BENEFIT BOOKLET

FOR THE

LOCAL UNION 598 PLUMBING & PIPEFITTING INDUSTRY

HEALTH & WELFARE PLAN

DESCRIBING
MEDICAL, DENTAL & VISION BENEFITS
FOR EMPLOYEES & DEPENDENTS

AND

LIFE INSURANCE, SAVINGS PLAN BENEFITS & HEALTH REIMBURSEMENT ARRANGEMENT FOR EMPLOYEES

January 1, 2016

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TRUSTEES' LETTER

This Benefit Booklet is the Plan Document for the Local Union 598 Plumbing & Pipefitting Industry Health & Welfare Plan (the Plan).

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

- Eligibility requirements for Employees and Dependents to participate in and receive benefits from the Plan;
- The benefits provided by the Plan;
- The circumstances that may result in termination of eligibility;
- The Health Reimbursement Account and Savings Plan for Employees;
- 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, and require or increase self-payments. You will be provided a Summary of Material Modifications when there is a material change to this Benefit Booklet.

Employees and their Dependents enrolled in the Medical Plan will also receive dental and vision benefits described in this Benefit Booklet and the Employee will receive the life insurance, HRA, and savings benefits described in this Benefit Booklet.

The Trustees have established a separate plan for Early Retirees and Medicare-Eligible Retirees and their Dependents known as the Local Union 598 Plumbing & Pipefitting Industry Early Retiree and Medicare-Eligible Retiree Health Reimbursement Arrangement, Medicare Supplement, Dental, Vision and Life Insurance Plan (the Retiree Plan). Call or write to the Plan Administrator, whose address and telephone number are on page 3 or go to the website at www.598benefits.aibpa.com, to obtain the Benefit Booklet for the Retiree Plan.

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** section, 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 or 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 Employee or Dependent has a change of address;**
- **The Employee 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 health and welfare coverage until the next Open Enrollment Period;**
- **Divorce or legal separation; and**
- **Your are planning to retire.**

The Plan has a website that provides free online access to paid claims information, eligibility status, enrollment applications, claim forms, a copy of this 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 as it relates to You. 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.

Employees and Dependents over age twelve (12) can create their own accounts. 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
800-205-7002
www.598benefits.aibpa.com

DEFINITION OF TERMS

When used in this Benefit Booklet:

Accidental Bodily Injury means an Injury caused by an external force or element such as a blow or fall that requires treatment by a Provider.

Acupuncture means the practice of piercing specific peripheral nerves with needles to relieve the discomfort of painful disorders, to induce surgical anesthesia or for therapeutic purposes.

Acupuncturist means a person licensed by the state in which the services are provided to practice Acupuncture.

Aetna means Aetna Life Insurance Company.

Ambulatory Surgical Facility means a licensed free-standing independently operated ambulatory surgical facility.

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

Benefit Period means claims incurred for Covered Services rendered January through December of a Calendar Year. A Benefit Period is established and begins when You have incurred, during a Calendar Year, Covered Services that exceed the Deductible amount. All Covered Services incurred during a Benefit Period are used in computing benefit payments. A Benefit Period terminates on the last day of the Calendar Year in which it was established.

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

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance. Chemical Dependency does not include an addiction to, or dependency on, tobacco, tobacco products or foods.

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 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 this Trust pursuant to the United Association National Reciprocity Agreement.

Co-Insurance means Your share of the cost for certain Covered Services (other than Co-Payments and Deductibles) calculated as a percentage of the Negotiated Rate for Covered Services provided by a Preferred Provider or the Global Charge or Usual and Customary Charge for Covered Services provided by a Non-Preferred Provider.

Co-Payment means the fixed dollar amount (for example, $25.00) You must pay for certain Covered Services.

Cosmetic or Reconstructive Surgery means any surgical procedure performed primarily to improve physical appearance or to change or restore bodily form without materially correcting a bodily function.

Covered Person means each Employee and Dependent who is covered by the Plan. 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.

Custodial Care means services or supplies, regardless of where or by whom they are provided which:

(a) A person without medical skills or medical background could provide or be trained to provide; or

(b) Are provided mainly to help the Covered Person with daily living activities, including, but not limited to:

(1) Walking, getting in and/or out of bed, exercising and moving the Covered Person;

(2) Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;

(3) Assistance with eating by utensil, tube or gastrostomy;

(4) Homemaking, such as preparation of meals or special diets, and house cleaning;

(5) Acting as a companion or sitter;

(6) Supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications;

(c) Provide a protective environment;

(d) Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve a Covered Person's Sickness, Injury or functional ability; or

(e) Are provided for the convenience of a Covered Person or the caregiver or are provided because the Covered Person's own home arrangements are not appropriate or adequate.

Deductible means the amount a Covered Person must pay for Covered 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 Employee's spouse. The term "spouse" means a person of the same or opposite sex whose marriage to the Employee 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 Employee'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 exception 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 eligible as a Dependent immediately prior to and upon reaching age twenty-six (26). Before the child reaches age twenty-six (26), the Employee must submit documentation to the Plan Administrator that establishes the child qualifies as a Dependent of the Employee under this provision and Section 105(b) of the Internal Revenue Code.

Durable Medical Equipment means Medically Necessary items that are able to withstand repeated use and that are prescribed by a Provider for therapeutic use in direct treatment of an Injury or Sickness. Examples include oxygen equipment, wheelchairs, crutches, and blood testing strips for diabetes. Durable Medical Equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs, hot tubs, or other household items, even if Provider recommended.

Early Retiree means a former Employee who meets the criteria to enroll in the Retiree Plan and is no longer an Employee or COBRA enrollee.

Elective Abortion means any abortion other than one where the mother's life would be endangered if the fetus was carried to term.

Emergency Medical Condition means an Injury or Sickness so serious that a reasonable person would seek care right away to avoid severe harm.

Employee means a person who has established eligibility for Plan benefits by working for an Employer or by having Contributions sent to the Trust pursuant to the Reciprocity Agreement. Employee also means a person who has lost eligibility for Plan Coverage and is enrolled for COBRA continuation coverage.

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.

Essential Health Benefit means ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care as these terms are defined in Section 1302 of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act and applicable regulations.

Experimental or Investigational Procedure means a drug, device, treatment, medical procedure, service, or supply if:

(a) It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, medical procedure, service, or supply is furnished;

(b) It or the patient informed consent document was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function;

(c) It is considered experimental or investigational by or not approved by the Food and Drug Administration, the American Medical Association, the Department of Health and Human Services and/or the appropriate medical society;

(d) Reliable Evidence indicates it is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

(e) The prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment of diagnosis.

Global Charge means the single expense incurred for a combination of all Medically Necessary Covered Services normally furnished by a Provider (or multiple Providers) before, during and after the principle medical service. The Global Charge will be based on a complete description of the Covered Service rather than a fragmented description of that Covered Service. The Global Charge will not exceed the Usual and Customary Charge allowed by the Plan.

Healthcare Expense means an expense incurred by a Covered Person for medical care as defined in Section 213(d) of the Internal Revenue Code and applicable regulations, guidance and publications issued by the Internal Revenue Service. Healthcare Expense does not include expenses reimbursed or reimbursable under any private, employer-provided, or public healthcare reimbursement or insurance arrangement, or any amount claimed as a deduction on the federal income tax return of a Covered Person. Healthcare Expenses are incurred when the healthcare is provided and not when the Covered Person is billed or pays the Healthcare Expense.

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

(a) A place which is licensed as a general Hospital; or

(b) A place which:

(1) Is operated for the care and treatment of resident inpatients;

(2) Has a registered graduate nurse (RN) always on duty;

(3) Has a laboratory and X-ray facility; and

(4) Has a place where major surgical operations are performed; or

(c) A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for a Mental and Nervous Disorder or Chemical Dependency, Hospital can also mean a facility which meets these requirements:

(a) Has rooms for resident inpatients;

(b) Is equipped to treat Mental and Nervous Disorders and/or Chemical Dependency;

(c) Has a resident Physician on duty or on call at all times;

(d) As a regular practice, charges the patient for the expense of confinement; and

(e) Is licensed by the proper authority of the area in which it is located.

A Hospital does not include a Hospital or institution or part of a Hospital or institution which is licensed or used principally as a convalescent home, rest home, nursing home, home for the aged, halfway house or board and care facilities.

Hospital Confinement means a Medically Necessary Hospital stay of twenty-four (24) consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board. How the Hospital classified the stay is irrelevant.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient Hospital services or admissions, including any applicable pre-admission certification requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

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

Injury means an Accidental Bodily Injury which requires treatment by a Provider. It must result in a loss independent of Sickness and other causes.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex muscles, nerves and tissues related to that joint). It includes TMJ or temporomandibular joint dysfunction, arthritis or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury.

Massage Therapist means an individual licensed by the state in which he is practicing Massage Therapy.

Massage Therapy means the use on the human body of pressure, friction, stroking, tapping or kneading, vibration or stretching by manual or mechanical means. Massage Therapy must be administered by a Massage Therapist.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons.

Medical Coverage means the Medical Benefits and Prescription Drug sections of this Benefit Booklet.

Medically Necessary means a Covered Service which is ordered by a Provider and which the Trustees, in conjunction with their advisors, determine is:

(a) Provided for the diagnosis or treatment of an Injury or Sickness;

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

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

(d) The most appropriate supply or level of service which can be provided on a cost-effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care); and

(e) Is not subject to any Exclusions and Limitations in the Benefit Booklet.

The fact that the Covered Person's Provider authorizes or approves services or supplies does not mean such services or supplies are Medically Necessary and covered by the Plan. The definition and determination of Medically Necessary does not apply to any services or supplies that are considered Preventative Care Services or Supplies.

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 the Retiree Plan.

Medicare-Eligible Retiree means a former Employee who meets the criteria to enroll in the Retiree Plan and is no longer an Employee, Early Retiree or COBRA enrollee.

Mental and Nervous Disorder means mental illness or functional nervous disorder. Conditions and diseases listed in the most recent edition of the International Classification of Diseases

(ICD) as psychosis, neurotic disorders or personality disorders; other non-psychotic mental disorders listed in the ICD to be determined by the Trustees. Mental or Nervous Disorder does not include the treatment of Chemical Dependency.

Naturopathic Care means the discipline that includes physiotherapy, natural healing processes, and minor surgery and has as its objective the maintaining of the body in, or of restoring it to, a state of normal health. Naturopathic care must be administered by a Naturopathic Physician.

Naturopathic Physician means an individual holding a doctoral degree in naturopathic medicine from a naturopathic school offering a four year full-time resident program of study in naturopathy leading to a doctoral degree in naturopathic medicine.

Negotiated Rate means the amount the Trust will pay for Covered Services provided by a Preferred Provider as determined by the PPO Network contract after You have satisfied the Deductible (if applicable) in a Calendar Year and paid the Co-Payment (if applicable).

Non-Preferred Provider or Non-PPO Provider or Non-PPO means a Hospital, clinic, facility or Provider that does not belong to the PPO Network.

Open Enrollment Period means the period in which Covered Persons can enroll or disenroll a Dependent or make other changes in coverage as authorized by the Trustees.

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

Out-of-Pocket Maximum means the most You pay during a Calendar Year for Medical Coverage before the Trust begins to pay at 100% of the Negotiated Rate or Global Charge or Usual and Customary Charge for Covered Services. This amount does not include balance billed charges, healthcare not covered by the Plan or healthcare above limits set by the Plan (for example, twelve (12) chiropractic visits per Calendar Year). There is a separate Out-of-Pocket Maximum for Prescription Drugs.

Palliative Care means medical services provided by a hospice care program that alleviates symptoms or affords temporary relief of pain but is not intended to effect a cure.

Percentage Payable means the amount the Trust will pay for Covered Services at the Negotiated Rate, the Global Charge or the Usual and Customary Charge after You have satisfied the Deductible (if applicable) in a Calendar Year and paid the Co-Payment (if applicable) until You have reached the Out-of-Pocket Maximum.

Physician means an individual licensed and holding a degree as a medical doctor (MD), a doctor of osteopathy (DO), a doctor of podiatry (DPM) or a doctor of chiropractic (DC) who is acting within the scope of his or her license in the state where he or she practices.

Plan means this 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.

Plan Document means the Benefit Booklet.

PPO Network means the Aetna PPO Network and any other PPO Network the Trust or Aetna contracts with for the benefit of a Covered Person.

Preferred Provider or **PPO Provider** means a Hospital, clinic, facility, and Provider which belongs to the PPO Network.

Prescription Drug means drugs and medications that require a written prescription from a Physician that must be dispensed by a licensed pharmacist or Physician and covered by the Plan.

Preventative Care Services is defined on page 52 of this Benefit Booklet.

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.

Provider means:

(a) A Physician;

(b) A doctor of medical dentistry (DMD);

(c) A Naturopathic Physician;

(d) An optometrist for covered medical services other than routine eye examinations and refractions for the purpose of testing vision acuity, provided that such covered medical services fall within the scope of his or her license in the state where he or she practices;

(e) A doctor of dental surgery (DDS);

(f) Denturist (under certain conditions);

(g) Dental Hygienist;

(h) Licensed clinical psychologist;

(i) Licensed clinical social worker who:

(1) Has a master's or doctor's degree in social work;

(2) Has at least two years of clinical social work practice;

(3) Is certified by the Academy of Certified Social Workers; and

(4) In states requiring license, certification or registration, is licensed, certified or registered as a social worker where the services are rendered.

(j) Master of Science or Arts;

(k) Certified Competent Clinical Audiologist;

(l) A nurse midwife who:

(1) Is a certified nurse practitioner;

(2) Is certified by the American College of Nurse Midwives;

(3) Is under the supervision of a Physician or Hospital; and

(4) Is licensed as a nurse midwife by the state in which care is rendered (if that state's laws license midwives).

(m) A physical or occupational therapist who is licensed as a physical or occupational therapist by the state in which care is rendered (if that state's laws license physical or occupational therapists) for Rehabilitative Services rendered upon the written referral of a Physician;

(n) Speech therapist who:

(1) Has a master's degree in speech pathology;

(2) Has completed an internship; and

(3) Is licensed as a speech therapist by the state in which he or she performs services (if that state's laws license speech therapists);

(o) A Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education; and works for a clinic or a Physician and can assess, treat and prescribe medication under a Physician's review. This does not apply if applicable law does not allow it;

(p) Nurse Practitioner (Certified);

(q) Acupuncturist; and

(r) Massage Therapist.

Reciprocity Agreement means the United Association National Reciprocity Agreement.

Rehabilitative Services means healthcare services that help a Covered Person keep, get back to, or improve skills and functioning for daily living that have been lost or impaired because the Covered Person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reliable Evidence means only published reports and articles in peer-reviewed authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment, medical procedure, service or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, medical procedure, service or supply.

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.

Retiree Plan means the Local Union 598 Plumbing & Pipefitting Industry Early Retiree and Medicare-Eligible Retiree Health Reimbursement Arrangement, Medicare Supplement, Dental, Vision and Life Insurance Plan, and any amendments, deletions, revisions and restatements thereto.

Sickness means a disease, disorder or condition, which requires treatment by a Provider.

(a) For a female Employee or a Dependent spouse, Sickness includes childbirth and pregnancy. It does not include complications which are the result of an Elective Abortion.

(b) For Dependent Children, Sickness does not include pregnancy or childbirth. It does include complications which are the result of pregnancy.

Skilled Nursing Care Facility means a facility licensed under applicable law to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour per-day nursing services supervised by registered nurses.

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.

TMJ/Temporomandibular Joint Syndrome means pain or other symptoms affecting the head, jaw and face that are believed to result when the temporomandibular joints (jaw joints) and the muscles and ligaments that control and support them do not work together correctly. TMJ is also referred to as myofascial pain syndrome.

Total Disability, Totally Disabled or Disabled means:

(a) For life insurance, refer to page 126 of the Benefit Booklet.

(b) For health and welfare benefits other than life insurance, means that because of Injury or Sickness You are completely and continuously unable to perform the material and substantial duties of Your regular occupation and are not engaging in any work or occupation for wages or profit.

Trust means the Local Union 598 Plumbing & Pipefitting Industry Health & 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.

Usual and Customary Charge means the Global Charge and/or Aetna's for a Covered Service which is no higher than the ninetieth (90^{th}) percentile of the Trust's most current prevailing

health care charge data. When there is insufficient health care charge data available for a Covered Service, the Usual and Customary Charge will be based on values or amounts established by the Trustees in conjunction with their advisors.

In some situations, the Global Charge will be limited to a specific percentage of the Usual and Customary Charge. These situations include, but are not limited to, the following:

(a) For multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity (all as determined by the Trustees in conjunction with their advisors) to the complete procedure, the Global Charge will be:

(1) One hundred percent (100%) of the Usual and Customary Charge for the primary procedure;

(2) Fifty percent (50%) of the Usual and Customary Charge for the secondary procedure, including any bilateral procedure; and

(3) Twenty-five percent (25%) of the Usual and Customary Charge for each additional covered procedure.

This applies to all surgical procedures except as determined by the Trustees in conjunction with their advisors.

(b) For surgical assistance by a Physician, the Global Charge will be twenty percent (20%) of the Usual and Customary Charge for the corresponding surgery.

(c) For surgical assistance by a Physician's Assistant or a registered nurse when used in lieu of surgical assistance by a Physician, the Global Charge will be ten percent (10%) of the Usual and Customary Charge for the corresponding surgery.

(d) For nonsurgical treatments performed during an office visit, the covered Global Charge will be limited to the Usual and Customary Charge for the nonsurgical treatment alone.

All Covered Services for Medical Coverage are subject to this Usual and Customary Charge definition. In no event will the Usual and Customary Charge exceed the billed amount or the amount for which the Covered Person is responsible.

You, Your means an Employee, Dependent or COBRA enrollee who is covered under the Plan.

When necessary to the meaning of any term or provision of this Benefit Booklet, and except when otherwise indicated by the context, either the masculine or the neuter pronoun will be deemed to include the masculine, feminine, and the neuter, and the singular will be deemed to include the plural; however, only one benefit will apply in any one case.

ELIGIBILITY

WHEN COVERAGE BEGINS FOR EMPLOYEES

An Employee becomes eligible for Plan coverage when Employers have made sufficient Contributions on the Employee's behalf to the Trust as described below.

To obtain Plan coverage, an Employee must meet one of the following requirements:

(a) The Employee must work at least 420 hours under a Collective Bargaining Agreement for an Employer within a period of four consecutive months or less and the Employer paid the Contributions to the Trust; or

(b) Within a period of four consecutive months or less, there must have been paid to the Trust for the Employee, pursuant to a Reciprocity Agreement, Contributions that equal or exceed the monetary value of 420 hours multiplied by the hourly Contribution rate as set forth in the Union's principal Collective Bargaining Agreement but not including any Contributions dedicated to the HRA or savings plan.

There is one exception. If You are unable to work during one or more of the four consecutive months due to an occupational Injury or Sickness, the period of occupational Injury or Sickness will be ignored when calculating the period of four consecutive months.

Your Plan coverage starts on the first day of the second month after You meet the requirements in (a) or (b) above. None of these Contributions will be credited to Your Reserve Account. For example, an Employee had 420 hours of Contributions paid to the Trust during January, February, and March. The Employee will have Plan coverage on May 1.

HOW TO MAINTAIN COVERAGE – RESERVE ACCOUNT

Except for the initial 420 hours of Contributions to establish Plan coverage, all Contributions made to the Trust (except HRA and savings plan contributions and Contributions dedicated to the Retiree Plan as determined by the Trustees) under a Collective Bargaining Agreement or Reciprocity Agreement are credited (in dollars) to a Reserve Account in Your name up to an amount equal to the cost of six (6) months of Plan coverage. Any Contributions above this limit will be forfeited to the Trust. You will continue to have Plan coverage, whether employed or not, if Your Reserve Account has sufficient money to pay the full cost of one month of the Plan coverage. For example, an Employee's Reserve Account has $1,500 in January. The cost of Plan coverage (for example, $1,100) will be deducted from the Reserve Account on approximately January 31 to provide February coverage, leaving a balance of $400 in the Reserve Account.

You may call the Plan Administrator or use the website (www.598benefits.aibpa.com) to determine the amount of money in Your Reserve Account.

If there is less than the cost of one month of Plan coverage in Your Reserve Account, You may maintain Plan coverage by making a timely self-payment in an amount equal to the difference between the monthly cost of Plan coverage and the money in Your Reserve Account. For example, if the cost of Plan coverage is $1,100 and You have $800 in Your Reserve Account, You may make a $300 self-payment to maintain Plan coverage. The envelope containing Your partial self-payment must be postmarked by the 15th day of the month for which You are paying for coverage. For example, the envelope containing the partial self-payment for April coverage must be postmarked by April 15. The Plan Administrator will send a partial self-pay notice to You at Your last known address if You are eligible to make a partial self-payment. You may also authorize the partial self-payment to be deducted from Your HRA.

To make a partial self-payment, You must have had Plan coverage in the previous month. If You do not make a partial self-payment to continue Plan coverage, You will not be eligible to make a partial self-payment until Your Reserve Account has sufficient money to pay for a month of Plan coverage.

Instead of making a partial self-payment, You have the option to elect COBRA. See the **COBRA Continuation Coverage Rights** section of the Benefit Booklet on page 33.

You will forfeit the money in Your Reserve Account to the Trust on the later of the following dates:

(a) There is no activity in Your Reserve Account for twelve (12) consecutive months. No activity means no Contributions to Your Reserve Account and no deductions from Your Reserve Account to pay for a month of Plan coverage; or

(b) You have had no Plan coverage for twelve (12) consecutive months.

Money in Your Reserve Account will also forfeit when You enroll in the Retiree Plan.

If the money in Your Reserve Account is forfeited, You must re-qualify for Plan coverage under the heading **When Coverage Begins for Employees** on page 20.

RECIPROCITY AGREEMENT

The Trust is a party to the United Association National Reciprocity Agreement. If You are working outside the geographic jurisdiction of the Union and would like to have health and welfare Contributions sent to this Trust, contact the Plan Administrator to find out if the local union where You are working is a party to the United Association National Reciprocity Agreement. If there is a reciprocity agreement, the Plan Administrator can assist You in having Your health and welfare Contributions transferred to this Trust in order to help maintain Your Plan coverage.

COVERAGE ELECTION WHEN WORKING OUTSIDE THE UNION'S GEOGRAPHICAL AREA

When You work outside the geographic jurisdiction of the Union, You have a one-time choice to elect:

(a) Medical Coverage and the life insurance benefit for a reduced premium (no dental or vision coverage); or

(b) Maintain full Plan coverage.

If You elect (a) You may not elect full Plan coverage until You work in the geographical jurisdiction of the Union or in another area that has a Reciprocity Agreement with the Trust and the Contribution rate is the same or greater than in the Union's principal Collective Bargaining Agreement. If You do not make an election, (b) will apply.

TERMINATION OF COVERAGE FOR EMPLOYEES

Your coverage will terminate, subject to the **DISABILITY WAIVER FOR EMPLOYEES** section on page 23, on the earliest of the following dates:

(a) The last day of the month in which the money in Your Reserve Account is insufficient to pay the full monthly cost of Plan coverage and You have not made a timely partial self-payment or a COBRA payment. For example, there was insufficient money in Your Reserve Account on January 31 to pay the full monthly cost of Plan coverage and You did not make a timely partial self-payment or a COBRA payment. Your Plan coverage will terminate on January 31, at 11:59 p.m.; or

(b) The date You enter full-time service in the United States Armed Forces.

DISABILITY WAIVER FOR EMPLOYEES

An Employee who becomes Totally Disabled as the result of an occupational Injury or Sickness may apply to the Trustees to have his Reserve Account frozen and have Plan coverage continued during the period of Total Disability but not longer than six months during the Employee's lifetime. Withdrawals from the Employee's Reserve Account or COBRA self-payments may continue Plan coverage after a maximum of six months of Trust paid coverage.

To be eligible for the disability waiver, the Employee must have had Plan coverage, other than COBRA coverage, at the time the occupational Injury or Sickness occurred.

To apply for a disability waiver, the Employee must submit a Physician's statement on a form provided by the Plan Administrator describing the nature of the Total Disability, the date the Total Disability began and the date the Employee is expected to return to work. The Trust will not pay for Plan benefits related to the occupational Injury or Sickness. The cost of this care is the responsibility of the workers' compensation carrier.

REINSTATEMENT OF COVERAGE FOR EMPLOYEES

If an Employee's Plan coverage terminates because there is insufficient money in his Reserve Account to pay the full monthly cost of the Plan coverage and You have not made a timely partial self-payment or elected COBRA, You will again become enrolled for Plan coverage without a self-payment on the first day of the month following the month Your Reserve Account has sufficient money to pay the full monthly cost of the Plan coverage, but only if the money in Your Reserve Account has not been forfeited. See the section entitled **How to Maintain Coverage – Reserve Account** on page 20 to determine when the money in Your Reserve Account is forfeited.

If You do not qualify for reinstatement of Plan coverage before the money in Your Reserve Account is forfeited, You must satisfy the conditions under the heading **When Coverage Begins for Employees** on page 20 to regain Plan coverage.

ELIGIBILITY CRITERIA FOR EARLY RETIREES AND MEDICARE-ELIGIBLE RETIREES

There is a separate Plan for Early Retirees, Medicare-Eligible Retirees and their Dependents known as the Retiree Plan. There is a separate Plan Document for the Retiree Plan which describes the eligibility criteria, benefits and other pertinent information. A copy of the Plan Document for the Retiree Plan may be obtained by calling or writing to the Plan Administrator whose address and telephone number are on page 3 of the Benefit Booklet or at www.598benefits.aibpa.com. In the event there is an inconsistency between the description of the Retiree Plan benefits and eligibility rules in this section and the Retiree Plan, the terms and conditions of the Retiree Plan will control.

Benefits for Early Retirees and their Dependents. The Retiree Plan provides a monthly payment to a Health Reimbursement Arrangement for each Early Retiree that can be used to reimburse the Early Retiree for Healthcare Expenses incurred by the Early Retiree and his Dependents. The Retiree Plan provides a life insurance benefit for the Early Retiree. Each Early Retiree has the option to purchase dental and vision coverage for himself and his Dependents.

Medicare-Eligible Retirees and their Medicare-Eligible Dependents. The Retiree Plan offers the Medicare Advantage Plan to Medicare-Eligible Retirees and their Medicare-Eligible Dependents at a reduced cost. The Retiree Plan provides a vision benefit to Medicare-Eligible Retirees and their Medicare-Eligible Dependents. Each Medicare-Eligible Retiree has the option to purchase dental coverage for himself and his Medicare-Eligible Dependents.

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

(a) Submit an application for retiree coverage to 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 this 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 had fifteen-thousand (15,000) or more hours of Employer Contributions (which can include reciprocity contribution hours) contributed to this Trust preceding Your pension effective date with the Washington State Plumbing and Pipefitting Industry Pension Plan.

Any former Employee whose application for Early Retiree coverage or Medicare-Eligible Retiree coverage through this Plan was accepted by the Plan Administrator prior to November 1, 2015, will be "grandfathered" and maintain eligibility for the Retiree Plan if he (i) returns 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 or (ii) his application for Early Retiree coverage or Medicare-Eligible Retiree coverage was accepted by the Plan Administrator or Trustees and he has deferred enrollment in the Retiree Plan or

ceased enrollment in the 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 which requires a Contribution to the Trust or because Contributions are made to the Trust under a Reciprocity Agreement. In this situation, the Early Retiree or Medicare-Eligible Retiree and his Dependents will lose eligibility coverage under the Retiree Plan. Retiree Plan coverage will be lost the first day of the month the Early Retiree or Medicare-Eligible Retiree does receive a pension from the Washington State Plumbing and Pipefitting Industry Pension Plan or returned to work under a Collective Bargaining Agreement which requires a Contribution to this Trust or because Contributions are made to this Trust under a Reciprocity Agreement.

There may be a period of time between the time Retiree Plan coverage terminates and the Early Retiree or Medicare-Eligible Retiree qualifies for Plan coverage as an Employee.

After losing Retiree Plan coverage, as long as the Early Retiree or Medicare-Eligible Retiree is working under a Collective Bargaining Agreement which requires a Contribution to the Trust or Contributions are made to the Trust under a Reciprocity Agreement, the Early Retiree or Medicare-Eligible Retiree will be allowed to make self-payments to the Trust for Plan for himself and his Dependents until he qualifies for Plan coverage as an Employee. The self-payment amount will be the COBRA rate minus two percent (2%). The self-payment is due at the office of the Plan Administrator by the first day of the month for which coverage is sought. There is a grace period of thirty (30) days to make the self-payment. If the self-payment is not paid in full prior to the time the grace period expires, Plan coverage will terminate retroactive to the date the last monthly self-payment was made. There can be no gap in health and welfare coverage from the time Retiree Plan coverage ends until Plan coverage from the self-payments begins.

An Early Retiree or Medicare-Eligible Retiree who returns to work will qualify for coverage as an Employee on the first day of the month following the accumulation of sufficient money in his Reserve Account to pay the full monthly cost for Employee coverage. Employee coverage will continue under the same rules applicable to other Employees as described on page 19 under the heading **How to Maintain Coverage – Reserve Account**.

Once You re-retire, You may transfer from Plan coverage to Retiree Plan coverage. It is Your responsibility to notify the Plan Administrator that You have re-retired and want to re-enroll for the Retiree Plan.

ENROLLMENT PROCEDURES FOR EMPLOYEES

At the time an Employee becomes eligible for benefits, the Plan Administrator will send enrollment information. You must complete the enrollment information, provide requested information about Your Dependents and complete the beneficiary designation form for Your life insurance benefit. Return the completed form to the Plan Administrator within thirty (30) days.

ENROLLMENT PROCEDURES FOR DEPENDENTS

Your spouse (You do not have a legal spouse if there is a divorce or legal separation) and Your Dependent children will be eligible for Plan coverage at the same time the Employee becomes eligible for Plan coverage.

If, after the Employee becomes eligible for Plan coverage, the Employee has a new spouse or Dependent Child, You may enroll Your new spouse or Dependent Child(ren) for Plan coverage. In the event of marriage, coverage is effective on the date of the marriage. If the Employee has a new Dependent Child as a result 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 Your new spouse or Dependent Child. You must enroll Your spouse or Dependent child for 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, Your Dependent will not be eligible for Plan coverage until the next Open Enrollment Period unless he qualifies for earlier enrollment under the **Special Enrollment Rights** section below. The address and telephone number for the Plan Administrator are on page 3.

WHEN COVERAGE FOR DEPENDENTS STARTS

A Dependent begins Plan coverage (assuming timely enrollment) on the latest of the following dates:

(a) The effective date of the Employee's Plan coverage; or

(b) The date the Employee acquires the Dependent or the date of marriage so long as the Dependent is timely enrolled for Plan coverage.

By enrolling a Dependent, the Employee is 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, and/or other information required by the Trustees to establish eligibility.

TERMINATION OF COVERAGE FOR DEPENDENTS

A Dependent's coverage 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 the Employee's coverage ends, for example, insufficient money in the Reserve Account, except when an Employee dies, his Dependents who are enrolled for Plan coverage at the time of death will continue to have Plan coverage until the Reserve Account has run out. Thereafter, the Dependents may continue Plan coverage by electing COBRA; or

(d) The date the Dependents enters full time service in the United States Armed Forces.

SPECIAL ENROLLMENT RIGHTS

There are special enrollment rights in the Plan as explained below.

Late Enrollees. A late enrollee is an Employee, or Dependent who did not enroll in the Plan when first eligible for coverage and does not qualify as a special enrollee. A late enrollee may enroll for coverage during the next Open Enrollment Period subject to the limitations in this Section.

Special Enrollee. A special enrollee is an Employee or Dependent that is allowed to enroll in the Plan after initial eligibility for coverage and before the next Open Enrollment Period because of one of the events described below.

Special Enrollment Period. If an Employee or Dependent qualifies as a special enrollee under one of the circumstances described below, he or she may enroll in the Plan during the special enrollment period described below.

Special Enrollees Due to a Loss of Other Group Health Coverage. If an Employee declined to enroll himself or a Dependent for Plan coverage when first eligible because other group health coverage was in effect, the Employee may enroll himself or a Dependent for Plan coverage within thirty (30) days after the other group health coverage ends, so long as the following conditions are met:

(a) The person to be enrolled was covered under another group health plan at the time coverage under this Plan was offered; and

(1) COBRA continuation coverage under another group health plan was exhausted. Failure to pay the premium or premature termination of COBRA continuation coverage does not satisfy this requirement;

(2) Coverage under another group health plan was terminated as the result of loss of eligibility for reasons such as legal separation, divorce, death, termination of employment or reduction in the number of hours of employment (failure to pay the premium does not satisfy this requirement); or

(3) Employer contributions toward the premium for other group health plan coverage were terminated.

Coverage under this Plan will become effective on the first day of the month following the Plan Administrator's receipt of a completed enrollment form. If the Plan Administrator does not receive a completed enrollment form within thirty (30) days after the date the other group health plan coverage ended, the individual will be considered a late enrollee.

Special Enrollees Due to a Change in Family Status. If an Employee declined to enroll himself for Plan coverage and later acquires a new Dependent, the Employee may enroll himself as a special enrollee.

If an Employee enrolled for Plan coverage later acquires a new Dependent, the Employee or may enroll the new Dependent for Plan coverage. Marriage, adoption, placement for adoption, placement of a foster child in Your home, or birth of a child is considered a change in family status. You must request enrollment for the newly-acquired Dependent within ninety (90) days of the marriage, adoption, placement for adoption, placement of the foster child or birth of a child. In the event of marriage, coverage will become effective on the date of marriage. In the case of the birth of a child, coverage will become effective on the date of birth. In the case of

adoption, placement for adoption or placement of a foster child, coverage will become effective on the date of the adoption, placement for adoption or placement of the foster child.

Contact the Plan Administrator for enrollment information. If the Plan Administrator does not receive the enrollment form within ninety (90) days of the date of the change in family status, the individual will be considered a late enrollee.

Special Enrollment Rights for Employees and Dependents under the Children's Health Insurance Program. A federal law, known as the Children's Health Insurance Program Reauthorization Act, requires the Plan to allow Employees and/or their Dependents who are eligible to enroll in the Plan but who are not enrolled a special enrollment opportunity under the following circumstances:

(a) An Employee's or Dependent's Medicaid or Children's Health Insurance Program coverage is terminated as a result of loss of eligibility and the Employee or Dependent requests coverage under the Plan within sixty (60) days of the loss of coverage; or

(b) An Employee or Dependent becomes eligible for a premium assistance subsidy from Medicaid or a state's Children's Health Insurance Program to help pay for the cost of Plan coverage and the Employee or Dependent requests Plan coverage within sixty (60) days after the date the Employee or Dependent is eligible for premium assistance.

To request health and welfare coverage from the Plan based on either of these circumstances, You should contact the Plan Administrator for an enrollment form and information about how to enroll. The address and telephone number for the Plan Administrator are on page 3.

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.

FAMILY AND MEDICAL LEAVE ACT

If an Employee leaves work for family and medical leave, Your Employer may be obligated to pay Contributions on Your behalf to the Trust under the Family and Medical Leave Act just as if You had continued working for Your Employer. Contact Your Employer if You have questions concerning Your rights under the Family and Medical Leave Act.

MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides protections to Employees who leave work to serve in the "Uniformed Services."

USERRA provides rights which include the following:

(a) Upon request, an Employee's Reserve Account will be preserved for a maximum of five (5) years. However, You may elect to continue to use Your Reserve Account to provide Plan coverage for Your Dependents after Your Plan coverage ends.

(b) There will be COBRA-type continuation coverage rights for Your Dependents to extend Plan coverage for a maximum of twenty-four (24) months after Plan coverage is lost because the Employee has entered the Uniformed Services. Self-payment rights under USERRA are administered in the same manner as COBRA continuation coverage which is described starting on page 33.

(c) When Your military service is expected to last thirty-one (31) days or less, Your Employer may be required to pay Contributions to the Trust on Your behalf for this limited period of time just as if You had continued working for Your Employer. You must notify Your Employer of the expected military service and must return to employment within the timeframe established by USERRA.

(d) If Plan coverage terminates because of military service, Plan coverage will be reinstated upon qualifying reemployment. No waiting period will be imposed on the Employee or Dependents in connection with the reinstatement of coverage upon qualifying employment if the waiting period would not have been imposed had coverage not terminated due to military service. This does not apply to the coverage of any Injury or Sickness incurred in or aggravated during military service.

If You have any questions concerning Your rights under USERRA, contact Your Employer. Also contact the Plan Administrator prior to Your leave for military service.

COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

This section has important information about Your right to COBRA continuation coverage, which is a temporary extension of Medical Coverage, HRA, dental, vision and life 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, 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. Depending on the type of qualifying event, Employees and Dependents may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders may also be qualified beneficiaries. This is discussed in more detail below. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHO IS ENTITLED TO ELECT COBRA?

If You are an Employee, You will become a qualified beneficiary if You lose Your Plan coverage because either of the following qualifying events happens:

(a) Your hours of employment are reduced, or

(b) Your employment ends for any reason.

If You are the spouse of an Employee, 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's hours of employment are reduced;

(c) Your spouse's employment ends for any reason;

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

(e) You become divorced or legally separated from Your spouse. If an Employee 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 Employee 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 of an Employee will become qualified beneficiaries if they lose Plan coverage because any of the following qualifying events happens:

(a) The parent-Employee dies;

(b) The parent-Employee's hours of employment are reduced;

(c) The parent-Employee's employment ends for any reason;

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

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

(f) 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 Employee 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 Employee's employment ends, reduction in hours of employment, 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 COVERAGE OPTIONS AVAILABLE BESIDES COBRA COVERAGE?

Yes. Instead of enrolling in COBRA coverage, there may be other options for You and Your 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 You or Your Dependents choose to elect COBRA coverage instead of enrolling in another group health plan for which You are eligible, You 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 Medical Coverage only, or for medical, HRA, dental, and vision coverage. Employees also have the right to elect life insurance. COBRA continuation coverage is identical to the Medical Coverage, HRA, dental, vision and life insurance coverage available to similarly situated Employees and Dependents, except the life insurance benefit is reduced to $5,000. If the Medical Coverage, 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. The coverage periods below are maximum periods.

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 Maximum Period**.

Death, Divorce, Legal Separation, Medicare-Entitlement or Child's Loss of Dependent Status. When the qualifying event is the death of the Employee, the Employee 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.

Termination of Employment or Reduction of Hours. When the qualifying event is the Employee's termination of employment or reduction of hours, COBRA continuation coverage for a qualified beneficiary lasts for up to eighteen (18) months. There are several ways in which this eighteen (18) months of COBRA continuation coverage can be extended.

Medicare Extension of Eighteen-Month Period of Continuation Coverage. When the qualifying event is the Employee's termination of employment or reduction of hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee can last until thirty-six (36) months after the date of Medicare entitlement. For example, if an Employee became entitled to Medicare eight (8) months before the date his coverage terminates because of a reduction of hours or termination of employment, COBRA continuation coverage for his spouse and Dependent child can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six [36] months minus eight [8] months).

Disability Extension of Eighteen-Month Period of Continuation Coverage. If a qualified beneficiary enrolled for Plan coverage is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, all qualified beneficiaries may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability must have started some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. A qualified beneficiary must notify the Plan Administrator in writing of the Social Security Administration's disability determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must follow the procedures specified in the box entitled **Notice Procedures** on page 35. Your written notice must include the name of the disabled qualified beneficiary, the date that the qualified beneficiary became disabled and the date that the Social Security Administration made its determination. Your written notice must also include a copy of the Social Security Administration's determination. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required time, then there will be no disability extension of COBRA continuation coverage.

Second Qualifying Event Extension of Eighteen-Month Period of Continuation Coverage. If the Employee's Dependent experiences another qualifying event during the eighteen (18) months of COBRA continuation coverage, the Employee's Dependent can get up to an additional eighteen (18) months of COBRA continuation coverage for a maximum of thirty-six (36) months if the Plan is properly notified about the second qualifying event. This extension is available to a Dependent receiving COBRA continuation coverage if the Employee dies, becomes entitled to Medicare (Part A, Part B or both) gets divorced or legally separated.

The extension is also available to a Dependent child when that child is no longer eligible for Plan coverage due to age. This extension is only available if the second qualifying event would have caused the Dependent to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, the qualified beneficiary must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event. You must follow the procedures specified in the box entitled **Notice Procedures** on page 35. Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce or legal separation, Your notice must include a copy of the divorce decree or legal separation. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required time, then there will be no extension of COBRA continuation coverage due to a second qualifying event

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 (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%).

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 to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if You pay a monthly payment later than its due date but during its grace period, Your Plan coverage will be suspended as of the due date and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim You submit for benefits while Your coverage is suspended may be denied and may have to be resubmitted once Your coverage is reinstated. If You fail to make a monthly payment by the end of the grace period, You will lose all rights to COBRA continuation coverage.

TERMINATION OF COBRA CONTINUATION COVERAGE BEFORE 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) The Employee's last Employer stops contributing to the Trust and makes a group health plan available for its employees previously covered by the Trust. In this situation, the group health plan maintained by the Employee's last Employer has the obligation to make COBRA continuation coverage available to any qualified beneficiary who is receiving COBRA continuation coverage from the Trust on the day before the cessation of Contributions by the Employer and whose last employment prior to the qualifying event was with the Employer;

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

(f) During a disability extension period (explained on page 33), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled. In this circumstance, COBRA continuation coverage will be terminated for all qualified beneficiaries who are receiving extended COBRA continuation coverage under the disability extension as of the later of (i) the first day of the month that is more than thirty (30) days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled; or (ii) the end of the COBRA continuation coverage period that applies without regard to the disability extension period.

A qualified beneficiary must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA continuation coverage, he becomes entitled to Medicare (Part A, Part B or both), becomes covered under another group health plan that does not impose any exclusion for a pre-existing condition, or is determined by the Social Security Administration to no longer be disabled. Follow the **Notice Procedures** on page 35 of the Benefit Booklet.

AUTOMATIC COBRA CONTINUATION COVERAGE FOR AN EMPLOYEE'S SPOUSE AND DEPENDENT CHILDREN IN CERTAIN CIRCUMSTANCES

When an Employee elects COBRA continuation coverage, coverage for his Dependents will continue automatically unless a Dependent independently declines COBRA continuation coverage. If the Employee chooses not to elect COBRA continuation coverage, a Dependent may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

Children Born to or Placed for Adoption with the Employee during the COBRA Period. A child born to, adopted by or placed for adoption with an Employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided the Employee has elected COBRA continuation coverage. The child's COBRA continuation coverage begins when the child is properly enrolled, and lasts for as long as COBRA continuation coverage lasts for other family members of the Employee. To be enrolled for Plan coverage, the child must satisfy the otherwise applicable eligibility requirements (for example age).

Alternate Recipients under Qualified Medical Child Support Orders. A child of an Employee who is receiving Plan benefits pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a Dependent child of the Employee regardless of whether that child would otherwise be considered a Dependent.

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

MEDICAL BENEFITS

The medical and Prescription Drug benefits are available to Employees and their Dependents. The Prescription Drug benefit is described on page 76 of the Benefit Booklet.

SUMMARY OF THE MEDICAL BENEFITS

Following this summary is more detailed information concerning the medical benefits. In the event of a conflict between the summary and the detailed information, the detailed information controls.

BENEFIT	PPO PROVIDERS (In-Network)	NON-PPO PROVIDERS (Out-of-Network)
Calendar Year Deductible-Employees and Dependents Individual Family	 $750.00 $2,250.00	
Calendar Year Out-of-Pocket Maximum for Medical Individual Family	 $3,000.00 $6,000.00	
Calendar Year Out-of-Pocket Maximum for Outpatient Prescription Drugs Individual Family	 $1,500.00 $3,000.00	 Not applicable.
Preventative Care Services	100% of Negotiated Rate. Deductible waived.	60% of Usual and Customary Charge or Global Charge after Deductible.
Outpatient Diabetic Instruction	100% of Negotiated Rate. Deductible waived.	100% of the Usual and Customary Charge or Global Charge. Deductible waived.
Physician/Provider Office Visit	$25.00 Co-Payment then 100% of Negotiated Rate. Deductible waived.	60% of Usual and Customary Charge or Global Charge after Deductible.
Telephonic/Video Physician Visit through Teladoc	100% of the charge is paid through October 31, 2016. Effective November 1, 2016, there is a $10.00 Co-Payment. Deductible waived. Must use the Teladoc network.	

BENEFIT	PPO PROVIDERS (In-Network)	NON-PPO PROVIDERS (Out-of-Network)
Independent Radiology, Pathology, X-Ray and Lab	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Complex Radiology (MRI, CT, PET, SPECT scans)	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Outpatient Rehabilitation Services	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible .
	Limit 60 visits per Calendar Year, PPO Providers and Non-PPO Providers combined.	
Inpatient Rehabilitation Services	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Limit 60 days per Calendar Year, PPO Providers and Non-PPO Providers combined.	
Developmental Care	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Non-Surgical Spinal Treatment Chiropractic Benefit	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Limit 12 visits per Calendar Year, PPO Providers and Non-PPO Providers combined.	
Alternative Provider Benefit (Acupuncture, Massage Therapy and Naturopathic Care)	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Limit 12 visits per Calendar Year, PPO Providers and Non-PPO Providers combined.	
TMJ and Jaw Joint Disorder	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Lifetime limit of $5,000, PPO Providers and Non-PPO Providers combined.	
Infertility Testing (Including testing and drugs, but no coverage for reversal	80% of the Negotiated Rate after Deductible.	60% of the Usual and Customary Charge or Global Charge after Deductible .

BENEFIT	PPO PROVIDERS (In-Network)	NON-PPO PROVIDERS (Out-of-Network)
of sterilization, artificial insemination or in-vitro)	Lifetime limit of $7,000 for medical and $3,000 for Prescription Drugs, PPO Providers and Non-PPO Providers combined.	
Maternity Services (Prenatal, delivery and postnatal)	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Physician Surgical Services– Inpatient & Outpatient	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Inpatient Hospital	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Organ Transplant Benefit	80% of Negotiated Rate after Deductible. Must use an Aetna designated Institute of Excellence	60% of Usual and Customary Charge or Global Charge after Deductible.
	Maximum benefit for a donor is $10,000 (PPO Providers and Non-PPO Providers combined)	
Urgent Care Center	$25.00 Co-Payment then 100% of Negotiated Rate. Deductible waived.	60% of Usual and Customary Charge or Global Charge after Deductible.
Hospital Emergency Room Services	$75.00 Co-Payment then 80% of Negotiated Rate after Deductible. Co-Payment waived if admitted to Hospital.	$75 Co-Payment then 80% of Usual and Customary Charge or Global Charge after Deductible. Co-Payment waived if admitted to Hospital.
Ambulance	80% of Negotiated Rate. Deductible waived.	80% of Usual and Customary Charge or Global Charge. Deductible waived.
Durable Medical Equipment	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Prosthetics (Artificial Limbs and Eyes)	80% of the Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Replacement limited to once per five years, PPO Providers and Non-PPO Providers combined.	

BENEFIT	PPO PROVIDERS (In-Network)	NON-PPO PROVIDERS (Out-of-Network)
Chemical Dependency		
• Inpatient and Residential Day Care	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
• Outpatient	$25.00 Co-Payment then 100% of Negotiated Rate. Deductible waived.	60% of Usual and Customary Charge or Global Charge after Deductible.
Mental and Nervous Disorders		
• Inpatient and Residential Day Care	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
• Outpatient	$25.00 Co-Payment then 100% of Negotiated Rate. Deductible waived.	60% of Usual and Customary Charge or Global Charge after Deductible.
Hospice Care		
• Inpatient	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
• Outpatient	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
Skilled Nursing Care Facility	Not covered except in lieu of inpatient hospitalization. If covered, 80% of Negotiated Rate after Deductible.	Not covered except in lieu of inpatient hospitalization. If covered, 60% of Usual and Customary Charge or Global Charge after Deductible.
	Limit 100 days per Calendar Year, PPO Providers and Non-PPO Providers combined.	

BENEFIT	PPO PROVIDERS (In-Network)	NON-PPO PROVIDERS (Out-of-Network)
Home Health Care	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
	Limit 130 visits per Calendar Year, PPO Providers and Non-PPO Providers combined.	
Outpatient Facility Services	80% of Negotiated Rate after Deductible.	60% of the Usual and Customary Charge or Global Charge after Deductible.
Tubal Ligations and Vasectomies (but not the reversal of these procedures)	80% of Negotiated Rate after Deductible.	60% of the Usual and Customary Charge or Global Charge after Deductible.
Alternative Care Coverage	80% of Negotiated Rate after Deductible.	60% of the Usual and Customary Charge or Global Charge after Deductible.
Clinical Trials Benefit	80% of Negotiated Rate after Deductible.	60% of Usual and Customary Charge or Global Charge after Deductible.
All Other Medical Coverage	80% of Negotiated Rate after Deductible.	60% of the Usual and Customary Charge or Global Charge after Deductible.

INTRODUCTION

Subject to all provisions of the Benefit Booklet including the **EXCLUSIONS AND LIMITATIONS** section, if a Covered Person, while enrolled for Medical Coverage, incurs Covered Services for the treatment of an Injury or Sickness that is Medically Necessary or for Preventive Care Services, the Trust will pay a percentage of the Covered Services as described in the **SUMMARY OF THE MEDICAL BENEFITS** section after the Deductible and/or Co-Payment, if applicable, has been met. Once the Out-of-Pocket Maximum has been met, the Trust will pay 100% of the Negotiated Rate for a PPO Provider or 100% of the Usual and Customary Charge or Global Charge for a Non-PPO Provider for the remainder of the Calendar Year except for those benefits which have lower maximums or other limitations. The Deductible and Out-of-Pocket Maximum are described below.

PPO Network. When You seek medical care from a Provider, Hospital, facility, or clinic that is a member of the PPO Network and the medical care is a Covered Service that is Medically Necessary or for Preventive Care Services, You will normally have lower out-of-pocket costs. This is because the Providers, Hospitals, facilities, and clinics in the PPO Network have

contracted to provide services at Negotiated Rates. Be sure to present Your identification card whenever You seek medical services.

How the PPO Network Works. Any time You need to see a Provider or be admitted to a Hospital, facility, or clinic, consult the PPO Network by using the Aetna PPO Network website at www.aetna.com and (i) click on "find a doctor"; (ii) go to the bottom right and select "search our public directory"; (iii) in the "what are You looking for" area, You can put in what You are searching for—doctor, hospital, etc.; (iv) in the "where" area, You should put in Your zip code or Your city and state. You can also search by category such as type of health care provider and medical condition; (v) You will be asked to select a plan. Select "Aetna Choice POS II (Open Access)," then click "Continue"; (vi) You will receive results based on Your requested provider type, plan, and location.

Non-PPO Providers. If You choose a Provider, Hospital, facility, or clinic that is a Non-PPO Provider, You are not required to switch to a Provider, Hospital, facility, or clinic that is a member of the PPO Network. However, You will normally pay greater out-of-pocket costs when You receive services from a Non-PPO Provider.

Non-PPO Provider Discounts. The Trust and Aetna have arrangements with organizations that attempt to obtain discounts for Your medical bills if the Provider, Hospital, facility, or clinic is a Non-PPO Provider. For example, assume You have met Your Deductible for the Calendar Year and a Non-PPO Provider charged $200. Under normal circumstances, You would pay sixty percent (60%) of the Usual and Customary Charge or Global Charge of the bill ($120.00) and the Trust would pay forty percent (40%) of the bill ($80). The Trust and Aetna may attempt to obtain a discount from the Non-PPO Provider who would, for example, agree to accept $150 in full payment of the Covered Charge. Under this scenario, You would pay sixty percent (60%) of the bill ($90) and the Trust would pay forty percent (40%) of the bill ($60).

Inadequate PPO Network. There may be instances where there is an inadequate PPO Network in Your area. Under the criteria described below, the Trust will pay a Non-PPO Provider at the PPO Provider rate for Covered Services that are Medically Necessary or Preventative Care Services. In order for this to occur, the following must occur:

- The Non-PPO Provider must contact Aetna at its provider service center (888-632-3862) before Your appointment or admission and request the Non-PPO Provider's bill be paid at the PPO Provider rate. If Aetna determines, based on Your medical circumstances and the extent of the PPO Network in Your area, that there is an inadequate PPO Network in Your area, it may authorize the Trust to pay a Non-PPO Provider at the PPO Provider rate for Covered Services.

PAYMENT OBLIGATION IF YOU USE A PPO PROVIDER

You are required to pay the Deductible and/or Co-Payment for the particular benefit as set forth in the **SUMMARY OF MEDICAL BENEFITS** section. Thereafter, the Trust pays a percentage of the Covered Services at the Negotiated Rate and You pay the Co-Insurance until You reach the Out-of-Pocket Maximum for the Calendar Year except for those benefits that have lower maximums or other limitations.

PAYMENT OBLIGATION IF YOU USE A NON-PPO PROVIDER

You are required to pay the Deductible and/or Co-Payment for the particular benefit as set forth in the summary. Thereafter, the Trust pays a percentage of the Covered Services at the Usual and Customary or Global Charge and You pay the Co-Insurance until You reach the Out-of-Pocket Maximum for the Calendar Year except for those benefits that have lower maximums or other limitations.

DEDUCTIBLE

Many of the medical benefits are subject to a Calendar Year Deductible. The per person Deductible is $750 of Covered Services in a Calendar Year. The family Deductible is $2,250 of Covered Services in a Calendar Year. Once $2,250 family Deductible has been paid for Covered Services during a Calendar Year by family members, no other family member must satisfy the Deductible for the remainder of that Calendar Year.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

After Medical Co-Payments, Deductible, and Co-Insurance (does not include Prescription Drug Co-Payments) paid by a Covered Person reach $3,000 in a Calendar Year (or $6,000 for a family), the Trust will pay 100% of the Covered Services for the treatment of an Injury or Sickness that is Medically Necessary and Preventive Care Services at the Negotiated Rate for a PPO Provider or at the Usual and Customary Charge or Global Charge for a Non-PPO Provider for the remainder of the Calendar Year except for those benefits which have lower maximums or other limitations. The Out-of-Pocket Maximum combines the Co-Payments, Deductibles and Co-Insurance You pay to PPO Providers and Non-PPO Providers. The Out-of-Pocket Maximum does not include amounts You pay for non-covered charges, charges above the Medical Plan's allowed limits, charges above the Usual and Customary Charge or Global Charge or Co-Payments for Prescription Drug benefits, dental benefits or vision benefits.

PRECERTIFICATION RECOMMENDATIONS

Precertification by Aetna is recommended for certain services such as inpatient stays, outpatient surgery, and other medical procedures described below. Precertification is a process that helps You and Your Provider determine whether the services being recommended are Covered Services under the Plan. It also allows Aetna to help Your Provider coordinate Your transition from an inpatient setting to an outpatient setting (called discharge planning) and to inform You about specialized programs or case management when appropriate.

You do not need to precertify services provided by a PPO Provider. PPO Providers are responsible for obtaining necessary precertification for You.

When You go to a Non-PPO Provider, it is Your responsibility to obtain precertification from Aetna for any services or supplies from the precertification list described below.

Prior to being hospitalized or receiving certain other medical services or supplies, there are certain precertification procedures that should be followed if You use a Non-PPO Provider.

You, a family member, a Hospital staff member, or Your Provider should notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies for which precertification is recommended in accordance with the timelines below. To obtain precertification, call Aetna at the telephone number listed on Your identification care.

Type of Admission	Time for Precertification
For non-emergency admissions	Call Aetna and request precertification from Aetna at least 14 days before the date You are scheduled to be admitted.
For an emergency outpatient medical condition	Call Aetna prior to the outpatient care, treatment or procedure if possible, or as soon as reasonably possible.
For an emergency Hospital admission	Call Aetna within 48 hours, or as soon as reasonably possible after You have been admitted.
For an urgent Hospital admission	Call Aetna before You are scheduled to be admitted. An urgent admission is a Hospital admission due to the onset of or change in a Sickness; the diagnosis of a Sickness or an Injury.
For outpatient non-emergency medical services requiring precertification	Call Aetna and request precertification at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide written notification to You and/or Your Provider of the precertification decision. If Your precertified service is approved, the approval is good for sixty (60) days, as long as You remain enrolled in the Plan.

When You have an inpatient admission to a facility, and have applied for precertification, Aetna will notify You, Your Provider and/or the facility about Your precertified length of stay. If Your Provider recommends that Your stay be extended, additional days will need to be certified. You, Your Provider or facility will need to call Aetna at the number on Your identification card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and Your Provider will receive notification of an approval or denial.

If precertification determines that the stay or services and supplies are not Covered Services, the notification will explain why, and how Aetna's decision can be appealed. You or Your Provider may request a review of the precertification decision by following the **CLAIM APPEAL PROCEDURES** in the Benefit Booklet.

Services and Supplies where Precertification is Recommended. Precertification is recommended for the following types of medical expenses:

(a) Stays in a Hospital;

(b) Stays in a Skilled Nursing Facility;

(c) Stays in a rehabilitation facility;

(d) Stays in a hospice facility;

(e) Outpatient hospice care;

(f) Stays in a residential treatment facility for treatment of Chemical Dependency and Mental and Nervous Disorders;

(g) Partial hospitalization programs for Chemical Dependency and Mental and Nervous Disorders;

(h) Home health care;

(i) Private duty nursing care;

(j) Applied behavioral analysis;

(k) Biofeedback;

(l) Electroconvulsive therapy;

(m) Neuropsychological testing; and

(n) Outpatient surgery.

How Failure to Precertify May Affect Your Benefits. The chart below illustrates the effect on Your benefits if precertification is not obtained and You use a Non-PPO Provider.

If Precertification is:	Then the Covered Services are:
Requested and approved.	Covered.
Requested and denied.	Not covered, may be appealed.
Not requested, but would have been covered if requested.	Covered.
Not requested, but would not have been covered if requested.	Not covered, may be appealed.

PREVENTIVE CARE SERVICES

PPO In Network. Deductible waived. Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. The Plan covers Preventive Care Services as follows:

(a) Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force with respect to the Covered Person. Examples of preventive care services include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.

(b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person.

(c) For infants, children, and adolescents, evidence informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

(d) For women, evidence informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA. Examples of covered services

include annual well-women visits, contraceptive methods and counseling, and breastfeeding support.

(e) The Plan only covers a Preventative Care Service when it is provided in accordance with the applicable recommendation or guideline. The Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in this section to the extent not specified in the applicable recommendation or guideline.

(f) The complete list of Preventive Care Services covered by the Plan is available at www.hhs.gov/healthcare/prevention and is subject to change. The Plan covers a new guideline or recommendation effective with the Calendar Year that begins on or after one (1) year from the date the new recommendation or guideline is issued or adopted, as applicable. The Plan does not cover any preventive care item or service after the date it is no longer included in the applicable recommendation or guideline, unless such coverage is provided for elsewhere in the Plan.

OUTPATIENT DIABETIC INSTRUCTION

PPO In-Network. Deductible waived. Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out-of-Network. Deductible waived. Covered Services paid at 100% of the Usual and Customary Charge or Global Charge.

Covered Services. Services and supplies are limited to outpatient diabetic self-management programs when they are provided by a healthcare professional for the treatment of diabetes. Healthcare professional means Physicians, nurses, pharmacists and registered dieticians who are knowledgeable about diabetes and the treatment of a person with diabetes.

PHYSICIAN/PROVIDER OFFICE VISIT

PPO In Network. Deductible waived. After a Co-Payment of $25.00, Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Services provided by a Provider for non-surgical office services related to the treatment of an Injury or Sickness. Covered Services by a Provider for treatment of Chemical Dependency or a Mental and Nervous Disorder are subject to the **CHEMICAL DEPENDENCY** or **MENTAL AND NERVOUS DISORDER** benefits described later in the Benefit Booklet.

TELEPHONIC/VIDEO PHYSICIAN VISIT THROUGH TELADOC

PPO In Network. The Trust pays 100% of the charge associated with the telephonic/video consultation with a PPO In Network Physician through the Teladoc network through October 31, 2016. Effective November 1, 2016, the Deductible is waived, and the Trust pays 100% of the charge after a $10.00 Co-Payment.

Non-PPO Out of Network. Not covered.

Covered Services. The Teladoc benefit allows You to consult a state licensed Physician by telephone or by video consultation from Your home or while traveling for non-emergency issues including:

Cold and Flu Symptoms	Bronchitis	Allergies
Poison Ivy	Pink Eye	Urinary Tract Infection
Respiratory Infection	Sinus Problems	Ear Infection

The Physician will diagnose the problem and recommend treatment. A prescription will be ordered when appropriate. Teladoc Physicians will not order diagnostic testing, but will refer You to Your primary Provider if that level of care is needed. Teladoc Physicians can advise whether You should see a specialist and the type of specialist You should see. The Teladoc program is available 24 hours per day, 7 days per week. Prior to speaking with a Teladoc Physician, You will be required to create a Teladoc account. To create an account, You will need Your Aetna member identification number and date of birth. You will need to complete a medical history disclosure, which is similar to the form You would complete in a Physician's office during an initial visit.

Contact information for the Teladoc program is (855) 835-2362 or Teladoc.com/Aetna.

INDEPENDENT RADIOLOGY, PATHOLOGY, X-RAY AND LAB

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied. There is one situation in which the Trust will pay a Non-PPO Provider for Covered Services at a higher rate. The situation is when Your Physician is a PPO Provider and the pathology center used by the Physician is a Non-PPO Provider. In this situation, the pathology center's bill for Covered Services will be paid at eighty percent (80%) of the Usual and Customary Charge or Global Charge after the Deductible has been satisfied.

Covered Services. Services provided by an independent radiology or pathology center for diagnostic radiology, pathology, x-ray and laboratory procedures required for the diagnosis of an Injury or Sickness. An independent radiology and pathology center is a freestanding facility offering radiology and pathology services that is not part of a Hospital and is properly licensed in the jurisdiction in which it is located.

COMPLEX RADIOLOGY

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. High end radiology means a magnetic resonance imaging (MRIs), CT scans, PET scans, SPECT scans, ultrasounds and other nuclear radiology required for the diagnosis of an Injury or Sickness that is performed on an outpatient basis.

OUTPATIENT REHABILITATION SERVICES

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of sixty (60) visits (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied to a maximum of sixty (60) visits (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Covered Services. Outpatient rehabilitation services are limited to physical, occupational, speech, cardiac rehabilitation and pulmonary rehabilitation performed to restore or improve function following an Injury or Sickness that is performed in a Provider's office or at an outpatient facility. The Outpatient Rehabilitation Services benefit is limited to sixty (60) visits (PPO Providers and Non-PPO Providers combined) per Calendar Year. Services excluded under this benefit include physical, occupational, cardiac rehabilitation and pulmonary rehabilitation services available through governmental programs; programs offered through school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the level of function; recreational life-enhancing relaxation; palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; and any other treatment not considered Medically Necessary by the Trustees after consultation with their advisors.

INPATIENT REHABILITATION SERVICES

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of sixty (60) days (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after the Deductible has been satisfied to a maximum of sixty (60) days (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Covered Services. Inpatient Rehabilitation Services are limited to physical, occupational, speech, cardiac rehabilitation, and pulmonary rehabilitation to restore or improve function following an Injury or Sickness. The Inpatient Rehabilitation Services benefit is limited to a maximum of sixty (60) days (PPO Providers and Non-PPO Providers combined) per Calendar Year.

DEVELOPMENTAL CARE

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Developmental Care is limited to physical, occupational and/or speech therapy to treat a Covered Person who has not reached the level of development expected for the Covered Person's age in one or more of the following areas of major life activity: intellectual; physical; receptive and expressive language; learning; mobility; and/or self-direction. Covered Services do not include services that are rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness or services that are educational in nature).

NON-SURGICAL SPINAL TREATMENT (CHIROPRACTIC BENEFIT)

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of twelve (12) visits (PPO Providers and Non-PPO Providers combined) in a Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied to a maximum of twelve (12) visits (PPO Providers and Non-PPO Providers combined) in a Calendar Year.

Covered Services. The benefit applies to the initial office visit and all treatment rendered by a Physician for therapy that involves manual manipulation of the musculoskeletal system. This benefit is limited to the treatment of musculoskeletal disorders (bone, muscle, and joint) to a maximum of twelve (12) visits (PPO Providers and Non-PPO Providers combined) in a Calendar Year. Services excluded are care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Covered Person, and care rendered on a non-acute asymptomatic basis. Benefits are limited to one (1) visit per day.

ALTERNATIVE PROVIDER BENEFIT

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of twelve (12) visits (PPO Providers and Non-PPO Providers combined) in a Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied to a maximum of twelve (12) visits (PPO Providers and Non-PPO Providers combined) in a Calendar Year.

Covered Services. Acupuncture, Massage Therapy and Naturopathic Care must be provided for the treatment of an Injury or Sickness. Acupuncture services must be received from an Acupuncturist. Massage Therapy services must be received from a Massage Therapist and Naturopathic Care must be received from a Naturopathic Physician.

TEMPOROMANDIBULAR (TMJ) AND JAW JOINT DISORDER

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum benefit of $5,000 (PPO Providers and Non-PPO Providers combined). The $5,000 maximum benefit applies to all services and supplies received for the treatment of TMJ and Jaw Joint Disorder including orthognathic surgery regardless of the cause or the reason for treatment.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied up to a maximum benefit of $5,000 (PPO Providers and Non-PPO Providers combined). The $5,000 maximum benefit applies to all services and supplies received for the treatment of TMJ and Jaw Joint Disorder including orthognathic surgery regardless of the cause or the reason for treatment.

Covered Services. The TMJ and Jaw Joint Disorder benefit is limited to treatment for the misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction, arthritis or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain

syndrome. It does not include a fracture or dislocation which results from an Accidental Bodily Injury; these expenses are covered under other provisions of the Plan.

Covered Services do not include services which are dental in nature including, but not limited to:

(a) Bite adjustment by equilibration (grinding the teeth) or temporary bridgework;

(b) Long-term bite therapy (including crowns, bridgework and orthodontia); and

(c) Long-term orthodontics or intra-oval splitting to reposition or align the teeth.

INFERTILITY TESTING

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum benefit of $7,000 for medical (PPO Providers and Non-PPO Providers combined) and $3,000 for Prescription Drugs.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after Deductible has been satisfied to a maximum benefit of $7,000 for medical (PPO Providers and Non-PPO Providers combined) and $3,000 for Prescription Drugs.

Covered Services. The infertility testing benefit does not include services, supplies and Prescription Drugs for artificial insemination, in-vitro fertilization or to reverse elective sterilization. These are not Covered Services.

MATERNITY SERVICES

PPO In Network. Covered Services paid at 80% of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Services while confined to a Hospital as a resident inpatient for childbirth including post-delivery follow up care. Benefits will be in accord with accepted medical practice as recommended by the attending Physician including a licensed nurse-midwife, a licensed Physician's assistant or a licensed advanced registered nurse-practitioner in consultation with the mother. Post-delivery follow up care includes but is not limited to visits by a licensed home health agency or a licensed registered nurse. Benefits for the newborn child will be the same as for the mother for three weeks following birth, even if there are separate Hospital admissions.

Following such three week period, coverage for the newborn will be in accord with other provisions of the Plan.

PHYSICIAN SURGICAL SERVICES – INPATIENT & OUTPATIENT

PPO In Network. Covered Services paid at 80% of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied. There is one situation in which the Trust will pay a Non-PPO Provider for Covered Services at a higher rate. The situation is when You have surgery, Your Physician and Hospital are PPO Providers and the anesthesiologist, radiologist, and/or assistant surgeon is a Non-PPO Provider. In this situation, the anesthesiologist's, radiologist's, and/or assistant surgeon's bill for Covered Services will be paid at eighty percent (80%) of the Usual and Customary Charge or Global Charge after the Deductible has been satisfied.

Covered Services. Inpatient and outpatient surgeries including the operating Physician's charge for surgery and radiotherapy, an assisting Physician's charge for surgery and radiotherapy when attendance is warranted by a need for supplemental skills and the anesthesiologist's charge for administering anesthetics during surgery.

If a Covered Person is advised by a Physician to have a surgical procedure performed, the Trust will pay one hundred percent (100%) of the expense incurred for a second opinion to determine the need for the surgery (including x-ray and laboratory services). The Deductible will not apply for the second opinion surgery. If the second surgical opinion does not confirm that the proposed surgery is Medically Necessary, the Trust will pay in the same manner for a third opinion.

INPATIENT HOSPITAL

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Covered Services consist of the following:

(a) The charge for a semi-private room or billed charges, whichever is less, up to the Hospital's most common rate for a room with two beds;

(b) The charge for isolation care when deemed necessary to protect the Covered Person from contamination; or

(c) The charge for use of an intensive care unit. The definition of an intensive care unit is the criteria of the Joint Commission on Accreditation of Hospitals. The Trustees reserve the right to decide whether the unit in a particular Hospital qualifies as an intensive care unit.

ORGAN TRANSPLANT

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied. The maximum benefit for the donor is $10,000 (PPO Providers and Non-PPO Providers combined). In order to have a transplant covered at the PPO In-Network rate, the transplant must be performed at a Hospital Aetna has designated as an Institute of Excellence. The current Institutes of Excellence in Washington and Oregon are:

Seattle Children's Hospital (Seattle, Washington)
Seattle Cancer Care Alliance (Seattle, Washington)
Swedish Hospital Center (Seattle, Washington)
University of Washington Medical Center (Seattle, Washington)
Virginia Mason Medical Center (Seattle, Washington)
Legacy Good Samaritan Hospital (Portland, Oregon)
Oregon Health & Science University (Portland, Oregon)

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied. The maximum benefit for the donor is $10,000 (PPO Providers and Non-PPO Providers combined).

Covered Services. Services for the organ transplant benefit are limited to:

(a) The use of temporary mechanical equipment, pending the acquisition of a "matched" human organ(s);

(b) Multiple transplant(s) during one operative session;

(c) Replacement(s) or subsequent transplant(s); and

(d) Follow up expenses for Covered Services.

The following are considered Covered Services for a donor(s):

(a) Testing to identify suitable donor(s);

(b) The expense for the acquisition of organ(s) from a donor;

(c) The expense of a donor pending the removal of a usable organ(s);

(d) Transportation for a living donor subject to the ambulance benefit; and

(e) Transportation of the organ(s) or a donor on life support.

A donor means a person who undergoes a surgical operation for the purpose of donating an organ for transplant surgery into a Covered Person.

For purposes of the organ transplant benefit, the term "organ" means any of the following:

(a) Kidney;

(b) Heart;

(c) Heart/lung;

(d) Liver;

(e) Pancreas (when condition not treatable by use of insulin therapy);

(f) Bone marrow; and

(g) Cornea.

URGENT CARE CENTER

PPO In Network. Deductible waived. After a Co-Payment of $25.00, Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied.

Covered Services. Services provided at an urgent care center. An urgent care center means a free-standing facility offering ambulatory medical service which is not part of a Hospital and is licensed by the proper authority in the jurisdiction in which it is located.

HOSPITAL EMERGENCY ROOM

PPO In Network. After a Co-Payment of $75.00, Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied. Co-Payment of $75.00 waived if admitted to the Hospital.

Non-PPO Out of Network. After a Co-Payment of $75.00, Covered Services paid at eighty percent (80%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied. Co-Payment of $75.00 waived if admitted to the Hospital.

Covered Services. Services provided in a Hospital emergency room provided the Covered Services are Medically Necessary and an Emergency Medical Condition exists. For example, medical services provided in a Hospital emergency room may not be Medically Necessary and may not qualify for payment if the Covered Service could have been provided in a less costly setting, i.e., an urgent care center or a Physician's office, without harm to You.

AMBULANCE

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate. Deductible waived.

Non-PPO Out of Network. Covered Services paid at eighty percent (80%) of Usual and Customary Charge or Global Charge. Deductible waived.

Covered Services. Services of a licensed ambulance company (including air ambulance) for the transportation of a Covered Person to, from or between Hospitals, when transportation by ambulance is for an Emergency Condition.

DURABLE MEDICAL EQUIPMENT

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. To be a Covered Service, the Durable Medical Equipment must serve a medical purpose, be appropriate for use in the Covered Person's home, is not useful to a person generally in the absence of an Injury or Sickness, can withstand repeated use and must be prescribed by a Physician. Items for comfort or convenience of a Covered Person are not a Covered Service. When it appears that the rental charges for Durable Medical Equipment will equal or exceed the purchase price, the Trustees may authorize purchase of the Durable Medical Equipment. Payment for the purchase of Durable Medical Equipment will generally be prorated over twelve (12) months beginning with the date of purchase.

PROSTHETICS (ARTIFICIAL LIMBS AND EYES)

PPO In-Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied. The replacement of a prosthetic is limited to once every five years.

Non-PPO Out-of-Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied. The replacement of a prosthetic is limited to once every five years.

Covered Services. Prosthetic devices (commonly known as artificial limbs and eyes) including replacement of a prosthetic device. The replacement of a prosthetic device must be Medically Necessary and is limited to a replacement once every five years.

CHEMICAL DEPENDENCY

PPO In-Network. For inpatient and residential day care, Covered Services are paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

For outpatient care, Deductible waived. After a Co-Payment of $25.00, Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out-of-Network. For inpatient and residential day care, Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after Deductible has been satisfied.

For outpatient care, Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services.

(a) Benefits will only be provided for services and supplies for treatment provided by an approved treatment facility which requires:

(1) The facility, program and Providers are licensed by the state and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs;

(2) Programs are accredited for the particular level of care by the Joint Commission on Accreditation of Hospitals or the Commission of Accreditation of Rehabilitation Facilities;

(3) Inpatient programs are provided by a licensed health care facility; and

(4) The staff is directly supervised by or the treatment plans are approved by Physicians, psychologists, nurse practitioners or clinical social workers and meet the standards of the Office of Alcohol and Drug Abuse Programs or the Mental Health Division.

The following services are not covered:

(a) Services resulting from educational programs for drinking drivers or from volunteer mutual support groups such as Alcoholics Anonymous or family education or support groups;

(b) Treatment solely for detoxification or primarily for maintenance care (providing an environment without access to drugs or alcohol);

(c) Charges for a program that is not an approved treatment facility; and

(d) Court-ordered diversion programs.

MENTAL AND NERVOUS DISORDER

PPO In Network. For inpatient and residential day care, Covered Services are paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

For outpatient care, Deductible waived. After a Co-Payment of $25.00, Covered Services paid at 100% of the Negotiated Rate.

Non-PPO Out of Network. For inpatient, Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

For outpatient care, Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after the Deductible has been satisfied.

Covered Services. Treatment of Mental and Nervous Disorders are limited to services provided by the following Providers and facilities:

(a) Physician;

(b) Licensed psychiatrist;

(c) Community mental health agency;

(d) A Hospital; or

(e) Licensed clinical social worker.

Each Provider or facility listed above must be licensed by the proper authority of the state in which it is located.

A community mental health agency means an agency which:

(a) Is licensed as such by the proper authority of the state in which it is located;

(b) Has in effect a plan for quality assurance and peer review; and

(c) Provides treatment under the supervision of a Physician or a licensed psychiatrist.

HOSPICE CARE

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Hospice care are services provided after the Covered Person is, in the opinion of a Physician, terminally ill with a life expectancy of less than six (6) months if the Injury or Sickness runs it normal course. Covered Services are inpatient and outpatient Palliative Care.

If a Covered Person elects Palliative Care, then he or she is not eligible for any other benefits for acute treatment of the terminal illness.

The Palliative Care must be provided by a Medicare or state certified hospice care program. A hospice care program is a coordinated program of home and inpatient care, available twenty-four (24) hours a day, that uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient/family unit experiencing a life threatening disease with a limited prognosis. A patient/family unit is the Covered Person and any family members who are caring for the Covered Person. These services include acute, respite and home care to meet the physical, psychological and special needs of the patient/family unit during the final stages of an Injury or Sickness and dying.

Palliative Care benefits are limited to the following levels of care:

(a) Routine home care;

(b) Continuous home care;

(c) Inpatient respite care; and

(d) Inpatient hospice care.

Additional Covered Services for Palliative Care include the following when provided under one of the previously listed levels of care:

(a) Durable Medical Equipment subject to the terms and conditions of other provisions in the Plan;

(b) Medications, including infusion therapy;

(c) Care by a member of the hospice interdisciplinary team; and

(d) Any other supplies required for Palliative Care.

Expenses for the following services and supplies are not covered:

(a) Care that is not palliative;

(b) Services provided to other than a terminally ill Covered Person, including charges for bereavement counseling for the Covered Person or family members, except when provided and billed by the hospice care program;

(c) Pastoral and spiritual counseling;

(d) Services provided by family members and volunteer workers;

(e) Homemaker or housekeeping services except by home healthcare aids as ordered by a hospice treatment plan;

(f) Supportive environmental materials including but not limited to handrails, ramps, air conditioners and telephone;

(g) Normal necessities of living including but not limited to food, clothing and household supplies;

(h) Food services such as "meals on wheels";

(i) Separate charges for reports, records or transportation;

(j) Legal and financial counseling services;

(k) Services and supplies not included in a hospice treatment program or not specifically set forth as a hospice benefit; and

(l) Services and supplies in excess of the stated maximums or services and supplies provided more than the maximum number of days of Palliative Care, unless otherwise approved by the Trustees.

SKILLED NURSING CARE FACILITY

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of 100 days (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after the Deductible has been satisfied to a maximum of 100 days (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Covered Services. For expenses incurred for Skilled Nursing Care Facility to be considered Covered Services, the following criteria must be met:

(a) The Covered Person must have been confined in a Hospital immediately prior to confinement in the Skilled Nursing Care Facility;

(b) The Covered Person's Physician must certify that the confinement is Medically Necessary to provide the Covered Person with skilled nursing care; and

(c) The confinement is for the treatment of an Injury or Sickness causing the Hospital confinement.

Covered Services are limited to the daily service rate, up to the maximum the Plan would pay if the Covered Person was in a semi-private Hospital room.

Covered Services do not include a stay in a Skilled Nursing Care Facility where care is provided principally for:

(a) Senile deterioration;

(b) Mental deficiency or retardation; or

(c) Routine nursing care, self-help or training, personal hygiene or Custodial Care.

HOME HEALTH CARE

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied to a maximum of 130 visits (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of the Usual and Customary Charge or Global Charge after Deductible has been satisfied to a maximum of 130 visits (PPO Providers and Non-PPO Providers combined) per Calendar Year.

Covered Services. For charges incurred for home health care to be considered Covered Services, the following criteria must be met:

(a) Home health care must be Medically Necessary for Your treatment because You are Totally Disabled and, in the opinion of Your Physician, would otherwise be confined to a Hospital or Skilled Nursing Care Facility;

(b) You must be under the direct care of Physician;

(c) The plan of treatment covering home health care must be established in writing by Your Physician prior to the commencement of the care;

(d) The plan of treatment must be reviewed and updated in writing by Your Physician at least once per month; and

(e) You are examined by Your Physician once every sixty (60) days.

For charges incurred for home health care to be considered Covered Services, the services must be provided by a home health care agency that meets the following requirements:

(a) It is primarily engaged in and is federally certified as a home health agency and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services;

(b) Its professional service policies are established by a professional group associate with such agency or organization including at least one Physician and at least one registered nurse to govern the services provided;

(c) It provides full-time supervision of home health care service by a Physician or registered nurse;

(d) It maintains a complete medical record for each patient; and

(e) It has an administrator.

Covered Services for home health care are limited to the following:

(a) Part-time or intermittent nursing care by a licensed practical nurse;

(b) Services by a registered nurse;

(c) Skilled nursing care including but not limited to:

(1) Giving injections, including I.V.s;

(2) Changing or irrigating urinary catheters;

(3) Drawing blood for testing;

(4) Taking of blood pressure;

(5) Giving insulin shots;

(6) Use of oxygen and breathing machines;

(7) Treatment of bed sores and other skin problems; and

(8) Bandaging surgical incisions.

(d) Speech language therapy for lost communication skills including but not limited to:

(1) Teaching communication skills;

(2) Alternate means of expression; and

(3) Help with choking or swallowing problems.

(e) Physical therapy including but not limited to:

(1) Planning an exercise program;

(2) Teaching balance and coordination skills; and

(3) Easy approach to getting in and out of a wheelchair or bed.

Covered Services for home health care do not include the following:

(a) Charges for services performed by Your immediate family or any person residing with You;

(b) Charges for general housekeeping services;

(c) Charges for services for Custodial Care;

(d) Charges for services provided as part of a hospice plan;

(e) Charges for services for which You are not, in the absence of this coverage, legally required to pay; and

(f) Charges for services associated with daily living such as self care activities that must be accomplished each day in order for a Covered Person to care for his own needs and participate in society.

OUTPATIENT FACILITY SERVICES

PPO In Network. Covered Services are paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. Outpatient surgery and outpatient therapy related to the treatment of an Injury or Sickness including physical, occupational, speech, cardiac rehabilitation, and pulmonary rehabilitation performed in a Physician's or Provider's office or at an outpatient facility.

TUBAL LIGATIONS AND VASECTOMIES

PPO In Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out of Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. In-patient and out-patient Physician surgical services for tubal ligations and vasectomies but not the reversal of these medical procedures.

ALTERNATIVE CARE COVERAGE

PPO In-Network. Covered Services paid at eighty percent (80%) of Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out-of-Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. If You, the case manager used by the Trust, and the Plan Administrator agree that medical services and/or Durable Medical Equipment not covered by the Plan can reasonably be expected to offer a cost-effective result without a sacrifice to the quality of Your care, the Trustees can allow the medical services and/or Durable Medical Equipment even though the medical services and/or Durable Medical Equipment are not a Covered Service by the Plan. Alternative Care Coverage must be approved in writing by the Trustees or their designee.

CLINICAL TRIALS

PPO In-Network. Covered Services paid at eighty percent (80%) of the Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out-of-Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. The Clinical Trial benefit is as follows:

(a) This Plan will not discriminate against a Covered Person who is qualified to participate in an approved clinical trial (defined in paragraph c below); deny his or her right to participate in that approved clinical trial; or deny, limit, or impose additional conditions on the coverage of routine patient costs (defined in paragraph e below) for items and services furnished in connection with participating in the approved clinical trial.

(b) A Covered Person is "qualified" to participate in an approved clinical trial if he or she is eligible according to the trial's protocol to participate for the treatment of cancer or other life-threatening condition (defined in paragraph d below) and either (i) the referring health care professional is a PPO Provider who concluded that the Covered Person's participation would be appropriate, or (ii) the person provides the Trustees or their designee with medical and scientific information establishing, to their satisfaction, that his participation in the approved clinical trial would be appropriate.

(c) An "approved clinical trial" is a Phase I, II, III, or IV clinical trial conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening conditions and is (i) approved or funded by one or more of the federal entities listed in the Public Health Service Act Section 2709(d); (ii) conducted in connection with an investigational new drug application reviewed by the U.S. Food and Drug Administration; or (iii) exempt from investigational new drug application requirements.

(d) A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

(e) "Routine patient costs" include items and services typically provided under the Medical Benefits portion of the Plan for a Covered Person who is not enrolled in a clinical trial, except it does not include (i) the investigational item, device, or service itself; (ii) items and services not included in the direct clinical management of the Covered Person but that, instead, are provided in connection with data collection analysis; or (iii) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

(f) The Plan may require a Covered Person to use a PPO Provider participating in the clinical trial if the PPO Provider will accept the Covered Person as a trial participant, but the limitations in paragraph (a) above apply when a qualified Covered Person participates in an approved clinical trial that is conducted outside the Covered Person's state of residence.

ALL OTHER MEDICAL COVERAGE

PPO In-Network. Covered Services paid at eighty percent (80%) of Negotiated Rate after the Deductible has been satisfied.

Non-PPO Out-of-Network. Covered Services paid at sixty percent (60%) of Usual and Customary Charge or Global Charge after Deductible has been satisfied.

Covered Services. All Covered Services under the Medical Coverage section of the Plan not otherwise discussed in the Benefit Booklet.

PRESCRIPTION DRUG BENEFITS

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Following this summary is more detailed information concerning the Prescription Drug benefit. In the event of a conflict between this summary and the detailed information that follows, the detailed information controls.

Drug Type	Prescription Drug Supply	Co-Payment
Generic drug	30-day supply	$5.00
Brand-name formulary drug	30-day supply	$20.00
Brand-name non-formulary drug	30-day supply	$40.00
Generic drug	90-day supply	$10.00
Brand-name formulary drug	90-day supply	$40.00
Brand-name non-formulary drug	90-day supply	$80.00
Specialty drugs		10% of cost up to $1,500 per Calendar Year

You are eligible for Prescription Drug benefits if You are enrolled for Medical Coverage. There are four Prescription Drug options available: the CVS Caremark National Retail Network; the CVS Caremark Mail Service Pharmacy; CVS Caremark Retail 90 Network; and the CVS Caremark Specialty Pharmacy. **You decide which option to use each time You fill a prescription except certain specialty Prescription Drugs must be obtained through the CVS Caremark Specialty Pharmacy.** See page 78.

You can purchase up to a 30-day supply of a Prescription Drug through a pharmacy that is a member of the CVS Caremark National Retail Network. You can purchase up to a 90-day supply of certain maintenance Prescription Drugs through the CVS Caremark Mail Service Pharmacy and CVS Caremark Retail 90 Network. The CVS Caremark Retail 90 Network allows You to obtain a up to a 90-day supply of maintenance Prescription Drugs at Caremark approved pharmacies such as Walgreens, Fred Meyer, Rite Aid, Albertsons and Safeway for the mail order price.

If You obtain a Prescription Drug from a pharmacy that is not a member of the CVS Caremark National Retail Network, CVS Caremark Mail Service Pharmacy, CVS Caremark Retail 90 Network, or the CVS Caremark Specialty Pharmacy, You are responsible for the full cost of the Prescription Drug.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

After Co-Payments for Prescription Drugs paid by a Covered Person reach $1,500 (or $3,000 for a family) in a Calendar Year, the Trust will pay 100% of the cost of outpatient Prescription Drugs covered by the Prescription Drug section of the Plan for the remainder of the Calendar Year.

IDENTIFICATION CARD

You will receive a Trust identification card. When obtaining a Prescription Drug from a member of the CVS Caremark National Retail Network or CVS Caremark Retail 90 Network, You should do the following:

(a) Present Your identification card at the pharmacy; and

(b) Pay the Co-Payment amount and Your transaction is complete. See page 76 for the Co-Payments.

FORMULARY AND NON-FORMULARY PRESCRIPTION DRUGS

This Plan uses a list of Prescription Drugs called a "formulary." This list is made up of certain brand name drugs. The Co-Payment is higher for brand name non-formulary Prescription Drugs. The formulary list is reviewed from time to time, and changes may be made. You may determine which brand name Prescription Drugs are formulary drugs and non-formulary Prescription Drugs by calling CVS Caremark at 866-818-6911.

CVS CAREMARK NATIONAL RETAIL NETWORK

To locate pharmacies in the CVS Caremark National Retail Network, call (866) 818-6911 or log on to the web at www.caremark.com, and use the pharmacy locator tab. Some of the pharmacies that participate in the CVS Caremark National Retail Network are:

- **$ Fred Meyer**
- **Walgreens**
- **Safeway**
- **Albertsons**
- **Rite Aid**

The Trust pays no portion of a retail Prescription Drug charge that is filled by a pharmacy that is not in the CVS Caremark National Retail Network.

Your Cost. When Your prescription is filled by a pharmacy in the CVS Caremark National Retail Network, You pay a portion of the cost; the Trust pays the rest. Your cost is as follows:

Generic Drug	$5.00 Co-Payment for up to a 30-day supply
Brand Name Formulary Drug	$20.00 Co-Payment for up to a 30-day supply
Brand Name Non-Formulary Drug	$40.00 Co-Payment for up to a 30-day supply

CVS CAREMARK SPECIALTY PHARMACY

Certain Prescription Drugs used for treating complex health conditions must be obtained through the CVS Caremark Specialty Pharmacy. The following is a partial list of medical conditions that may require Prescription Drugs that fall under the CVS Caremark Specialty Pharmacy: antivirals, Crohn's disease, hematologics, hemophilia, HIV/AIDS, immune deficiency, infertility, renal disease, pulmonary cystic fibrosis, growth hormone deficiency, multiple sclerosis, arthritis, and hepatitis B and C. You may call Caremark at (800) 237-2767 for a list of Prescription Drugs subject to the CVS Caremark Specialty Pharmacy or log onto the web at www.cvscaremarkspecialtyrx.com for a list of Prescription Drugs subject to the CVS Caremark Specialty Pharmacy.

Prescription drugs subject to the CVS Caremark Specialty Pharmacy must be ordered through Caremark by Your Physician. Physicians should call (800) 237-2767 or fax (800) 323-2445 to order a Specialty Prescription Drug.

Your Cost. You are required to pay ten percent (10%) of the cost of a Prescription Drug subject to the CVS Caremark Specialty Pharmacy up to an Out-Of-Pocket Maximum of $1,500 per Covered Person per Calendar Year. After You have paid $1,500 in a Calendar Year for Prescription Drugs covered by the Prescription Drug section of the Plan, the Trust will pay 100% of the Medically Necessary Prescription Drugs that You obtain for the remainder of the Calendar Year.

CVS CAREMARK MAIL SERVICE PHARMACY AND CVS CAREMARK RETAIL 90 NETWORK

The Trust offers two cost-savings Prescription Drug programs for maintenance medication through CVS Caremark Mail Service Pharmacy and CVS Caremark Retail 90 Network. For medications taken on a long-term basis (called maintenance medication), obtaining Your Prescription Drugs from CVS Caremark Mail Service Pharmacy or CVS Caremark Retail 90 Network will result in lower Co-Payments for You.

Your Cost. When Your Prescription Drug is filled using the CVS Caremark Mail Service Pharmacy or CVS Caremark Retail 90 Network, You pay a portion of the cost; the Trust pays the rest. Your Co-Payment is as follows:

Generic Drug	$10.00 Co-Payment for up to a 90-day supply
Brand Name Formulary Drug	$40.00 Co-Payment for up to a 90-day supply
Brand Name Non-Formulary Drug	$80.00 Co-Payment for up to a 90-day supply

CVS Caremark Retail 90 Network. You may call Caremark at (866) 818-6911 or go to the web at www.caremark.com to locate a pharmacy that will dispense a 90-day supply of a maintenance Prescription Drug at the mail order Co-Payment.

CVS Caremark Mail Service Pharmacy. If appropriate, have Your Physician write a prescription for a 90 day supply of a maintenance Prescription Drug. The prescription will be dispensed for up to a 90-day supply and You will be charged the mail order Co-Payment detailed above.

Complete the order form for a new or refill prescription. You may call Customer Service for an order form or obtain an order form online at www.caremark.com. See page 80 for Customer Service telephone numbers.

Send the order form to CVS Caremark Mail Service Pharmacy with:

(a) New or refill prescription; and

(b) Co-Payment – Make check payable to Caremark Mail Order Pharmacy. Credit cards accepted: Visa, MasterCard, American Express, and Discover. Please do not send cash.

Mail Your order form to:

CVS Caremark
PO Box 659541
San Antonio, TX 78265

Prescription Delivery. Allow two weeks for delivery from the date You mail Your order. Most Prescription Drugs will be delivered by U.S. Postal Service. In case of emergency, Prescription Drugs may be shipped overnight for an additional fee.

New Prescriptions. If You have not previously used the CVS Caremark Mail Service Pharmacy, there are two options to help You obtain Your first order of Prescription Drugs as soon as possible:

(a) Have Your Physician phone in the prescription to the CVS Caremark Mail Service Pharmacy at (800) 378-5697; or

(b) You may call (866) 239-4543 and request that Caremark obtain Your new prescription from Your Physician.

Refills by Phone

(a) Call the touch-tone automated phone number: (866) 818-6911

(b) Available twenty-four (24) hours per day, seven (7) days per week.

(c) Have the prescription number and credit card ready when You call.

Refills by Internet

(a) Log on to www.caremark.com

(b) Available twenty-four (24) hours per day, seven (7) days per week

CAREMARK CUSTOMER SERVICE

Important Contact Information

Customer Service: (866) 818-6911. Available twenty-four (24) hours per day, seven (7) days per week.

COVERED PRESCRIPTION DRUGS

The Prescription Drug benefit covers Medically Necessary Prescription Drugs. The Prescription Drug benefit covers the following items when dispensed by a CVS Caremark Pharmacy for use outside of a medical facility:

(a) Prescription Drugs and vitamins (Federal Legend and State Restricted Drugs as prescribed by a Provider). This benefit includes coverage for off-label use of FDA-approved drugs.

(b) Compounded medications of which at least one ingredient is a Prescription Drug. Prior authorization may be required. See page 75.

(c) Prescription oral agents for controlling blood sugar levels.

(d) Glucagon and allergy emergency kits.

(e) Hypodermic needles, syringes and alcohol swabs used for self-administering injectable prescription medications.

(f) Disposable diabetic testing supplies; test strips, testing agents, lancet and testing units (limit one per Covered Person per year).

(g) Prescription Drugs for the treatment of nicotine dependency. The Co-Payment is waived. You may only receive one 30 to 90 day supply of this type of Prescription Drug without a Co-Payment.

(h) Birth control, drugs and devices that require a prescription, including emergency contraceptives.

(i) Fertility agents, both oral and injectable, limited to $3,000 lifetime while covered by all Trust Plans.

(j) Multiple vitamins, prenatal vitamins, and pediatric vitamins that require a prescription.

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS FOR PRESCRIPTION DRUGS

Non-Covered Prescription Drugs. A partial list of non-covered Prescription Drugs include:

(a) Drugs and medications that may be lawfully obtained over the counter without a prescription even if prescribed by a Provider. Examples include vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements.

(b) Drugs for the purpose of cosmetic use or to promote or stimulate hair growth.

(c) Drugs for Experimental or Investigational Procedures.

(d) Biologicals, blood or blood derivatives.

(e) Any prescriptions refilled in excess of the number of refills specified by the Provider, or any refills dispensed after one year from the Provider's original order.

(f) Drugs dispensed for use or administration in a healthcare facility or Provider's office, or take home drugs dispensed and billed by a medical facility. The exceptions are for Prescription Drugs provided as part of this Plan's Specialty Pharmacy Provision, which are payable under this benefit, regardless of where they are administered.

(g) Replacement of lost or stolen medication.

(h) Insulin therapy drugs or solutions, and drugs requiring parenteral administration or use, and injectable medications.

(i) Drugs to treat sexual dysfunction without prior authorization.

(j) Weight management drugs.

(k) Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered under this benefit). See Durable Medical Equipment benefits for available coverage.

(l) Drugs to treat infertility, including fertility enhancement medication over the $3,000 lifetime maximum benefit allowance.

(m) All drugs that are not FDA-approved drugs.

RETAIL VACCINATION NETWORK PROGRAM

The Plan provides many seasonal and preventive care vaccinations with no Co-Payment required as described below.

You must obtain the seasonal or preventive care vaccinations from a participating network provider of the CVS Caremark National Retail Network that administers vaccinations. For a list of CVS Caremark National Retail Network pharmacies that administer seasonal and preventative care vaccinations, call 866-818-6911, or check with Your local pharmacy for services the pharmacy provides.

Seasonal Vaccination Program. The vaccinations covered by the Seasonal Vaccination Program administered by a participating pharmacy with no Co-Payment are noted below. Services may

vary by location, vaccine and age so check with Your local pharmacy for services and restrictions.

(a) Injectable seasonal influenza vaccine (Trivalent);

(b) Intranasal seasonal influenza vaccine (FluMist);

(c) Intradermal influenza vaccine;

(d) Injectable seasonal influenza vaccine (Ouadrivalent); and

(e) Injectable seasonal influenza vaccine high-dose (Fluzone).

Preventive Care Vaccination Program. The vaccinations covered by the Preventive Care Vaccination Program administered by a participating pharmacy with no Co-Payment are immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person. Services may vary by location, vaccine and age so check with Your local pharmacy for services and restrictions.

OTHER LIMITATIONS

Mandatory Generic Policy. Pharmacies will automatically substitute a generic prescription drug equivalent for a brand name prescription drug. Pharmacies substitute only A and AB rated generic prescription drugs that have been proven to be both clinically and therapeutically equivalent to the brand name prescription drug.

If You or Your Provider request a brand name prescription drug and a generic prescription drug equivalent is available, You will be required to pay the difference in cost between the brand name prescription drug and generic prescription drug, in addition to the brand name prescription drug Co-Payment. Your total cost will not exceed the cost of the brand name prescription drug.

If there is a medical reason why You cannot tolerate the generic prescription drug, Your Provider may appeal the higher payment obligation for the cost of the brand name prescription drug as follows:

(a) Your Provider should go to the Caremark website and download a prior authorization request form at the following address: www.caremark.com. Scroll to the bottom of the page and click on "For Pharmacists and Medical Professionals." Then click on the "Prior Authorization Information" and follow the instructions.

(b) If You or Your Provider have questions regarding the appeal process, call the CVS Caremark Customer Service line at the number on the back of Your identification card (1-866-818-6111).

(c) After submission of the Prior Authorization Information, CVS Caremark will notify Your Provider if the request to pay only that brand name drug Co-Payment has been granted. If the request has been denied, CVS Caremark will describe Your appeal rights.

Prior Clinical Authorization. Certain Prescription Drugs require prior authorization or approval before they will be dispensed. When You present a prescription, the Caremark Online System screens the prescription prior to dispensing. For certain Prescription Drugs, a notice appears on the pharmacist's computer to check with Your Physician before dispensing the Prescription Drug. You, Your Physician, or pharmacist can call (888) 414-3125 to start the prior clinical authorization process for Your prescription. Caremark Member Services will generally complete the review within twenty-four (24) hours. You will be informed of the decision for approval or denial of Your Prescription Drug. The type of Prescription Drugs that require prior authorization are anabolic steroids, growth hormones, and erectile dysfunction medications. You may call Caremark at (888) 414-3125 for a list of Prescription Drugs that require prior clinical authorization. Your physician may call (800) 294-5979 to start the prior authorization process.

Prior Authorization Requirement for Compound Prescription Drugs that Exceed $500. A compound prescription drug is the practice in which a licensed pharmacist, a licensed Physician, or in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. Compound prescription drugs must contain at least one ingredient that is a FDA approved prescription drug in a therapeutic amount.

If the cost of a compound prescription drug exceeds $500, Your Provider who wrote the prescription must obtain prior authorization from Caremark before the Trust will pay its portion of the compound prescription drug. To obtain prior authorization for a compound prescription drug that exceeds $500, Your Provider must take the following steps:

(a) The Provider who issued the prescription must submit a prior authorization request form to CVS Caremark. The prior authorization request form can be found at www.caremark.com. Scroll to the bottom of the page and click on "For Pharmacists and Medical Professionals." Then click on the "Prior Authorization Information" and follow the instructions.

(b) If You, Your Provider or pharmacist have questions regarding the prior authorization process, please call the CVS Caremark Customer Service line at the number on the back of Your identification card (1-866-818-6111).

(c) After submission of the prior authorization request form, CVS Caremark will notify Your Provider if the request has been approved. If the request has been denied, CVS Caremark will describe Your appeal rights.

The Co-Payment for a compound prescription drug is the same as the Co-Payment for a prescription drug obtained through the CVS Caremark National Retail Network.

Quantity Limitation Program. There may be instances where the pharmacy will dispense less than a 30-day or 90-day supply of a Prescription Drug. The Quantity Limitation Program manages the quantity of a Prescription Drug You can receive. The quantity of a Prescription Drug may be limited to less than a 30-day or 90-day supply based upon current medical findings, manufacturer-labeling information and/or Food and Drug Administration guidelines. The Quantity Limitation Program targets Prescription Drugs that are not used on a daily basis but on a per episode basis. Examples include Prescription Drugs for nausea and vomiting, migraine headaches, erectile dysfunction and acute pain. Prescriptions may be limited to a specific number of doses per month or per fill or by number of days' supply You can receive at one time.

DENTAL BENEFITS

INTRODUCTION

If You or Your Dependent, while enrolled for dental benefits, incur expense 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 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 age nineteen (19) or older during a Calendar Year. There is no maximum benefit for Dental Services for a Covered Person 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 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:

(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 Benefits and it is installed no later than ninety (90) days after the Covered Person ceases to be covered for Dental Benefits.

(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. This benefit will not be paid in addition to the Jaw Joint Disorder (TMJ) benefit.

(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 in 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) above 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) Performance of any procedure rendered 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; and

(r) Any expense subject to any other exclusion or limitation in the Benefit Booklet including the **Exclusions and Limitations** section starting on page 112.

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 151 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.

HOW TO USE THE VISION PLAN

(a) You can obtain Your vision benefits from a Vision Service Plan ("VSP") network provider or an out-of-network provider. In most instances, You will have lower out-of-pocket costs 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
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

Type of Vision Service	VSP Network Payment Amount	Out-of-Network Maximum Benefit Payment Amount	Frequency of Service
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%) off the regular price or five percent (5%) 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) Employee'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 Employee.

(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;

(g) Laminated 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).

DIABETIC EYE CARE PROGRAM

The Diabetic Eye Care Program is intended to be a supplement to a Covered Person's medical plan. 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. This is referred to as "Coordination of Benefits."

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 below. 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 Employee'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 his grievance rights 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.

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

COORDINATION OF BENEFITS (COB)

This COB section applies when a Covered Person has medical and/or 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 medical and/or 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 medical or 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); medical care components of group long-term care contracts such as skilled nursing care; medical benefits under group or individual automotive contracts; and Medicare or any other government programs other than Medicaid or as permitted by law.

(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 medical and/or dental benefits to which this COB section applies and which may be reduced because of the benefits provided by other Plans.

Allowable Expense means a medical and/or 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 Provider 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) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

(b) If a Covered Person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary Charges or Global 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.

(c) 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.

(d) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary Charges or Global 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 Provider 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 Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(e) 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 second surgical opinions, pre-certification of admissions and preferred Provider arrangements.

Closed Panel Plan means a Plan that provides healthcare benefits to a Covered Person primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan and that excludes coverage for services provided by other Providers, 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 or 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 or retiree or covering the Covered Person as a Dependent of the Employee, member, subscriber or 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 or 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.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

In situations where You are enrolled for coverage under this Plan and are also eligible for Medicare, this Plan will only pay for Covered Services when required to do so by federal law. In all other situations, the Plan will integrate with benefits under Parts A and B of Medicare even if You have not signed up for both parts.

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.

EXCLUSIONS AND LIMITATIONS

This section of the Benefit Booklet applies to all benefits in the Benefit Booklet except Life insurance benefit, the HRA, and savings benefits.

The Trust does not pay for:

(a) Any expense or charge for Injury or Sickness 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. If a Covered Person's claim for Workers' Compensation benefits is initially denied on the ground that it does not arise out of or in the course of employment, the Trust may advance benefits to the Covered Person while resolution of the Workers' Compensation claim is being finally determined. Any such advance will be subject to the Plan's **SUBROGATION AND REIMBURSEMENT** section of the Benefit Booklet;

(b) Any expense or charge which is in excess of the Usual and Customary Charge or Global Charge for a Non-PPO Provider (unless a specific exception applies) or the Negotiated Rate for a PPO Provider;

(c) Any expense or charge for services or supplies not Medically Necessary except for allowed Preventive Care Services;

(d) Any expense or charge incurred before coverage begins or after coverage ends except as allowed for Covered Dental Services.

(e)

(f) Any expense or charge resulting from the Covered Person's commission or attempted commission of a felony;

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

(h) Any expense or charge for Custodial Care. See the definition of Custodial Care in the **DEFINITION OF TERMS** section starting on page 4 of the Benefit Booklet.

(i) Any expense or charge which results from Cosmetic or Reconstructive Surgery, except;

(1) For Injuries received while covered under the Plan;

(2) For repair of defects which result from surgery for which the Covered Person was paid benefits under the Plan;

(3) For the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction, provided the Covered Person has been continuously covered under this Plan since birth;

(4) For the reconstruction of a breast as allowed by the Women's Health and Cancer Rights Act benefit as described on page 119 of the Benefit Booklet; or

(5) Penile implants following radical prostate cancer surgery.

(j) Any expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Trustees in conjunction with their advisors, and present significant symptomatic mental problems) or any treatment of obesity (including surgery to treat morbid obesity). However, the Trust will cover screening for obesity for adults as recommended by the United States Preventative Services Task Force;

(k) Any expense or charge for orthopedic shoes, orthotics or other supportive devices for the feet, including non-surgical treatment of feet (including, without limitation, treatment of weak or fallen arches, flat or pronated feet, metatarsalgia, hallux valgus, hallux flexus, hallux rigidus or hallux varus, or paring or excision of callus or corn, or trimming of toenails);

(l) Any expense or charge for treatment of Jaw Joint Disorders (except to the extent specifically provided);

(m) Any expense or charge for sexual transformations or any treatment related to sexual dysfunction, except Prescription Drugs detailed in the Prescription Drug Benefit section of the Benefit Booklet;

(n) Any expense or charge related to Mental and Nervous Disorders which are classified as sexual deviations or disorders;

(o) Any expense or charge for chelation therapy except for acute arsenic, gold, mercury or lead poisoning;

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

(q) Any expense or charge for services or supplies which:

(1) Are considered an Experimental or Investigational Procedure; or

(2) Result from or relate to the application of an Experimental or Investigational Procedure except as allowed by the Clinical Trials benefit.

(r) Any expense or charge which is primarily for the Covered Person's education, training or development of skills needed to cope with an Injury or Sickness;

(s) Any expense or charge related to tobacco cessation except for Prescription Drugs designed to help You stop using tobacco products;

(t) Any expense or charge which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, caretaker, or Provider;

(u) Any expense or charge for telephone calls to or from a Hospital or Provider except for the Teladoc benefit;

(v) Any expense or charge which results from breast augmentation or reduction which is not associated with cancer of the breast;

(w) Any expense or charge for 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 supplies are required by law to be paid by the Plan; or for confinement or care obtained in a Hospital or other facility owned or operated by any federal, state or local governmental agency or program unless there is an unconditional requirement to pay for such confinement or care without regard to any rights against others, contractual or otherwise.

(y) Any expense or charge which results from or is caused by war (whether declared or not), service in the armed forces of any country, invasion, civil or international war or hostilities, insurrections or riot;

(z) Any expense or charge for baby delivery by a lay midwife and facility benefits for at-home delivery of a baby;

(aa) Any expense or charge for surgical procedures which alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism. Additionally, reversals or reversions of surgical procedures which alter the refractive character of the eye and complications of these procedures are excluded;

(bb) Any expense or charge for a hearing aid;

(cc) Any expense or charge for an internet Physician visit except as allowed by the Teladoc benefit;

(dd) Any expense or charge for private nursing service or personal items such as telephones, televisions and guest meals in a Hospital or Skilled Nursing Care Facility;

(ee) Any expense or charge for self-help training programs including, but not limited to, those to stop smoking, control weight or provide general fitness and other services or supplies, including drugs prescribed for or used as part of such program except for Prescription Drugs designed to help You stop using tobacco products;

(ff) Any expense or charge for instructional programs, including but not limited to, those to learn to self-administer drugs or nutrition or teach a person how to use Durable Medical Equipment or how to care for a family member except as specifically provided under the Outpatient Diabetic Instruction benefit;

(gg) Any expense or charge 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;

(hh) Any expense or charge for appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education such as an air conditioner, humidifier, air filter, whirlpool, heat lamp or tanning lamp;

(ii) Any expense or charge described elsewhere in this Benefit Booklet as not covered;

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

(kk) Any expense or charge for services or supplies which violate any statute of regulations;

(ll) Any expense or charge for services or supplies which are payable under a government or privately supported medical research program;

(mm) Any expense or charge for any service or supply attributable to someone other than the Covered Person except for the Organ Transplant donor benefit;

(nn) Any expense or charge which is not a Covered Service under the terms of the Plan;

(oo) Any expense or charge for any service or supply incurred outside the United States except in emergency situations. Emergency situations are defined as instances of a serious injury, the onset of a serious condition which requires immediate medical intervention to prevent death, or a serious impairment of health. Emergencies do not include elective care or care of a minor Injury or Sickness;

(pp) Any expense or charge for private duty nursing;

(qq) Any expense or charge for over-the-counter drugs; and

(rr) Any expense or charge for Hospital care or medical coverage for which benefits are available who are eligible for Medicare and for whom Medicare is primary to Plan coverage whether or not the Covered Person has qualified for such benefits enrollment or other procedure available to him.

GENERAL PROVISIONS

PAYMENT OF CLAIMS

Written notice of a claim for medical and dental benefits must be given to the Plan Administrator as soon as possible after a Covered Service is incurred. 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 medical and dental claims will be made by the Trust or Aetna for a Covered Service upon timely receipt of a fully completed claim form that meets all the requirements of the Plan. The Trust or Aetna will make payment to the Provider, Hospital, facility, or clinic unless the Covered Service has already been paid by the Covered Person. Whether the Trust or Aetna pays You or the Provider, Hospital, facility, or clinic, 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.

Claim forms for medical and dental benefits 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. This Plan complies with the Newborns and Mothers' Health Protection Act.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides 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 is subject to the Deductible and Co-Payments as detailed in the Plan.

DISCLOSURE OF NON-GRANDFATHERED HEALTH PLAN STATUS

This information is required by the Patient Protection and Affordable Care Act (the Affordable Care Act). Effective January 1, 2016, the Plan is not a grandfathered health plan under the Affordable Care Act. A non-grandfathered health plan must provide in-network Preventative Care Services at no cost to the Covered Person.

Questions regarding which requirements under the Affordable Care Act apply to a non-grandfathered health plan 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 this 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, OFFSET OF FUTURE BENEFITS AND DEDUCTION FROM RESERVE ACCOUNT

If the Trust, Aetna, or Plan Administrator mistakenly pays a claim for a Covered Person or makes a payment to a person, Provider, Hospital, facility, or clinic who is not entitled to the payment, or a Covered Person or family member does not honor a **SUBROGATION AND REIMBURSEMENT OBLIGATION**, the Trustees have the right to recover the payment from any person paid or anyone who benefitted from it, including a Provider, Hospital, facility, or clinic. The Trustees' right to recover includes the right to deduct the amount paid by mistake or not repaid via a **SUBROGATION AND REIMBURSEMENT OBLIGATION** 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 or even if that family member did not fail to honor the **SUBROGATION AND REIMBURSEMENT OBLIGATION**. The Trustees also have the right to deduct money from Your Reserve Account in excess of the money necessary for one month of coverage in order to recover a mistaken payment or if the Covered Person or a family member fails to honor the **SUBROGATION AND REIMBURSEMENT OBLIGATION**.

SUBROGATION AND REIMBURSEMENT OBLIGATION

For purposes of this section, the following definitions apply:

(a) "Covered Person" means an individual covered by this Plan as well as the estate, heirs, guardian and/or conservator of a Covered Person. "Covered Person" also includes any trust established for the purpose of receiving "Recovery Funds" and/or paying future income, care or medical expenses to or for a Covered Person as the result of a "Third Party Claim."

(b) "Recovery Funds" means any amount recovered by or for a Covered Person from a "Third Party" as the result of a "Third Party Claim."

(c) "Third Party Claim" means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action by a Covered Person against a Third Party (or any right to assert the foregoing) alleging or claiming the Third Party may be responsible (from a liability and/or financial standpoint) for the Injury or Sickness of a Covered Person for which Covered Services are paid or may be paid from the Trust.

(d) "Third Party" means any individual or entity who may be fully or partially responsible (from a liability and/or financial standpoint) for the Injury or Sickness of a Covered Person for which Covered Services are paid or may be paid from the Trust. "Third Party" includes any insurer of such individual or entity and includes, but is not limited to, all types of liability insurance as well as other forms of insurance that may pay money to or on behalf of a Covered Person including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection coverage and worker's compensation coverage.

Exclusion of Benefits. The Plan will not pay any medical or dental benefits for any Injury or Sickness with respect to which the Covered Person has, or may have, a Third Party Claim except as specifically provided in this section.

Subrogation Rights. Upon payment of Covered Services for an Injury or Sickness of a Covered Person that are related to a Third Party Claim, the Trust shall be subrogated to all a Covered Person's rights, claims, interests, rights of action, judgments, and recoveries to the extent of the full amount the Trust paid or may pay to or on behalf of the Covered Person relating to the Third Party Claim. The Third Party and the Covered Person shall do whatever is necessary to secure such rights and do nothing to prejudice them.

The Trust or its Trustees may pursue the Third Party to recover the Covered Services for an Injury or Sickness the Trust paid or may pay that are related to the Third Party Claim in the Trust's name or in the name of a Covered Person. The Trust and its Trustees are entitled to all subrogation rights and remedies of a Covered Person under common law and statutory law as well as under the Benefit Booklet.

Right of Recovery. In addition to the Trust's subrogation rights, the Trust and its Trustees require the Covered Person and his attorney, if any, to protect the Trust's reimbursement rights. The following rules apply:

(a) A Covered Person agrees to hold any Recovery Funds in trust for the Trust up to the amount of Covered Services the Trust paid or may pay for the Injury or Sickness of a Covered Person that are related to the Third Party Claim. The Trust shall be paid first from the Recovery Funds.

(b) A Covered Person grants the Trust a first security interest, an equitable lien, and/or constructive trust for all Recovery Funds up to the amount of Covered Services the Trust paid or may pay for the Injury or Sickness of a Covered Person that are related to the Third Party Claim. If the Covered Person is represented by an attorney, all Recovery Funds shall be deposited in the attorney's trust account. No portion of the Recovery Funds shall be paid to the Covered Person, the attorney, or anyone other than the Trust until the Trust's right to reimbursement in this section has been fully satisfied.

(c) The Trust is entitled to a first priority recovery from the Recovery Funds for the full amount of Covered Services it has paid or may pay for the Injury or Sickness of a Covered Person that are related to the Third Party Claim. The payment obligation exists regardless of whether: (i) a Covered Person has been made whole; (ii) the Third Party admits liability or asserts that a Covered Person is also at fault; (iii) a Covered Person only sought the recovery of non-economic damages; or (iv) a claim has been resolved through a disputed claims settlement where the parties agree the Injury or Sickness is not work related or not caused by the Third Party. The Trustees reject the make whole, common fund, and collateral source theories and the Trust's rights shall not be affected by similar doctrines or rules, whether established at common law or by statute, that would reduce the Trust's right to full recovery under this section of the Benefit Booklet.

(d) The Trust may require a Covered Person and his attorney to sign an agreement to abide by this section of the Benefit Booklet as a prerequisite to paying for Covered Services for an Injury or Sickness that is related to a Third Party Claim.

(e) A Covered Person and his attorney shall do nothing to prejudice the Trust's right of recovery under this section of the Benefit Booklet.

(f) The Trust may, at the discretion of the Trustees, suspend payment or deny payment of Covered Services for an Injury or Sickness of a Covered Person related to the Third Party Claim if a Covered Person and/or his attorney fail to perform all acts required by this section of the Benefit Booklet or the Trustees have a reasonable basis to believe a Covered Person and/or his attorney will not honor all of his obligations under this section of the Benefit Booklet.

Additional Obligations of a Covered Person and Rights of the Trust and the Trustees. In connection with the Trust's right to subrogation and reimbursement, a Covered Person shall do the following as applicable and agrees that the Trust and the Trustees may do one or more of the following at the Trustees' discretion:

(a) If a Covered Person seeks payment for Covered Services for an Injury or Sickness for which there may be a Third Party Claim, a Covered Person shall notify the Plan Administrator of the potential Third Party Claim. A Covered Person has this responsibility even if the first request for payment of Covered Services is a bill or invoice submitted to the Trust by a Provider, Hospital, facility, or clinic.

(b) Upon request from the Plan Administrator, a Covered Person shall provide the Plan Administrator with all available information relating to the potential Third Party Claim.

(c) A Covered Person shall immediately disclose to the Plan Administrator all Recovery Funds and all settlements of any kind that have been obtained that are related to the Third Party Claim.

(d) By accepting payment of Covered Services relating to an Injury or Sickness for which there may be a Third Party Claim, a Covered Person agrees that the Trust and its Trustees have the right to intervene in any lawsuit, mediation or arbitration filed by or on behalf of a Covered Person seeking damages from a Third Party.

(e) A Covered Person agrees that the Plan Administrator, Trust and/or Trustees may notify any Third Party or Third Party's representative or insurer of the Trust's recovery rights set forth in this section of the Benefit Booklet.

(f) This section of the Benefit Booklet applies regardless of whether a Covered Person's Injury or Sickness for which there may be a Third Party Claim occurred before the Covered Person became enrolled in the Plan.

(g) If any term, provision, agreement or condition in this section of the Benefit Booklet is held by a Court to be invalid or unenforceable, the remainder of the section shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

(h) The Trustees have the authority to compromise subrogation and reimbursement claims on a case by case basis depending on the facts and circumstances.

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, 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, and the deduction of money from Your Reserve Account in excess of the money necessary for one month of coverage.

MOTOR VEHICLE INSURANCE

Many state insurance laws require no-fault personal injury protection ("PIP") coverage. PIP coverage provides immediate payment by a Covered Person's automobile insurance carrier for medical bills and wage loss. The Plan will not provide medical or dental benefits to the extent the Covered Person recovers or is entitled to recover under PIP.

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.

The life insurance benefit for Employees enrolled for Medical Coverage as a result of employer contributions, or employer contributions and a partial self-payment, at the time of death is $10,000. If the Employee is age seventy (70) or older and enrolled for Medical Coverage as a result of employer contributions, or employer contributions and a partial self-payment at the time of death, the life insurance benefit paid by Reliance is $5,000 and the Trust will make a payment of $5,000 to Your beneficiary. The group contract between the Trust and Reliance provides that if an Employee is confined in a Hospital or at home on the date he or she would have become insured for the life insurance benefit, the life insurance benefit will become effective on the date the confinement ends. If an Employee dies and life insurance benefit are denied based on this exclusion, the Trust will make a payment of $10,000 to Your beneficiary.

If an Employee is enrolled for Medical Coverage as a result of COBRA at the time of death and the Employee elected the life insurance benefit as part of the COBRA election and timely paid the required premium, the life insurance benefit 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); or

(d) The date You ceased to qualify as an Employee unless You have elected to continue the life insurance benefit as part of Your COBRA election and timely

pay the required premium. See the Retiree Plan for the life insurance benefits for Early Retirees and Medicare-Eligible Retirees.

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 (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 REGARDING 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 health care 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

HEALTH REIMBURSEMENT ARRANGEMENT

Introduction. The Health Reimbursement Arrangement ("HRA") gives Employees and former Employees with an HRA account flexibility to meet their family's health care needs. Employers contribute money for Employees' HRA accounts. The Contribution rate is determined by the Collective Bargaining Agreement and is $0.25 per hour effective January 1, 2016. Money in Your HRA that is not used in one year will be carried over to the following year.

There is a separate health reimbursement arrangement for Early Retirees in the Retiree Plan. Contact the Plan Administrator or go to the website www.598benefits.aibpa.com for a Retiree Plan booklet.

This section of the Benefit Booklet 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 money in Your HRA can be used to reimburse You for Healthcare Expenses incurred by You and Your Dependents on a tax-free basis. In general terms, Healthcare Expenses are (i) Co-Payments and Deductibles You pay for health coverage, (ii) self-payments and COBRA payments to maintain health and welfare coverage, and (iii) out-of-pocket payments You make for Healthcare Expenses such as physical therapy, glasses, etc. A more detailed description of Healthcare Expenses is under the heading **Allowable Uses for the Money in Your HRA Account**.

Once an HRA account has been established for You, You will receive a debit card that can be used to pay medical and Prescription Drug Deductibles and Co-Payments. The amount of money on Your debit card will reflect the amount of money in Your HRA account. If Your debit card is lost or stolen, You are responsible for the replacement cost. Each month that a HRA Contribution is transferred to Your HRA account, that amount will be added to Your debit card. For reimbursement of other Healthcare Expenses, You will need to submit a claim to the Plan Administrator. If the claim is accepted, a check will be issued to You or You may sign up for direct deposit and receive reimbursement directly to Your bank account or savings account.

When Your HRA Account is Established. An Employee becomes an HRA participant when HRA Contributions are first transferred to Your HRA account. You will remain an HRA participant as long as there is money in Your HRA account. The transfer of money to Your HRA account will normally take place on the last day of the month.

An Employee must have health and welfare coverage provided by a Plan sponsored by the Trustees (other than the Retiree Plan) as a prerequisite to having the HRA Contribution transferred to his HRA account. For example, assume Employee A works under a Collective Bargaining Agreement that requires his Employer to pay $0.25 per hour for the HRA. Employee A worked 100 hours in August 2016. Employee A's Employer pays the HRA Contribution ($25) to the Trust by September 20, 2016. If Employee A has health and welfare coverage provided by a Plan sponsored by the Trustees (other than the Retiree Plan) for September 2016, the $25 will be transferred to his HRA account on the last business day in September 2016. If Employee A does not have health and welfare coverage provided by a Plan sponsored by the Trustees (other than the Retiree Plan) for September 2016, the $25 HRA Contribution will remain in the Trust until the Employee has a month of health and welfare coverage provided by a Plan sponsored by the Trustees (other than the Retiree Plan) or the HRA Contribution is forfeited.

Forfeiture of HRA Contributions. If an HRA Contribution is made to the Trust, but has not been transferred to Your HRA account because You have not had health and welfare coverage provided by a Plan sponsored by the Trustees as described above, Your HRA Contribution will be forfeited thirty-six (36) months after receipt of the HRA Contribution by the Trust. For example, Employee A worked 100 hours in August 2016 and had $25 in HRA Contributions contributed to the Trust in September 2016. Before the HRA Contribution can be transferred to the Employee's HRA account, the Employee must have one month of health and welfare coverage provided by a Plan sponsored by the Trustees. If the Employee does not have health and welfare coverage provided by a Plan sponsored by the Trustees for thirty-six (36) months (October 2016 through September 2019), the $25 in HRA Contributions will be forfeited.

Once HRA Contributions have been transferred to Your HRA account, the money in Your HRA account is not subject to forfeiture under current Plan rules.

Contributions. The amount of the HRA Contribution an Employer contributes to the Trust is determined by the Collective Bargaining Agreement. The Contribution rate is $0.25 per hour effective January 1, 2016, and subject to change through contract negotiations. The funds allocated to the HRA accounts are general Trust assets and there is no specific Trust assets segregated or earmarked for Employees or their HRA accounts.

Self-payments by Employees to their HRA accounts is prohibited.

Your HRA Account. The Plan Administrator will establish and maintain an HRA account for each Employee who meets the participation rules described above. Your HRA account will be used to receive Your HRA Contributions, to pay administrative expenses associated with the HRA, and to reimburse You for Healthcare Expenses incurred by You or a Dependent.

Although each Employee's HRA account will be separately identified, the combined assets of all HRA accounts will be identified in the Trust's financial statements as HRA reserves. The HRA account established for each Employee is merely a recordkeeping account for the purpose of tracking the Contributions into Your HRA account and the administrative expenses and Healthcare Expenses deducted from Your HRA account.

Each October, You will receive a statement from the Plan Administrator detailing Contributions 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. The Trustees have the authority to credit HRA accounts with investment income in the future as circumstances warrant.

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

Download the Mobile App. 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 Money in Your HRA Account. The money in Your HRA account can be used to reimburse You for Healthcare Expenses that are incurred by You or a Dependent subject to the HRA rules. Healthcare Expense is defined in Section 213(d) of the Internal Revenue Code. 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 expenses You or a Dependent incur after money has been deposited in Your HRA for:

- Co-Payments
- Deductibles
- Unreimbursed dental expenses
- Unreimbursed vision expenses
- Hearing aids
- Chiropractic treatments
- Premiums for other medical, prescription drug, dental, vision or long-term care insurance
- Physical therapy
- COBRA payments to continue health and welfare coverage

You are not entitled to be reimbursed from Your HRA account if the Healthcare Expense has been reimbursed or is reimbursable from any other health plan or insurance policy or for any amount that is claimed as a deduction on Your or Your Dependent's federal income tax return.

Time Limits Applicable to Payment from Your HRA Account. You may request reimbursement from Your HRA account only for a Healthcare Expense incurred after the date an HRA account has been established for You. For example, if money was transferred to Your HRA account for the first time on October 31, 2016. Healthcare Expenses incurred by the Employee or a Dependent prior to October 31, 2016 are not eligible for reimbursement from the Employee's HRA account.

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 of service. A claim for reimbursement submitted more than twelve (12) months after the date of service will be denied. In the case of a divorce, a claim for reimbursement of a Healthcare Expense for Your ex-spouse must be submitted within ninety (90) days of the date of divorce. A claim for reimbursement for a Healthcare Expense for Your ex-spouse submitted more than ninety (90) days of the date of divorce will be denied.

How to Apply for Payments from Your HRA Account. Once an HRA account has been established, the Employee 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 or Prescription Drug expenses for You and Your Dependents. By using Your debit card for a medical or Prescription Drug Co-Payment, Deductible, or other out-of-pocket medical or Prescription Drug expenses, You are certifying that the Co-Payment, Deductible, or other Healthcare Expense was incurred for You or a Dependent enrolled for Plan coverage and is a Healthcare Expense as that term is defined in Section 213(d) of the Internal Revenue Code.

For dental and vision claims as well as medical and Prescription Drug claims for which You do not use 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 family member who incurred the Healthcare Expense and his or her relationship to You;

(c) A description of the Healthcare Expense;

(d) 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

(e) 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 is insufficient money in Your HRA account when a claim for reimbursement is received, that claim will be "pended" until the earliest of:

(a) The date there is sufficient money in Your HRA account to pay the claim; or

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

Expenses of Operating the HRA. The monthly fee for the administration of Your HRA account is $4.00. The monthly administrative fee will be automatically deducted from Your HRA account regardless of whether there has been activity in Your HRA account that month. The Trustees may change the monthly administrative fee but will not do so without providing advance written notice to You.

Your Right to Terminate Participation in Your HRA Account. You have the right to terminate Your participation in the HRA each year in November and any time You lose health and welfare coverage provided by a Plan sponsored by the Trustees. If You terminate Your participation in the HRA, You forfeit all money 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 money in Your HRA account, You are not eligible for the tax credit. As a result, if You lose Your health and welfare coverage, You have the option of spending the remainder of Your HRA account or terminating Your participation in the HRA, forfeiting the money in Your HRA account, and applying for the tax credit (if You qualify for the tax credit based on income requirements) if You obtain medical coverage from one of the Health Care Exchange plans.

Reciprocity for Travelers. If You are a traveler from a United Association Local Union other than Local 598 who is temporarily working in Local 598's geographic area and has elected to have his health Contribution sent to his home health trust, the HRA Contribution will be sent to Your home health trust.

If the Local 598 Trust is Your home trust, You travel to another Local Union's geographic area, and You have Contributions sent to this Trust, reciprocated Contributions (up to $0.25 per hour) will be applied to Your HRA account only if the hourly Contribution where You are working exceeds the hourly Contribution for health coverage in the Union's Collective Bargaining Agreement ($11.65 per hour as of January 1, 2016). For example, if You travel to another Local Union's area where the health Contribution is $8.00 per hour, the full $8.00 per hour will go into Your Reserve Account and no money will go into Your HRA account. If You travel to another Local Union's area where the health Contribution is $13.00 per hour, $12.75 per hour will go into Your Reserve Account and $0.25 per hour will go into Your HRA account.

Early Retirees and Medicare-Eligible Retirees. The Trust does not make a Contribution to this HRA account for Early Retirees and Medicare-Eligible Retirees. However, Employees can accumulate money in their HRA accounts and continue to use the money in their HRA accounts after they become Early Retirees or Medicare-Eligible Retirees. There is a separate health reimbursement arrangement for Early Retirees described in the Retiree Plan. Contact the Plan Administrator or go to the website www.598benefits.aibpa.com for the Retiree Plan.

Death of an Employee, Early Retiree, or Medicare-Eligible Retiree. If an Employee, Early Retiree, or Medicare-Eligible Retiree dies with money 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 money in Your HRA account for reimbursement of Healthcare Expenses they incur after Your death in accordance with the terms of the Plan.

If You die and there are no surviving Dependents, the money in Your HRA account shall be forfeited and reallocated to the general assets of the Trust.

Claims Appeal Procedures. You or Your Dependents have the right to appeal any decision by the Plan Administrator related to Your HRA account. You must follow the **Claim Appeal Procedures** which are described on page 151 of the Benefit Booklet.

SAVINGS PLAN

Savings contributions in the amount stated in the Collective Bargaining Agreement are paid to You by Your Employer as gross wages, subject to all taxes, and then deducted from Your paycheck at the full rate called for in the Collective Bargaining Agreement. Your Employer is then obligated to send the savings contributions to the Trust.

Each month, the Plan Administrator will deposit the savings contributions received on Your behalf into an individual savings account in Your name at a bank, savings and loan or credit union designated by You. Before savings contributions can be transferred to Your savings account, You must complete an authorization form allowing the Trust to make a direct deposit to a bank, savings and loan or credit union of Your choice. You may obtain the direct deposit authorization form by contacting:

Plumbers & Steamfitters Local 598
1328 Road 28
Pasco, WA 99301
(509) 545-1446

or

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

Savings contributions will normally be transferred electronically to Your designated bank, savings and loan or credit union by the 25th day of the month.

In the event the savings contributions deposited in Your bank, savings and loan or credit union account do not agree with Your records, contact the Plan Administrator. The Plan Administrator will check the savings contributions deposited on Your behalf against the amount You claim is owed. If Your Employer has not contributed all amounts due, collection efforts will be made. Amounts collected will be deposited into Your savings account after collection.

In the event You choose not to open a savings account, the Trust will issue a check to You for Your accumulated savings contributions received by the Trust twice per year (approximately June 20 and December 20). The check will not include any interest. At the time the Trust issues a check to You for Your savings contributions, $20.00 will be deducted from Your savings contributions to cover the costs associated with issuing a check for Your savings contributions.

If You have a claim for savings benefits that is denied in whole or in part, You must follow the **Claim Appeal Procedures** which are described on page 151 of the Benefit Booklet.

CLAIM APPEAL PROCEDURES

WHERE TO FILE AN APPEAL

All types of appeals involving eligibility for coverage, medical, dental, HRA, and savings 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 filed with 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 filed with 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 the vision benefit and the 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 benefit that is based on the Plan; or

(c) An action or decision by Aetna, the Plan Administrator, the Appeal Review Committee, or the Trustees.

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:

Medical and prescription drugs (post-service claims)	30 days
Dental	30 days
Disability waiver	45 days
Eligibility, a self-payment, coverage for a Dependent, a COBRA issue, HRA and Savings Plan issues, a rescission of coverage issue, or other issue.	90 days

MEDICAL AND PRESCRIPTION DRUG CLAIMS

The Plan Administrator is responsible for reviewing medical and prescription drug 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 medical care or treatment can be obtained and a delay in obtaining the medical 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 Provider with knowledge of the Covered Person's medical 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 medical 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 Provider's bill that will be paid. 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 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.

DENTAL CLAIMS

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 a 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 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.

Disability Waiver

The Plan Administrator or its designee will provide notice of the benefit determination (whether the claim is approved or denied) within forty-five (45) days after receipt of an application for disability waiver. If the Plan Administrator determines an extension of time is necessary to complete review of the claim because of matters beyond its control, the 45-day period may be extended up to thirty (30) days provided the Plan Administrator notifies You of the extension of time for processing the claim during the initial 45-day period. If, prior to the end of the first 30-day extension, the Plan Administrator determines that a further extension of time is necessary to complete review of the claim because of matters beyond its control, the 30-day extension may be extended up to an additional thirty (30) days provided the Plan Administrator notifies You of the extension before the end of the first 30-day extension. If an extension of time is required, You will be notified in writing and the notice shall specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional information, if any, needed by the Plan Administrator and a date a decision is expected. 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 the time limits 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 a health and welfare plan, a late self-payment, coverage for a Dependent, COBRA coverage issues, HRA and Savings Plan, 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. The Covered Person 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 a medical expert based on the expert's reputation for outcomes in contested cases. Rather, the Plan will contract with medical 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, e.g., Medical Necessity;

(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) If the adverse benefit determination is based on a decision involving Medical Necessity or because the service is an Experimental or Investigational Procedure, You will be notified of Your right to receive a statement of the scientific or clinical judgment for the decision free of charge upon request;

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

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

(h) 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 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 medical judgment, such as whether a particular treatment, drug or other item is an Experimental or Investigational Procedure or Medically Necessary, a health care professional who has appropriate medical training and experience will be consulted. If a health care professional is consulted, that person will be different from any health care

professional previously consulted involving Your claim and will not be the subordinate of the health care professional previously consulted. If a health care 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.

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 denies 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 this 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 this 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 medical, prescription drug or dental judgment, including but not limited to determinations based on Medical Necessity, healthcare setting, appropriateness, level of care, or a determination that a treatment is an Experimental or Investigational Procedure, 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 a medical, prescription drug or dental judgment, or a rescission of coverage claim, as opposed to eligibility

requirements (e.g., worker classification or similar determination). Eligibility and disability waiver 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 Independent Review Organization (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 medical records;

(b) The claimant's health care professional's recommendation;

(c) Reports from health care professionals and other documents submitted by the Plan, claimant or the claimant's Provider;

(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 medical records, the recommendations and reports of the claimant's health care 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 MEDICAL 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 medical 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 Provider, 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 176.

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 Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell a Provider about Your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary, or 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 Providers. The Plan may provide medical information about You to Providers, including doctors, nurses, and hospital personnel who are involved in Your care. For example, the Plan may disclose Protected Health Information about You to Providers 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 Providers and participants with information about treatment alternatives and other related functions;

(5) Health care 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, medical reviews, legal services, fraud and abuse detection and compliance programs;

(9) Submitting claims for stop-loss reimbursement;

(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 Physician.

(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 Employee. This includes mail related to the Employee's Dependents who are covered under the Plan and includes mail with information on the use of Plan benefits by the Employee and Dependents and information on the denial of any Plan benefits to the Employees 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 medical claims for payment or to provide utilization management or pharmacy benefit 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 Providers 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 Provider when needed by the Provider 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 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 Provider 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 176. 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 176. 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 176. 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 176 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 176. 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 for the Trust at the address on page 176.

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 176.

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 OF THE PLAN

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 Health & Welfare Plan also referred to as the Plan describing medical, dental & vision benefits for Employees and Dependents, life insurance benefits, Savings Plan benefits and Health Reimbursement Arrangement benefits for Employees.

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

Employer Trustees	Labor Organization Trustees
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:

501

TYPE OF PLAN

The Plan is a health and welfare plan that provides life insurance, savings and HRA benefits for Employees only. The Plan provides medical, dental and vision benefits for Employees and their Dependents.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to the terms of Collective Bargaining Agreements between Plumbers and Steamfitters Local 598 and Employers. The Collective Bargaining Agreements provide that Employers will make required Contributions to the Trust for the purpose of enabling Employees working under the Collective Bargaining Agreements 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 benefits provided by the Plan are paid directly from assets of the Trust unless a benefit is 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.

Medical, Prescription Drug, Dental, HRA, and Savings Benefits. Claims arising from the medical and Prescription Drug benefits for Employees and their Dependents are paid directly from Trust assets, although a premium is paid to an insurance carrier for specific and aggregate stop loss coverage for medical and Prescription Drug benefits. Claims arising from dental benefits for Employees and their Dependents are paid directly from Trust assets. HRA and savings benefits for Employees are paid directly from Trust assets.

Retail, Mail Order, and Specialty Prescription Drug Program. The retail, mail order and special pharmacy drug programs for Employees and their Dependents is provided by:

CVS Caremark
221 Sanders Road
Northbrook, IL 60062

Preferred Provider Organization. The Trust has entered into a contract with a Preferred Provider Organization that can be used by Employees and their Dependents for medical benefits. The Trust is responsible for funding claims submitted by Providers, Hospitals, facilities and clinics. The Preferred Provider Organization is responsible for the administration of contracts with Providers, Hospitals, facilities and clinics. The Preferred Provider Organization currently is:

Aetna Life Insurance Company
600 University Street, Suite 920
Seattle, WA 98101

Vision Benefits. The Trust has entered into a contract with Alaska Vision Services, Inc. to provide vision benefits for Employees and their Dependents. 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. Life insurance benefit for Employees are provided by Reliance Standard Life Insurance Company. The 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

Specific and Aggregate Stop-Loss Insurance. The Trust has entered into a contract with an insurance company that provides specific and aggregate stop-loss insurance for Medical Coverage. The Trust pays the stop loss insurance carrier a fee for the insurance it provides. The stop loss insurance carrier currently is:

HCC Life Insurance Company
225 Town Park Drive Suite 145
Kennesaw, GA 30144

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 this Benefit Booklet starting on page 33 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.