost of the facility's most common semi-private room rate. Thus, if you are confined in private room accommodations, the Plan will pay, subject to deductible and co-insurance, the facility's most common rate for semi-private room accommodations, and the Plan will not cover room and board in excess of the facility's most common semi-private room rate. The Plan will cover charges for general nursing care and other services subject to the Plan's deductibles and co-insurance. The deductible and co-insurance amounts for in-network providers and facilities are different than the deductible and co-insurance amounts for out-of-network providers and facilities.

If you are admitted as an inpatient, for a prescribed course of treatment for alcoholism and/or drug abuse dependency, to a hospital or to an approved Rehabilitation Facility (including detoxification in an Approved Rehabilitation Facility), the Plan will cover charges for such treatment subject to the Plan's deductibles and co-insurance.

Unless otherwise required by law, the Plan will not cover services that are investigational,

experimental, unproven, or not Medically Necessary.

Ohio law sets certain requirements for a facility or doctor. Be sure to check the status of your doctor or facility before receiving services.

10.04 Preventive Care Services

The Plan will provide Preventive Care Benefits identified as provided under the Affordable Care Act. The list of covered Preventive Care Services is updated on a regular basis. Listed below is the current list. All unspecified age and risk groups will be as provided under the Affordable Care Act. The Plan will provide in-network Preventive Care Benefits at no cost to Participants and their eligible Dependents.

10.04.01 Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults age 21 and over
- Colorectal cancer screening for adults age 50 to 76
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce skin cancer risk
- Depression screening
- Type 2 Diabetes screening for adults age 18 and over, with intensive behavioral counseling for those with abnormal blood glucose to promote a healthful diet and physical activity
- Diet counseling and nine nutritional counseling classes per Plan Year for adults at higher risk for chronic disease
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- HIV screening and counseling, including pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at increased risk of HIV acquisition, including related monitoring and support services as recommended by the individual's health care provider
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - COVID-19
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating Physician
- Obesity screening and counseling for all adults with a BMI of 30 or higher

- Screening for hepatitis B virus infection in adults at high risk for infection
- Screening for hepatitis C virus (HCV) infection
- Screening for latent tuberculosis infection in populations at increased risk
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for those at increased risk
- Unhealthy alcohol misuse screening and counseling
- Unhealthy drug use screening (does not include drug testing)

10.04.02 Covered Preventive Services for Women, Including Pregnant Women

- Anxiety screening
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA-related cancer risk assessment, genetic counseling, and genetic testing (for BRCA 1 and 2), once per Plan Year
- Breast cancer risk-reducing medication (for example, such as tamoxifen, raloxifene, or aromatase inhibitors) counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breast feeding supplies, for pregnant and nursing women
- Cervical cancer screening, once per Plan Year
- Chlamydia Infection screening for all sexually active women
- Depression screening and counseling for pregnant and postpartum women
- Food and Drug Administration–approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
- Domestic and interpersonal violence screening and counseling for all women.
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women age 24 and younger, and older women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia
- Osteoporosis screening for women over age 50 or younger if at increased risk
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Screening for diabetes after pregnancy in women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes
- Screening for urinary incontinence
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Urinary incontinence screening
- Well-woman visits to obtain recommended preventive services

10.04.03 Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Anxiety screening for adolescent women

- Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices
- Autism screening
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Depression screening for members up to age 21
- Developmental screening for children up to age 36 months, limited to three screenings per lifetime
- Dyslipidemia screening for children at higher risk of lipid disorders up to age 21
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for members up to age 21
- Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - COVID-19
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- Interventions, including education or brief counseling, to prevent initiation of tobacco (including e-cigarettes) use in school-aged children and adolescents
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Obesity screening and counseling
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Screening and counseling for interpersonal and domestic violence
- Screening for hepatitis B virus infection in adolescents at high risk for infection
- Sexually Transmitted Infection (STI) prevention counseling for sexually active adolescents
- Skin Cancer counseling for children, adolescents, and young adults ages 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce

risk for skin cancer
- Syphilis screening for adolescents who are at increased risk for infection
- Tuberculin testing for children at higher risk of tuberculosis up to age 21
- Vision screening for all children

10.05 Loss of Time Benefits Active Participants Only

Payments will be made at the Weekly Loss of Time rate stated in the Schedule of Benefits when Active Participant is wholly and continuously disabled by an accidental bodily injury occurring off the job, or sickness not connected with employment that prevents him from working at his occupation and which requires the regular care and attendance of a legally qualified Physician or Surgeon.

Benefits for Active Participants begin with the 1st day of disability due to accidental bodily injury, or the 8th day of disability due to a sickness, and will continue up to the maximum number of weeks stated in the Schedule of Benefits for any one period of disability. However, should the Active Participant's treating provider submit sufficient documentation to the Plan that the Participant's same-cause disabling condition still exists after the maximum number of weeks stated in the Schedule of Benefits, and will likely continue to exist thereafter, then the Active Participant can remain eligible for weekly disability benefits for the duration of that condition but only for up to thirteen (13) more weeks.

Successive periods of disability due to the same or related causes not separated by return to active employment for a period of two (2) full weeks shall be considered one period of disability.

Note: To receive a weekly loss of time benefit, you must not be receiving wages from any employer or collecting any state workers' compensation or unemployment benefits. You must also be covered under the Plan when you became injured, ill, or unable to work due to pregnancy.

10.06 Medical Reimbursement Accounts

The Trustees shall establish medical reimbursement accounts for Participants for whom Contributions are made pursuant to collective bargaining agreements between a participating Union and a contributing Employer.

Medical expenses not covered elsewhere will be paid from the Participant's Medical Reimbursement Account as provided herein.

Spouses and Dependents of deceased Participants may continue to be reimbursed for medical care expenses up to an amount equal to the unused reimbursement amount remaining at the time of death.

These Contributions shall not create or constitute a vested benefit.

10.06.01 Eligible Medical Expenses

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") § 213 which have not been paid under the Plumbers and Pipefitters Local Union 396 Health and Welfare Fund or other plan or arrangement. Such expenses, to the extent the Participant has funds in his/her individual Medical Reimbursement Account, Include, but are not limited to:

- Deductibles and co-payments applied to covered medical expenses under any qualified hospitalization plan or a qualified plan of a Dependent Spouse;
- Menstrual care products (tampons, pads, liners, cups, sponges, or other similar products);

- Self-payments to maintain eligibility under any qualified hospitalization plan or premium or other payments required to maintain coverage under the Plan of a Participant's Spouse;
- Unreimbursed prescription medicines (prescribed by a doctor or other licensed provider acting within the scope of his or her license), including co-pays;
- Unreimbursed medical services fees (from doctors, chiropractors, dentists, Surgeons, registered nurses, specialists, and other licensed providers acting within the scope of their license);
- Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);
- Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
- Unreimbursed dental expenses;
- Any other medical expenses identified in Internal Revenue Code § 213.

10.06.02 Ineligible Medical Expenses

The Plan will reimburse you for any and all claims for expenses including those for insulin which are considered non-covered and/or excluded by the Plumbers and Pipefitters Local Union 396 Health and Welfare Fund or any other health and welfare fund or insurance plan, so long as the expense is identified in Code § 213. Such reimbursement shall be limited to the amount of the Participant's Medical Reimbursement Account balance.

10.06.03 How to Obtain Reimbursement

When an Eligible Participant or Dependent has unreimbursed medical expenses and a balance in the Participant's Medical Reimbursement Account, the Participant should submit proof of such out-of-pocket expenses on forms available from the Fund Office to the Administrator of the Plumbers and Pipefitters Local Union 396 Health and Welfare Fund, 3660 Stutz Drive, Suite 101, Canfield, OH 44406. Separate bills may be itemized on the same claim form. Forms must be accompanied by receipts for bills. The Plan will send reimbursement checks quarterly with no reimbursements made for the first six months of the Plan. Claims for medical expense reimbursement must be filed no later than twelve (12) months following the date of service. The Plan may assess an administrative fee against the Eligible Person's Account for processing reimbursement claims. Any unused balances in the Participant's Medical Reimbursement Account will be carried over to the next Plan Year, subject to provisions below about "Cancellation of Account" and "Changes".

10.06.04 Earnings

Periodically, the Trustees shall credit interest or other earnings, less administrative expenses, to Eligible Participants' Medical Expense Reimbursement Accounts.

10.06.05 Cancellation of Account

Any Participant or former Participant, or the Spouse or Dependents of a deceased Participant, may at any time permanently opt-out of coverage and waive future reimbursement under the Reimbursement Accounts provisions.

Any individual who performs work within the scope of the collective bargaining agreement of the Union for a non-contributing Employer shall have his or her account cancelled and the balance of his or her account shall revert to the Plan's sub-trust for medical reimbursement, regardless of whether the Participant waives future reimbursement as set forth above.

10.06.06 Changes

This Medical Reimbursement Account Program is based on existing law, as currently interpreted. If there are legislative changes, governmental announcements or financial considerations which affect this Program, the Trustees reserve the right to change or cancel

the Program, including cancellation of existing Medical Reimbursement Accounts. If the Program is to be discontinued or changed, the Trustees will provide Eligible Persons with as much written notice as possible.

10.07 Death Benefits

10.07.01 Active Participants Only

Upon proof of the death of any Active Participant, the Fund will pay, subject to the provisions of the Plan, the Death Benefits specified in the Schedule of Benefits.

10.07.02 Beneficiary

Each covered Participant shall designate a beneficiary, which designation shall be filed with the Fund. If, at the death of the Active Participant, there is no surviving designated beneficiary as to all or part of the death benefits payable, such death benefits shall be paid, at the option of the Fund, to any one of the following surviving relatives of the Active Participant: spouse, child or children, mother, father, brother or sister, or to the estate of the Active Participant. Payment to any of the above named shall, to the extent thereof, release the Fund from all liability.

The Active Participant may change the beneficiary from time to time by filing a written notice of such change through the Trustees. Such change of beneficiary shall relate back and take effect as of the date the Active Participant signed the notice, whether or not the Active Participant is living on the date of the filing, but without prejudice to the Fund on account of any payment made before such notice is filed.

Please note that as these benefits are self-funded, they would be considered taxable income to the beneficiary. You should consult with your personal tax advisor in that regard.

10.07.03 Extended Coverage

If an Active Participant, before attaining age 60, becomes totally disabled from bodily injury or disease so as to be wholly prevented from performing any work or engaging in any occupation for remuneration or profit, and if he or she dies within one year after termination of the earned benefit period, and while remaining continuously so disabled, the Fund will pay the amount of the Active Participant's benefits as determined by the Schedule of Benefits.

If an Active Participant has become totally disabled and then, not later than one year after furnishing written proof satisfactory to the Fund that such total disability has continued, the Fund will extend coverage for benefits throughout the period of such total disability.

Total and permanent disability will be acknowledged and recognized to exist if the Active Participant has suffered the entire and irrecoverable loss of both eyes, severance of both hands, above the wrist and one foot above the ankle.

If an Active Participant has furnished proof of total disability, but becomes able to again perform some work or to engage in some occupation for remuneration or profit, or if he refuses to be examined as required or fails to furnish proof of total disability within the time required, all coverage on the Active Participant shall terminate immediately.

The Fund shall have the right at any time during total disability to require proof of existence and continuance of such disability, and to make examination of the Active Participant, by a Fund appointed examiner, but not more than once a year after the benefit coverage has been extended for two years.

10.07.04 Notice of Claims

No payment shall be made on account of the death of any Active Participant under this provision, unless written notice of death is received by the Fund within 12 months after the date of death.

10.07.05 Accidental Death and Dismemberment Benefits Active Participants Only

When a bodily injury caused solely by an accident occurring while benefit coverage is in force shall, directly and independently of all other causes, result in any of the following losses within ninety days after the accident, the Fund will pay for the loss based on the Principal Sum stated in the Schedule of Benefits in addition to any other benefits amounts as follows:

10.07.06 The Principal Sum for Loss of Life

The Principal Sum for Loss of:

(1) both hands; (2) both feet; (3) both eyes; (4) any two such members.

One-half the Principal Sum for Loss of:

(1) one hand; (2) one foot; (3) one eye.

"Loss" as used in this section with reference to hand or foot means complete severance through or above the wrist or ankle Joint and with reference to eye means the irrecoverable loss of the entire sight of the eye.

If more than one specific loss results from one accident, the amount provided for the greatest loss sustained will be paid.

These benefits are payable whether injury is on or off the job.

Payments will be made directly to the Covered Participant if living, otherwise to his beneficiary. The Covered Participant may change the beneficiary at any time by completing the proper form.

10.08 Prescription Drug Benefits

A Prescription Administrator has contracted with the Fund to provide an efficient and cost-effective program that will be easy for Participants and Dependents to use when purchasing prescriptions at a Network Pharmacy. A listing of the major participating pharmacies may be obtained from the Fund Office.

The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy each time you have a prescription filled. If you do not use your identification card, you will have to file a claim for payment directly to the Fund Administrator. Your claim may be subject to deductible and co-insurance amounts. When possible, please check with your pharmacy to determine if a generic equivalent is available which will result in a direct savings to you and the Fund.

The Plan utilizes a formulary which can help your Physician prescribe medications to resolve medical needs while limiting the financial impact to both the Participant and the Plan. The formulary recommends that Physicians prescribe proven and effective, but often less-expensive alternatives, whenever practical. Caremark determines where drugs fall on their formulary based on many factors, but mainly the determinations are made on safety and efficacy of the medications. The formulary divides drugs into four categories: (1) Generic drugs; (2) Preferred Brand drugs; (3) Non-Preferred Brand drugs; and (4) Specialty drugs.

The copay structure is based on which category the medication falls into. For Generic drugs the copay will be $15 at retail and $30 at mail order, for Preferred Brand drugs the copay will be the maximum of $20 or 20% at retail and the maximum of $40 or 20% at mail order, Non-

Preferred Brand drugs will be the maximum of $35 or 40% at retail and the maximum of $70 or 40% at mail order; and Specialty drugs will be the maximum of $150 and 40% at retail with a minimum $100 copay. In addition, members who elect to receive brand medications when a generic equivalent is available will be charged the difference between the cost of the generic and the brand drug in addition to the brand co-payment. For a complete formulary list please log into www.caremark.com.

All Participants who use maintenance medication are encouraged to use the mail order program. The savings will benefit both Participant and the Fund since co-payments for a 90-day supply is the same as a retail prescription.

The formulary no longer covers the brand products Aciphex, Prevacid, Nexium and Protonix **unless** you have previously tried and failed Prilosec OTC or Omeprazole as a prescription benefit. You must have been on Prilosec OTC or Omeprazole by your Physician writing a prescription for it and have had that prescription processed at your pharmacy by using your pharmacy prescription card. If you have tried and failed Prilosec OTC or Omeprazole, and you require one of these drugs, you will then pay the applicable category copay for the branded drugs if your prescription history with Caremark shows that you have utilized Prilosec OTC or Omeprazole as a prescription benefit in the past. You will need to have your doctor write a prescription specifically for Prilosec OTC and present this prescription to your pharmacist so you may obtain supplies through your Caremark pharmacy plan. You are not required to change medications but if you continue to use Nexium, Aciphex, Prevacid or Protonix without first utilizing Prilosec OTC or Omeprazole you will be required to pay 100% of the cost of these drugs. The Plan will cover Dexilant as a Preferred Brand drug, even if you have not previously tried and failed another medication.

Prudent RX Program

In order to provide a comprehensive and cost-effective prescription drug program for participants and dependents, the Plan has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists participants and dependents by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled participants and dependents who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist participants and dependents in obtaining copay assistance from drug manufacturers to reduce the cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, all in accordance with privacy laws.

All eligible participants and dependents are enrolled in the PrudentRx program. The individual can then choose to opt out of the program. PrudentRx will contact the participant or dependent if such person is required to enroll in the copay assistance for any medication that he or she takes. If the person does not return the call, chooses to opt-out of the program, or does not affirmatively enroll in any copay assistance as required by a manufacturer, such person will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by the participant, a dependent, or a manufacturer's copay assistance program, will not count toward the Plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, the cost share payments for these medications, whether made by the participant, dependent or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

Effective December 26, 2020 through the end of the Public Health Emergency regarding COVID-19 that the Secretary of Health and Human Services issued on January 31, 2020 ("Public Health Emergency"), the Plan will waive cost-sharing for any COVID-19 preventive service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force or any COVID-19 immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC, including the administration of any such vaccine by a Network or Non-Network Provider. This will be covered under the medical benefit and the outpatient prescription drug benefit within 15 days of such recommendation. The Plan will pay Non-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

Effective after the Public Health Emergency ends, the Plan will cover any FDA-approved COVID-19 preventive service or vaccination as a Preventive Service.

COVID-19 Antiviral Therapy Program

Effective December 22, 2021 through the end of the COVID-19 Public Health Emergency, the Plan, through its prescription benefit manager CVS Caremark, will process and reimburse COVID-19 oral antiviral drug claims, whether at an in-network or out-of-network pharmacy. The ingredient cost is paid for by the federal government; the dispensing fee is paid for by the Plan. This includes a $10 dispensing fee to pharmacies, which replaces the normal network dispensing fee. Only oral antiviral therapies for COVID-19 that received Emergency Use Authorization from the FDA are covered. A quantity limit of one (1) course of therapy for each of the oral antiviral products within a 30-day window will be applied. An age limit will be applied as follows: 12+ for the Pfizer oral antiviral therapy and 18+ for the Merck oral antiviral therapy. Member cost-share will be set at $0.00.

10.08.01 Mail Order Program

The Mail Order Program was designed to allow members to receive large quantities of maintenance medication (e.g. heart medication, blood pressure medication, diabetic medication, etc.). You can obtain a 90-day supply of your prescription with refills permitted as prescribed by the Physician.

10.08.02 Exclusions

The Following services, supplies and charges are not covered under this benefit:

1. Contraceptive devices (except for generic FDA-approved contraceptive methods prescribed by a woman's health care provider or other licensed provider acting within the scope of his or her license);
2. Therapeutic devices
3. Artificial appliances
4. Disposable insulin syringes which are not prescribed

5. Fees for administering or injecting Prescription Drugs;
6. Charges for more than a 90-day supply of Prescription Drugs;
7. Any refill or Prescription Drug, dispensed after one year from the date of the original Prescription Order;
8. Drugs you can purchase without a Prescription;
9. Prescription Drugs consumed or administered at a location where Prescription Order is issued;
10. Fertility drugs;
11. Nicorette gum and/or other tobacco cessation related medication, except for FDA-approved pharmacotherapy for cessation for tobacco cessation when prescribed by a Physician or other licensed provider acting within the scope of his or her license;
12. Gene Therapy products or treatment, as defined by the U.S. Food and Drug Administration.
13. Male sexual dysfunctional drugs (except a 4-pill monthly limit for Viagra)
14. Anorexiants (diet pills)
15. Diabetic supplies (e.g., glucometers, lancets, test strips) (however, certain supplies might be covered as Durable Medical Equipment; see Section 10.01.10, above)
16. Ostomy products
17. Lost or stolen prescriptions

10.09 General Exclusions

10.09.01 All Medical Expenses Are Subject to the Usual, Customary, and Reasonable Charge

Benefits are not provided for services, supplies, or charges:

1. Which are not prescribed by or under the direction of a Physician or other licensed provider acting within the scope of his or her license.
2. Which are not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. Which are Experimental/Investigative.
5. Which are not Medically Necessary, as determined by the Plan**.**
6. To the extent governmental units or their agencies provide benefits.
7. For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war or during the commission of a felony by the Covered Participant, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
10. Which are received in a military facility for a military service-related injury, ailment, condition, disease, disorder or illness.
11. For Surgery and other services only to improve appearance but not to restore body function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.
12. Primarily for educational, vocational or training purposes.
13. For the treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
14. For marital counseling
15. For birth control devices, except FDA–approved contraceptive methods and sterilization procedures, as prescribed by a health care provider for women with reproductive capacity.
16. Any non-Medically Necessary services relating to infertility.
17. For treatment of sexual problems that is not Medically Necessary.
18. For reverse sterilization.
19. For or related to the treatment of temporal mandibular joint syndrome with intraoral

prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction not caused by documented organic disease or physical trauma.

20. For personal hygiene and convenience items.
21. For hypnosis and acupuncture.
22. For missed appointments or completion of a claim form.
23. For fraudulent or misrepresented claims.
24. For expenses of care for conditions that State or local law require be treated in a public facility.
25. For topical anesthetics or stand-by anesthesia.
26. For penile implants or any treatment leading to or in connection with penile implants, unless such implants or treatment is Medically Necessary.
27. Evaluation and treatment of sleep disorders centers (unless determined to be medically necessary which will then be limited to one treatment per year).
28. Any loss sustained or contracted as a result of an Eligible Participant or Eligible Dependent being under the influence of any narcotic or other drug that was not prescribed to that individual by a Physician or other licensed provider acting within the scope of his or her license, or as a consequence of the use thereof, unless such loss is the result of domestic violence or the loss and/or narcotic/drug use is the direct result of an underlying health factor.
29. Charges related to massotherapy.
30. Exercise equipment.
31. Air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, hypo-allergenic pillows/mattresses, or waterbeds.
32. Loss caused by (a) accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or (b) sickness for which the Covered Participant is entitled to benefits under any Workman's Compensation or Occupational Disease Law, unless specifically provided for in the Schedule of Benefits.
33. Care rendered within any facility of, or provided by, the United States Veterans' Administration.
34. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country.
35. Expenses for or in connection with hearing aids.
36. Expenses for or in connection with cosmetic surgery, except cosmetic surgery which is not primarily for beautification but is performed to correct or improve a bodily function or congenital malformation, or as provided for under the Women's Health and Cancer Rights Act.
37. Expenses for travel or transportation except ambulance charges as specified under the Major Medical Expenses Benefit.
38. Charges for services furnished by an institution which is primarily a rest home, a home for the aged, a nursing home, a convalescent home, or any institution of like character providing custodial care.
39. Treatment on or to the teeth; treatment of gingival tissues (gums) others than for tumors; Physician's services for extraction of teeth; non-surgical treatment of dental abscesses.
40. Charges for services of a dentist except for the treatment necessary to alleviate damage to teeth or to extract broken and injured teeth, including the replacement of such teeth in whole or in part, where such damage or injury resulted from an accidental bodily injury
41. Charges for services of a dentist except for the surgical removal of impacted (whole or partially) wisdom teeth including anesthesia.
42. Charges for dental X-rays, except when performed in connection with an accidental bodily injury or as mandated by the ACA.
43. Elective procedures except for elective sterilization subject to the conditions described elsewhere in this SPD.

44. Medical treatment received in connection with a pregnancy by Dependent Children, except for certain expenses mandated by the ACA and covered as Preventive Care Services.
45. Any expenses when a Participant is not eligible for benefits.
46. Gene Therapy products or treatment, as defined by the U.S. Food and Drug Administration.
47. Charges due to injuries or illnesses that arise out of the acts or omissions of any person or entity, or that arise under any no-fault coverage.

10.09.02 Limitations on Covered Expenses

Benefits are not payable:

1. For any charges for room and board which are in excess of the hospital's most common rate for semi-private accommodations.
2. For any cosmetic surgery, unless the result of an accident or as provided for under the Women's Health and Cancer Rights Act.

10.10 No Surprises Act - In-Network Cost Sharing for Out-of-Network Services

Effective April 1, 2022, you may only be responsible for In-Network Cost Sharing for certain services, even if an Out-of-In-Network Provider provided those services. "In-Network Cost Sharing" means that the amount you pay out-of-pocket (including amounts paid toward the Deductible, Coinsurance payments, and Copayments) will not be more than it would be if an In-Network Provider provided the services. In addition, the Plan will apply the amount you pay for the services to your In-Network Deductible and In-Network Out-of-Pocket Maximum in the same manner it would apply the amount you would have paid if an In-Network Provider provided those services.

10.11 Surprise Billing Situations

Effective April 1, 2022, you will only be responsible for In-Network Cost Sharing for Surprise Billing Situations.

Network Cost Sharing for Non-Network Services

You may only be responsible for Network Cost Sharing for certain services, even if a Non-Network Provider provided those services.

"**Network Cost Sharing**" means:

- The amount you pay out-of-pocket (including amounts paid toward the Deductible, Coinsurance payments, and Copayments) will not be more than it would be if a Network Provider provided the services. In addition, the Plan will apply the amount you pay for the services to your Network Deductible and Network Out-of-Pocket Maximum in the same manner it would apply the amount you would have paid if a Network Provider provided those services.

"Qualifying Payment Amount ("QPA") means:

- QPA is used to calculate your Network Cost Sharing for items and services covered by the balance-billing protections of the No Surprises Act. In general, your Network Cost Sharing for emergency items and services, air ambulance services, and non-emergency items and services furnished by Non-Network providers in a Network facility, will be the lesser of the billed charges or the QPA.

Surprise Billing Situations

You will only be responsible for Network Cost Sharing for Surprise Billing Situations.

"**Surprise Billing Situation**" refers to:

- Non-Network Emergency Care;
- Non-Network air ambulance services; and
- Non-Network Non-Emergency Care at a Network Facility where there is no Notice and Consent. However, Ancillary Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished are not subject to balance billing even in the absence of Notice and Consent.

"Ancillary Services" mean the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

"**Emergency Care**" means:

- Services in an emergency department of a hospital or an independent freestanding emergency department as well as post-stabilization services in certain instances. The Plan will not require prior authorization for Emergency Care in an emergency department of a hospital or an independent freestanding emergency department. The Plan will not impose any administrative requirement or limitation on Non-Network Emergency Care that is more restrictive than for Network Emergency Care.

"**Notice and Consent**" means that:

- 72 hours before providing the services, the Provider sent you (through postal mail or email) notice of its network status and an estimate of charges; and
- You consented in writing to receiving Non-Network services.

Continuing Care Patients

If, while you are a Network Provider's Continuing Care Patient, the Provider's Network status changes (for example, the Provider no longer participates in the Plan's Network), you will only be responsible for Network Cost Sharing for that Provider's services (if those services are related to the reason you are classified as a Continuing Care Patient) for the period ending on the earlier of:

- The 90-day period beginning on the date the Provider's network status changed; or
- The date on which you are no longer a Continuing Care Patient.

A "**Continuing Care Patient**" is, with respect to a Provider:

- Undergoing treatment for a Serious and Complex Condition;
- Undergoing institutional or inpatient care;
- Scheduled to undergo nonelective surgery, including postoperative care;
- Pregnant and undergoing pregnancy treatment; or
- Terminally ill (as defined by the Social Security Act) and receiving treatment for such illness.

A "**Serious and Complex Condition**" is:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that—
    - Is life-threatening, degenerative, potentially disabling, or congenital; and
    - Requires specialized medical care over a prolonged period of time.

Plan Payment of No Surprises Act Claims

When the Plan receives a “clean claim” which generally means receipt of the information needed to decide a claim for payment for services by a Non-Network provider or facility, the Plan will send an initial payment or a notice of denial of payment not later than thirty (30) calendar days after the Non-Network provider or facility submits a bill related to items and services that fall within the scope of the No Surprises Act balance billing protections.

Provider Directory Information

The Plan will verify and update the provider directory information included on its public website database that contains a list of each health care provider and health care facility with which the Plan has a direct or indirect contractual relationship for furnishing items and services under the Plan. The Plan will provide for the removal of such a provider or facility when it has been unable to verify information during a period specified by the Plan. Notification will be provided that the information contained in the directory was accurate as of the date of publication of such directory and that an individual enrolled under the Plan should consult the database or contact the Plan to obtain the most current provider directory information.

In the case of an individual enrolled under the Plan who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under the Plan, the Plan will follow a protocol under which, in the case such request is made through a telephone call— (A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and (B) retains such communication in such individual’s file for at least 2 years following such response.

External Claims Review

An adverse determination that involves consideration of whether the Plan complied with the surprise billing and cost-sharing protections of the No Surprises Act is eligible for external review.

10.12 General Provisions

In the event that it shall be found that any Covered Participant to whom a benefit is payable is unable to care for his affairs because of illness or accident, any payment due (unless prior claim therefor shall have been made by a dully qualified guardian or other legal representative) may be paid to the Spouse, children, parents, brothers and sisters, nephews and nieces or other person deemed by the Trustees to have incurred expense for such Covered Participant otherwise entitled to such payment. Any such payment shall be a payment for the account of the Covered Participant and shall be a complete discharge of any liability of the Plan and Fund thereof.

The Fund, through its Physician, shall have the right and opportunity to examine the person whose injury or sickness is the basis of claim when and so often as it may reasonably require during pendency of claim hereunder.

If any time limitation of the Plan with respect to giving notice filing proof of loss or commencing an action at law or in equity is less than that permitted by the law of the state in which the Covered Person resides at the time the Plan is in effect such limitation is hereby extended to agree with the minimum period permitted by such law.

Consent of the Covered Participant's beneficiary, if any, shall not be requisite to any change of beneficiary or to any other changes in the Plan.

The Covered Persons shall have the sole right to select their own Physician, Surgeon and hospital and a Physician-patient relationship shall be maintained.

10.12.01 Women's Health and Cancer Rights of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for;

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply:

- In-network deductible for an individual is $600 and $1,200 for a family. The out-of-network deductible for an individual is $1,200 and $2,400 for a family.
- The in-network coinsurance is 25% and the out-of-network coinsurance is 35%.

10.12.02 Common Accident

If a Participant and one or more of his Covered Dependents, or if two or more of a Participant's Covered Dependents receive injuries in the same accident and, as a result of those injuries, incur covered expenses during the same calendar year in which the accident occurs, regardless of the date the Participant and/or Covered Dependent(s) enrolled in the Plan, only one Deductible Amount will be deducted from the total covered expenses incurred for those

individuals during the remainder of that calendar year if the following conditions are met:

- The covered services are incurred no later than 90 days after the accident; and
- The combined allowed amount for covered services for all covered persons involved in the accident is at least equal to one covered person's deductible.

In no event will the provisions of the preceding paragraph be applied if, as a result, a lesser amount should become payable than would otherwise have become payable.

10.12.03 Coordination of Benefits (COB)

All benefit provisions of the plan are subject to this provision. Quite frequently, because Participant and Spouse are working, members of a family are covered under more than one (1) group plan of Participant benefits. Thus, in some instances, benefits are received under two (2) group plans in a total amount greater than the Medical Expense actually incurred.

To avoid duplication of benefits for Allowable Expenses, the benefits paid under the Group Plan shall be reduced so that the total benefits under all plans shall not exceed the Allowable Expense incurred during any calendar year.

"Allowable Expenses" means any necessary, reasonable, and customary item of expense for medical care or treatment covered under at least one (1) of such plans covering the individual for whom a claim is made.

The group health benefits will be coordinated with any other plan providing benefits or services for Allowable Expenses. If another Plan, covering an individual insured under this Group Plan, does not have a coordination of benefits payable for Allowable Expenses under the other plan will be paid in full before any benefits are paid under this Group Plan.

Where both group plans contain a coordination of benefits provision, our Plan will pay first (1st) or second (2nd) based on the following rules:

1. A plan covering a person as a participant will pay benefits first (1st). A plan covering a person as a Dependent will pay second (2nd), except where the Medicare Secondary Payer rules require the Plan to pay benefits first (1st).
2. If a Dependent Child is covered by both parents' plans, the benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first (1st). The benefits of the plan which covers the child of parent whose date of birth, excluding year of birth, occurs later in a calendar year will be determined second (2nd).

If this Plan is coordinating with a plan which contains the gender-based rule and, as a result, the plans do not agree on the order of benefits, the gender-based rule will determine the order.

When the parents are divorced or separated, the order is:

(a) The Plan of the parent with custody pays first (1st). The Plan of the parent without custody pays second (2nd).

(b) If the parent with custody has remarried, the order is:

(i) The plan of the parent with custody;

(ii) The plan of the step-parent;

(iii) The plan of the parent without custody.

If there is a court decree which states that one (1) of the parents is responsible for the child's health care expenses, the plan of that parent will pay first (1st). That order will supersede any order given in (a) or (b). See Section 7.05 regarding Qualified Medical Child Support Orders (QMSCOs).

If a person is covered under more than one (1) plan, the plan he or she was covered under longer pays first (1st). The exceptions to the rule are: A group plan that covers a person other than as a laid-off or retired Participant, or Dependent of such person, will determine the benefits that are paid first (1st). A group plan that covers a person as a laid- off or retired Participant, or Dependent of such person, will determine the benefits that are paid second (2nd).

10.12.04 Genetic Information Nondiscrimination Act of 2008 (GINA)

The Fund shall not adjust its contribution amounts for its Participants on the basis of **genetic** information.

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.

11. Subrogation and Recoupment

This Plan will use its right of Subrogation and Recoupment if you or your Dependent are paid benefits under this Plan for expenses due to injuries or illnesses which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"). The term "Covered Person" as used hereinafter shall include the employee, Participant, or any eligible Dependent as defined elsewhere in the Plan.

11.01 Subrogation

In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"). The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

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

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

11.02 Reimbursement

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

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

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

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

You are also advised that when you or your eligible Dependents submit a claim to this Plan for injury or illness, you will be required to complete and execute a form requesting the following information.

1. How the injury or illness occurred.
2. The identity of any potentially responsible third parties, including their insurer, adjuster, and claim numbers.
3. Accident reports.
4. An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

You may also be required to sign other documents and do whatever is reasonably necessary. to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

You or your eligible Dependent shall not do anything to impair or negate this Plan's Right of Subrogation. If you or your eligible Dependent(s) perform any act or fail to act, and such should compromise the Plan's right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either you or your eligible Dependent(s) in the amount of any outstanding lien.

The Plan may recover mistaken payments in any other lawful manner, as well.

11.03 Recovery of Overpayment

If the Fund makes an overpayment, the Fund may, at any time:

- Recover the overpayment from the party to whom it made the overpayment or the party on whose behalf it made the overpayment; or
- Offset the overpayment amount from future claim payment(s).

By accepting benefits and/or assignment of benefits under the Plan, you:

- Create an *equitable lien by agreement* under which the Fund may seek recovery of any overpayment; and
- Agree that the Fund, in seeking recovery of any overpayment, may pursue your general assets, and/or the assets of the entity to whom or on whose behalf the Fund made the overpayment.

12. Claims Settlement/Appeals Procedure

REVIEW PROCEDURE FOR MEDICAL, DENTAL, VISION, PRESCRIPTION, LOSS OF TIME, DEATH, AND ACCIDENTAL DEATH AND DISMEMBERMENT CLAIMS

You or your authorized representative may appeal the decision to deny any claim for medical, dental, vision, disability retiree program, loss of time, death or accidental death and dismemberment benefits in whole or part. 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. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure.

Note: References to "the Plan" in this Section 12 refer to this Plan document, the Fund Office, as well as parties that the Fund has authorized to administer benefits on its behalf, including Medical Mutual and Caremark.

Note: Appeals of insured benefits, such as dental, vision, Medicare Advantage Plan, must be filed directly with the insurance company in accordance with its rules as set forth in the certificate of coverage and other applicable documents.

12.01 Filing of Claims

A claim must be filed for you to receive benefits.

12.01.01 Filing of Claims Adjudicated by Medical Mutual

With respect to those claims adjudicated by Medical Mutual, claims must be filed within one year from the date of service. Many providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your provider. If your provider does not have a claim form, Medical Mutual will send you one, or you may print a claim form by going to www.MedMutual.com under the Members' section.

In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are pre-approved by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider. To pre-approve treatment by a Non-PPO Network Provider, your Physician must provide Medical Mutual with:

- the proposed treatment plan for the Covered Services;
- the name and location of the proposed Non-PPO Network Provider
- copies of your medical records, including diagnostic reports; and
- an explanation of why the Covered Services cannot be provided by a PPO Network Provider.

Medical Mutual will determine whether the Covered Services can be provided by a PPO Network Provider and that determination will be final and conclusive. Medical Mutual may elect to have you examined by a Physician of its choice and will pay for any required physical examinations. You and your Physician will be notified if Covered Services provided by a Non-PPO Network Provider will be covered as if they had been provided by a PPO Network Provider. If you do not receive written pre-authorization for Covered Services, benefits will be provided as described in the Schedule of Benefits for Covered Services received from a Non-PPO Network Provider.

12.01.02 Filing of Claims Adjudicated by CVS Caremark

With respect to those claims adjudicated by Caremark, claims must be filed within one year

from the date of service. The Claimant must present his or her identification card along with his or her prescription to any participating pharmacy. If the Claimant elects to have his or her prescription filled by a pharmacy other than a participating pharmacy, call or notify Caremark, in writing, and Caremark will send you a form or you may print a claim form by going to www.Caremark.com.

12.01.03 Filing of Claims Adjudicated by the Fund Office

With respect to those claims adjudicated by the Fund Office, claims must be filed within one year from the date of the illness, injury, illness, or death (as applicable). To file a claim, return your completed claim form, along with all required supporting documents, to the Fund Office. Contact the Fund Office to obtain the applicable claim form. The claim form will include a description of the documents (if any) you must submit with your claim.

12.02 Benefit Determination

12.02.01 Benefit Determination in General

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. The Plan will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification is called a Notice of the Adverse Benefit Determination.

12.02.02 Benefit Determination for Urgent Care Claims

The Plan will notify you of its benefit determination for an Urgent Care Claim no later than 72 hours after the Fund receives the claim, unless you fail to provide enough information for the Plan to make a benefit determination. If you do not provide information required to make a benefit determination, the Plan will notify you, no later than 24 hours after the Fund receives the claim, of the specific information necessary to make the determination. You will then have 48 hours to provide the requested information. The Plan will notify you of its benefit determination no later than 48 hours after the earlier of:

- The receipt of the requested information; or
- The end of the period you were afforded to provide the requested information.

12.02.03 Benefit Determination for Pre-Service Claims

If the Pre-Service Claim provides all the information the Plan needs to make a benefit determination, the Plan will notify you of its determination no later than 15 days after Medical Mutual receives the claim. If, due to matters beyond the Plan's control, the Plan cannot make a benefit determination within 15 days, the Plan may extend this period by 15 days, so long as it notifies you of the circumstances requiring the extension, and the date by which the Plan expects to make a determination. If the Pre-Service Claim is missing information, the Plan will notify you no later than 15 days after Medical Mutual receives the claim, and will specifically describe the required information. You will then have 45 days to provide the requested information.

12.02.04 Benefit Determination for Post-Service Claims

If the Post-Service Claim provides all the information the Plan needs to make a benefit determination, the Plan will notify you of its determination no later than 30 days after Medical Mutual receives the claim. If, due to matters beyond the Plan's control, the Plan cannot make a benefit determination within 30 days, the Plan may extend this period by 15 days, so long

as it notifies you of the circumstances requiring the extension, and the date by which the Plan expects to make a determination. If the Post-Service Claim is missing information, the Plan will notify you within 30 days after Medical Mutual receives the claim, and will specifically describe the requested information. You will then have 45 days to provide the requested information.

12.02.05 Benefit Determination for Concurrent Care

Concurrent Care is an ongoing course of treatment that the Plan already approved for a certain period of time or number of treatments. If the Plan decides to reduce or terminate your Concurrent Care (other than by Plan amendment or termination), the Plan will notify you before the end of the previously approved period of time or number of treatments, sufficiently in advance of the reduction or termination, to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated. If you request to extend the Concurrent Care beyond the period of time or number of treatments that, the request will be determined as an Urgent Care Claim or Pre-Service Claim.

12.02.06 Rescission of Benefits

In accordance with the Patient Protection and Affordability Care Act, PPACA, the Fund 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 the Fund. If the Fund 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 Participant's failure to timely pay premiums is not a rescission.

12.03 Notice of Adverse Benefit Determinations

If your claim is denied in whole or part, you will be provided notification 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:

- Identification of the claim (for example and as applicable, the date of service, health care provider, claim amount);
- If applicable, a statement that, upon request and free of charge, you will be provided the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (however, the Fund will not consider a request for such information as a request for an appeal or external review);
- The specific reasons for the adverse benefit determination (including, when applicable, the denial code and its corresponding meaning);
- Reference to the specific Plan provisions on which the adverse benefit determination was based;
- A description of any additional material or information necessary to process the claim and an explanation of why such material or information is necessary;
- As applicable, an explanation of the Plan's external review processes, including time limits and information regarding how to initiate an appeal and/or external review;
- Notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- Notice of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act section 2793, to assist with internal claims and appeals and external review processes (as applicable);
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar

criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon written request;
- Notice that you are entitled to receive, for free upon request, access to and copies of documents that are relevant to your claim;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

A document, record, or other information is “relevant” to your claim if such document, record, or other information:
- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards in making the benefit determination; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

If the Claimant receives an adverse benefit determination –

(i) The Claimant has one hundred eighty (180) days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
(ii) The Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
(iii) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant’s claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined in accordance with applicable law;
(iv) These procedures provide for a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
(v) These procedures provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
(vi) These procedures provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
(vii) All claims and appeals concerning medical benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.
(viii) The identification of medical or vocational experts whose advice was obtained in connection with a Claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided upon written request;

(ix) These procedures provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(x) These procedures provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

- A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant;
- All necessary information, including the benefit determination on review, shall be transmitted to the Claimant by telephone, facsimile, or other available similarly expeditious method; and

(xi) The procedures for claims and appeals involving medical benefits provide that if, during the appeal, any new or additional evidence is considered, relied upon, or generated, the Claimant will be provided free of charge with copies of that evidence before a notice of final adverse benefit determination is issued. The Claimant will have an opportunity to respond before the time frame for issuing a notice of adverse benefit determination expires. Additionally, if a final adverse benefit determination will be issued based on a new or additional rationale, the Claimant will be provided that rationale free of charge before the notice of final adverse benefit determination is issued. The Claimant will have an opportunity to respond before the timeframe for issuing a notice of final adverse benefit determination expires.

12.04 Appeal of Adverse Benefit Determinations

Our procedures contain certain mandatory levels of appeal. After exhaustion, the Claimant may bring a civil action under Section 502(a) of ERISA. We also provide for a voluntary appeal as described below.

12.04.01 Claims Adjudicated by Medical Mutual

With respect to those claims adjudicated by Medical Mutual, the Claimant is required to appeal any adverse benefit determination directly to Medical Mutual in accordance with these procedures.

Once the Claimant receives the determination on such appeal, the Claimant has the right to a second-level external review through an Independent Review Organization ("IRO"), if certain criteria are met. The request for external review must be made within four (4) months from the Claimant's receipt of the adverse benefit determination from Medical Mutual or Caremark. The Claimant may be eligible to have a decision reviewed through the external review process if the following criteria are met:

- The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
- The mandatory internal appeal process has been exhausted unless under applicable law you are not require to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review and you request an expedited external review to proceed simultaneously with an urgent internal appeal, or if you do not receive a timely internal appeal decision);
- The Claimant is or was covered under the Plan at the time the service was requested, or, in the case of retrospective review, was covered under the Plan when the service was provided; and
- The Claimant has provided all of the information and forms necessary to process the external review.

The external review will be conducted by an IRO accredited by a nationally recognized accrediting organization. The Claimant will not be required to pay for any part of the cost of

the external review. All IROs act independently and impartially and are assigned to review the claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The IRO conducting the review will be provided with a copy of the records that are relevant to your medical condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

1. External Review for Non-Urgent Care Claim Appeals

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the interview. The IRO will notify the Claimant and give the Claimant ten (10) business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision.

2. Expedited External Review for Urgent Care Claim Appeals

The Claimant may request an external review for urgent care claims at the same time the Claimant requests and expedited internal appeal of an urgent claim.

An expedited review may be requested if the Claimant's condition, without immediate medical attention, could result in serious jeopardy to the Claimant's life or health or the Claimant's ability to regain maximum function; or the Claimant has received a final internal appeal denial concerning admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision.

If the IRO grants the appeal, then the IRO's decision is final and binding. However, if the IRO denies the appeal, a voluntary appeal is available whereby the Claimant may then appeal any such adverse determination to the Fund's Board of Trustees as described below.

Appeals to medical Mutual should be addressed as follows:

Member Appeals Department
Medical Mutual Services
P.O. Box 94580
Cleveland, Ohio 44101-4580
MZ: 01-4B-4809
Fax: (216) 687-7990

3. Voluntary Appeal

Once you have filed your appeal through Medical Mutual and the IRO as detailed above, and you have been denied at both levels of review, you have the right to file a lawsuit in federal court. However, prior to initiating federal court action you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing of the Notice of Final Decision on your appeal.

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting,

you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Fund will not assert a failure to exhaust administrative remedies;

2. The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;

3. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

    - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;
    - A statement that you have the right to have a personal representative with regard to your claim;
    - A notice of any circumstances which may impair the impartiality of the Board of Trustees;

5. The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

The decision of the Board of Trustees is final and binding.

12.04.02 Claims Adjudicated by Caremark

With respect to those claims adjudicated by Caremark, the Claimant is required to appeal any adverse benefit determination directly to Caremark in accordance with these procedures. Once the Claimant receives Caremark's determination on such appeal, a voluntary appeal is available whereby the Claimant may then appeal any such adverse determination to the Fund's Board of Trustees in accordance with these procedures.

Appeals to Caremark should be addressed as follows:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

12.04.03 Claims Adjudicated by the Fund Office

With respect to those claims adjudicated by the Fund Office, the Claimant is required to appeal any adverse benefit determination directly to the Board of Trustees in accordance with these procedures.

Appeals should be directed to the Board of Trustees and addressed as follows:

Board of Trustees
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406

12.05 Timing of Notification of Benefit Determination on Review

Except as otherwise provided below, 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.

12.05.01 Urgent Care Claims on Review

In the case of a claim involving urgent care, the Claimant shall be notified, in accordance with these procedures, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination.

12.05.02 Pre-Service Claims on Review

In the case of a pre-service claim, the Claimant shall be notified, in accordance with these procedures, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an adverse benefit determination.

12.05.03 Post-Service Claims on Review

In the case of a post-service claim, in those appeals to the Board of Trustees, the Board of Trustees shall make a benefit determination no later than the date of the meeting of the Board of Trustees 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 notify the Claimant in writing 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 5 days after the benefit determination is made.

12.05.04 Disability Claims on Review

The Board of Trustees shall make a benefit determination no later than the date of the 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 notify the Claimant in writing 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 5 days after the benefit determination is made.

12.05.05 Calculating Time Periods

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to these procedures due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review 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.

12.05.06 Furnishing Documents

In the case of an adverse benefit determination on review, you shall be provided such access to, and copies of, documents, records, and other information described below as is appropriate.

12.06 Manner and Content of Notification of Benefit Determination on Review

The Claimant shall be provided with written or electronic notification of the benefit determination on review. Any electronic notification shall comply with the standards imposed by applicable law.

In the case of an adverse benefit determination, the notification shall set forth items provided in Section 12.03, as well as:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined in accordance with applicable law;
- A statement describing any voluntary appeal procedures and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; and
- **In the case of an adverse benefit determination on review of a claim for *disability benefits*—**
    - An explanation as to why the Plan disagreed with the views of (a) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (b) a disability determination of the Social Security Administration.
    - 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.
    - 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.
    - 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.
    - 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.

In addition, notices of adverse benefit determination on review involving medical benefits will be culturally and linguistically appropriate and will include the following:

- Sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount (if applicable);
- Notice of the availability, upon request, of the diagnosis code and treatment coder and their corresponding meanings, if applicable;
- Notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available.

If an internal guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination your right to receive a copy for free upon request.

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

12.07 Definitions

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. The Plan will only consider a claim to be an urgent care claim if an individual acting on behalf of the plan, possessing an average knowledge of health and medicine, determines the claim to be an urgent care claim; or a physician with knowledge of the patient's medical condition determines the claim to be an urgent care claim.

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.

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.

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.

12.08 Limitation of Actions Under ERISA Section 502(a)

No civil action under ERISA Section 502(a) can be filed in any court against the Plan more than three (3) years after the initial denial of a claim for benefits by a Participant or his/her authorized representative.

12.09 Decision on Appeal to Be Final

The decision by Medical Mutual, an IRO, CVS Caremark, the Board of Trustees, or any insurance company or other entity engaged by the Plan, as applicable, on appeals shall be final, 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 level of appeal must be exhausted before any legal action is brought.

12.10 Choice of Law and Venue

A Participant, Beneficiary, Dependent, Surviving Spouse, or any other individual or entity asserting any right under this Plan, or hereby bound directly or indirectly or with rights or obligations hereunder, shall only bring an action in connection with the Plan exclusively in the United States District Court for the Northern District of Ohio at Youngstown, Ohio, or, to the extent not preempted by ERISA, in the Mahoning County, Ohio Court of Common Pleas.

The Plan shall be construed under and in accordance with the law and the laws of the United States of America. In the event there is a matter involving state law that is not preempted by federal law, Ohio law shall be the controlling state law.

13. COBRA Continuation Coverage Rights

13.01 General Notice of COBRA Continuation Coverage Rights
Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Fund. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Fund and under federal law, you should review the remainder of the Fund's Summary Plan Description or contact the Fund Office.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Fund coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

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

If you're the Spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

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

Your Dependent Children will become qualified beneficiaries if they lose coverage under the

Fund because of the following qualifying events:

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to: Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund, 3660 Stutz Drive, Suite 101, Canfield, OH 44406.

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18

additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund is properly notified about the second qualifying event. This extension may be available to the Spouse and any Dependent Children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Fund as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Fund had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my Fund coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period[1], you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Fund may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Fund informed of address changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

13.02 American Rescue Plan Act of 2021 – Extended COBRA Enrollment Period & COBRA Premium Assistance

13.02.01 Extended Enrollment Period

Effective April 1, 2021 through 60 days after the date the Plan sends you notice of the extended enrollment period, you are eligible to enroll in COBRA coverage if:

- You are a "qualified beneficiary" (as that term is defined above in Section 13.01, above) because the participant's hours of employment were reduced or employment ended for any reason other than gross misconduct or the participant's choice; and
- You would be eligible for COBRA coverage on April 1, 2021 if:
    - You elected to enroll in COBRA coverage during the normal COBRA election period; or
    - You had not ended your COBRA coverage.

If you are eligible for the extended enrollment period, the Plan will send you a notice. If you wish to enroll under the extended enrollment period, you must elect such coverage no later than 60 days after receiving that notice.

If you enroll in COBRA coverage under the extended enrollment period, your coverage will be effective from April 1, 2021 through the date your COBRA coverage would have ended if you had previously elected COBRA or had not ended your coverage (as applicable).

13.02.02 Premium Assistance

From April 1, 2021 through September 30, 2021, COBRA premiums will be waived during the time you are eligible for, and enrolled in, COBRA continuation coverage, if:

- You are a "qualified beneficiary" (as that term is defined above in Section II, subsection F, "COBRA Continuation Coverage") because the participant's hours of employment were reduced or employment ended for any reason other than gross misconduct or the participant's choice; and
- You are eligible for COBRA continuation coverage because you enrolled during the normal COBRA election period or you enrolled during the extended enrollment period (as described above).

However, your eligibility for COBRA premium assistance will end on the earlier of:

- The date you are eligible for other group health coverage or Medicare (even if you do not elect to enroll in other coverage);
- The date your COBRA eligibility expires; or
- September 30, 2021.

You must notify the Plan if you are no longer eligible for premium assistance because

you are *eligible* for other group health coverage or Medicare (even if you do not elect to enroll in other coverage). The plan will provide additional information regarding how and when to provide notice that you are no longer eligible for premium assistance, as well as the penalties for failing to provide timely notice.

13.03 COVID-19 Emergency Extension of Certain COBRA Deadlines

Effective March 1, 2020, when determining deadlines to elect COBRA coverage, make COBRA premium payments, and notify the Plan of a qualifying event (when the covered employee or qualified beneficiary is responsible for notifying the Plan) or determination of disability, the Plan will disregard the period beginning March 1, 2020 and ending on the earlier of:

- One year from the date the deadline would have been under normal, non-emergency COBRA procedures; and
- The date that is 60 days after the announced end of the "National Emergency" or such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury.

"National Emergency" refers to the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the determination, under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, that a national emergency exists beginning March 1, 2020, which the President issued on March 13, 2020.

Example: A Qualified Beneficiary would have been required to make a COBRA election by March 1, 2021. With the Emergency Extension, the Qualified Beneficiary now has until the earlier of:

- May 1, 2022 (one year from the date the deadline would have been under normal, non-emergency COBRA rules); and
- 60 days after the end of the National Emergency.

14. Family and Medical Leave Act of 1993

Generally, the Family and Medical Leave Act (FMLA) requires your Employer to provide you with up to twelve (12) weeks of unpaid leave during any twelve (12) month period for specified family and medical reasons, if you are eligible. During this period, your Employer must provide health coverage for you on the same terms and conditions that you receive if you continue to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your Employer is obligated to provide Family and Medical Leave only if your Employer employs fifty (50) or more employees each working day during each of twenty (20) or more workweeks during the current or preceding calendar year.

During the FMLA leave, your Employer must make Contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered Employer must grant an eligible Participant up to a total of twelve (12) workweeks of unpaid leave during any twelve (12) month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (Spouse, child, or parent) with a serious health condition; or
- To take medical leave when the Participant is unable to work because of a serious health condition.
- Eligible employees are entitled to up to twelve (12) weeks of leave because of "any qualifying exigency" arising out of the fact that the Spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- An eligible employee who Is the Spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to leave up to twenty-six (26) weeks in a single twelve (12) month period to care for the service member. This military care giver leave is available during "a single twelve (12) month period" during which an eligible employee is entitled to a combined total of twenty-six (26) weeks of all types of FMLA leave.
- Arrangements will need to be made for Participants to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, a Participant must be restored to his or her original job or to an equivalent job. In addition, Participant's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

15. Coverage During and Subsequent to Service in the Uniformed Services

Uniformed Service: "Uniformed Service" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full- time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services: "Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by Section 12503 of Title 10 or Section 15 of Title 32.

Any eligible employee who becomes absent from his position of employment by reason of service in the uniformed services shall be entitled to elect continuing coverage for himself and his Dependents. This right to elect coverage exists even if the eligible employee will also be covered under a military health plan.

In order to be entitled to continuing coverage, the eligible employee must give advance written or verbal notice of uniformed service to his employer and the Fund Office. This notice will only be excused if the giving of such notice is precluded by military necessity, or if under the circumstances giving notice is deemed otherwise impossible or unreasonable. An eligible employee who wishes to elect continuation coverage from the Fund may elect such coverage under this Section or COBRA (see Section 13), but not both.

Any eligible employee who elects continuing coverage may be required to pay for said coverage as follows:

(1) In the case of an eligible employee who performs service in the uniformed services for less than 31 days, such eligible employee may not be required to pay more than the normal employee contribution rate;
(2) In the case of an eligible employee who performs service in the uniformed services for more than 30 days, such eligible employee may be required to pay not more than 102 percent of the full premium under the Plan.

In the event the eligible employee has a reserve of bank hours, he may use the bank hours in order to cover monthly premiums until all bank hours are exhausted. Thereafter, the eligible employee will be responsible for paying premiums as outlined above. If the eligible employee does not elect continuing coverage, the individual's hour bank shall be frozen until such time as he returns from uniformed services and re-enters employment.

Additionally, if an employer so chooses, it may voluntarily pay the full premium for coverage under the Plan for service members and their families.

The maximum period of coverage available under this election shall be the lesser of:

(1) 24 months from the date on which the eligible employee's absence begins; or
(2) the day after the date on which the eligible employee fails to apply for or return for a position of employment, as set forth below.

Upon the completion of service in the uniformed services, the eligible employee shall notify the Fund Office and his employer of the intent to apply for or return to a position of employment

as follows:

(1) In the case of an eligible employee whose period of service in the uniformed services was less than 31 days, by reporting to the employer:

(a) not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation of the eligible employee from the place of that service to the eligible employee's residence; or

(b) as soon as possible after the expiration of the eight-hour period referred to in clause (1), if reporting within the period referred to in such clause is impossible or unreasonable through no fault of the eligible employee.

(2) In the case of an eligible employee who is absent from a position of employment for a period of any length for the purposes of an examination to determine the eligible employee's fitness to perform service in the uniformed services, by reporting in the manner and time referred to in subparagraph (a) above.

(3) In the case of an eligible employee whose period of service in the uniformed services was for more than 30 days but less than 181 days, by submitting an application for re-employment with the employer not later than 14 days after the completion of the period of service or if submitting such application within such period is impossible or unreasonable through no fault of the eligible employee, the next first full calendar day when submission of such application becomes possible.

(4) In the case of an eligible employee whose period of service in the uniformed services was for more than 180 days, by submitting an application for re-employment with the employer not later than 90 days after the completion of the period of service.

(a) An eligible employee who is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed services shall, at the end of the period that is necessary for the eligible employee to recover from such illness or injury, report to his employer (in the case of person described in subparagraph (a) or (b) above) or submit an application for re-employment with such employer (in the case of a person described in subparagraph (c) or (d) above). Except as provided below, such period of recovery may not exceed two years.

(b) Such two-year period shall be extended by the minimum time period to accommodate the circumstances beyond such eligible employee's control which make reporting within the periods specified above impossible or unreasonable.

Upon an eligible employee's honorable discharge and return from the uniformed service, the eligible employee shall have the right to immediate reinstatement of coverage under the Plan upon re-employment without being subjected to any exclusion or waiting period, provided the eligible employee fulfills the notice requirements outlined above. However, coverage will not be afforded for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. In addition to the required notice, the eligible employee shall also supply the Fund Office with copies of his discharge papers showing the date of his induction or enlistment in uniformed service and the date of his discharge. Failure on the part of the eligible employee to file such

documentation with the Fund Office and/or provide the above notice may be deemed an indication that the eligible employee does not wish to restore his eligibility status under the Plan.

16. Notice of Privacy Practices

THIS NOTICE DESCRIBES:

1. **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND**
2. **HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.**

PLEASE REVIEW THIS INFORMATION CAREFULLY.

16.01 Effective Date

The effective date of this Notice is April 1, 2022.

16.02 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 a copy of health and claims records

- You can ask to see or get a copy of your health and claims records 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are 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 consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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.

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
- You can complain if you feel we have violated your rights by contacting us the Privacy Official, Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund, 3660 Stutz Drive, Suite 101, Canfield, OH 44406.
- 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.

16.03 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 payment for your care
- Share information in a disaster relief situation

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

We will not use or disclose psychotherapy notes about you from your therapist without your written permission. However, we may use and disclose such notes when needed to defend against litigation filed by you.

16.04 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.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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 and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual 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.

16.05 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

16.06 Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

16.07 For Information On or to Exercise Your Individual Privacy Rights

For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

17. Benefit Plan in Review

How are Remittance Reports Processed?
Reports and payments are mailed directly to the Fund's Office. All monies received are deposited in the Trust Fund bank account. Hours listed in the reports and the amounts paid are credited to each Participant's personal account by the Fund Office and provide the basis for determining benefits.

Who Audits the Fund Office Records?
The books and accounts of the Fund are audited yearly by a firm of independent certified public accountants. A copy of the latest financial report will be furnished to anyone upon request.

Who Is Responsible for Monies Paid?
The Trustees, who serve without pay, are responsible for the management of all business affairs of the Fund, including the receipt and disbursement of all money.

Half of these Trustees are appointed by the Union and half are appointed by the Employers. These Trustees, in tum, delegate the day-to-day work to an Administrator who has an office force to accomplish the work.

All Contributions except for necessary expenses and reserves goes toward helping member. No salary or commission of any kind is paid to any trustee, employer representative or to any union official or union agent.

How Are Cash Funds Protected?
All monies received are deposited in banks in the name of the Welfare Trust Fund. No withdrawals or disbursements can be made except by authorization of the Board of Trustees upon signature of at least two designated Trustees. The Trustees, the Administrator and all the office Participants are covered by fidelity bond insurance.

How Do I Become Eligible for Benefits?
To become eligible for benefits, you must complete a Participant Identification Record on which you will list accurate data about yourself and your Dependents. You can get this card from the Fund Office. Eligibility is based on required Contributions received in your behalf during a Work Period as provided for in the Rules of Eligibility. These Contributions will make you eligible, in the subsequent benefit period, for the applicable plan of benefits.

How Long Will My Eligibility Continue?
As long as you meet the eligibility requirements as provided in the Rules of Eligibility and sufficient Contributions are received in your behalf during a Work Period, you will receive benefits in a subsequent Benefit Period.

What If My Hours Are Insufficient for Benefits?
If you are not eligible because sufficient Contributions have not been received by the Fund in your behalf, you may become eligible by making a self-payment as provided for in the Rules of Eligibility.

How Can I Be Sure I Have Sufficient Contributions?
We suggest that you keep a record of the hours you worked as shown on your pay stubs. In this way you can easily tell if you have enough Contributions before the eligibility period closes.

Will I Be Covered During Disability?
The Fund will credit you, if you are an eligible Participant with 2 hours of credit for each day

you are unable to work because of an occupational injury for which you are receiving Worker's Compensation or weekly loss of time benefits from this Fund. This credit will be given without any cost to you or to your Employer for a period not greater than 26 weeks upon receipt by the Fund Office of written proof of disability signed by your doctor. Any additional credits needed to continue your eligibility must be paid by you.

Who Determines Benefits?
When the Fund started in 1963, the Trustees set up a table of benefits based upon estimated income and estimated benefit payment. Since that time, the Trustees have periodically reviewed the actual income ant the actual benefit payment experience, and as a result of their studies the Schedule of Benefits has been revised from time to time.

One of the principal responsibilities of the Board of Trustees is to provide the best benefit schedule in keeping with the income while maintaining overall security in the financial strength of the Fund.

What Benefits Are Provided?
For the active Participant, the active Participant's Spouse, and Dependents, the Welfare Plan pays hospitalization, medical, and surgical benefits. In addition, the Participant is covered by Loss of Time weekly benefits which are payable if the Participant is unable to work because of non-occupational illness or injury; during such time the Participant must be under the regular care of a Physician.

No maternity benefits are provided to Dependent Children, except for Essential Benefits (as that term is defined by the Patient Protection and Affordable Care Act) or otherwise required by law.

Death Benefits are also provided for the Covered Participant.

Who Are My Dependents?
Your Spouse and your Dependent Children (as defined in Section 18).

How Are Benefits Collected?
If you or your Dependents are hospitalized or otherwise entitled to benefits, you should obtain a claim form by phoning or writing to the Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund, 3660 Stutz Drive, Suite 101, Canfield, OH 44406.

Whether you phone or write, always state your full name, address. social security number. and the name of your last Employer. This permits quick and positive identification of your welfare account.

When the claim form is sent to you, it must be presented to your doctor who will complete the medical section; certain other questions must be answered by you and your Employer.

The form is then returned to the Plumbers & Pipefitters Welfare Fund Office along with your bills for hospitalization, surgery, and ambulance service. Payment is made directly to you unless an assignment has been made to the hospital or doctor.

Your claim can be handled by mail; you do not have to take time off to visit the Fund Office.

Will My Other Policies Affect Benefits?
If you or your Spouse or Dependents are covered by another group benefit plan, the Coordination of Benefits provisions described in this booklet would apply.

What Is Meant by Coordination of Benefits?
Coordination of Benefits is the practice by which two group benefit plans “share” the coverage on members of the same family who are covered by separate group benefit plans. The plan in which the claimant is covered as a Participant is usually the primary plan and pays first.

Do I Need Help in Collecting Benefits?
The Fund Office is set up to see that you are paid all the benefits to which you may be entitled. In case of death claim, the Fund Office, upon notification, will send the proper forms to your beneficiary and help with filing without cost to the claimant.

What Benefits Are Paid for Work Injuries?
While you are at work, you are covered by State Worker's Compensation Insurance. This insurance is carried by your Employer as required by State Law, and it pays direct benefits to an injured Participant. Because you are protected under such a policy, the Welfare Fund does not pay for occupational injuries.

However, if an active Participant dies because of injuries on or off the job, the Welfare Fund Benefit Plan provides for the payment of death and accident benefits. Also, it pays specific amount if a Participant loses a hand, foot, or an eye, or two such bodily members, either on or off the job. Such payments are independent of any amount that would be payable under Worker's Compensation laws.

A word of advice regarding occupational injuries. If you believe any condition is due to any injury in the course of your employment, you should insist upon payments due you under Worker's Compensation laws. If you don't, you may permanently deny yourself future benefits if later you should become disabled or hospitalized.

What Are My Unemployment Benefits?
If you are not disabled by illness or injury, you are entitled to apply to the State of Ohio for unemployment compensation.

Will I Be Protected If I Work Outside the Fund Area?
Reciprocity Agreements have been adopted by the Trustees for this Fund. Where the agreements are in effect, they provide for the transfer of Contributions of remittances to the Welfare Fund where the Participant is a member.

What Is Meant by the Term "Earned Benefit Period?"
An earned Benefit Period is that period following a Work Period for which you have established coverage for benefits by hours worked.

What If I Retire Before the Expiration of An Earned Benefit Period?
If you retire before the expiration of an Earned Benefit Period when you have established eligibility by hours worked, you will be entitled to all benefits, including loss of time.

What If I Make A Self-Payment to Establish Eligibility and Then Retire Before the Expiration of My Earned Benefit Period?
If you retire before the expiration of the Benefit Period for which self-payment was made, you will continue to receive all benefits until the expiration of the Earned Benefit Period.

Are Retirees Entitled to Any Benefits Under the Fund?
Eligible retirees who are age 65 and over may be entitled to hospital and medical/surgical benefits as listed in the pages describing a Medicare Supplement with prescription coverage. The Death Benefit for Early Retirees is $10,000. The Death Benefit for Medicare Eligible Retirees who are age 65 and over is $2,000.

18. Definition of Terms

The following terms shall have the meanings set forth below, unless the context of the Trust Agreement clearly requires otherwise.

"Contributions"' shall mean the regular payment which the Employer has agreed to contribute to the Fund on behalf of his Participants.

"Dentist" shall mean a Doctor of Dentistry who is legally qualified to practice dentistry in accordance with all applicable laws.

“Dependent” refers to Dependent Children and a Participant’s Spouse.

“Dependent Child” (plural, “Dependent Children”) refers to a Participant’s biological or adopted child up to age 26, regardless of student status, marital status, support tests, or the availability of employer-based coverage. “Dependent Child” also refers to a Participant’s unmarried biological or adopted child who is older than age 26 and is incapable of self-sustaining employment due to mental or physical disability, and (1) would have otherwise qualified as a Dependent Child when he or she became incapable, (2) is chiefly dependent upon the Eligible Participant for support and maintenance, and (3) the Eligible Participant furnishes due proof of such incapacity.

"Earned Benefit Period" shall mean that period for which an Active Participant is eligible to receive benefits under the Plan by virtue of having the required amount of Contributions paid by his Employer who is required to contribute to the Fund by the provisions of a labor agreement negotiated with the Union.

"Eligible Participant" (also referred to as "Covered Participant") shall mean a Participant who is at the time eligible for benefits as provided in the Rules of Eligibility.

“Emergency Services” refers to treatment for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a person, who possesses an average knowledge of health and medicine, could reasonably expect that, in the absence of immediate medical attention, would result in the following:

- Placing the individual’s health (or, if the individual is pregnant, the individual’s unborn child’s health) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part.

"Employer" shall mean any Employer who is a member of the Youngstown Chapter of P.H.C.C., Inc. of Eastern Ohio and Western Pennsylvania, or any other Association or group of Employers or any individual Employer who has duly executed a collective bargaining agreement with the Union requiring periodic payments to the Fund in the form of remittances or Contributions on behalf of its Participants, or any Employer not a party to such a collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement.

“Hospital" shall mean any institution which meets all of the following requirements:

- Maintains permanent and full-time facilities for five or more resident patients.
- Has a licensed Physician or Surgeon in regular attendance.
- Continuously provides 24-hour-a-day nursing service by registered nurses.
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care for injured and sick persons on a basis other than as rest home, nursing home, convalescent home, or a place for the aged.

- Is operating lawfully in the jurisdiction where it is located.

"Hospital Expense" benefit provides reimbursement for expenses you've incurred as a result of being confined in a covered hospital.

“Marriage” includes any marriage, including a same-sex marriage that is legally recognized as a marriage under any state law.

"Medical Necessity or Medically Necessary" means the service or supply is:

- Consistent with the symptom or diagnosis and treatment of the covered individual's illness or injury;
- Appropriate with regard to standards of good medical practice;
- Not solely for the covered individual's convenience or that of his Physician or the facility at which the covered individual receives treatment; and
- Performed in the least costly setting where services can be safely appropriately provided (e.g., rendered to the covered individual as an inpatient only when the services cannot be safely provided as an outpatient).

Evidence to help decide whether services or supplies were Medically Necessary may be required from the providers of the service before benefits are provided.

"Member of the Family" (also referred to as "covered Dependent") shall include the Participant’s Spouse and all Dependent Child(ren).

“National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak” refers to the public health emergency related to COVID-19 declared by the Secretary of Health and Human Services on January 31, 2020, pursuant to section 319 of the Public Health Service Act.

"Participant" shall mean an individual who is employed by an Employer and is represented for collective bargaining purposes by the Union.

"Physician or Surgeon" shall mean a licensed physician or surgeon who is legally qualified to practice medicine in accordance with all applicable laws.

“Spouse” shall mean any individual who is lawfully married under any state law, including any individual who is lawfully married to a person of the same sex.

"Trust" and "Fund" shall mean the trust estate, as it is from time to time constituted, including investments, the income from any such investments, Contributions, and any other properties received or held by the Trustees for the purposes of the Trust Agreement.

"Trustees" shall mean the Trustees designated in accordance with Article 1, Section 7 of the Restated Agreement and Declaration of Trust of Plumbers and Pipefitters Local Union 396 Health and Welfare Fund.

“Usual, Customary, and Reasonable” fees or charges (also referred to as “UCR”) shall mean the highest allowable expenses that the Plan will accept for a given treatment or procedure. The terms mean charges for services and supplies essential to the care of the individual which do not exceed the usual charges for those services and supplies by health providers in that area. The amount the Plan will pay will be based on the amount for a service or supply customarily charged by the majority of health providers in that geographic area. If the charge is more than the customary charge determined by the Plan, the individual will have to pay the difference.

19. Statement of Your Rights Under ERISA

As a Participant in the Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive information about your Plan and benefits
Examine, without charge, at the Fund Office and at other specific locations, such as work sites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrative Manager or Board of Trustees, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this summary annual report.

Obtain a complete list of the employers sponsoring the Plan, upon written request to the Administrative Manager, which list is available for examination by Participants and beneficiaries.

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.

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

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

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

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

Assistance with Your Questions

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

20. Enrollment / Change of Address Form

Plumbers and Pipefitters Local Union #396 Health and Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 270-0453, ext. 2784

Enrollment / Change of Address Form

If this form is to change current information, mark type of change below:

Add Dependents _____ Change of Address _____
Delete Dependents _____ Change Beneficiary _____

Please complete and return this form to assure enrollment or that your changes are processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

Member Name: _____

Social Security: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

Sex:

Marital Status: _____

Spouse Name: _____

Date of Marriage: _____

Social Security No. _____

Date of Birth: _____

Sex: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Are any family members covered by another group health plan? _____ Yes _____ No

DEATH BENEFIT INFORMATION

Name _____ SSN#: _____

Relationship: _____

Address: _____

_____

Intentionally withholding or falsifying information requested on the form may result in loss of coverage for you and your Dependents.

Member Signature: _____ Date: _____