BENEFIT BOOKLET

FOR THE

LOCAL UNION 598 PLUMBING & PIPEFITTING INDUSTRY

EARLY RETIREE AND MEDICARE-ELIGIBLE RETIREE

HEALTH REIMBURSEMENT ARRANGEMENT,

MEDICARE ADVANTAGE, DENTAL, VISION,

AND LIFE INSURANCE PLAN

January 1, 2016

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TRUSTEES' LETTER

The Benefit Booklet is the Plan Document for the Local Union 598 Plumbing & Pipefitting Industry Early Retiree and Medicare-Eligible Retiree Health Reimbursement Arrangement, Medicare Advantage, Dental, Vision, and Life Insurance Plan (the "Plan" or "Retiree Plan").

The Benefit Booklet describes the Plan's requirements relating to:

- Eligibility requirements for Early Retirees, Medicare-Eligible Retirees and Dependents to participate in and receive benefits from the Plan;
- The circumstances that may result in termination of eligibility;
- The benefits provided by the Plan;
- Your cost of obtaining benefits from the Plan;
- Appeal rights if Your claim to enroll in the Plan or Your claim for benefits from the Plan is denied; and
- Your rights under the Employee Retirement Income Security Act.

The Plan provisions and benefits are not vested. The Trustees have the right to amend, change, or terminate the Plan, including the right to change eligibility rules, change or reduce benefits, change, reduce or eliminate the Benefit Credits to the HRA, and require or increase self-payments. You will be provided a Summary of Material Modifications when there is a material change to the Benefit Booklet.

The Trustees (or a subcommittee of Trustees) have the full and exclusive discretionary authority to determine the scope of benefits provided by the Plan, the policies and procedures for the Plan, to administer and interpret the Plan Document, determine eligibility to participate in the Plan, determine eligibility for benefits provided by the Plan and resolve all questions arising in the administration, interpretation and application of the Plan, subject to the Claim Appeal Procedures on page 71, and Your rights under the Employee Retirement Income Security Act.

No individual Trustee, Union representative, Employer representative, or employee of the Plan Administrator is authorized to interpret the Plan Document for the Trustees. The Trustees have authorized employees of the Plan Administrator to respond informally to written or oral questions on an informal basis. However, the written and oral answers are not binding upon the Trustees.

Terms and phrases that start with capital letters are defined terms. See the **DEFINITION OF TERMS** section starting on page 4.

It is very important that You notify the Plan Administrator whenever one of the following events occurs:

- **The Early Retiree, Medicare-Eligible Retiree or Dependent has a change of address;**
- **The Early Retiree or Medicare-Eligible Retiree has a new Dependent such as a new spouse, the birth of a child, adoption of a child, placement of a child in Your home pending adoption, or placement of a foster child in Your home. If You do not notify the Plan Administrator of this change in family status within ninety (90) days of the event, Your new Dependent will not be eligible to enroll for Plan coverage;**
- **The Early Retiree or Dependent becomes Medicare-eligible;**
- **Divorce or legal separation; and**
- **The Early Retiree or Medicare-Eligible Retiree is planning to return to work.**

The Plan has a website that provides online access to information about the Health Reimbursement Arrangement, paid claims information, eligibility status, enrollment applications, claim forms, a copy of the Benefit Booklet including updates, the ability to ask questions to customer service representatives, and links to the Plan's providers.

To sign up, You need the last six digits of Your Social Security number. Go to www.598benefits.aibpa.com. Once there, click on "Participant Login." Follow the instructions to complete the form. You will then be directed to the benefits homepage. Click the "Sign Up" link on the left-hand side of the page and follow the instructions to create Your account. Use a name and password that only You will know. Also indicate a hint question and answer so that Your password can be provided if You forget it.

Early Retirees, Medicare-Eligible Retirees and Dependents over age twelve (12) can create their own account. The online system requires consent on a case by case basis for a person to review another person's claims information. The only exception is that a parent can review a Dependent child's claims information if the Dependent child is under age twelve (12).

If You would like further information or assistance concerning the Plan, please call or write:

Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

503-224-0048 or 800-205-7002
www.598benefits.aibpa.com

DEFINITION OF TERMS

Benefit Booklet means this document and any amendments, deletions or additions hereto.

Benefit Credits means the amount credited to an Early Retiree's or Dependent's HRA Account as described in the Benefit Booklet.

Calendar Year means January 1 through December 31 of the same year.

Collective Bargaining Agreement means:

(a) A Collective Bargaining Agreement between the Union and an Employer which provides for the payment of Contributions to the Trust;

(b) A Collective Bargaining Agreement between any labor organization other than the Union that is approved by the Trustees and an Employer which provides for the payment of Contributions to the Trust; and

(c) Any extensions, amendments, modifications, supplements or renewals of any of the above-described Collective Bargaining Agreements or any substitute or successor agreements which provide for the payment of Contributions to the Trust.

Contributions or Employer Contributions means payments to the Trust by an Employer as required by the terms of a Collective Bargaining Agreement or Special Agreement. Contributions or Employer Contributions also means payments sent to the Trust pursuant to the United Association National Reciprocity Agreement.

Covered Person means each Early Retiree, Medicare-Eligible Retiree and Dependent who is properly enrolled for Plan coverage. Covered Person includes persons who are covered by the Plan pursuant to COBRA.

Covered Services means services or supplies for which benefits are payable under the Plan. A Covered Service is considered incurred on the date the service or supply is provided.

Deductible means the amount a Covered Person must pay for Dental Services during a Calendar Year before the Trust begins to pay the Percentage Payable.

Dental Hygienist means a person who has been trained in an accredited school or dental college, who is duly licensed by the state in which he is practicing the art of dental prophylaxis, and who is practicing under the direction and supervision of a Dentist.

Dental Services means services and supplies provided to diagnose, prevent or treat diseases or conditions of the teeth and supporting tissues as described in the **DENTAL BENEFITS** section of the Benefit Booklet.

Dentist means a person who is licensed to practice dentistry by the state in which the dental procedure is performed and is practicing within the scope of his license. A Dentist does not include a person who lives with You or is part of Your family (You, Your spouse, child, brother, sister or parent of You or Your spouse).

Dependent means:

(a) An Early Retiree or Medicare-Eligible Retiree's spouse. The term "spouse" means a person of the same or opposite sex whose marriage to the Early Retiree or Medicare-Eligible Retiree is legal in the state or country where it occurred. Same-sex spouses are eligible for Plan benefits on the same basis as opposite-sex spouses.

(b) Children. An Early Retiree or Medicare-Eligible Retiree's children, as defined below, from birth to the end of the calendar month in which the child reaches age twenty-six (26) (or beyond age twenty-six [26] if the child satisfies the continuing disability requirement in (c) below):

(1) Natural children;

(2) Adopted children;

(3) Stepchildren;

(4) A child placed in Your home for the purpose of adoption where You have a legal obligation of total or partial support of the child in anticipation of adoption;

(5) A child for whom You are required to provide Plan coverage pursuant to a qualified medical child support order; and

(6) A foster child placed in Your home by an authorized agency or by judgment, decree, or order of any court of competent jurisdiction.

(c) Disabled Child. A child also includes an unmarried child who is at least age twenty-six (26) and prevented from earning a living because of mental or physical handicap, provided he or she was so handicapped and enrolled for Plan coverage immediately prior to and upon reaching age twenty-six (26). Before the

child reaches age twenty-six (26), the Early Retiree or Medicare-Eligible Retiree must submit documentation to the Plan Administrator that establishes the child qualifies as a Dependent of the Early Retiree or Medicare-Eligible Retiree under this provision and Section 105(b) of the Internal Revenue Code.

Early Retiree means a former Employee who is not Medicare-eligible, who meets the Plan criteria to enroll in the Retiree Plan and is enrolled in the Retiree Plan. An Early Retiree who returns to work covered by a Collective Bargaining Agreement or Special Agreement or has Contributions sent to this Trust per a Reciprocity Agreement shall cease to be an Early Retiree under the Plan immediately prior to the first hour of such employment.

Employee means a person who is working for an Employer in a position covered by a Collective Bargaining Agreement or Special Agreement is having Contributions sent to the Trust pursuant to the Reciprocity Agreement or has established eligibility for Employee Plan benefits by previously working for an Employer or by having Contributions sent to the Trust pursuant to a Reciprocity Agreement. Employee also means a person who has lost eligibility for Employee Plan coverage and is enrolled for COBRA continuation coverage under the Employee Plan.

Employee Plan means the Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Plan and any amendments, deletions, revisions and restatements thereto.

Employer means an entity (including a sole proprietor or partnership) obligated to make Contributions to the Trust by a Collective Bargaining Agreement or Special Agreement.

Healthcare Expense means an expense incurred for "medical care" as defined in Section 213(d) of the Internal Revenue Code, but only to the extent that such expenses are incurred after the date the HRA account is established for the Early Retiree, the expense is not reimbursed or reimbursable by an employer-provided accident or health plan, any other group or individual accident or health plan, and the expenses are not claimed as a deduction on Your or a Dependent's federal income tax return.

HRA means Health Reimbursement Arrangement as described in the Benefit Booklet.

HRA Account means a separate bookkeeping record maintained by the Plan Administrator to record Benefit Credits for an Early Retiree or Dependent as described in the Benefit Booklet.

Medically Necessary means the orthodontic care for an adult which is preauthorized by a Physician and/or Dentist and meets the following criteria:

(a) Provided for the diagnosis or treatment of a medical condition;

(b) Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's medical condition;

(c) Prescribed in accord with generally accepted medical or dental practice on a national basis;

(d) The most appropriate treatment, supply or level of service which can be provided on a cost-effective basis; and

(e) Is not subject to any exclusions or limitations in the Benefit Booklet.

The fact that the Covered Person's Physician and/or Dentist preauthorize orthodontic care for an adult does not mean the orthodontic care is Medically Necessary and covered by the Plan.

Medicare means benefits provided under Title XVIII of the Federal Social Security Act.

Medicare Advantage Plan means the UnitedHealthcare Group Medicare Advantage PPO Plan and any successor plan that the Trustees make available to Medicare-Eligible Retirees and their Medicare-eligible Dependents through this Plan.

Medicare-Eligible Retiree means a former Employee who is eligible for Medicare, who meets the Plan criteria to enroll in the Retiree Plan and is enrolled in the Retiree Plan. A Medicare-Eligible Retiree who returns to work covered by a Collective Bargaining Agreement or Special Agreement or has Contributions sent to the Trust per a Reciprocity Agreement shall cease to be a Medicare-Eligible Retiree under the Plan immediately prior to the first hour of such employment.

Our, We, Us means the Trustees or a subcommittee of Trustees.

Percentage Payable means the amount the Trust will pay for Dental Services at the Usual and Customary Charge after You have satisfied the Deductible in a Calendar Year until You have reached the Calendar Year maximum benefit.

Plan or Retiree Plan means the Benefit Booklet and any amendments, deletions or additions to the Benefit Booklet that are applicable to a Covered Person.

Plan Administrator means the entity the Trustees hire to administrator the Plan and Trust. That entity currently is BeneSys, Inc., 1220 SW Morrison Street, Suite 300, Portland, OR 97205, 503-224-0048 and 800-205-7002.

Plumbing and Pipefitting Industry means work of any nature, for an employer or as an employer, that falls within the trade jurisdiction of the United Association or any local union affiliated with the United Association.

Prohibited Employment means work as an employee or otherwise (for example, independent contractor, owner, or consultant) in the Plumbing and Pipefitting Industry that does not meet one of the following criteria:

(a) Work for or as an employer that has a contractual obligation to make Contributions to the Trust;

(b) Work for or as an employer that contributes to a health and welfare trust or plan sponsored by a local union affiliated with the United Association;

(c) Work for an employer that will remit Contributions on Your behalf to the Trust pursuant to a Reciprocal Agreement;

(d) Work for or as an employer that is involved in contract negotiations that meets one of the criteria in paragraphs (a) through (c) above; or

(e) Work for an employer that does not meet one of the criteria in paragraphs (a) through (d) above, so longer as the individual has received approval from the Trustees to engage in the work without jeopardizing his eligibility for the Retiree Plan.

Protected Health Information means individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. § 160.103 is adopted for use in the Benefit Booklet.

Reciprocity Agreement means the United Association National Reciprocity Agreement.

Reserve Account means a separate bookkeeping record maintained by the Plan Administrator that credits the hours or Contributions that an Employer pays to the Trust on behalf of an Employee including Contributions from a Reciprocity Agreement.

Special Agreement means a written agreement between the Trustees or the Trust and an Employer or the Union that allows the Employer or Union to make Contributions to the Trust for Employees who are not covered by a Collective Bargaining Agreement but who are covered by a Special Agreement.

Trust means the Local Union 598 Plumbing and Pipefitting Industry Health and Welfare Fund.

Trust Agreement means the Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund Trust Agreement effective January 1, 2006, and amendments thereto and restatements thereof.

Trustees means the individuals who govern the Plan and the Trust and their successors.

Union means United Association Local Union 598 and any successor.

United Association means the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada.

Usual and Customary Charge means the …

You, Your means an Early Retiree, Medicare-Eligible Retiree or Dependent who is covered under the Retiree Plan.

ELIGIBILITY

ELIGIBILITY REQUIREMENTS FOR EARLY RETIREES AND MEDICARE-ELIGIBLE RETIREES

The criteria to enroll in the Retiree Plan as an Early Retiree or Medicare-Eligible Retiree and become eligible for the benefits provided by the Retiree Plan are as follows:

(a) Submit an application to enroll in the Retiree Plan with the Plan Administrator within sixty (60) days of Your pension effective date (defined in (c) below) with the Washington State Plumbing and Pipefitting Industry Pension Plan;

(b) Be retired and receiving a monthly pension from the Washington State Plumbing and Pipefitting Industry Pension Plan;

(c) Have health and welfare coverage through the Employee Plan in the month immediate prior to Your pension effective date with the Washington State Plumbing and Pipefitting Industry Pension Plan. Your pension effective date is the first day of the month in which Your pension from the Washington State Plumbing and Pipefitting Industry Pension Plan becomes effective; and

(d) Have fifteen-thousand (15,000) or more hours of Employer Contributions (which can include reciprocity contribution hours) contributed to the Trust preceding Your pension effective date with the Washington State Plumbing and Pipefitting Industry Pension Plan.

ENROLLMENT PROCEDURES FOR EARLY RETIREES AND MEDICARE-ELIGIBLE RETIREES

At the same time you submit an application for pension benefits with the Washington State Plumbing and Pipefitting Industry Pension Plan, you should submit an application to enroll in the Retiree Plan. An application can be obtained from the Plan Administrator, whose address and telephone number are listed on page 2. You may also obtain an application from the Trust's website at www.598benefits.aibpa.com.

The Plan Administrator will inform you whether your application has been accepted or rejected. If your application is rejected, the reason(s) for the rejection will be stated. You may appeal the decision to the Trustees by following the Claim Appeal Procedures in the Benefit Booklet.

GRANDFATHER RULE

Any former Employee whose application to enroll for Early Retiree coverage or Medicare-Eligible Retiree coverage was accepted by the Plan Administrator prior to November 1, 2015,

will be "grandfathered" and be able to re-enroll in the Retiree Plan if he (i) loses eligibility for Plan coverage due to returning to work under a Collective Bargaining Agreement which requires Contributions to the Trust or returns to work and Contributions are made to the Trust under a Reciprocity Agreement after his employment ends; or (ii) his application for Early Retiree coverage or Medicare-Eligible Retiree coverage was accepted by the Plan Administrator and he was allowed to defer enrollment in the Retiree Plan or ceased enrollment in the Retiree Plan for a period of time because he had medical and prescription drug coverage through a spouse's group health plan and retained re-enrollment rights.

EARLY RETIREES AND MEDICARE-ELIGIBLE RETIREES WHO RETURN TO WORK

This Section deals with the situation where an Early Retiree or Medicare-Eligible Retiree is no longer enrolled in the Retiree Plan because he has returned to work under a Collective Bargaining Agreement or Special Agreement which requires a Contribution to the Trust or because Contributions will be made to the Trust under a Reciprocity Agreement. In this situation, the Early Retiree or Medicare-Eligible Retiree and his Dependents will lose Plan coverage immediately prior to the first hour of such employment. You must notify the Plan Administrator in writing as soon as you return to work.

Once You re-retire, You must submit a new application to enroll for Plan coverage unless re-enrollment is automatic under the Grandfather Rule on page 10. It is Your responsibility to notify the Plan Administrator that You have re-retired and want to re-enroll for Plan coverage.

DEPENDENT ELIGIBILITY

Refer to the definitional section of the Benefit Booklet, page 4, to determine which family members qualify as Dependents.

If You are enrolled in the Retiree Plan as an Early Retiree or a Medicare-Eligible Retiree, Your Dependents may also be enrolled for Plan coverage.

In the event a Dependent becomes ineligible for Retiree Plan coverage (for example, in the event of a divorce, legal separation, or child reaching age 26), You must notify the Plan Administrator within thirty-one (31) days of the event resulting in ineligibility.

Dependents will be eligible for Plan coverage at the same time the Early Retiree or Medicare-Eligible Retiree becomes eligible for Plan coverage.

If, after the Early Retiree or Medicare-Eligible Retiree becomes eligible for Retiree Plan coverage, You have a new Dependent, You may enroll Your new Dependent for Retiree Plan coverage. In the event of marriage, coverage is effective on the date of the marriage. In the event of birth, adoption, placement of a child in Your home pending adoption, or placement of a

foster child in Your home, coverage is effective from birth, adoption, or placement in Your home.

You must contact the Plan Administrator for an enrollment form and information about how to enroll the new Dependent. The address and telephone number for the Plan Administrator are on page 2. You must enroll the new Dependent for Retiree Plan coverage within ninety (90) days after the date of marriage, birth, adoption or placement of a child in Your home. If You do not do so, the Dependent will not be eligible for Plan coverage.

WHEN COVERAGE FOR EARLY RETIREES OR MEDICARE-ELIGIBLE RETIREES STARTS

Retiree Plan coverage starts for an Early Retiree or a Medicare-Eligible Retiree on the date specified by the Plan Administrator or the Trustees at the time the application for Retiree Plan coverage is accepted.

WHEN COVERAGE FOR DEPENDENTS START

Retiree Plan coverage starts for a Dependent (assuming timely enrollment) on the latest of the following dates:

(a) The effective date of the Early Retiree or Medicare-Eligible Retiree's Retiree Plan coverage; or

(b) The date that You acquire the Dependent or the date of marriage so long as the Dependent is enrolled for Retiree Plan coverage within ninety (90) days of the event.

By enrolling a Dependent, You are making the representation that the individual satisfies the Plan's definition of Dependent. If that representation is not correct, the individual's coverage may be terminated retroactively. The Plan Administrator may request documentation of a Dependent's eligibility including a marriage license or birth certificate, court papers showing legal adoption, or other information required by the Trustees to establish Dependent status.

WHEN COVERAGE FOR AN EARLY RETIREE OR MEDICARE-ELIGIBLE RETIREE ENDS

Coverage in the Retiree Plan will terminate on the earliest of the following dates:

(a) Immediately prior to Your return to work under a Collective Bargaining Agreement or Special Agreement which requires a Contribution to the Trust, or You return to work for an employer who is obligated to make Contributions to the Trust for You under a Reciprocity Agreement;

(b) The date the Retiree Plan terminates or is amended and You are no longer eligible for Retiree Plan coverage;

(c) The date You notify the Plan Administrator that coverage in the Retiree Plan is being terminated voluntarily;

(d) The date of Your death; or

(e) The date a required premium was not timely paid to the Trust.

WHEN COVERAGE FOR DEPENDENTS ENDS

A Dependent's coverage in the Retiree Plan will terminate on the earliest of the following dates:

(a) For a spouse, the last day of the month in which a divorce or legal separation occurs;

(b) For a child, the last day of the month in which the child reaches age twenty-six (26) unless the child is eligible for continued coverage under the disability provision;

(c) The date Your coverage ends, except when Your coverage ends due to death. In this situation, Dependents who are enrolled for Plan coverage at the time of Your death can continue Retiree Plan coverage as described below;

(d) The date a required premium was not timely paid to the Trust;

(e) The date the Retiree Plan terminates or is amended and the Dependent no longer qualifies for Retiree Plan coverage; or

(f) You or Your Dependent notifies the Plan Administrator that coverage for the Dependent is being terminated voluntarily.

CONTINUED COVERAGE FOR DEPENDENTS IN THE EVENT OF AN EARLY RETIREE OR MEDICARE-ELIGIBLE RETIREE'S DEATH

If an Early Retiree or Medicare-Eligible Retiree dies while enrolled for Plan coverage, his spouse and Dependent children can continue Plan coverage until the earliest of the following dates:

(a) The Dependent child reaches age 26;

(b) Five (5) years from the date of death;

(c) The date a required premium was not timely paid to the Trust;

(d) The date the Retiree Plan terminates or is amended and the Dependent no longer qualifies for Retiree Plan coverage; or

(e) Your Dependent notifies the Plan Administrator that coverage is being terminated voluntarily.

See page 41 of the Benefit Booklet for a description of the circumstances in which Benefit Credits to the HRA account will continue following the death of the Early Retiree.

MEDICAL CHILD SUPPORT ORDERS

The Trustees will recognize and be bound by Qualified Medical Child Support Orders. You may contact the Plan Administrator to obtain the procedures the Trustees follow when a Medical Child Support Order is received.

CLAIM APPEAL PROCEDURES

If You or a Dependent's application to enroll in the Retiree Plan is denied or if You or a Dependent's enrollment in the Retiree Plan is terminated, You or the Dependent may appeal the decision by following the CLAIM APPEAL PROCEDURES which are described on page 71 of the Benefit Booklet.

COVERAGE OPTIONS FOR MEDICARE-ELIGIBLE RETIREES AND/OR MEDICARE-ELIGIBLE DEPENDENTS

INTRODUCTION

By enrolling in the Retiree Plan, a Medicare-Eligible Retiree and/or Medicare-Eligible Dependent will be enrolled in the Medicare Advantage Plan. The Medicare Advantage Plan is a group contract between the Trust and UnitedHealthcare which provides medical and prescription drug benefits through the UnitedHealthcare Group Medicare Advantage PPO. You may call or write the Plan Administrator to receive a summary of the medical and prescription drug benefits provided by the Medicare Advantage Plan.

The Trust pays a portion of the monthly premium for the Medicare Advantage Plan. You or Your Dependent are responsible for paying the balance of the monthly premium. You can call the Plan Administrator to determine the monthly cost.

LIFE INSURANCE BENEFIT

The dental and vision benefits are described in the Benefit Booklet starting on page 27.

For every month that a Medicare-Eligible Retiree is enrolled for the Medicare Advantage Plan, You will be enrolled for the $5,000 life insurance benefit described in the Benefit Booklet. The Trust pays the premium for Your life insurance benefit. There is no life insurance benefit for Dependents.

DENTAL AND VISION BENEFITS

There are four (4) options available for a Medicare-Eligible Retiree and his Dependents as follows:

(a) Elect dental and vision coverage;

(b) Elect dental coverage only;

(c) Elect vision coverage only; or

(d) Elect not to receive dental or vision coverage.

If you do not make an election, no dental or vision coverage will be provided.

The Medicare-Eligible Retiree and Dependents must elect the same coverage. For example, assume a family consisted of a Medicare-Eligible Retiree and a Medicare-Eligible Dependent.

Whatever dental and vision coverage decision is made by the Medicare-Eligible Retiree is applicable to the Medicare-Eligible Dependent.

You are responsible to pay the full cost of the dental and/or vision coverage. You can call or write the Plan Administrator to determine the monthly cost.

DENTAL AND/OR VISION COVERAGE MUST BE CONTINUOUS

You must elect dental and/or vision coverage at the time You first enroll in the Retiree Plan. You must maintain continuous dental and/or vision coverage thereafter.

If You do not elect dental and/or vision coverage at the time You enroll in the Retiree Plan or You drop dental and/or vision coverage after enrolling (for example, if You were to stop making the monthly payment), You will not be eligible to re-enroll in dental and/or vision coverage in the future. There is one exception to this general rule. If You or Your Dependent has had continuous dental and/or vision coverage since enrolling in the Retiree Plan through another group or individual plan, You or Your Dependent may enroll for dental and/or vision coverage when the group or individual dental and/or vision plan terminates provided You or Your Dependent enroll within sixty (60) days of the date the other dental and/or vision coverage has ended.

PAYMENT OF THE MONTHLY PREMIUM FOR THE MEDICARE ADVANTAGE PLAN, DENTAL AND VISION COVERAGE

The monthly premium for the Retiree Plan coverage You and/or Your Medicare-Eligible Dependent select must be paid in full by the first day of the month. For example, coverage for the month of January 2016 must be paid by the first business day of January 2016. There is a grace period until the last business day of the month to pay the full premium. If the full premium is not paid by the last business day of the month, coverage will terminate retroactive to the last day of the previous month. If mailed, the payment must be postmarked by the last business day of the month. If coverage is terminated for non-payment, coverage will not be reinstated and You and Your Dependents will have no further enrollment rights in the Retiree Plan.

There are several payment options available including:

(a) Have the monthly premium deducted from Your Washington State Plumbing and Pipefitting Industry Pension Plan check;

(b) Have the monthly premium deducted from Your HRA Account;

(c) Arrange with the Plan Administrator for an ACH Transfer so the monthly premium is automatically deducted from Your checking or savings account; or

(d) Write a check to the Trust and send the check to the Plan Administrator.

COVERAGE OPTIONS FOR EARLY RETIREES AND DEPENDENTS

INTRODUCTION

By enrolling in the Retiree Plan, an HRA Account will be established and funded for each Early Retiree. The HRA Account in described in more detail on pages ___ through ___.

LIFE INSURANCE BENEFIT

For every month that the Trust makes a Contribution to Your HRA Account, You will also be enrolled for the $5,000 life insurance benefit described in the Benefit Booklet. The Trust pays the premium for Your life insurance benefit. There is no life insurance benefit for Dependents.

DENTAL AND VISION BENEFITS

The dental and vision benefits are described in the Benefit Booklet starting on page 27.

There are four (4) options available for a Early Retiree and Dependents as follows:

(e) Elect dental and vision coverage;

(f) Elect dental coverage only;

(g) Elect vision coverage only; or

(h) Elect not to receive dental or vision coverage.

If You do not make an election, no dental or vision coverage will be provided.

The Early Retiree and Dependents must elect the same coverage. For example, assume a family consisted of a Early Retiree and a Dependent. Whatever dental and vision coverage decision is made by the Early Retiree is applicable to the Dependent.

You are responsible to pay the full cost of the dental and/or vision coverage. You can call or write the Plan Administrator to determine the monthly cost.

DENTAL AND/OR VISION COVERAGE MUST BE CONTINUOUS

You must elect dental and/or vision coverage at the time You first enroll in the Retiree Plan. You must maintain continuous dental and/or vision coverage thereafter.

If You do not elect dental and/or vision coverage at the time You enroll in the Retiree Plan or You drop dental and/or vision coverage after enrolling (for example, if You were to stop making the monthly payment), You will not be eligible to re-enroll in dental and/or vision coverage in the future. There is one exception to this general rule. If You or Your Dependent has had continuous dental and/or vision coverage since enrolling in the Retiree Plan through another group or individual plan, You or Your Dependent may enroll for dental and/or vision coverage when the group or individual dental and/or vision plan terminates provided You or Your Dependent enroll within sixty (60) days of the date the other dental and/or vision coverage has ended.

PAYMENT OF THE MONTHLY PREMIUM FOR DENTAL AND VISION COVERAGE

The dental and/or vision coverage You and/or Your Dependent select must be paid in full by the first day of the month. For example, coverage for the month of January 2016 must be paid by the first business day of January 2016. There is a grace period until the last business day of the month to pay the full premium. If the full premium is not paid by the last business day of the month, coverage will terminate retroactive to the last day of the previous month. If mailed, the payment must be postmarked on by the last business day of the month. If coverage is terminated for non-payment, coverage will not be reinstated and You and Your Dependents will have no further enrollment rights in the Retiree Plan.

There are several payment options available to You including:

(a) Have the monthly premium deducted from Your Washington State Plumbing and Pipefitting Industry Pension Plan check;

(b) Have the monthly premium deducted from Your HRA Account;

(c) Arrange with the Plan Administrator for an ACH Transfer so the monthly premium is automatically deducted from Your checking or savings account; or

(d) Write a check to the Trust and send the check to the Plan Administrator.

COBRA CONTINUATION COVERAGE RIGHTS

THIS SECTION IS APPLICABLE TO DEPENDENTS OF EARLY RETIREES AND MEDICARE-ELIGIBLE RETIREES

INTRODUCTION

This section has important information about Dependents' right to COBRA continuation coverage, which is a temporary extension of HRA, dental and vision insurance coverage. This section explains COBRA continuation coverage, when it may become available, and what needs to be done to preserve the right to COBRA continuation coverage.

The Trust offers no greater rights than what the COBRA statute, regulations and case law requires, and this section of the Benefit Booklet should be construed accordingly.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage that would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event (and any required notice of that event is properly provided), COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose Plan coverage because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHO IS ENTITLED TO ELECT COBRA?

If You are the spouse of an Early Retiree or Medicare-Eligible Retiree, You will become a qualified beneficiary if You lose Your Plan coverage because any of the following qualifying events happens:

(a) Your spouse dies;

(b) Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both); or

(c) You become divorced or legally separated from Your spouse. If an Early Retiree or Medicare-Eligible Retiree cancels Plan coverage for his or her spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost Plan coverage earlier. If the ex-spouse notifies the Plan Administrator within sixty (60) days after the divorce or legal separation and can establish that the Early Retiree or Medicare-Eligible Retiree

canceled the Plan coverage earlier in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Dependent Children (including children participating under a Qualified Medical Child Support Order) of an Early Retiree or Medicare-Eligible Retiree will become qualified beneficiaries if they lose Plan coverage because any of the following qualifying events happens:

(a) The parent dies;

(b) The parent becomes entitled to Medicare benefits (Part A, Part B, or both);

(c) The parents become divorced or legally separated; or

(d) The child is no longer eligible for Plan coverage due to age.

ELECTING COBRA COVERAGE

For the following qualifying events (divorce, legal separation or a child losing dependent status), You must notify the Plan Administrator in writing within sixty (60) days after the divorce, legal separation or child losing dependent status using the procedures specified in the box. If these procedures are not followed and the notice is not provided in writing to the Plan Administrator during the 60-day notice period, a spouse or Dependent child who loses Plan coverage will not be offered COBRA continuation coverage.

NOTICE PROCEDURES

Any notice that You provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver the written notice to the Plan Administrator at this address:

Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the name of the Trust (Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund), the name and address of the Early Retiree or Medicare-Eligible Retiree covered by the Plan and the names(s) and address(es) of the qualified beneficiary(ies). The notice must also state the qualifying event (divorce, legal separation or child who no longer qualifies as a Dependent) and the date the qualifying event happened. If the qualifying event is a divorce or legal separation, Your notice must include a copy of the divorce decree or legal separation.

If the Plan Administrator receives timely written notice that one of the three qualifying events (divorce, legal separation or child losing Dependent status) has happened, the Plan Administrator will notify the family member of the right to elect COBRA continuation coverage. A qualified beneficiary will also be notified of the right to elect COBRA continuation coverage automatically (without any action required by You) when Plan coverage is lost because the Early Retiree or Medicare-Eligible Retiree's death or becoming entitled to Medicare (Part A, Part B or both).

A qualified beneficiary must elect COBRA continuation coverage within sixty (60) days of receiving the COBRA election notice or, if later, sixty (60) days after Plan coverage ends. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. If a qualified beneficiary does not elect COBRA continuation coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The election to accept COBRA continuation is effective on the date the election is mailed to the Plan Administrator. A qualified beneficiary may change a prior rejection of COBRA continuation coverage to acceptance of COBRA continuation coverage until the election period expires.

ARE THERE OTHER COVERAGE OPTIONS AVAILABLE BESIDES COBRA COVERAGE?

Yes. Instead of enrolling in COBRA coverage, there may be other options for Dependents through the health insurance marketplace, Medicaid or another group health plan. Some of these options may cost less than COBRA coverage.

Health Insurance Marketplace. The marketplace offers "one-stop shopping" to find and compare private health insurance options. Through the marketplace, You could be eligible for a tax credit that lowers Your monthly premiums and cost-sharing reductions that lower Your out-of-pocket costs for Deductibles, co-insurance and co-payments. You have a sixty (60) day special enrollment period following the time You lose Your Plan coverage in which to enroll in the marketplace. After sixty (60) days, Your special enrollment period will end and You will not be able to enroll until the marketplace's next open enrollment period. To find out more about enrolling in the marketplace, visit www.healthcare.gov.

Enrollment in Another Group Health Plan. You may be eligible to enroll in health coverage under another group health plan (such as Your spouse's health plan) if You request enrollment within thirty (30) days of the loss of Plan coverage. If a Dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which the Dependent is eligible, the Dependent may have another opportunity to enroll in the other group health plan within thirty (30) days of losing Your COBRA coverage.

BENEFITS AVAILABLE UNDER COBRA CONTINUATION COVERAGE

A qualified beneficiary has the right to elect COBRA continuation coverage for HRA, dental or vision coverage. COBRA continuation coverage is identical to the HRA, dental and vision insurance coverage available to similarly situated Dependents. If the HRA, dental, or vision coverage is modified, COBRA continuation coverage will be modified in the same way. All qualified beneficiaries must select the same coverage.

HOW LONG COBRA CONTINUATION COVERAGE LASTS

COBRA continuation coverage is a temporary continuation of Plan coverage. When the qualifying event is the death of the Early Retiree or Medicare-Eligible Retiree, the Early Retiree becoming entitled to Medicare (Part A, Part B, or both), divorce, legal separation, or a child who no longer qualifies as a Dependent, COBRA continuation coverage for a qualified beneficiary lasts for up to thirty-six (36) months.

COBRA coverage can end before the end of the maximum coverage period for several reasons which are described in the section entitled **TERMINATION OF COVERAGE CONTINUATION COVERAGE BEFORE THE END OF THE MAXIMUM PERIOD**.

COST OF COBRA CONTINUATION COVERAGE

A qualified beneficiary who elects COBRA continuation coverage may be required to pay the entire cost of COBRA continuation coverage. The cost may not exceed 102% of the cost of the group health plan coverage for a similarly situated person who is not receiving COBRA continuation coverage. The cost of COBRA continuation coverage may increase from time to time during Your period of COBRA continuation coverage to the extent permitted by federal law.

WHEN AND HOW PAYMENT FOR COBRA CONTINUATION COVERAGE MUST BE MADE

First Payment for COBRA Continuation Coverage. If You elect COBRA continuation coverage, You do not have to send a payment with the election form. However, You must make Your first payment for COBRA continuation coverage within forty-five (45) days after the date of Your election. This is the date the election form is post-marked, if mailed. If You do not make Your first payment for COBRA continuation coverage within that 45-day period, You will lose all COBRA continuation coverage rights.

Your first payment must cover the cost of COBRA continuation coverage from the time Your Plan coverage would have otherwise terminated up to the time You make the first payment. You are responsible for making sure the amount of Your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of Your first payment.

Your first payment for COBRA continuation coverage should be sent to:

Local Union 598 Plumbing & Pipefitting Industry
Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

Monthly Payments for COBRA Continuation Coverage. After You make Your first payment for COBRA continuation coverage, You will be required to pay for COBRA continuation coverage for each subsequent month of coverage. These monthly payments are due by the first day of the month. If You make a monthly payment by the first day of the month, Your Plan coverage will continue for that coverage period without any break. **The Plan Administrator may not send periodic reminder notices of payments due for these coverage periods.**

Monthly payments for COBRA continuation coverage should be sent to:

Local Union 598 Plumbing & Pipefitting Industry
Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

Grace Period for Monthly Payments. Although monthly payments are due by the first day of the month, You have a grace period of thirty (30) days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period. If You fail to make a monthly payment by the end of the grace period, You will lose all rights to COBRA continuation coverage. If mailed, the COBRA payment must be postmarked on or before the end of the grace period.

TERMINATION OF COBRA CONTINUATION COVERAGE BEFORE THE END OF THE MAXIMUM PERIOD

COBRA continuation coverage will automatically end (even before the end of the maximum coverage period) for any of the following reasons:

(a) The premium is not paid by the end of the grace period;

(b) After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any exclusion for a pre-existing condition;

(c) The Trust no longer provides group health coverage to any of its Covered Persons;

(d) After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both); or

(e) The date the qualified beneficiary notifies the Plan Administrator that he or she will discontinue COBRA continuation coverage.

A qualified beneficiary must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA continuation coverage, he or she becomes entitled to Medicare (Part A, Part B or both), or becomes covered under another group health plan that does not impose any exclusion for a pre-existing condition. Follow the Notice Procedures on page ___ of the Benefit Booklet.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or COBRA continuation coverage rights should be addressed to the Plan Administrator whose address and telephone number are listed below. For more information about Your rights under the Employee Retirement Income Security Act, 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 the EBSA's website. For more information about options available through the Health Insurance Marketplace, visit www.healthcare.gov.

KEEP THE PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES AND CHANGES IN FAMILY STATUS

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members or if You acquire a new Dependent. You should also keep a copy of any notices You send to the Plan Administrator.

The Plan Administrator

The name, address, telephone number, and website of the Plan Administrator are:

BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205
503-224-0048

800-205-7002
www.598benefits.aibpa.com

DENTAL BENEFITS

SUMMARY

If You or Your Dependent, while enrolled for dental benefits, incur expenses for Dental Services, the Trust will pay a percentage of the Dental Services after the Deductible is satisfied. The Trust will pay up to the maximum benefit for each Covered Person enrolled for Dental Benefits each Calendar Year. The Percentage Payable, Deductible and maximum benefit are described below.

INDIVIDUAL AND FAMILY DEDUCTIBLE

The individual Deductible is $50.00 of Dental Services per Covered Person in a Calendar Year. The family Deductible is $150 of Dental Services in a Calendar Year. Once $150 has been paid for covered Dental Services in a Calendar Year by family members, no other family member must satisfy the Deductible for the remainder of the Calendar Year.

PERCENTAGE PAYABLE

After the Deductible is satisfied, the Trust pays eighty percent (80%) of the Usual and Customary Charge for Dental Services up to the maximum benefit.

MAXIMUM BENEFIT EXCEPT FOR ORTHODONTIA TREATMENT

$3,000 for Dental Services for each Covered Person enrolled for Dental Benefits age nineteen (19) or older during a Calendar Year. There is no maximum benefit for Dental Services for a Covered Person enrolled for Dental Benefits under age nineteen (19) except for orthodontia benefits.

ORTHODONTIA MAXIMUM BENEFIT

The Trust pays fifty percent (50%) of the Usual and Customary Charge for orthodontia services up to a maximum of $2,000 for a Dependent child enrolled for Dental Benefits under age nineteen (19). The benefit includes x-rays, extractions, appliances and all other procedures necessary for the orthodontic diagnosis and treatment. Treatment must start while covered by the Plan. After the Trust has paid $2,000 in orthodontia benefits, no additional benefits for orthodontia services will be paid.

COVERED DENTAL SERVICES

The following are covered Dental Services for Covered Persons enrolled for Dental Benefits:

(a) Routine oral examinations by a Dentist, but not more than twice during a Calendar Year.

(b) Routine prophylaxis (cleaning and scaling of teeth) by a Dentist or Dental Hygienist but not more than twice during a Calendar Year.

(c) Fluoride treatment by a Dentist or Dental Hygienist for a Dependent child under the age of sixteen (16), but not more than once during a Calendar Year.

(d) Prosthetic devices (including dentures, gold restorations, bridges and crowns) and the fitting of those devices if the device was ordered after the Covered Person became covered for Dental Services and it is installed no later than ninety (90) days after the Covered Person ceases to be covered for Dental Services.

(e) Replacement of an existing removable denture or fixed bridgework.

(f) Addition of teeth to a removable denture or fixed bridgework.

(g) Addition of teeth to an existing partial removable denture or bridgework.

(h) Orthodontic care, treatment, services and supplies, for a Dependent child only except as allowed in Subsection (i).

(i) For adults (age nineteen [19] and older), orthodontic care is allowed (subject to the $2,000 limit) when Medically Necessary for treatment of a medical condition. This benefit is subject to preauthorization by a Physician and/or Dentist.

(j) X-rays as described below:

  (1) Full mouth series: benefits are limited to one service in five consecutive Calendar Years;

  (2) Panoramic x-ray: benefits are limited to one service in five consecutive Calendar Years;

  (3) Bite wing films: benefits are limited to four films per Calendar Year.

(k) Sealants for a Dependent child under the age of sixteen (16). This benefit applies only to the permanent molars. This benefit is allowable once during a Calendar Year.

(l) Periodontal services consisting of scaling and root planning is allowed once each three consecutive Calendar Years.

(m) Periodontal maintenance is allowed once in a three month period after the active periodontal services have last been provided.

(n) Full mouth debridement is allowed once per lifetime and the benefit will not be allowed if prophy was performed in the previous eighteen (18) months.

(o) Dental implants, implant supported prosthetics and any related services associated with evaluation, preparation, maintenance, placement and removal of implants.

CONDITIONS

The Trust will pay benefits for (e), (f), and (g) under **Covered Dental Services** only if:

(a) The replacement or addition of teeth is required to replace one or more natural teeth for the first time;

(b) The existing denture or bridgework cannot be made serviceable and was installed five years prior to its replacement; or

(c) The existing denture is an immediate temporary denture requiring replacement by a permanent denture and the replacement is delivered or installed within twelve (12) months following the installation of the temporary denture (subject to Subsection (d) above).

EXCLUSIONS

The Trust will not pay for:

(a) Any expense which was incurred while the Covered Person is on active duty or training in the armed forces, National Guard or reserves of any state or country and for which any governmental body or its agencies are liable;

(b) Any procedure provided principally to improve the appearance of the Covered Person;

(c) Any expense for orthodontic treatment other than for a Dependent child under age nineteen (19) (including correction of malocclusion) except as allowed by Subsection (i) under Covered Dental Services;

(d) Any facings on crowns posterior to second bicuspids;

(e) Any specialized techniques involving precision dentures for personalization or characterization;

(f) Orthodontia performed exclusively on primary teeth;

(g) Any expense for any portion of a dental procedure performed before the effective date or after the termination of Your dental coverage except as allowed by Subsection (d) under Covered Dental Services;

(h) Any expense for replacement of lost or stolen appliances, dentures or bridge-work;

(i) Any expense for dental appointments that are not kept, completion of claim forms or completion of reports requested by the Plan Administrator in order to process a claim;

(j) Any expense which is not identified as a Covered Dental Service in this Dental Benefits section;

(k) Any expense exceeding the maximum benefit;

(l) Any expense for direct or indirect pulp-capping;

(m) Any expense related to cosmetic or reconstructive procedures including realignment of teeth (except as specifically allowed by the Orthodontia Maximum Benefit or the orthodontic care benefit in Subsection (i) under Covered Dental Services);

(n) Any expense related to the diagnosis or treatment of congenitally missing teeth or congenital malformations;

(o) Any expense for duplication of treatments, procedures or supplies including but not limited to when a Covered Person transfers from the care of one Dentist to the care of another Dentist;

(p) Any expense for night guards;

(q) Any expense for grathologic recordings;

(r) Any expense which arises out of or in the course of any employment with any employer or self-employment for which the Covered Person is or could be entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a workers' compensation carrier.

(s) Any expense or charge which is in excess of the Usual and Customary Charge;

(t) Any expense resulting from the Covered Person's commission or attempted commission of a felony;

(u) Any expense which the Covered Person does not have a legal obligation to pay;

(v) Any expense or charge for Dental Services or supplies which are not provided in accord with generally accepted professional standards on a national basis;

(w) Any expense for Dental Services or supplies received from a federal, state or local governmental agency or program where the care is available without cost to the Covered Person except to the extent the services or supplied are required by law to be paid by the Plan;

(x) Any expense which would be covered by a personal injury protection insurance required by statute under an automobile insurance policy whether or not the Covered Person obtained an automobile insurance policy including such coverage;

(y) Any expense incurred while the Covered Person's legal residence is not within the United States;

CLAIM APPEAL PROCEDURES

If You have a claim for dental benefits that is denied in whole or in part, You must follow the **CLAIM APPEAL PROCEDURES** which are described on page 71 of the Benefit Booklet.

VISION BENEFITS

INTRODUCTION

The vision benefit is provided by a group contract between the Trust and Alaska Vision Services Plan. The terms of the group contract are summarized below. In the event of a conflict between this summary and the group contract, the terms of the group contract control. If You would like a copy of the group contract, contact the Plan Administrator.

If Your or Your Dependent, while enrolled for vision benefits, incur expenses for covered vision services and materials, Alaska Vision Services Plan will pay for the covered vision services and materials as described below.

HOW TO USE THE VISION PLAN

(a) Vision benefits can be obtained from a Vision Service Plan ("VSP") network provider or an out-of-network provider. In most instances, there is a lower out-of-pocket cost by using a VSP network provider. See **SUMMARY OF YOUR VISION BENEFITS** below.

(b) To find a VSP network provider, call VSP at (800) 877-7195, or visit the VSP website at www.vsp.com.

(c) If You use a VSP network provider, identify Yourself as a VSP member. Your VSP provider will handle the rest.

(d) You do not have to use a VSP network provider. You may use a VSP network provider to dispense Your glasses even if Your exam was performed by a non-VSP provider. Likewise, You may obtain an eye exam from a VSP network provider and have Your glasses dispensed from a non-VSP provider.

SUMMARY OF YOUR VISION BENEFITS

Type of Vision Service	VSP Network Payment Amount	Out-of-Network Maximum Benefit Payment Amount	Frequency of Service
Examination	Paid in full	Up to $50	Once every 12 months
Frames	Up to $150	Up to $70	Once every 12 months
Single lenses	Paid in full	Up to $50	Once every 12 months
Bifocal lined lenses	Paid in full	Up to $75	Once every 12 months
Trifocal lined lenses	Paid in full	Up to $100	Once every 12 months

Type of Vision Service	VSP Network Payment Amount	Out-of-Network Maximum Benefit Payment Amount	Frequency of Service
Lenticular	Paid in full	Up to $125	Once every 12 months
Contact lens exam	You pay a maximum of $60, VSP pays the rest.	Not covered	Once every 12 months
Contact lenses (elective) Only covered in lieu of lens and frame	Up to $150	Up to $105	Once every 12 months
Contact lenses and examination* (necessary)	Paid in full	Up to $210	Once every 12 months

* Contact lenses are necessary when certain benefit criteria are satisfied. Call VSP at 800-877-7195 to determine the specific benefit criteria for contact lenses to be necessary. If You obtain necessary contact lenses, You will not be eligible for a frame and lenses for twelve (12) months from the date the contact lenses were obtained.

LENS OPTIONS

Lens Option	VSP Network Payment Amount	Out-of-Network Maximum Benefit Payment Amount
Progressive multi-focal lenses	Paid in full	Up to $75
Polycarbonate lenses	Paid in full	Not covered
Anti-reflective coating	Paid in full	Not covered

LOW VISION BENEFITS

This section describes benefits for professional services for severe vision problems not correctable with regular lenses.

Type of Vision Service	VSP Network Payment Amount	Out-of-Network Maximum Benefit Payment Amount	Maximum Benefit
Supplemental testing (includes evaluation, diagnosis, and prescription of corrective eyewear or vision aids where indicated)	Paid in full up to maximum benefit	Up to $125	Maximum benefit for all low vision services and materials is $1,000 every two years
Supplemental care aides	75% of cost up to maximum benefit	75% of cost up to maximum benefit	Maximum benefit for all low vision services and supplemental aides is $1,000 every two years

DISCOUNTS AND SAVINGS WHEN USING A VSP NETWORK PROVIDER

(a) Thirty percent (30%) off additional pairs of glasses or sunglasses from a VSP network provider on the same day as Your eye exam, or get twenty percent (20%) off from any VSP network provider within twelve (12) months of Your last exam.

(b) Average thirty-five percent to forty percent (35%–40%) savings on lens options such as scratch resistance, anti-reflective coatings, and progressives.

(c) Average fifteen percent (15%) discount off the cost of contact lens exam (fitting and evaluation).

(d) Twenty percent (20%) discount off the amount over Your $150 frame allowance.

(e) Average fifteen percent (15%) discount off the regular price or five percent (5%) discount off the promotional price of laser vision surgery. Discounts only available from contracted facilities.

PROCEDURE IF YOU USE AN OUT-OF-NETWORK PROVIDER

(a) Obtain Your exam and any necessary eyewear (lenses, frame or contacts) and pay the bill in full. Remember to get an itemized receipt.

(b) Mail the itemized receipt to:

VSP
PO Box 997105
Sacramento, CA 95899

(c) When mailing the receipt, be sure to identify the Vision Plan as Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund and include the following information:

(1) Early Retiree or Medicare-Eligible Retiree's name;

(2) Address;

(3) Social Security number;

(4) Patient's name;

(5) Date of birth of patient; and

(6) Patient's relationship to the Early Retiree or Medicare-Eligible Retiree.

(d) If You have Internet access, You may sign on to www.vsp.com and select the Out-of-Network Reimbursement Form and follow the directions.

(e) You must submit the out-of-network provider's itemized billing statement to VSP within twelve (12) months of the date of service.

(f) VSP will reimburse You according to the out-of-network maximum benefit payment amount in the **SUMMARY OF YOUR VISION BENEFITS** section.

WHAT IS COVERED AND WHAT IS NOT COVERED

(a) **Services Covered.**

(1) *Vision Examination*. Includes a refraction test to determine the need for glasses, analysis for binocularity, and testing of the overall health of the eyes and related optic structures. This benefit is available once every twelve (12) months from the last exam. The cost of the exam is covered in full if the exam is performed by a VSP network provider.

(b) **Eyewear Covered.**

(1) *Lenses*. Benefits from a VSP network provider for standard lenses, lined bifocal, lined trifocal, and lenticular are paid in full and available once every twelve (12) months from the last date of service.

(2) *Frame*. A frame from a VSP network provider is paid up to $150 and is available once every twelve (12) months from the last frame purchased. Before You select Your frame, check with Your VSP network provider to find out which frames are fully covered by the Plan.

(3) *Elective Contacts*. Benefits from a VSP network provider for elective contact lenses are paid in full up to $150. You are responsible for a co-payment for the contact lens exam up to a maximum of $60. Optional contact lenses are available once every twelve (12) months from the last day of service.

(4) *Necessary Contacts.* When You meet VSP's criteria for necessary contact lenses from a VSP provider, the contact lenses and examination

(evaluation and fitting) are paid in full and available once every twelve (12) months from the last date of service.

(c) **Services and Eyewear not Covered.** There is no benefit for professional services or materials connected with:

(1) Orthopedics or vision training and any associated supplemental testing;

(2) Plano lenses (less than +0.50 diopter power);

(3) Two pair of glasses instead of bifocals;

(4) Replacement of lenses and frame which are lost or broken, except at the normal intervals when services are otherwise available;

(5) Medical or surgical treatment of the eyes;

(6) Corrective vision treatment of an experimental nature;

(7) Costs for services and/or materials above the Plan allowances; and

(8) Services and/or materials not indicated in the **SUMMARY OF YOUR VISION BENEFITS** section of the Benefit Booklet.

VISION BENEFIT LIMITATIONS

Vision benefits are designed to cover visual needs rather than cosmetic materials. When You select any of the following extras, the Vision Plan will pay the basic cost of the allowed lenses or frames and You will pay the additional cost for the following options:

(a) Optional cosmetic processes;

(b) Color coatings;

(c) Mirror coatings;

(d) Scratch coatings;

(e) Blended lenses;

(f) Cosmetic lenses;

(h) Oversize lenses;

(i) UV (ultraviolet) protective lenses;

(j) Certain limitations on low vision care;

(k) A frame that costs more than the Vision Plan allowance; and

(l) Contact lenses (except as noted elsewhere in the Vision Benefits section).

(g) Laminated lenses;

DIABETIC EYE CARE PROGRAM

The Diabetic Eye Care Program is intended to be a supplement to a Covered Person's medical coverage. Providers will first submit a claim form to the Covered Person's medical plan and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP.

Examples of symptoms which may result in a Covered Person seeking services under the Diabetic Eye Care Program include but are not limited to:

(a) Blurry vision;

(b) Transit loss of vision;

(c) Trouble focusing; and

(d) Floating spots.

Examples of conditions which may require management under the Diabetic Eye Care Program include, but are not limited to:

(a) Diabetic retinopathy (a weakening in the small blood vessels on the back of the eye);

(b) Diabetic macular edema (swelling of the retina in diabetes); and

(c) Rubeosis (abnormal blood vessel growth on the iris and the structure in the front of the eye).

The Diabetic Eye Care Program is available only through VSP Network Doctors.

Covered Services for Diabetic Eye Care Program:

Eye examination:	Covered in full after a copayment of $20.00
Special ophthalmological services:	Covered in full

Exclusions and Limitations for Diabetic Eye Care Program:

The Diabetic Eye Care Program provides coverage for limited vision-related medical services. A current list of these procedures will be made available to the Covered Person upon request. The

frequency at which these services may be provided is dependent upon specific service and the diagnosis associated with such service.

Not Covered by Diabetic Eye Care Program:

(a) Frames, lenses, contact lenses, and any other ophthalmic materials;

(b) Orthoptics or vision training and any associated supplemental testing;

(c) Surgery of any type and any pre- or post-operative services;

(d) Treatment of any pathological conditions;

(e) An eye examination required as a condition of employment;

(f) Insulin or any medications or supplies of any type; and

(g) Local, state, and/or federal taxes, except where VSP is required by law to pay.

CLAIM APPEAL PROCEDURE FOR VISION BENEFITS

(a) **Complaints and Grievances.** Covered Persons should report any complaints and/or grievances to VSP at the address or telephone number on page 39. Complaints and grievances are disagreements regarding access to care, quality of care, treatment, or services. Complaints and grievances may be submitted to VSP verbally or in writing. A Covered Person may submit written comments and supporting documents concerning his complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt unless special circumstances require an extension. In that case, resolution shall be achieved as soon as possible but not later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, it will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

(b) **Appeal of a Denied Claim.** If a claim is denied in whole or in part, a request may be submitted to VSP by the Covered Person or his authorized representative for a full review of the denial.

Initial Appeal. The appeal must be filed within 180 days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied including the Early Retiree or Medicare-Eligible

Retiree's name, his VSP member identification number, the Covered Person's name and date of birth, the provider of services, and the claim number. The Covered Person may review, during normal working hours, or receive by mail any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documents concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided to the Covered Person within thirty (30) calendar days after receipt of a request for review.

Second Level Appeal. If the Covered Person disagrees with the response to the initial appeal, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies. When the Covered Person has completed the appeal process stated above, additional voluntary alternative dispute resolution options may be available including mediation or arbitration. You may contact the Plan Administrator or VSP for details. Additionally, under Section 502(a)(1)(B) of the Employee Retirement Income Security Act, the Covered Person has the right to bring a civil action against VSP when all available levels of review have been completed, the claim was not approved, and the Covered Person disagrees with the outcome.

Time of Action. No lawsuit shall be brought against VSP until the Covered Person has exhausted the appeal procedures and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with VSP. No action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoice was submitted to VSP.

ADDRESS AND TELEPHONE NUMBER FOR VISION SERVICE PLAN

Contact information for VSP grievances and appeals is as follows:

Vision Service Plan Insurance Company
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
T: (800) 877-7195

HEALTH REIMBURSEMENT ARRANGEMENT FOR EARLY RETIREES

INTRODUCTION

A Health Reimbursement Arrangement account (HRA) will be established for each Early Retiree upon enrollment in the Retiree Plan and, in certain limited circumstances described below, for a Dependent. The Trustees decide the amount of Benefit Credits, if any, that will be deposited into each HRA account. **The amount of Benefit Credits deposited into an HRA account is not a vested amount. The Trustees retain the full authority to increase, decrease, or eliminate the Benefit Credits deposited into HRA accounts.**

HRA BENEFIT CREDITS FOR EARLY RETIREES ENROLLED PRIOR TO JANUARY 1, 2016

If You have been recognized as an Early Retiree prior to January 1, 2016, a monthly Benefit Credit will be deposited in Your HRA account on or about the first day of each month. The Benefit Credit amount starting January 1, 2016 until changed by the Trustees, is as follows:

(a) $500 per month if You were recognized as an Early Retiree prior to January 1, 2016, unless (b) applies; or

(b) $800 per month if You were recognized as an Early Retiree prior to January 1, 2016, and You have a spouse that is not Medicare-eligible on the first day of the month.

HRA BENEFIT CREDITS FOR EARLY RETIREES ENROLLED AFTER DECEMBER 31, 2015

If You are first recognized as an Early Retiree after December 31, 2015, a monthly Benefit Credit will be deposited into Your HRA account on or about the first day of each month. The Benefit Credit depends on the number of hours of Employer Contributions (which can include reciprocity contribution hours) contributed to the Trust preceding Your pension effective date with the Washington State Plumbing and Pipefitting Industry Pension Plan as follows:

Hours of Employer and Reciprocity Contributions	**Monthly Benefit Credits as a percentage of the Benefit Credit for Early Retirees enrolled prior to January 1, 2016**
15,000 to 22,499 hours	25%
22,500 to 29,999 hours	50%
30,000 to 37,499 hours	75%
37,500 or more hours	100%

For example, if an Early Retiree, who is not married, enrolls in the Plan on March 1, 2016, and has 22,000 hours of Employer and reciprocity Contributions, his monthly Benefit Credit would be $125.00 ($500 x 25% = $125.00).

ADDITIONAL HRA BENEFIT CREDITS FOR EARLY RETIREES WITH A FORFEITED RESERVE ACCOUNT

When an Employee terminates enrollment in the Employee Plan and becomes enrolled in the Retiree Plan, his Reserve Account is forfeited. Benefit Credits equal to the credits in Your Reserve Account that was forfeited will be credited to Your HRA account.

WHEN BENEFIT CREDITS TO YOUR HRA STOP

Benefit Credits to Your HRA will stop on the earliest of the following dates:

(a) You work in Prohibited Employment;

(b) You become eligible for Medicare (except as described below);

(c) You return to work under a Collective Bargaining Agreement or Special Agreement which requires a Contribution to the Trust or You return to work for an employer who is obligated to make Contributions to the Trust for You under a Reciprocity Agreement;

(d) You notify the Plan Administrator that coverage in the Retiree Plan is being terminated voluntarily;

(e) You die (except as described below); or

(f) The Trustees terminate the Retiree Plan or change the eligibility rules and You are no longer eligible for the Retiree Plan or You remain eligible for the Retiree Plan but ineligible for HRA Benefit Credit.

HRA BENEFIT CREDITS FOR AN EARLY RETIREE'S SPOUSE OR DEPENDENT CHILD(REN)

If an Early Retiree becomes eligible for Medicare or dies and at the time of Medicare eligibility or death, has a spouse who is not Medicare-eligible or a Dependent child who is not Medicare-eligible and under age 26, Benefit Credit will continue to be made to an HRA in Your name or the name of Your spouse or Your Dependent child (in the event of Your death) until the earliest of the following events:

(a) You return to work under a Collective Bargaining Agreement or Special Agreement which requires a Contribution to the Trust or You return to work for an employer who is obligated to make Contributions to the Trust for You under a Reciprocity Agreement;

(b) Five (5) years from the date of Your Medicare eligibility or death;

(c) Your spouse reaches age 65;

(d) Your Dependent child reaches age 26;

(e) Your Spouse or Dependent child becomes eligible for Medicare;

(f) The Retiree Plan is terminated; or

(g) The Trustees change the HRA Benefit Credit rules for a spouse and/or Dependent child.

The monthly contribution to the HRA account for the spouse or Dependent child shall be in an amount determined by the Trustees from time to time.

WHAT IS AN HRA AND HOW CAN IT BE USED?

The HRA is intended to qualify as a "health reimbursement arrangement" as that term is defined in Internal Revenue Service Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code. This section of the Benefit Booklet will be interpreted at all times in a manner consistent with this intent.

The Benefit Credits in Your HRA can be used to reimburse You for Healthcare Expenses incurred by You and Your Dependents on a tax-free basis. In no event shall any Benefit Credits be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement for Healthcare Expenses. A more detailed description of what constitutes a Healthcare Expense is under the heading **Allowable Uses for the Benefit Credits in Your HRA Account** on page 43 of the Benefit Booklet.

Early Retirees and Dependents are not allowed to contribute to the HRA. However, a Dependent may be required to pay the "appropriate premium" for continuation of HRA coverage under COBRA. See **COBRA Continuation Coverage Rights** section on page 20 of the Benefit Booklet for more information.

WHEN YOUR HRA ACCOUNT IS ESTABLISHED

An Early Retiree becomes an HRA participant when Benefit Credits are first transferred to Your HRA account. You will remain an HRA participant as long as there are Benefit Credits in Your HRA account. The transfer of Benefit Credits to Your HRA account will normally take place on the first business day of the month.

The Plan Administrator will establish and maintain an HRA account for each Early Retiree (and, in limited situations described on page 41, a Dependent) who meets the participation rules described in the Benefit Booklet. Your HRA account will be used to receive Benefit Credits and to reimburse You for Healthcare Expenses incurred by You or a Dependent.

Although each Early Retiree's HRA account will be separately identified, the combined Benefit Credits of all HRA accounts will be identified in the Trust's financial statements as HRA reserves. The HRA account established for each Early Retiree is merely a recordkeeping account for the purpose of tracking the Benefit Credits into Your HRA account and deductions from Your HRA account.

Each October, You will receive a statement from the Plan Administrator detailing Benefit Credits to and deductions from Your HRA account.

Your HRA account will not be credited with any investment gains or losses that result from the investments. Expenses associated with the administration of Your HRA account will not be deducted from Your HRA account. The Trustees have the authority to credit HRA accounts with investment income and deduct administrative expenses from Your HRA account in the future as circumstances warrant.

You can access Your HRA account through the internet at www.598benefits.aibpa.com. Once logged in You can view Your HRA account Benefit Credits, claims payment history, submit claims, sign up for text notifications, and direct deposit reimbursement.

If You own an iPhone or android, You can download the mobile app. Search for "A&I" in the Apple App Store or android Google Play Market and log in with the same user name and password as Your online account. You can upload a receipt from Your phone, file a claim, and view Your HRA account balance 24/7.

ALLOWABLE USES FOR THE BENEFIT CREDITS IN YOUR HRA ACCOUNT

The Benefit Credits in Your HRA account can be used to reimburse You for Healthcare Expenses that are incurred by You or a Dependent as described in this section. Healthcare Expense means "medical care" as defined in Section 213(d) of the Internal Revenue Code and that definition is adopted for use in the Plan. IRS Publication 502 "Medical and Dental Expenses" under the headings "What Medical Expenses are Includable" and "What Expenses are not Includable" provide general guidance. As a general rule, Healthcare Expenses include

unreimbursed Healthcare Expenses You or a Dependent incur after Benefit Credits have been deposited in Your HRA for:

(a) Co-Payments, Coinsurance, and Deductibles for a medical insurance plan, a dental insurance plan, a vision insurance plan or a prescription drug plan;

(b) Unreimbursed medical, dental, or vision expenses;

(c) Hearing aids; and

(d) Premiums for a medical, prescription drug, dental, or vision insurance plan.

"Incur" and "Incurred" means the date the service or treatment is provided, not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

INELIGIBLE EXPENSES

In no event will the following expenses be eligible for reimbursement from Your HRA account:

(a) Expenses that are not for "medical care" as defined in Section 213(d) of the Internal Revenue Code;

(b) Expenses incurred prior to the date that Your HRA account was established.

(c) Expenses that have been reimbursed by another health plan or for which You expect to receive reimbursement under another health plan;

(d) Expenses that You have claimed or intend to claim as a deduction on Your or Your Dependent's Federal Income Tax Return;

(e) Expenses not substantiated to the satisfaction of the Plan Administrator or Trustees; or

(f) A COBRA payment, self-payment, or partial self-payment to maintain or continue health and welfare coverage under the Employee Plan.

TIME PERIOD TO SUBMIT A CLAIM

A claim for reimbursement of a Healthcare Expense must be submitted to the Plan Administrator within twelve (12) months from the date the Healthcare Expense was incurred. A

claim for reimbursement submitted more than twelve (12) months after the date the Healthcare Expense was incurred will be denied.

HOW TO APPLY FOR PAYMENTS FROM YOUR HRA ACCOUNT

Once an HRA account has been established, You will receive a debit card with the Trust logo. You can use the debit card to pay for co-payments, deductibles, and for other out-of-pocket medical and prescription drug expenses incurred by You and Your Dependents. By using Your debit card for a co-payment, deductible, or other out-of-pocket medical or prescription drug expenses, You are certifying that the co-payment, deductible, medical, or prescription drug expense qualifies as a Healthcare Expense and was incurred for You or a Dependent and is eligible for reimbursement from Your HRA account.

For Healthcare Expenses that are not reimbursed through Your debit card, You must complete a claim form to receive reimbursement. Claims can be submitted electronically through the secured website or by using the Mobile App, or You can file a paper claim form which can be obtained from the Plan Administrator or at www.598benefits.aibpa.com.

You must provide satisfactory proof to the Plan Administrator that You or a Dependent has incurred an eligible unreimbursed Healthcare Expense. The documentation must include the following:

(a) The date the Healthcare Expense was incurred;

(b) The amount of the Healthcare Expense for which reimbursement is requested;

(c) The family member who incurred the Healthcare Expense and his or her relationship to You;

(d) A description of the Healthcare Expense;

(e) Your certification that the unreimbursed Healthcare Expense is not subject to payment from any other health plan or insurance policy and will not be claimed as a deduction on Your or a Dependent's income tax return; and

(f) Any other evidence of payment or proof that the Plan Administrator or Trustees determine is necessary to verify the request for reimbursement.

A reimbursement form may be obtained from the Trust's website at www.598benefits.aibpa.com or by calling the Plan Administrator at (800) 205-7002.

If there are insufficient Benefit Credits in Your HRA account when a claim for reimbursement is received, that claim will be "pended" until the earliest of:

(a) The date there are sufficient Benefit Credits in Your HRA account to reimburse You for the Healthcare Expense; or

(b) December 31 of the year in which the claim was filed.

ADJUDICATION OF CLAIMS

The Plan Administrator is responsible for reviewing and adjudicating claims for reimbursement from Your HRA account. The time frame for granting or denying a claim for reimbursement from Your HRA account is set forth in the **Claim Appeal Procedures** section of the Benefit Booklet.

YOUR RIGHT TO TERMINATE YOUR HRA ACCOUNT

You have the right to terminate Your participation in the HRA at any time after the Plan Administrator has received written notice of termination. If You terminate Your participation in the HRA, You forfeit all Benefit Credits in Your HRA account. In order to terminate participation in Your HRA, You need to provide written notice to the Plan Administrator. You may obtain a termination form from the Trust's website at www.598benefits.aibpa.com or by calling the Plan Administrator at (800) 205-7002.

You might choose to terminate participation in Your HRA in order to be eligible for the tax credit if You purchase coverage from one of the Health Care Exchange Plans. As long as You have Benefit Credits in Your HRA account, You are not eligible for the tax credit.

DEATH OF AN EARLY RETIREE OR MEDICARE-ELIGIBLE RETIREE

If an Early Retiree or Medicare-Eligible Retiree dies with Benefit Credits in an HRA account, his estate or personal representative may submit claims for reimbursement of Healthcare Expenses that were incurred before the death. In addition, Your spouse or Dependents can continue to use the Benefit Credits in Your HRA account for reimbursement of Healthcare Expenses they incur after Your death in accordance with the terms of the Plan.

FORFEITURE OF THE HRA ACCOUNT

All Benefit Credits will be forfeited on the earliest of the following dates:

(a) You work in Prohibited Employment;

(b) You die without a spouse or Dependent child;

(c) There has not been a monthly Benefit Credit to Your HRA account and there have been no deductions from Your HRA account (other than to pay administrative expenses) for thirty-six (36) consecutive months;

(d) The Retiree Plan is terminated; or

(e) The Trustees change the terms of the Retiree Plan to provide for a forfeiture of HRA accounts under rules that do not currently exist. **The Benefit Credits in Your HRA account are not vested.**

Benefit Credits forfeited will be reallocated to the general assets of the Trust.

CLAIM APPEAL PROCEDURES

If You have a claim related to the HRA that is denied in whole or in part, You must follow the CLAIM APPEAL PROCEDURES which are described on page 71 of the Benefit Booklet.

COORDINATION OF BENEFITS (COB) FOR DENTAL BENEFITS

This COB section applies when a Covered Person has dental coverage under more than one Plan as defined below.

HOW COB WORKS

This COB section contains rules that govern the order in which Plans will pay a claim for dental benefits. The Plan that pays first is the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is called the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that the payments from all Plans do not exceed 100% of the total Allowable Expense as defined below.

DEFINITIONS

For purposes of this section, the following definitions apply:

Plan means any of the following that provide benefits or services for dental care or treatment:

(a) Plan includes: group insurance contracts, health maintenance organization contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or self-insured) for dental benefits.

(b) Plan does not include: hospital indemnity coverage or other fixed-indemnity coverage; accident-only coverage; specific disease or specific accident coverage; school accident-type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans unless permitted by law.

This Plan means, in this COB section, the part of the Benefit Booklet providing for dental benefits to which this COB section applies and which may be reduced because of the dental benefits provided by other Plans.

Allowable Expense means a dental expense, including Deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable Expense. Any expense that a healthcare professional by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(a) If a Covered Person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary Charges, a relative value schedule reimbursement methodology or other similar reimbursement methodology, the amount in excess of the highest reimbursement amount allowed by the Primary Plan for a specific benefit is not an Allowable Expense.

(b) If a Covered Person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees allowed by the Primary Plan is not an Allowable Expense.

(c) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary Charges, a relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the healthcare professional has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or a payment amount that is different than the Primary Plan's payment arrangement and if the healthcare professional's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(d) The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include pre-certification of dental procedures.

Closed Panel Plan means a Plan that provides dental benefits to a Covered Person primarily in the form of services through a panel of healthcare professionals that have contracted with or are employed by the Plan and that excludes coverage for services provided by other healthcare professionals, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent awarded custody by a court decree or, in the absence of court decree, is the parent with whom the Dependent child resides more than one-half of the Calendar Year excluding any temporary visitation.

Primary Plan means the Plan under the COB provisions that pay first.

Secondary Plan means the Plan under the COB provisions that pay after the Primary Plan.

ORDER OF BENEFIT DETERMINATION RULES (WHICH PLAN PAYS FIRST?)

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(a) The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

(b) (1) Except as provided in (b)(2) below, a Plan that does not contain a COB provision is always the Primary Plan unless the provisions of both Plans state that the complying Plan is Primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basis package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the insurer or Plan sponsor. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits and insurance-type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

(c) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is the Secondary Plan.

(d) Each Plan determines its order of benefits using the first of the following rules that apply:

(1) **Non-Dependent or Dependent.** The Plan that covers the Covered Person other than as a Dependent, for example as an Employee, member, subscriber, Early Retiree, or Medicare-Eligible Retiree is the Primary Plan and the Plan that covers the Covered Person as a Dependent is the Secondary Plan. However, if the Covered Person is a Medicare beneficiary and, as a result of the federal law, i.e., provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is: (i) secondary to the Plan covering the Covered Person as a Dependent; and (ii) primary to the Plan covering the Covered Person as other than a Dependent (e.g., a retired employee) then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an Employee, member, subscriber or retiree is the Secondary Plan and the other Plan covering the Covered Person as a Dependent is the Primary Plan.

(2) **Dependent Child Covered Under More Than One Plan.** When a Dependent child is covered by more than one Plan, the order of benefit determination is as follows:

(A) For a Dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parent longest is the Primary Plan. This is called the Birthday Rule.

(B) For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married, the following rules apply:

(i) If a court decree states that one of the parents is responsible for the Dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. The rule applies to plan years commencing after the Plan is given notice of the court decree. If the parent with responsibility has no healthcare coverage for the Dependent child's healthcare expenses, but that parent's spouse does, the parent's spouse's Plan is the Primary Plan. This subparagraph does not apply with respect to any plan year during which benefits are paid or provided before the Plan has actual knowledge of the court decree provision.

(ii) If a court decree states that both parents are responsible for the Dependent child's healthcare expenses or that the parents have joint custody without specifying that one parent is responsible, the Birthday Rule described above applies.

(iii) If there is no court decree allocating responsibility for the Dependent child's healthcare expenses, the order of benefits for the Dependent child are as follows: (i) the Plan covering the custodial parent; (ii) the Plan covering the spouse of the custodial parent; (iii) the Plan covering the non-custodial parent; then (iv) the Plan covering the spouse of the non-custodial parent.

(C) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the order of benefits shall be determined by the first applicable provision, under paragraph d(2)(A) or d(2)(B) above shall determine the order of benefits as if those individuals were parents of the Dependent Child.

(D) For a Dependent child covered under the Plans of both a parent and a spouse, the **Longer or Shorter Length of Coverage** provision below shall determine the order of benefits. If coverage under either or both the parent's Plan and the spouse's Plan began the same day, the Birthday Rule will apply.

(3) **Active Employee or Retired or Laid-Off Employee.** The Plan that covers a Covered Person as an active Employee, that is, an Employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering the same Covered Person as a retired or laid-off Employee is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(4) **COBRA or Similar Continuation Coverage.** If a Covered Person whose coverage is provided pursuant to COBRA or under a right-of-continuation pursuant to State or other Federal law is covered under another Plan, the Plan covering the Covered Person as an Employee, member, subscriber, Early Retiree or Medicare-Eligible Retiree or covering the Covered Person as a Dependent of the Employee, member, subscriber, Early Retiree or Medicare-Eligible Retiree is the Primary Plan and the Plan covering the Covered Person pursuant to COBRA or under a right-of-continuation pursuant to State or other Federal law is the Secondary Plan. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage.** The Plan that has covered the Covered Person as an Employee, member, subscriber, Early Retiree or Medicare-Eligible Retiree for the longer period of time is the Primary Plan and the Plan that has covered the Covered Person for the shorter period of time is the Secondary Plan.

(6) **None of the Above**. If the preceding rules do not determine the order of benefits, then Allowable Expenses shall be shared equally between the

Plans. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply COB rules. The Plan, acting through its Plan Administrator, has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell or get the specific consent of the Covered Person to do this. Each Covered Person claiming benefits under this Plan must give the Plan any facts it needs to coordinate benefits.

CORRECTION OF PAYMENT

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

RIGHT OF RECOVERY

If the benefits paid by the Trust is more than it should have paid under the COB rules, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for that person. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

PAYMENT OF CLAIMS

Written notice of a claim for dental benefits and HRA reimbursements must be given to the Plan Administrator as soon as possible. The written notice should clearly identify the Covered Person. In order to be eligible for payment, a claim for Covered Services must be submitted to the Plan Administrator within twelve (12) months of the date that the service or supply was provided, except in the event of legal incompetence.

Claim forms may be obtained from the Union, the Plan Administrator, or at www.598benefits.aibpa.com.

Payment for dental claims will be made by the Trust for a Covered Service upon timely receipt of a fully completed claim form that meets all the requirements of the Plan. The Trust will make payment to the dental office unless the Dental Services have already been paid by the Covered Person. Whether the Trust pays You or the dental office, You will always receive a written explanation of what the Trust has paid and how much, if any, of the bill remains to be paid by You.

Payment for HRA reimbursements will be made to the Early Retiree.

Claim forms for dental benefits and HRA reimbursements should be sent to:

Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

Claim forms for vision benefits should be sent to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899

Claim forms for life insurance benefit should be sent to:

Reliance Standard Insurance Company
Claims Department
PO Box 8330
Philadelphia, PA 19101

BENEFITS NOT TRANSFERRABLE

No person other the Covered Person is entitled to receive benefits from the Plan. The right to benefits is not transferable, even among family members.

NEWBORNS AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and insurance companies offering group health insurance coverage 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 forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section. Also, under federal law, group health plans and health insurance companies offering group health insurance coverage may not set the limit of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable than any earlier portion of the stay. 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 newborn earlier than forty-eight (48) hours or ninety-six (96) hours, as applicable, or require a provider to obtain prior authorization from the group health plan or insurance company for prescribing a length of stay not in excess of the above periods.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998, requires medical plans to provide benefits for mastectomy-related services as follows:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast in order to produce a symmetrical appearance; and

(c) Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

This benefit may be subject to the deductible and co-payments as detailed in the medical plan.

DISCLOSURE OF NON-GRANDFATHERED HEALTH PLAN STATUS

This information is required by the Patient Protection and Affordable Care Act (the Affordable Care Act). The Plan is not a grandfathered health plan under the Affordable Care Act.

The Plan is not subject to many of the Affordable Care Act provisions because it is a "retiree only plan" in that it does not cover Employees. This Retiree Plan is separate from the Employee Plan.

Questions regarding the Affordable Care Act can be directed to the Plan Administrator or You may contact the Employee Benefit Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

GENDER AND NUMBER

Whenever any words are used in the Benefit Booklet in the masculine gender, they shall also be construed to include the feminine gender in all situations where they would so apply. Whenever any words are used in the singular, they shall also be construed to include the plural in all situations where they would so apply. Whenever any words are used in the plural, they shall also be construed to include the singular in all situations where they would so apply.

RETURN OF OVERPAYMENT AND OFFSET OF FUTURE BENEFITS

If the Trust or Plan Administrator mistakenly pays a claim for a Covered Person or makes a payment to a Dentist, dental office or other person or entity who is not entitled to the payment, the Trustees have the right to recover the payment from any person paid or anyone who benefitted from it, including a Dentist or dental office. The Trustees' right to recover includes the right to deduct the amount paid by mistake from future Covered Services incurred by the Covered Person or any family member even if the mistaken payment was not made on that family member's behalf.

FALSE OR FRAUDULENT CLAIMS

The Trustees reserve the right to impose restrictions upon the payment of future Covered Services to any Covered Person who submits a claim or information that is false or fraudulent including, without limitation, refusing to provide future Covered Services and the deduction from future Covered Services amounts owed to the Trust because of payments made in reliance upon such false or fraudulent claim or information.

LIFE INSURANCE BENEFIT

INTRODUCTION

The life insurance benefit is provided by a group contract between the Trust and Reliance Standard Insurance Company (Reliance). The terms of the group contract are summarized below. In the event of a conflict between this summary and the terms of the group contract, the terms of the group contract control. If You would like a copy of the group contract, contact the Plan Administrator.

LIFE INSURANCE BENEFIT

The life insurance benefit for Early Retirees who die while receiving a Contribution to their HRA, and Medicare-Eligible Retirees who die while enrolled in the Medicare Advantage Plan is $5,000. There is no life insurance benefit for Dependents.

WHEN INSURANCE ENDS

Your life insurance benefit automatically ends on the earliest of:

(a) The date the group contract between Reliance and the Trust terminates;

(b) The last day of the month for which a required premium is paid on Your behalf to Reliance by the Trust;

(c) The date You enter military service (not including reserve or National Guard);

(d) For an Early Retiree, the date You no longer qualify for a Contribution to the HRA; or

(e) For a Medicare-Eligible Retiree, the date You are no longer enrolled in the Medicare Advantage Plan.

WAIVER OF PREMIUM IN THE EVENT OF TOTAL DISABILITY

Total Disability and Totally Disabled as used in this section of the Benefit Booklet means Your complete inability to engage in any type of work for wage or profit for which You are suited by education, training, or experience.

Life insurance benefit will continue without premium payment while You are Totally Disabled for one year if:

(a) You become Totally Disabled prior to age sixty (60);

(b) The Total Disability begins while You are insured for the life insurance benefit;

(c) The Total Disability begins while the group contract between Reliance and the Trust is in force;

(d) The Total Disability lasts at least six months;

(e) The premium continues to be paid; and

(f) Reliance receives proof of Total Disability within one year from the date it began.

If proof of Total Disability is approved by Reliance, neither You or the Trust is required to pay the premium. Also, any premiums paid from the start of the Total Disability will be returned. It is Your responsibility to notify the Trust if You become eligible for the Waiver of Premium in the Event of Total Disability.

Reliance may ask You to submit annual proof of continued Total Disability. The amount of insurance may then be extended for additional one-year periods. You may, at Reliance's expense, be required to be examined by a Physician approved by Reliance as part of the proof. Reliance will not require You to be examined more than once a year after the life insurance has been extended two full years.

The amount of insurance extended will be the amount of life insurance that was in force at the time the Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if You had not been Total Disabled.

The amount of insurance extended to You under the Waiver of Premium in the Event of Total Disability will cease on the earliest of:

(a) The date You no longer meet the definition of Total Disability;

(b) The date You refuse to be examined;

(c) The date You fail to furnish the required proof of Total Disability;

(d) The date You become age seventy (70); or

(e) The date You retire.

You may use the Conversion Privilege described later in this section when the Total Disability extension ends. Please refer to the Conversion Privilege section for rules. You are not entitled to convert if You return to work and are again eligible for life insurance as a result of Trust-paid premiums. If You use the Conversion Privilege, benefits will not be payable under the Waiver of Premium in the Event of Total Disability provision unless the converted policy is surrendered to Reliance.

If You qualify for benefits in accordance with the Waiver of Premium in the Event of Total Disability provision because You have been diagnosed by a physician as Totally Disabled due to the following condition(s) or procedure, as later defined:

(a) Life-Threatening Cancer;

(b) Heart Attack (myocardial infarction);

(c) Kidney (renal) Failure;

(d) Receipt of Major Organ Transplant; or

(e) Stroke.

Reliance will pay You an additional one-time lump-sum benefit equal to ten percent (10%) of the life insurance benefit.

This lump-sum payment applies only to the first condition or procedure described above to occur among those hereinafter defined which qualifies You for Waiver of Premium in the Event of Total Disability benefit. No further lump-sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability or as a result of occurrence of any other condition or procedure.

Life-Threatening Cancer means a malignant neoplasm (including hematologic malignancy), as diagnosed by a physician who is a board-certified oncologist, and which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. The following types of cancer are not considered a Life-Threatening Cancer: (i) early prostate cancer diagnosed as T2c or less according to the TNM scale; (ii) colorectal cancer diagnosed as T2, N1, MO, or less according to the TNM scale; (iii) breast cancer diagnosed as T3, N2, MO, or less according to the TNM scale; (iv) First Carcinoma in Situ; (v) pre-malignant lesions (such as intraepithelial neoplasia); (vi) brain glioma; (vii) benign tumors or polyps; (viii) tumors in the presence of the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS); or (ix) any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life-Threatening Cancers.

First Carcinoma in Situ means the first diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. First Carcinoma in Situ must be diagnosed pursuant to a pathological diagnosis or clinical diagnosis.

Heart Attack (myocardial infarction) means the death of a segment of the heart muscle as a result of blockage of one or more coronary arteries. In order to be covered under this provision, the diagnosis by a Physician of Heart Attack (myocardial infarction) must be based on (i) new electrocardiographic changes consistent with and supporting a diagnosis of Heart Attack (myocardial infarction); (ii) a concurrent diagnostic elevation of cardiac enzymes; and (iii) therapeutic and functional classifications 3 or above and C or above respectively, according to the New York Heart Association.

Kidney (Renal) Failure means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with dialysis on a regular basis. Kidney Failure is provided under this provision only if the diagnosis has been made by a Physician who is a board-certified nephrologist.

Physician for purposes of this section of the Benefit Booklet means a duly licensed practitioner who is recognized by the law of the jurisdiction in which treatment is received as qualified to treat the type of condition for which the claim is made. The Physician may not be You or a member of Your immediate family and must be approved by Reliance.

Receipt of Major Organ Transplant means that You have been the recipient of a major organ transplant and that there is clinical evidence of major organ(s) failure which, according to the diagnosis of a Physician, required Your failing organ(s) or tissue to be replaced with organ(s) or tissue from a suitable donor under generally accepted medical procedures. Organ or tissues covered by this definition are limited to liver, kidney, lung, entire heart, pancreas, or pancreas-kidney.

Stroke means a cerebrovascular accident or infarction (death) of brain tissue as diagnosed by a Physician which is caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 180 days following the occurrence of the stroke. Stroke does not include transient ischemic attack or other cerebral vascular events.

Receipt of this additional lump-sum payment may be taxable. You should seek assistance from Your personal tax advisor.

CONVERSION PRIVILEGE

You can use the conversion privilege when Your life insurance is no longer in force. It has several parts. They are:

(a) If the life insurance ceases due to Your termination as an Employee or COBRA enrollee, an individual life insurance policy can be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after Your life insurance benefit terminates. The first premium must also be paid at that time. The issuance of the policy is subject to the following conditions:

(1) The policy will, at Your option, be on any one of Reliance's forms, except for term life insurance. It will be the standard-type issue by Reliance for the age and amount applied for;

(2) The policy issued will be for an amount not over what You had before Your life insurance terminated;

(3) The premium due for the policy will be at Reliance's usual rate. This rate will be based on the amount of insurance, class of risk, and Your age at the date the policy is issued; and

(4) Proof of good health is not required.

(b) If the insurance ceases due to the termination or amendment of the group contract, an individual life insurance policy can be issued. You must have been insured for at least five years under the group contract. The same rules as in (a) above will be used except that the face amount of the insurance will be the lesser of: (i) the amount of Your group life insurance; or (ii) $5,000.

(c) If the life insurance reduces as provided in the group contract, an individual life insurance policy can be issued. The same rules as in (a) above will be used except that the face amount of the insurance will not be greater than the amount which ceased due to reduction.

(d) If You die during the time provided in (a) above in which You are entitled to apply for an individual policy, Reliance will pay the benefit under the group contract that You were entitled to convert. This will be done whether or not You applied for the individual policy.

(e) Any policy issued with respect to (a), (b), or (c) above will be put in force at the end of the 31-day period in which application must be made.

BENEFICIARY AND PAYMENT PROVISIONS

You may name Your beneficiary by completing, signing, and returning the beneficiary designation form to the Plan Administrator. Beneficiary designation forms may be obtained from the Plan Administrator and the Union. A beneficiary designation form is not effective until signed, dated, and received by the Plan Administrator.

If You name more than one beneficiary, You must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if You wish to change the beneficiary designation.

If the beneficiary dies at the same time as You, or within fifteen (15) days after Your death, but before Reliance received written proof of Your death, payment will be made as if You survive the beneficiary unless noted otherwise.

If You have not named the beneficiary, or the named beneficiary is not surviving at Your death, any benefits due shall be paid to the first of the following classes that survive You:

(a) Your legal spouse, legally recognized civil union/domestic partner, or domestic partner named in an affidavit of domestic partnership;

(b) Your surviving children (including legally adopted children) in equal shares;

(c) Your surviving parents in equal shares;

(d) Your surviving siblings in equal shares; or if none of the above; and

(e) Your estate.

If a beneficiary, in the opinion of Reliance, cannot give a valid release (and no guardian has been appointed), Reliance may pay the benefit to the person who has custody or provides the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If You have not named a beneficiary, or the named beneficiary is not surviving at Your death, Reliance may pay up to an amount not exceeding the greater of ten percent (10%) or $1,000 of the benefit to the person(s) who, in Reliance's opinion, has incurred expenses in connection with Your last illness, death, or burial. The balance of the benefit, if any, will be held by Reliance until an individual or representative is:

(a) Validly named;

(b) Appointed to receive the proceeds; and

(c) Can give a valid receipt to Reliance.

The benefit will be held with interest at a rate set by Reliance.

Reliance will not be liable for any payment it made in good faith.

FILING A CLAIM FOR LIFE INSURANCE BENEFIT

Written notice of a claim for life insurance benefit must be provided to the Plan Administrator or Reliance as soon as reasonably possible. The notice should be sent to the Plan Administrator or Reliance at the following address:

Reliance Standard Life Insurance Company
Claims Department
PO Box 8330
Philadelphia, PA 19101

The notice should include the insured's name and the group policy number which is GL151100.

Claim forms are available from the Plan Administrator or may be requested by writing to the above address or by calling 1-800-644-1103.

For any claim for benefits, written proof must be sent to the Plan Administrator or Reliance within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as reasonably possible. Proof of loss must be given within one year unless the claimant is legally incapable of doing so.

Payment will be made as soon as proper proof is received. All benefits will be paid to You if living. Any benefit unpaid at the time of Your death, or due to death, will be paid to Your beneficiary.

No legal action may be brought against Reliance to recover the life insurance benefit within sixty (60) days after written proof of loss has been given. No action may be brought after three years from the time written proof of loss is required to be submitted.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION RE LIFE INSURANCE

Non-Disability Benefit Claims. If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than ninety (90) days after Reliance's 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 ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims. If a disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than forty-five (45) days after Reliance's receipt of the claim. This period may be extended for up to thirty (30) days, provided that it is determined that such an extension is necessary due to matters beyond Reliance's control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond Reliance's control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims. A claimant shall be provided with written notification of an adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

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

(b) Reference to the specific plan/policy provisions on which the determination is based;

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

(d) A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims. A claimant shall be provided with written notification of an adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

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

(b) Reference to the specific plan/policy provisions on which the determination is based;

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

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

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

APPEAL OF AN ADVERSE BENEFIT DETERMINATION

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
PO Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims.

(a) Claimants (or their authorized representatives) must appeal within sixty (60) days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;

(b) Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;

(c) Claimants 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;

(d) The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(e) No deference to the initial adverse benefit determination shall be afforded upon appeal;

(f) The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and

(g) Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims.

(a) Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;

(b) Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;

(c) Claimants 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;

(d) The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(e) No deference to the initial adverse benefit determination shall be afforded upon appeal;

(f) The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(g) Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

(h) In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a healthcare professional:

(1) who has appropriate training and experience in the field of medicine involved in the appeal; and

(2) 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.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims. The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than sixty (60) days after receipt of the claimant's timely request for review, unless it is

determined that special circumstances require an extension of time for processing the appeal. 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 60-day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

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 timely filed, 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 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.

Disability Benefit Claims. The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than forty-five (45) days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. 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 45-day period. In no event shall such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

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 timely filed, 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 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.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims. A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

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

(b) Reference to the specific plan/policy provisions on which the determination is based;

(c) 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; and

(d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA (where applicable).

Disability Benefit Claims. A claimant shall be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

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

(b) Reference to the specific plan/policy provisions on which the determination is based;

(c) 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;

(d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA (where applicable);

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

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

Definitions. 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.

The term "relevant" means a document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

(a) Was relied upon in making the benefit determination;

(b) 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;

(c) Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or

(d) In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

ADDRESS AND TELEPHONE NUMBER

The address and telephone number of Reliance Standard Life Insurance Company is:

2001 Market Street, Suite 1500
Philadelphia, PA 19103
(267) 256-3518

CLAIM APPEAL PROCEDURES

WHERE TO FILE AN APPEAL

All types of appeals involving eligibility for the Plan, dental and HRA benefits should be submitted in writing to:

Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

APPEALS CONCERNING VISION BENEFITS

These appeals should be submitted to Vision Service Plan at the following address:

Vision Service Plan Insurance Company
PO Box 997100
Sacramento, CA 95899

APPEALS CONCERNING LIFE INSURANCE

These appeals should be submitted to Reliance Standard Life Insurance Company at the following address:

Reliance Standard Insurance Company
Claims Department
PO Box 8330
Philadelphia, PA 19101

CLAIM APPEAL PROCEDURES

The procedures below are the sole and exclusive procedures available to a Covered Person or any other person (claimant) who is dissatisfied with a decision involving the Plan other than a vision benefit and a life insurance benefit including:

(a) An eligibility determination, including a rescission of coverage, i.e. discontinuation of coverage that has a retroactive effect for a reason other than failure to make a timely payment;

(b) A benefit determination, including the denial, reduction, termination or failure to provide or make payment (in whole or in part) for a Dental Benefit;

(c) A decision concerning Benefit Credits to Your HRA or any other decision concerning Your HRA; or

(d) An action or decision made by the Plan Administrator.

Time Frame for Initial Decision by Plan Administrator

The time frame in which an initial decision concerning a claim will be made depends on the type of claim submitted. There are different time frames for different types of claims as follows:

Dental and HRA Reimbursements	30 days
Eligibility for the Plan, an HRA contribution, a self-payment, coverage for a Dependent, a COBRA issue, a rescission of coverage issue, or other issue.	90 days

Dental and HRA Reimbursement Claims

The Plan Administrator is responsible for reviewing dental and HRA reimbursement claims. You will be notified in writing whether Your claim is approved or denied. The time frame in which a denial notice will be provided is based on the type of claim You have submitted.

Urgent Care Claim. An urgent care claim is a claim where the terms of the Plan require prior authorization before dental care or treatment can be obtained and a delay in obtaining the dental care or treatment could:

(a) Seriously jeopardize the life or health of the Covered Person to regain maximum function; or

(b) In the opinion of a healthcare professional with knowledge of the Covered Person's dental condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the event there is an urgent care claim, the Plan Administrator or its designee will provide notice of the benefit determination (whether approved or denied) within seventy-two (72) hours after receipt of the urgent care claim unless insufficient information is provided to determine whether, or to what extent, benefits are covered or payable by the Plan. In such a case, the Plan Administrator or its designee shall notify the Covered Person as soon as possible but not later than twenty-four (24) hours after receipt of the urgent care claim and identify the specific information necessary to complete review. The Covered Person shall have at least forty-eight

(48) hours to provide the requested information. The Covered Person will be notified of the decision as soon as possible but not later than forty-eight (48) hours after either receipt of the information or the end of the additional time period, whichever is earlier. The Covered Person may appeal an adverse benefit determination to the Appeal Review Committee/ Trustees and they or their designee will act on the appeal within seventy-two (72) hours after receipt.

Pre-Service Claim. A pre-service claim is a claim where the terms of the Plan require prior authorization before dental care or treatment can be obtained. Unlike an urgent care claim, a Covered Person's health is not in serious jeopardy at the time the pre-service claim is submitted. In the event there is a pre-service claim, the Plan Administrator or its designee shall provide notice of the benefit determination (whether approved or denied) within a reasonable period of time but not later than fifteen (15) days after receipt of the claim. The time period may be extended up to an additional fifteen (15) days for matters beyond the control of the Plan Administrator or the its designee, but the Covered Person will be notified of the extension before the end of the initial 15-day period. The notice will identify the circumstances requiring the extension and the date by which the Plan Administrator or its designee expects to issue a decision. If the extension is necessary because the Covered Person did not submit necessary information, the notice will describe the information required and give the Covered Person an additional period of at least forty-five (45) days to furnish the information. The Covered Person may appeal an adverse benefit determination to the Appeal Review Committee/Trustees and they or their designee will act on the appeal within thirty (30) days after receipt.

Post-Service Claim. A post-service claim is a claim for payment of benefits after the care or treatment has been provided. An example is the amount of a Dentist's bill that will be paid or a Healthcare Expense that will be reimbursed from Your HRA. The Plan Administrator or its designee will provide notice of the benefit determination (whether the claim is approved or denied) within a reasonable period of time but not later than thirty (30) days after receipt of the claim. The time period may be extended up to an additional fifteen (15) days for matters beyond the Plan Administrator's or its designee's control but the Covered Person will be notified of the extension before the end of the 30-day period. The notice will identify circumstances requiring an extension of time and the date by which the Plan Administrator or its designee expects to issue the decision. If the extension is necessary because the Covered Person did not submit necessary information, the notice will describe the information needed and give the Covered Person an additional period of at least forty-five (45) days to furnish the information. The Covered Person or authorized representative may appeal an adverse benefit determination to the Appeal Review Committee/Trustees and they or their designee will act on the appeal within the time limit specified in the **Review by the Appeal Review Committee/Trustees** section.

Eligibility and Other Types of Claims

The Plan Administrator is responsible for reviewing claims concerning eligibility-type issues such as ineligibility to enroll in the Retiree Plan, dental coverage or vision coverage, a late self-

payment, coverage for a Dependent, COBRA coverage issues, HRA issues, a rescission of coverage issue, and other Plan related issues. You will be notified in writing of the decision. The written decision will normally be provided within ninety (90) days after receipt of Your written notice concerning a claim. You or Your authorized representative may appeal an adverse eligibility decision to the Appeal Review Committee/Trustees and they or their designee will act on the appeal within the time limits specified in the **Review by the Appeal Review Committee/Trustees** section.

Independence of Decision Makers

Throughout the claims and appeals process, the Plan will insure that all claims and appeals are adjudicated in a manner designed to insure the independence and impartiality of the persons involved in making the decision. The Plan will not provide bonuses to individuals or organizations based on the number of denials made by the claims adjudicator or the entity employing the claims adjudicator. The Plan will not contract with an expert based on the expert's reputation for outcomes in contested cases. Rather, the Plan will contract with experts based on each expert's professional qualifications.

Content of Adverse Benefit Determination

If Your claim is denied by the Plan Administrator, or its designees, the adverse benefit determination will be in writing and will provide:

(a) Information sufficient to identify the claim including (to the extent applicable) the date of the service, the name of the healthcare provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning and an explanation of the standard used in making the decision;

(b) The specific reason(s) for the adverse benefit determination which may include a denial code and its meaning;

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

(d) If the adverse benefit determination is based on an internal rule, guideline, protocol or similar criterion, the internal rule, guideline, protocol or similar criterion will be described or You will be notified of Your right to receive the document free of charge upon request;

(e) A description of internal review procedures including information on how to initiate an appeal and the time limits for filing an appeal;

(f) A statement of Your right to bring a civil action for the benefit under ERISA; and

(g) Contact information for any ombudsman/health insurance consumer assistance services available under the Public Service Health Act.

Procedure to Appeal an Adverse Benefit Determination

If You disagree with the adverse benefit determination issued by the Plan Administrator or its designee, You or Your authorized representative may file a written appeal within 180 days after receipt of the adverse benefit determination. The written appeal must be filed as follows:

Local Union 598 Plumbing & Pipefitting
Industry Health & Welfare Fund
ATTN: Appeal Review Committee
1220 SW Morrison, Suite 300
Portland, OR 97205

You or Your authorized representative may request, in the appeal, to appear at a hearing before the Appeal Review Committee/Trustees when Your appeal is considered.

Upon written request to the Plan Administrator, You or Your authorized representative will be entitled to review or receive Your entire claim file.

Scope of Review

If the Plan Administrator's decision is appealed, the appeal will be referred to the Appeal Review Committee and, if necessary, the Trustees as described in the **Review by the Appeal Review Committee/Trustees** subsection. In either case, the claim will be reviewed de novo (meaning without deference to the initial decision). All relevant information will be reviewed regardless of whether the information was previously submitted.

If the Appeal Review Committee or Trustees intends to issue an adverse benefit determination based on new or additional evidence or a new rationale, it will provide the new or additional evidence or new rationale to You free of charge as soon as possible and in advance of the date the decision will be made in order to give You a reasonable opportunity to respond prior to the decision being made.

If the claim involves issues of dental judgment, such as whether a particular treatment, drug or other item is an experimental or investigational procedure or Medically Necessary, a healthcare professional who has appropriate medical training and experience will be consulted. If a healthcare professional is consulted, that person will be different from any healthcare professional previously consulted involving Your claim and will not be the subordinate of the

healthcare professional previously consulted. If a healthcare professional is consulted, he will be identified regardless of whether the advice is relied on.

Review by the Appeal Review Committee / Trustees

The Trustees appoint the Appeal Review Committee which consists of an equal number of Employer Trustees and Union Trustees. The Appeals Review Committee may consistent of one Employer Trustee and one Union Trustee.

Upon receipt of an appeal, the Plan Administrator will submit the appeal and all relevant information to the Appeal Review Committee or Trustees. If a timely request to appear at the meeting is made by the claimant, the claimant may appear at the meeting to present evidence and testimony or the claimant may be represented at the meeting by an attorney or other representative of his choosing at his own cost and expense.

The appeal will be considered by the Appeal Review Committee or Trustees no later than the next regularly scheduled meeting of the Trustees following receipt of the appeal unless the appeal is received less than thirty (30) days prior to the meeting. In that event, the Appeal Review Committee or Trustees will consider the appeal no later than the date of the subsequent Trustees' meeting. If due to special circumstances, the Appeal Review Committee or Trustees requires an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

If the Appeal Review Committee deadlocks, the appeal will be submitted to the Trustees at their next regularly scheduled meeting.

A decision by the Appeal Review Committee or the Trustees will be in writing and sent to You within five (5) days after the decision is made.

Content of an Adverse Benefit Determination on Appeal

If either the Appeal Review Committee or the Trustees deny Your appeal, the adverse benefit determination will be in writing and include the same type of information described under the heading **Content of Adverse Benefit Determination** and will also include a discussion of the reason(s) for the decision and reference to the specific Plan provision(s) on which the adverse benefit determination is based. If Your appeal is granted, You will be notified of the decision in writing.

Authority of the Appeal Review Committee / Trustees

The Appeal Review Committee and the Trustees, whichever decides the appeal, has the full and exclusive authority to administer the Trust and Plan, interpret all Trust and Plan documents

including the Benefit Booklet and resolve all questions arising in the administration, interpretation and application of the Trust and the Plan. The Appeal Review Committee and the Trustees' authority include but are not limited to:

(a) The right to resolve all matters when review has been requested;

(b) The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA; and

(c) The right to construe and interpret all Trust documents including but not limited to the Plan and the Benefit Booklet.

External Review Process

If You disagree with the adverse benefit determination issued by the Appeal Review Committee or Trustees and the decision involves a dental judgment, including but not limited to determinations based on Medical Necessity, healthcare setting, appropriateness, level of care, or a rescission of coverage claim, You or Your authorized representative may file a written appeal within four (4) months after the date of receipt of the adverse benefit determination. The written appeal must be filed as follows:

Local Union 598 Plumbing & Pipefitting
Industry Health & Welfare Fund
Attention: Appeal Review Committee
1220 SW Morrison, Suite 300
Portland, OR 97205

The written appeal must describe the adverse benefit determination that is being appealed.

Preliminary Review

Within five (5) business days after receipt of the appeal, the Plan Administrator will make a preliminary review of the appeal which will include:

(a) A determination whether the claimant is covered by the Plan at the time the health care item or service was requested or in the case of a post-service claim was covered by the Plan at the time the health care item or service was provided;

(b) A determination whether the appeal involves dental judgment, or a rescission of coverage claim, as opposed to eligibility requirements. Eligibility appeals are not subject to the External Review Process;

(c) A determination whether the claimant has exhausted the internal claims review procedures or whether exhaustion is not required; and

(d) A determination whether the claimant has provided all forms and information required to process the appeal.

Within one (1) business day after completing the preliminary review, the Plan Administrator will notify the claimant in writing whether the appeal is eligible for external review. If the appeal is not complete, the claimant will be notified of the additional information or materials that are required and that it must be received within the four-month period for requesting external review or, if later, forty-eight (48) hours after receipt of the notice that the submission is incomplete. If the Plan Administrator determines the appeal is complete but not eligible for external review, the reasons will be provided and the claimant will be provided contact information for the Employee Benefits Security Administration (866) 444-3272.

The Plan or the Plan Administrator will contract with at least three (3) independent review organizations (IROs) that are accredited by URAC or a similar nationally-recognized accrediting organization. The IRO will decide the appeal. The appeal will be submitted to an IRO on a random or rotating basis. The IRO will not receive a financial incentive for determinations that uphold adverse benefit determinations.

Referral to IRO

The Plan or its designee will provide the IRO with all documents and information considered by the Appeal Review Committee/Trustees related to the appeal within five (5) business days of the referral of the appeal to the IRO. If the Plan or its designee fails to timely provide documents and information to the IRO, the IRO can terminate the external review and make a decision to reverse the adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the claimant and Plan.

If the IRO receives new information or documentation from the claimant, the IRO must notify the Plan within one (1) business day of receipt. Thereafter, the Appeal Review Committee/Trustees may, but is not required to, reconsider the adverse benefit determination in light of the new information or documentation. Reconsideration by the Appeal Review Committee/Trustees will not delay the IRO review. If the Appeal Review Committee/Trustees decides to reverse the prior adverse benefit determination, the claimant and the IRO will be notified within one (1) business day after the decision is made.

The IRO will review all information and documents timely received. The IRO will decide the appeal on a de novo basis, meaning without regarding to any decisions or conclusions reach by the Appeal Review Committee/Trustees. In addition to the documents and information

provided by the Plan or its designee and claimant, the IRO may consider the following in reaching its decision:

(a) The claimant's dental records;

(b) The claimant's healthcare professional's recommendation;

(c) Reports from healthcare professionals and other documents submitted by the Plan, claimant or the claimant's healthcare professional;

(d) The terms of the Plan;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(f) Any applicable clinical review criteria developed and used by the Plan unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(g) The opinion of the IRO's clinical reviewer after considering relevant information and documents.

Decision by the IRO

The IRO must provide a written decision to the claimant and Plan within forty-five (45) days after receipt of the request for review. The decision of the IRO should include, to the extent relevant, the following:

(a) A general description of the reason for the appeal, including information sufficient to identify the claim, the diagnosis code and its meaning, the treatment code and its meaning and the reason for the denial that is subject to appeal;

(b) The date the IRO received the appeal and the date of decision;

(c) Reference to documents and information considered in reaching the decision including, if applicable, the claimant's dental records, the recommendations and reports of the claimant's healthcare professional, clinical review criteria developed and used by the Plan, the applicable terms of the Plan and appropriate practice guidelines, including the applicable evidence-based standards;

(d) A discussion of the principal reasons for the decision, including any evidence-based standards relied upon;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the claimant or the Plan;

(f) A statement that judicial review may be available to the claimant; and

(g) Contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Service Health Act.

If the IRO reverses the decision of the Appeal Review Committee/Trustees, the Plan must immediately provide coverage or payment as directed by the IRO.

Expedited Review by the IRO

The Plan will allow a claimant to make a request for expedited external review at the time the claimant receives:

(a) An adverse benefit determination that involves a medical condition for which the time frame for completion of the expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and a request for expedited internal review has been filed; or

(b) The claimant has received an adverse benefit determination from the Appeal Review Committee/Trustees and the claimant has a medical condition where the time frame for completion of the appeal process to the IRO would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function or the appeal concerns an 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.

Upon receipt of a request for expedited external review, the Plan Administrator or its designee will immediately make a preliminary determination if the appeal is eligible for the expedited external review under the standards detailed above. The Plan Administrator or its designee will notify the claimant in writing whether the appeal is eligible for an expedited decision by the IRO.

Upon a determination that a request is eligible for expedited external review, the Plan Administrator will transmit all necessary documents and information to the IRO electronically or by any other available expeditious method.

The IRO must consider the information and documents provided to it, to the extent it considers them appropriate. In reaching a decision, the IRO will review the appeal on a de novo basis, meaning without regard to any decisions or conclusions reached during the earlier stages of the Plan's review procedures.

The IRO will issue a decision as expeditiously as possible but in no event more than seventy-two (72) hours after the IRO receives the request for expedited external review. If the decision of the IRO is verbal, it must, within forty-eight (48) hours of providing the verbal decision, provide written confirmation of the decision to the claimant and the Plan.

PRIVACY PRACTICES OF THE PLAN

NOTICE OF PRIVACY PRACTICES OF THE TRUST AND PLAN

THIS SECTION DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

POLICY REGARDING YOUR PROTECTED HEALTH INFORMATION

This section describes the legal obligations of the Plan and Your legal rights regarding Your Protected Health Information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Among other things, this section describes how Your Protected Health Information may be used or disclosed to carry out treatment, payment, or health care operations, and for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain health information known as Protected Health Information. Generally, Protected Health Information is health information, including demographic information, collected from You or created or received by a healthcare professional, a health care clearinghouse, a health plan, or the Plan, from which it is possible to individually identify You and that relates to:

(a) Your past, present, or future physical or mental health condition;

(b) The provision of health care to You; or

(c) The past, present, or future payment for health care services provided to You.

If You have any questions about this section or about the Plan's privacy practices, please contact the HIPAA Compliance Officer whose address and telephone number are listed on page 92.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to:

(a) Maintain the privacy of Your Protected Health Information;

(b) Provide You with certain rights with respect to Your Protected Health Information;

(c) Give You this information which describes the Plan's legal duties and privacy policies regarding Your Protected Health Information; and

(d) Follow the terms of this notice until modified.

The Trustees may change the terms of this section and make new provisions regarding the use and disclosure of Your Protected Health Information that the Plan maintains, as allowed or required by law. If there are material changes to this section, You will be provided with a revised notice mailed to Your last known address.

HOW THE PLAN MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

Under the law, the Plan may use and disclose Your Protected Health Information under certain circumstances without Your permission. The following paragraphs describe different ways the Plan may use and disclose Your Protected Health Information. Each paragraph will explain what is meant and may present examples. Not every use or disclosure in a paragraph will be listed. However, all of the ways the Plan is permitted to use and disclose Your Protected Health Information will fall within one (1) of these paragraphs.

(a) **To Make or Obtain Payment**. The Plan may use and disclose Your Protected Health Information to determine Your eligibility for Plan benefits, to facilitate payment for the treatment and services You receive from healthcare professionals, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell a healthcare professional about Your dental history to determine whether the Plan will cover the treatment. The Plan may also share Your Protected Health Information with a utilization review or precertification service organization. The Plan may also share Your Protected Health Information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

(b) **To Facilitate Treatment.** The Plan may use and disclose Your Protected Health Information to facilitate treatment or services by healthcare professionals. The Plan may provide dental information about You to healthcare professionals, including Dentists who are involved in Your care. For example, the Plan may disclose Protected Health Information about You to Dentists who are treating You.

(c) **For Health Care Operations.** The Plan may use and disclose Your Protected Health Information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. For example, health care operations include activities such as:

(1) Quality assessment and improvement activities;

(2) Activities designed to improve health or reduce health care costs;

(3) Clinical guideline and protocol development, case management and care coordination;

(4) Contacting healthcare professionals and participants with information about treatment alternatives and other related functions;

(5) Healthcare professional competence or qualification review and performance evaluation;

(6) Accreditation, certification, licensing and credentialing activities;

(7) Underwriting, including stop-loss underwriting, premium rating and related functions to create, renew or replace health insurance or health benefits. However, Your genetic information will not be used for underwriting purposes;

(8) Review and auditing, including compliance reviews, dental reviews, legal services, fraud and abuse detection and compliance programs;

(9) Submitting claims for reimbursement under coordination of benefit provisions;

(10) Business planning and development, including cost management and planning related to analyses and formulary development; and

(11) Business management and general administration activities of the Plan, including customer service and resolution of appeals and grievances.

(d) **When Required by Law.** The Plan will disclose Protected Health Information about You when required to do so by federal, state or local law. For example, the Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a medical malpractice case.

(e) **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose Protected Health Information about You when necessary to prevent a serious threat to Your health and safety, to the health and safety of the public or another person. Any disclosure, however, will only be made to someone able to help

prevent the threat. For example, the Plan may disclose Protected Health Information about You in a proceeding regarding the licensure of a Dentist.

(f) **Military.** If You are a member of the armed forces, the Plan may disclose Protected Health Information about You as required by military command authorities. The Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

(g) **For Treatment Alternatives.** The Plan may use and disclose Your Protected Health Information to send You information about or recommend possible treatment options or alternatives that may be of interest to You.

(h) **For Disclosure to the Trustees.** The Plan may disclose Your Protected Health Information to another health plan maintained by the Trust or to the Trustees for plan administration functions performed by the Trustees on behalf of the Plan. In addition, the Plan may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan may also disclose to the Trustees information whether You are participating in the Plan. Your Protected Health Information cannot be used for employment purposes without Your specific authorization.

(i) **Spouses and Family Members.** With only limited exceptions, the Plan will send all mail to the Early Retiree or Medicare-Eligible Retiree. This includes mail related to the Early Retiree or Medicare-Eligible Retiree's Dependents who are covered under the Plan and includes mail with information on the use of Plan benefits by the Early Retirees, Medicare-Eligible Retirees and Dependents and information on the denial of any Plan benefits to the Early Retirees, Medicare-Eligible Retirees and Dependents. If a person covered by the Plan has requested Restrictions or Confidential Communications and the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

(j) **Personal Representative.** The Plan will disclose Your Protected Health Information to individuals authorized by You, or to an individual designated as Your personal representative, attorney-in-fact, etc., so long as You provide written notice/authorization and any supporting documents (for example, power of attorney). Even if You designate a personal representative, federal law permits the Plan to elect not to treat the person as Your personal representative if the Plan has a reasonable belief that:

(1) You have been, or may be, subject to domestic violence, abuse or neglect by such person;

(2) Treating such a person as Your personal representative could endanger You; or

(3) Plan representatives determine, in their professional judgment, that it is not in Your best interest to treat the person as Your personal representative.

(k) **Business Associates.** The Plan contracts with business associates who perform various services for the Plan. For example, the Plan Administrator handles many functions in connection with the operation of the Plan. To perform these functions, or provide the services, the Plan's business associates may receive, create, maintain, transmit, use or disclose Your Protected Health Information, but only after agreeing, in writing, to implement appropriate safeguards concerning Your Protected Health Information. For example, the Plan may disclose Your Protected Health Information to a business associate to process Your dental claims for payment or to provide utilization management services but only after the business associate enters into a business associate contract with the Trust.

(l) **Other Covered Entities.** The Plan may use or disclose Your Protected Health Information to assist healthcare professionals in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose Your Protected Health Information to a healthcare professional when needed by the healthcare professional to provide treatment to You or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.

(m) **To Conduct Health Oversight Activities.** The Plan may disclose Your Protected Health Information to a health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

(n) **Legal Proceedings.** If You are involved in a lawsuit or a dispute, the Plan may disclose Your Protected Health Information in response to a court or administrative order. The Plan may also disclose Your Protected Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the legal dispute, but only if efforts have been made

to tell You about the request or to obtain a court or administrative order protecting the information requested.

(o) **Law Enforcement.** The Plan may disclose Your Protected Health Information to law enforcement officials if asked to do so. Some of the reasons for such a disclosure include, but are not limited to:

(1) It is required by law or some other legal process;

(2) Locate or identify a suspect, fugitive, material witness or missing person;

(3) A death believed to be the result of criminal conduct; or

(4) It is necessary to provide evidence of a crime that occurred.

(p) **National Security and Intelligence.** The Plan may disclose Your Protected Health Information to authorized federal officials to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

(q) **Research.** The Plan may disclose Your Protected Health Information to researchers when:

(1) The individual identifiers have been removed; or

(2) When the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approved the research.

(r) **Inmates.** If You are an inmate in a correctional institution, the Plan may disclose Your Protected Health Information to the correctional institution or to a law enforcement official for:

(1) The institution to provide health care to You;

(2) Your health and safety and the health and safety of others; or

(3) The safety and security of the correctional institution.

(s) **Coroners, Medical Examiners, and Funeral Directors.** The Plan may disclose Your Protected Health Information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for

the coroner or medical examiner to perform other duties authorized by law. The Plan may disclose information to funeral directors so they may carry out their duties.

(t) **Organ and Tissue Donation.** If You are an organ or tissue donor, the Plan may disclose Protected Health Information after Your death to organizations that handle organ or tissue donation and transplantation or to an organ or tissue donation bank.

(u) **Workers' Compensation.** The Plan may disclose Your Protected Health Information for workers' compensation or similar programs but only as authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs that provide benefits for work-related Injuries or Sicknesses.

(v) **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** The Plan is required to disclose Your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

(w) **Public Health Risks.** The Plan may disclose Your Protected Health Information for public health activities. These activities generally include the following:

(1) To prevent or control disease, injury or disability;

(2) To report births and deaths;

(3) To report child abuse or neglect;

(4) To report reactions to medications or problems with products;

(5) To notify people of recalls of products they may be using;

(6) To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and

(7) To notify the appropriate governmental authority if the Plan believe that a person has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if You agree, or when required or authorized by law.

(x) **Disclosures to the Centers for Medicaid and Medicare Services.** The Plan may disclose Your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare Services, in order to comply with mandatory Medicare coordination of benefit requirements. The Plan may share required data, including health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

(y) **Disclosures to You.** At Your request, the Plan is required to disclose the portion of Your Protected Health Information that contains medical and dental records, billing records and other records used to make decisions regarding Your health care benefits. The Plan is also required, when requested, to provide You with an accounting of most disclosures of Your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the Protected Health Information was not disclosed pursuant to Your authorization.

AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Other uses or disclosures of Your Protected Health Information not discussed above will only be made with Your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose Your psychiatric notes; will not use or disclose Your Protected Health Information for marketing purposes; and the Plan will not sell Your Protected Health Information, unless You give the Plan written authorization. You may revoke written authorization at any time so long as the revocation is in writing. Once the Plan receives Your written revocation, it will only be effective for further uses and disclosures. It will not be effective for any Protected Health Information that may have been used or disclosed in reliance upon the written authorization prior to receiving Your written revocation.

MINIMUM NECESSARY DISCLOSURE OF PROTECTED HEALTH INFORMATION

The amount of Protected Health Information the Plan will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, the Plan will follow more stringent state privacy laws that relate to use and disclosure of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding Your Protected Health Information that the Plan maintains:

(a) **Right to Request Restrictions.** You have the right to request restrictions or limitations on the Protected Health Information the Plan uses or discloses about You for treatment, payment or health care operations. You also have the right to request a limit on Your Protected Health Information that the Plan discloses to someone involved in Your care or the payment for Your care such as a family member or friend. For example, You could ask that the Plan not use or disclose information about a surgery You had.

Except as provided in the next paragraph, the Plan is not required to agree to Your request. However, if the Plan does agree to the request, it will honor the restriction until You revoke it or the Plan notifies You.

The Plan will comply with any restriction request if: except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment); and the Protected Health Information pertains solely to a health care item or service for which the healthcare professional involved has been paid in full by You or someone else.

To request restrictions, You must make Your request in writing to the HIPAA Compliance Officer at the address on page 92. In Your written request, You must tell the Plan:

(1) What Protected Health Information You want to limit;

(2) Whether You want to limit the Plan's use, disclosure or both; and

(3) To whom You want the limits to apply, for example, non-disclosure to Your spouse.

(b) **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with You about health matters in a certain way or in a certain location. For example, You may ask that the Plan communicate with You only at a certain post office box, telephone number or by email.

To request confidential communications, You must make Your request in writing to the HIPAA Compliance Officer at the address on page 92. The Plan will not ask You the reason for the request. Your written request must specify how or where You wish to receive confidential communications. The Plan will accommodate all reasonable requests.

(c) **Right to Inspect and Copy Your Protected Health Information.** You have the right to inspect and copy Your Protected Health Information that may be used to make decisions about Your Plan benefits. If the Protected Health Information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the Protected Health Information can be readily produced in that form and format. If the Protected Health Information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If the Plan cannot agree on an electronic form and format, it will provide You with a paper copy. A request to inspect and copy records containing Your Protected Health Information must be made in writing to the HIPAA Compliance Officer at the address on page 92. If You request a copy of Your Protected Health Information, the Plan may charge a reasonable fee for copying, mailing, or other supplies associated with the request.

(d) **Right to Amend Your Protected Health Information.** If You believe that Your Protected Health Information maintained by the Plan is inaccurate or incomplete, You may request that the Plan amend Your Protected Health Information. The request may be made as long as the Protected Health Information is maintained by the Plan.

A request for an amendment of Protected Health Information records must be made in writing to the HIPAA Compliance Officer at the address on page 92 and must provide a reason for the request.

The Plan may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny Your request if You ask the Plan to amend Protected Health Information that: is not part of the Protected Health Information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information that You would be permitted to inspect and copy; or is already accurate and complete. If the Plan denies Your request, You have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed Protected Health Information will include Your statement.

(e) **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of Your Protected Health Information. The accounting will not include: disclosures for purposes of treatment, payment or health care operations; disclosures made to You; disclosures made pursuant to Your authorization; disclosures made to friends or family members in Your presence or because of an emergency; disclosures for national security purposes; and disclosures incidental to otherwise permissible disclosures.

The request for an accounting must be made in writing to the HIPAA Compliance Officer at the address on page 92. The accounting request should specify the time period for which You are requesting the accounting. Accounting requests may not be made for periods of time going back more than six years from the date of the request. Your request should state the form You want the list of disclosures (for example, paper or electronic). The Plan will provide the first accounting You request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform You of the fee in advance.

(f) **Right to be Notified of a Breach.** You have the right to be notified in the event that the Plan, or a business associate, discovers a breach of Your unsecured Protected Health Information.

(g) **Right to a Paper Copy of the Plan's Privacy Practices Notice.** You have a right to a paper copy of the Plan's Privacy Practices. You may ask the Plan to give You a copy of this notice at any time. To receive a paper copy, please contact the HIPAA Compliance Officer at the address on page 92.

COMPLAINTS

If You believe that Your privacy rights have been violated, You may file a complaint with the HIPAA Compliance Officer or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, You should notify the HIPAA Compliance Officer, in writing, at the address on page 92.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

HIPAA COMPLIANCE OFFICER

HIPAA Compliance Officer
Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund

1220 SW Morrison Street, Suite 300
Portland, OR 97205
(503) 224-0048 or (800) 205-7002

If You have any questions regarding this notice, please contact the HIPAA Compliance Officer.

AMENDMENT AND TERMINATION

PLAN AMENDMENTS AND RESTATEMENTS

The Benefit Booklet/Plan Document may be amended or restated from time to time by the Trustees in accordance with the voting procedures in the Trust Agreement. **None of the Plan provisions or benefits are vested**.

PLAN TERMINATION

The Trustees may terminate the Plan in accordance with the voting procedures in the Trust Agreement.

In the event of termination of the Plan, all Contributions and assets of the Plan shall continue to be used for the purpose of paying benefits under the provisions of the Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health and welfare benefits to Covered Persons under this Plan and for paying reasonable expenses of administering the Plan until all Contributions and assets of the Plan are exhausted, unless some other disposition of assets is required under the Employee Retirement Income Security Act, the Internal Revenue Code, or in applicable regulations.

SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains information required by the Employee Retirement Income Security Act of 1974 (ERISA) and is a general explanation of certain terms of the Plan and other legal instruments, and is not intended to modify or change them in any way.

The rights and duties of all persons connected with the Plan are set forth in these instruments, which may be inspected at the office of the Plan Administrator.

PLAN NAME

Local Union 598 Plumbing & Pipefitting Industry Early Retiree and Medicare-Eligible Retiree Health Reimbursement Arrangement, Medicare Advantage, Dental, Vision and Life Insurance Plan, also referred to as the Plan.

EFFECTIVE DATE

January 1, 2016

PLAN YEAR

The Plan Year is the 12-month period ending on September 30.

PLAN SPONSOR

The Plan is sponsored by the Joint Labor-Management Board of Trustees, the name and address of which are:

Board of Trustees
Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Fund
c/o BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205
(503) 224-0048 or (800) 205-7002

TYPE OF ADMINISTRATION

The Plan is administered by the Board of Trustees with the assistance of a contract administrative organization, the name, address and telephone number of which are:

BeneSys, Inc.
1220 SW Morrison Street, Suite 300

Portland, OR 97205
(503) 224-0048 or (800) 205-7002

AGENT FOR SERVICE OF PROCESS

The person designated as the Plan's agent for service of process is:

Lee Centrone
BeneSys, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205

In addition, service of legal process on the Plan may be made on any member of the Board of Trustees whose names and addresses are listed below.

BOARD OF TRUSTEES

Employer Trustees	Labor Organization Trustees
Mack Bland III Apollo Mechanical 1207 W. Columbia Drive Kennewick, WA 99336	Pete Nicacio Plumbers and Steamfitters Local 598 1328 Road 28 Pasco, WA 99301
Wayne Gohl, Jr. Northwest Refrigeration Contractors 3401 Ahtanum Road Yakima, WA 98903	Timothy Still Plumbers and Steamfitters Local 598 1328 Road 28 Pasco, WA 99301
Don Jarrett Apollo Mechanical 1207 W. Columbia Drive Kennewick, WA 99336	Randall Walli Plumbers and Steamfitters Local 598 Training Center 1328 Road 28 Pasco, WA 99301
Mack Bland IV Apollo Mechanical 1207 W. Columbia Drive Kennewick, WA 99336	

EMPLOYER AND PLAN IDENTIFICATION NUMBERS

The Employer Identification Number assigned by the Internal Revenue Service is:

91-0973983

The Plan Identification Number assigned by the Trustees is:

502

TYPE OF PLAN

The Plan is a health and welfare plan that provides dental and vision benefits for Early Retirees, Medicare-Eligible Retirees and their Dependents, life insurance benefits for Early Retirees and Medicare-Eligible Retirees, an HRA for Early Retirees and a Medicare Advantage Plan for Medicare-Eligible Retirees and Medicare-Eligible Dependents.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to the terms of Collective Bargaining Agreements between the Union and Employers. The Collective Bargaining Agreements provide that Employers will make required Contributions to the Trust for the purpose of enabling former Employees who worked under the Collective Bargaining Agreements and who are now Early Retirees or Medicare-Eligible Retirees to participate in the benefits provided by the Plan. The Contribution rate is specified in the Collective Bargaining Agreements.

A complete list of Employers contributing to the Trust may be obtained upon written request to the Trustees and is available for examination during regular office hours at the Plan Administrator's office. Copies of the Collective Bargaining Agreements can be obtained from the Plumbers and Steamfitters Local 598 or the Plan Administrator. Information about whether an employer or union is a sponsor and a complete list of sponsors is available upon written request from the Plan Administrator.

FUNDING

The HRA and dental benefits provided by the Plan are paid directly from assets of the Trust. Vision and life insurance benefits are insured.

PLAN TERMINATION

The Trustees have the authority to terminate the Plan.

If the Plan terminates for any reason, all money and assets remaining in the Plan, after the payment of expenses, will be used for the continuation of the benefits provided by the then

existing Plan until such money and assets have been exhausted, unless some other disposition is required in regulations adopted by the Secretary of Labor.

The Trustees are providing Plan benefits to the extent that money is currently available to pay the costs of the Plan. The Trustees retain the full and exclusive authority to determine the extent to which money is available to pay the costs of the Plan and the expenditure of such money. Benefits are not vested or guaranteed to continue indefinitely and the Plan may be amended or terminated at any time by the Trustees.

LIABILITY OF THIRD PARTIES AND THE TRUSTEES

No Employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the Employer to make Contributions required by its Collective Bargaining Agreement or Special Agreement. In the event the Trust does not have sufficient assets to permit continued payments, nothing contained in this Plan or the Trust Agreement will be construed to obligate any Employer to make benefit payments or Contributions other than the Contributions for which the Employer may be obligated by the Collective Bargaining Agreement or Special Agreement. Likewise, there will be no liability upon the Trustees, individually or collectively, or upon Plumbers and Steamfitters Local 598 to provide money to fund the benefits established by this Plan if assets are not sufficient to make such benefit payments.

ORGANIZATIONS PROVIDING BENEFITS, FUNDING MEDIA AND TYPE OF ADMINISTRATION

The names and addresses of all of the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the benefit plan and whether benefits are guaranteed under an insurance policy) are set forth below.

Dental and HRA Benefits. Claims arising from dental claims for Early Retirees, Medicare-Eligible Retirees and their Dependents who have elected dental benefits are paid directly from Trust assets. Claims arising from the HRA are paid directly from Trust assets.

Vision Benefits. The Trust has entered into a contract with Alaska Vision Services, Inc. to provide vision benefits for Early Retirees, Medicare-Eligible Retirees and their Dependents who have elected vision benefits. The vision benefits are insured under a group contract between the Trust and Alaska Vision Services, Inc. Alaska Vision Services, Inc. is responsible for administering the contract and paying claims.

Alaska Vision Services, Inc.
3333 Quality Drive
Rancho Cordova, CA 95670

Life Insurance. The Trust has entered into a contract with Reliance Standard Life Insurance Company to provide life insurance benefits for Early Retirees and Medicare-Eligible Retirees. The life insurance benefits are insured under a group contract between the Trust and Reliance Standard Life Insurance Company. Reliance Standard Life Insurance Company is responsible for administering the group contract and paying claims.

Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103
(267) 256-3518

Medicare Advantage Plan. Medicare-Eligible Retirees and Medicare-Eligible Dependents have access to medical and prescription drug coverage through a group Medicare Advantage Plan. The medical and prescription drug benefits provided by the Medicare Advantage Plan are insurance and provided under a group contract between the Trust and UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company is responsible for administering the Medicare Advantage Plan and paying claims.

UnitedHealthcare Insurance Company
9701 Data Park Drive
Minnetonka, MN 55343

ERISA STATEMENT OF RIGHTS

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

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

(d) Continue health care coverage for You and Your 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 the Benefit Booklet starting on page 20 for the rules governing Your COBRA Continuation Coverage rights.

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

If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within thirty (30) days, You may file suit in a federal court. In such a case, the court may require the Trustees 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 Trustees. If You have a claim for benefits that 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 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.

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement, obtaining documents from the Trustees, about Your rights under ERISA or Your rights under the Health Insurance Portability and Accountability Act of 1996, You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory. Alternatively, You may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 866-444-3272 or by writing to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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 at 866-444-3272. You may also find answers to Your questions and a list of Employee Benefits Security Administration field offices at www.dol.gov/ebsa.