

Plumbers and Steamfitters

Local 486

Medical Plan

Summary Plan Description

January 2018



Plumbers and Steamfitters Local No. 486
Medical Plan

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January 1, 2018

PLUMBERS AND STEAMFITTERS LOCAL 486
MEDICAL PLAN

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January, 2018

To All Covered Participants:

We have prepared this booklet to advise you of the comprehensive benefits provided to eligible employees, retirees and their dependents under the Plumbers and Steamfitters Local 486 Medical Plan.

This booklet explains your benefits in a brief and simple way - how you become eligible, what benefits are provided, how to submit a claim, and how you may lose your eligibility. You must be eligible for benefits before you can claim them. Please read this booklet carefully so you know how the Plan can help you.

The basic benefits of the Plan provide coverage for certain major medical, prescription and dental expenses. HMO alternatives are offered as well, in place of the major medical and prescription benefits. Weekly accident and sickness benefits are also provided for employees as summarized in this booklet.

It should be noted that if you are injured while at your place of work or require medical care as a result of your employment, you should obtain care through the arrangements provided by your employer under workers' compensation laws. This Plan does not provide benefits for care needed if you are hurt on the job. However, in cases of non-occupational injury, certain income replacement is available as described in this booklet.

This booklet is a summary of plan provisions related to the plan of benefits; it is not the sole governing instrument. It does not contain the detailed Agreement and Declaration of Trust, other plan documents under which the plan is established and maintained, or the related Collective Bargaining Agreement, all of which govern the operation and administration of this Plan and together constitute the Plan's governing documents. The Plan must be interpreted in accordance with these documents which are available for your inspection at the Office of the Administrator.

We urge you to read your Plan booklet carefully so that you are familiar with the benefits to which you are entitled and the Plan's eligibility requirements.

We hope that you share our pride in you Plan and the measure of security it provides to those who work in the industry.

Sincerely,

BOARD OF TRUSTEES

Revised January 2018

TABLE OF CONTENTS

ELIGIBILITY.....	1
EMPLOYEES.....	1
<i>Initial Eligibility</i>	1
<i>Continuing Eligibility</i>	2
<i>Continued Eligibility While Disabled</i>	2
<i>Termination of Eligibility</i>	3
<i>Reinstatement</i>	3
<i>Reciprocal Agreements</i>	3
<i>Military Service</i>	3
DEPENDENTS	4
<i>Initial Eligibility</i>	4
<i>Adopted Children</i>	4
<i>Qualified Medical Child Support Orders</i>	4
<i>Termination of Eligibility</i>	5
<i>Coverage after Death of Eligible Employee</i>	5
<i>Waiver of Coverage</i>	5
<i>Proof of Dependency</i>	6
RETIRED EMPLOYEES	6
<i>Initial Eligibility</i>	6
<i>Disabled Retirees</i>	7
<i>Termination of Eligibility</i>	7
<i>Waiver of Coverage</i>	7
<i>Reinstatement</i>	7
<i>Special Enrollment Rights</i>	7
<i>The Family Medical Leave Act (FMLA)</i>	8
<i>Right to Receive a Certificate of Health Coverage</i>	9
SELF-PAYMENT PROVISIONS.....	9
PARTICIPATION.....	9
ELIGIBILITY	9
SELF-PAYMENT	9
TERMINATION OF SELF-PAYMENT	10
RECIPROCAL AGREEMENTS	10
CONTINUATION OF COVERAGE	10
MAXIMUM PERIOD OF COVERAGE.....	10
COORDINATION OF SELF-PAYMENT RULES AND COBRA	11
NOTIFICATION REQUIREMENTS	11

ELECTION OF CONTINUATION COVERAGE.....	12
PAYMENT OF CONTINUATION COVERAGE.....	12
TERMINATION OF CONTINUATION COVERAGE.....	12
CONTINUATION OF COVERAGE FOR ELIGIBLE MILITARY LEAVE.....	12
MAJOR MEDICAL EXPENSE BENEFIT.....	13
MAJOR MEDICAL EXPENSE DEDUCTIBLE.....	13
COVERED MEDICAL EXPENSES.....	14
ADDITIONAL INFORMATION REGARDING COVERED MEDICAL BENEFITS.....	15
<i>Hospital Room and Board</i>	15
<i>Hospital Miscellaneous Expenses</i>	15
<i>Hospital Pre-Certification Program</i>	15
<i>Physician Visits</i>	16
<i>Surgical Expense Benefit</i>	16
<i>Multiple Surgical Procedures</i>	17
<i>Reconstructive Breast Surgery</i>	17
<i>Definition of Surgical Procedure</i>	17
<i>Diagnostic X-ray And Laboratory Expense Benefit</i>	17
<i>Charges Not Covered</i>	17
<i>Maternity Benefit</i>	18
<i>Extended Care Facility Benefit</i>	18
<i>Emergency Expense Benefit</i>	18
ADDITIONAL ACCIDENT EXPENSE BENEFIT.....	19
WELL CHILD CARE.....	19
PEDIATRIC HEARING AID BENEFIT.....	19
PREFERRED PROVIDER ORGANIZATION.....	20
PRESCRIPTION DRUG BENEFIT.....	21
<i>Prescription Drug Copayment</i>	21
<i>Identification Card</i>	21
<i>Receiving a Prescription</i>	21
<i>Mail Order Option</i>	22
<i>Charges Not Covered</i>	22
HMO BENEFIT.....	23
ACTIVE EMPLOYEES/RETIREES NOT ELIGIBLE FOR MEDICARE.....	23
SUPPLEMENTAL MEDICARE BENEFIT.....	23
COVERED EXPENSES.....	23
ENROLLMENT.....	24
HOW TO FILE A CLAIM.....	24

DENTAL BENEFIT	24
WEEKLY ACCIDENT AND SICKNESS BENEFIT	25
GENERAL LIMITATIONS AND EXCLUSIONS	26
COORDINATION OF BENEFITS.....	28
MEDICARE COORDINATION	29
ACTIVE EMPLOYEES AND DEPENDENTS AT AGE 65	29
RETIRED DISABLED EMPLOYEES AND DEPENDENTS.....	29
RETIREES	29
SUBROGATION.....	29
CLAIMS PROCEDURES	30
OBTAINING AND COMPLETING CLAIMS FORMS.....	30
SEND ALL COMPLETED CLAIM FORMS TO THE ADMINISTRATOR	31
GENERAL RULES TO REMEMBER	31
HOW TO APPEAL A DENIAL OF CLAIM	32
INFORMATION OR CLAIMS FORMS	37
WHEN TO NOTIFY THE ADMINISTRATOR	37
GENERAL INFORMATION	38
BOARD OF TRUSTEES' DISCRETION	38
AMENDMENT OR TERMINATION OF PLAN.....	38
NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN.....	38
TYPE OF ADMINISTRATION OF THE PLAN	38
NAMES AND ADDRESSES OF THE TRUSTEES	38
LEGAL PROCESS	39
IRS PLAN IDENTIFICATION NUMBER.....	39
PLAN NUMBER	39
PLAN YEAR	39
FUNDING MEDIUM	40
SOURCE OF CONTRIBUTIONS	40
PLAN DOCUMENTS AND REPORTS	40
YOUR ERISA RIGHTS.....	40
APPENDIX A.....	42
SCHEDULE OF BENEFITS.....	42

APPENDIX B..... 46
 HOW MAJOR MEDICAL WORKS46

APPENDIX C 52
 SCHEDULE OF DENTAL PROCEDURES.....52

ELIGIBILITY

EMPLOYEES

Initial Eligibility

(Journeyman Classification)

You are eligible to participate in this Plan if you work for a contributing employer who is obligated by a Collective Bargaining Agreement to make contributions to the Plumbers and Steamfitters Local 486 Medical Plan or if your employer has made contributions on your behalf to a health and welfare plan that has a valid reciprocal agreement with the Plumbers And Steamfitters Local 486 Medical Plan.

In general, benefits begin on the first day of the month following the month in which a minimum of 1,000 hours has been received by the Plan on your behalf.

As a new Journeyman member of Plumbers and Steamfitters Local 486 (including Tradesmen and Servicemen under Schedule A of a National Agreement), you have the option to receive initial full coverage under the following terms and conditions:

- the only medical plan option available is the HMO option
- you must pay a monthly amount equal to the HMO premium charged to the Plan for the HMO option chosen;
- weekly accident and sickness benefits are excluded;
- you must work 250 hours per quarter to continue self-payment; and
- you acknowledge in writing that you understand that the cost of such coverage could increase.

(Helper Classification)

As a Helper member of Plumbers and Steamfitters Local 486, the following benefits are excluded from your coverage during the period for which you are covered as a Helper: HMO benefits, prescription drugs, dental benefits, weekly accident and sickness benefits. The Helper classification is a transitional classification intended to lead to apprenticeship status. Once a Helper meets the 1,000 hours requirement for eligibility and moves directly to an Apprentice status, then initial eligibility for Apprentice benefits need not be re-established.

(Apprentice Classification)

As an Apprentice member of Plumbers and Steamfitters Local 486, you receive full coverage from the first day of the month after you complete 250 hours of employment with a contributing employer, subject to the following terms and conditions:

- HMO, prescription drug, dental, and weekly accident and sickness benefits are excluded for First Year Apprentices
- You must continue to meet eligibility rules described below
- hours worked as a Tool and Material Handler do not count towards satisfaction of initial eligibility as an Apprentice.

(Newly Organized Employees)

Effective January 1, 2018, as a newly organized employee of an employer who participates in the Plan, you will receive full coverage from the first day of the month following the month in which contributions are first received from your employer on your behalf.

(New Non-Collectively Bargained Employees)

Effective January 1, 2018, as a new non-collectively bargained employee of an employer who participates in the Plan, you will receive full coverage from the first day of the month following the month in which contributions are first received from your employer on your behalf.

*Continuing Eligibility**

You and your dependents are eligible for coverage during a coverage quarter provided you work at least:

- 250 hours in the corresponding work quarter; or
- a total of 500 hours in the corresponding and previous work quarter; or
- a total of 750 hours in the corresponding and two preceding work quarters; or
- a total of 1,000 hours in the corresponding and three preceding work quarters.

The following chart shows the coverage quarter that corresponds with your work quarter:

<u>Work Quarter</u>	<u>Corresponding Coverage Quarter</u>
January - February - March	June - July - August
April - May - June	September - October - November
July - August - September	December - January - February
October - November - December	March - April - May

Example:

To be eligible for coverage during the months of June, July and August, you must work at least:

- 250 hours in the preceding January, February and March; or
- a total of 500 hours in the preceding October through March; or
- a total of 750 hours in the preceding July through March; or
- a total of 1,000 hours in the preceding April through March.

***NOTE: These rules apply to all collectively bargained employees. They also apply to non-collectively bargained employees who began participating in the Plan prior to January 1, 2018. For non-collectively bargained employees who began participation on or after January 1, 2018, eligibility continues for as long as the employer makes contributions for you pursuant to the terms of a valid participation agreement.**

Continued Eligibility While Disabled

If you become disabled while eligible for benefits under the Plan and have at least ten years of coverage under the Plan, your eligibility for coverage continues, subject to self-pay provisions, until the earlier of:

- the end of the 29-month period beginning on the date your disability began;
- the date your disability ends; or
- the date you become eligible for Medicare.

For the purposes of this section, disability must be certified by your treating doctor, as well as by a doctor selected by the Fund. In lieu of those certifications, if you have received an award of disability from the Social Security Administration, you will have satisfied the Fund's requirements for disability under this section.

The Trustees, in determining whether or not you are disabled, reserve the right to require you to submit to physical examination(s) at the Plan's expense by any physician selected by the Trustees.

When your eligibility under this section terminates, if you are eligible for Medicare, and you meet the other requirements for continued eligibility, your self-pay rates will be those available to Medicare-qualified participants. If you are not eligible for Medicare, you will be entitled to COBRA continuation coverage.

Termination of Eligibility

Your coverage under the Plan automatically terminates on the first day of the month following the date on which you cease to satisfy the eligibility requirements for employees as described in the section entitled "Continuing Eligibility" above.

Your coverage may be continued after this date, however, under the circumstances described in the sections entitled "CONTINUATION OF COVERAGE" on page 10 and "SELF-PAYMENT PROVISIONS" on page 9.

Reinstatement

If your eligibility for coverage ends, you again will be eligible for all benefits in the coverage quarter following completion of at least 250 hours in any calendar work quarter, or 500 hours in any two consecutive calendar work quarters, or 750 hours in any three work quarters, or 1,000 hours in any four consecutive work quarters. However, if you are out of coverage for a period of eight consecutive coverage quarters, you must again satisfy the initial eligibility rules unless you have not been working because of: (a) total disability, or (b) involuntary separation from the trade because of lack of work in the jurisdiction of Plumbers And Steamfitters Local 486, or (c) have been called to active duty in the Armed Services.

Reciprocal Agreements

When no reciprocal agreement is in effect under which contributions can be made to the Plan, time spent working in the jurisdiction of a sister local is not counted in determining the maximum time self-payments are allowed (eight consecutive coverage quarters).

Military Service

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter military service are entitled to COBRA continuation rights as described on page 12. If you return to employment covered by this Plan within the time frame specified under the law after discharge from military service, you and your dependents are covered from the first day contributions are made to the Plan on your behalf only if you were eligible for coverage prior to entrance into the Service.

If you enter military service before you are eligible for coverage, you are credited with hours of employment accumulated prior to military service upon resuming employment with a contributing employer.

DEPENDENTS

Initial Eligibility

Your eligible dependents are:

- your spouse;
- your children (including legally adopted children, stepchildren and eligible foster children) who have not attained age 26 and who are not eligible to enroll in an employer-sponsored health plan.
- your children who are incapable of self-sustaining employment by reason of mental or physical disability and who are chiefly dependent upon you for

support and maintenance on the date they reach age 26. Eligibility will continue if they become incapacitated prior to attaining the limiting age for dependent coverage under the Plan. Proof of incapacity must be furnished to the Trustees no later than 30 days after the date the child ceases to be covered under the Plan. The Trustees reserve the right to require proof of the uninterrupted continuance of incapacity. They also have the right, at their expense, to have any physician(s) examine a child when and as often as they may reasonably require during incapacity.

For your dependents to be eligible for coverage under the Plan, you must be an eligible employee. Coverage for your eligible dependents begins on the latest of:

- the effective date of the Plan;
- the date your coverage becomes effective; or
- the date you acquire the dependent.

In the case of marriage, however, coverage for your spouse begins on the first day of the month following the date of your marriage. You must notify the Board of Trustees within 30 days from the date you acquire a new dependent. You may obtain the proper forms from the Administrator.

Adopted Children

Coverage for an adopted child of an eligible employee will begin when the child is “placed,” determined in accordance with the law, not when the adoption becomes final. Please notify the Administrator if you intend to adopt a child to receive additional information on the procedures necessary to allow your child to be covered under the Plan.

Qualified Medical Child Support Orders

The law now provides that an “alternative recipient,” as defined below, under a “qualified medical child support order,” also defined below, must continue to receive medical coverage in compliance with a court order. A “**qualified medical child support order**” is a judgment or court decree that requires a group health plan to provide coverage to the children of a plan participant, under a state domestic relations law.

The term “**alternate recipient**” means any child of an employee who is recognized under a medical child support order as having a right to enrollment under a group health plan.

Termination of Eligibility

In general, coverage for your dependent ends when either you or your dependent loses eligibility for coverage. If you lose eligibility, your dependent’s coverage ends on the date you become ineligible for coverage. If your dependent ceases to be a dependent

as defined by the Plan, his or her coverage terminates on the first day of the month following the date he or she ceases to be an eligible dependent. When your dependent's coverage terminates, no expenses incurred after the date eligibility ceases are payable, even if the condition which required treatment began before the termination of coverage.

In the case of a child who is incapacitated due to a mental or physical disability, coverage automatically terminates on the earliest of:

- the end of such incapacity;
- the failure to provide required proof of the uninterrupted continuance of such incapacity or to submit to any required examination within 30 days after requested; or
- the termination of dependent coverage for reasons other than reaching the limiting age, as provided in the Plan.

There are exceptions to these rules for dependents who elect to self-pay pursuant to COBRA continuation coverage (see page 11).

Coverage after Death of Eligible Employee

If you die while covered under the Plan, your eligible dependents may continue coverage. The cost for this continued coverage is determined by the Trustees. However, coverage may terminate if your dependent loses his or her status as an eligible dependent under the Plan. If your spouse remarries, coverage terminates on the date of marriage.

Your dependents may be able to elect to self-pay for COBRA continuation coverage (see page 11) when coverage under this provision ends.

Waiver of Coverage

Eligible dependents may waive coverage but only if other health insurance coverage is available and the dependents choose to enroll in that coverage instead of in the Plan. If dependents waive coverage, they may re-enroll in this Plan at a later date without penalty, but only upon termination of (or loss of eligibility for) the other coverage.

Proof of Dependency

In cases where eligibility of a dependent cannot be determined by the Plan Administrator through standard enrollment procedures, you may be required to furnish additional proof of dependent status. Some examples of acceptable evidence are the following:

- a certified copy of the birth certificate;
- a certified copy of adoption papers;

- for incapacitated unmarried children age 26 or over, a statement by the dependent's physician certifying incapacity;
- marriage certificate.

RETIRED EMPLOYEES

Initial Eligibility

To be eligible for retiree benefits as stated in the Schedule of Benefits, as a collectively bargained employee who was not a participant in the U.A. Local 782 Pension Plan, you must be either:

- at least age 55, retired, have earned not less than 17 pension credits under any combination of the Steam and General Pipefitters Local 438 Pension Plan, the Plumbers and Gasfitters Local 48 Pension Plan, or the Plumbers and Steamfitters Local 486 Pension Plan in the 26 calendar years immediately preceding the effective date of your retirement under said plan, and covered under this Plan during the 6-month period immediately preceding your retirement; or
- eligible for a Disability Pension from the Plumbers and Gasfitters Local 48 Pension Plan, the Steam and General Pipefitters Local 438 Pension Plan, or the Plumbers and Steamfitters Local 486 Pension Plan and eligible for coverage in the quarter immediately preceding the date of your disability.

To be eligible for retiree benefits as stated in the Schedule of Benefits, as a non-collectively bargained employee or as a collectively-bargained employee who was a participant in the U.A. Local 782 Pension Plan, you must either meet the eligibility requirements for collectively bargained employees explained above, or you must be:

- at least age 55, retired, a participant in the Plumbers and Steamfitters Local 486 Medical Plan, and have at least 17 years of participation in the 26 calendar years immediately preceding your retirement, under any combination in the Steam and General Pipefitters Local 438 Medical Plan, the Plumbers and Gasfitters Local 48 Medical Plan, or the Plumbers and Steamfitters Local 486 Medical Plan, and covered under this Plan during the 6-month period immediately preceding your retirement.

For retiree coverage, you must apply in writing to the Trustees on forms available from the Administrator and make the required self-payments. Please note that the self-payment amount may be different depending on age and coverage under Medicare. Your application must be certified by the Administrator in accordance with the terms of the Trust Agreement.

Disabled Retirees

In order to be eligible for the disability self-pay rates, your disability must be certified by

your treating doctor, as well as by a doctor selected by the Fund. In lieu of those certifications, if you have received an award of disability from the Social Security Administration, you will have satisfied the Fund's requirements for disability under this section. Retirees who are eligible for retiree benefits under this section, and who have met the Plan's requirements for disability status, will be subject to those rules in the section entitled "Continued Eligibility While Disabled" on page 2.

Termination of Eligibility

Your eligibility for coverage as a retiree ends when you no longer are considered retired under the provision of the Plumbers and Gasfitters Local 48 Pension Plan or the Steam and General Pipefitters Local 438 Pension Plan, or the Plumbers and Steamfitters Local 486 Pension Plan, or when you fail to make required self-payment for retiree coverage, if earlier.

Waiver of Coverage

Eligible retirees and/or their dependents may waive coverage but only if other health insurance coverage is available and the retiree and/or dependents choose to enroll in that coverage instead of in the Plan. If retirees and/or their dependents waive coverage, they may re-enroll in this Plan at a later date without penalty, but only upon termination of (or loss of eligibility for) the other coverage.

Reinstatement

If you are retired and eligible for retiree benefits and return to covered employment, you become eligible for coverage as an active employee after meeting the initial eligibility rules for employees (see page 1).

Special Enrollment Rights

If while you are enrolled for COBRA Continuation Coverage you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Dependent for coverage for the balance of the period of COBRA Continuation Coverage by doing so within 30 days after the marriage, birth, adoption, or placement for adoption. Notice is to be provided to the Fund Office by using the Fund's Notice Form, available from the Fund Office.

You may add a new spouse or child to your COBRA Continuation Coverage. However, the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to extend a COBRA Continuation Coverage period in certain circumstances, are children born to, adopted, or placed for adoption with the Employee.

If while you are enrolled for COBRA Continuation Coverage, your dependent(s) lose coverage under another group health plan, you may enroll that Dependent for coverage for the balance of the period of COBRA Continuation Coverage by doing so within 30 days after the termination of the other coverage. Notice is to be provided to the Fund Office by using the Fund's Notice Form, available from the Fund Office.

In order to be eligible for this special enrollment right, the dependent must have been eligible for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the dependent must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to loss of eligibility under another plan, including, but not limited to, termination of employment, termination of employer contributions or exhaustion of COBRA Continuation Coverage under another plan. Loss of eligibility does not include a loss of coverage due to failure of the individual or participant to pay premiums on a timely basis or termination of employment for cause. **Adding a dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.**

The Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (“FMLA”) requires participating employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee’s child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the FLMA, your participating employer is required to maintain pre-existing coverage under the Plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12 week FMLA leave entitlement, or do not intend to return from leave. Your coverage will also cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described in the previous section.

The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA. If you fail to return from FMLA for impermissible reasons, the Fund may offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of benefits paid on your behalf during the period of FMLA leave.

Right to Receive a Certificate of Health Coverage

If your health care coverage stops, you and your covered dependents will receive a certificate that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage. To obtain a certificate, please contact the Fund Office.

SELF-PAYMENT PROVISIONS

PARTICIPATION

To participate in the Plan under the self-payment provisions, you must have been eligible as a covered employee in the quarter prior to the self-payment quarter and you must be readily available to work in the jurisdiction of Plumbers and Steamfitters Local 486. Non-collectively bargained employees who began participation on or after January 1, 2018 do not have a right of self-payment under this Plan.

ELIGIBILITY

If you are about to lose your eligibility for benefits, you may retain your eligibility (and that of your dependents) by contributing directly to the Plan. In general, you may not self-pay to obtain coverage in more than eight consecutive quarters.

SELF-PAYMENT

The amount of the self-payment is established by the Trustees and may be changed from time to time. You may obtain information about the self-payment from the Administrator. Your self-payment must be received by the Administrator by the 25th of the month following the close of the work quarters.

TERMINATION OF SELF-PAYMENT

If you are eligible to make the required self-payment contribution and fail to do so within the specified time, you lose your eligibility immediately. To become re-eligible, you must again meet the requirements set forth under the section entitled "Reinstatement" (see page 3).

RECIPROCAL AGREEMENTS

When no reciprocal agreement is in effect under which contributions can be made to the Plan, time spent working in the jurisdiction of a sister local is not counted in determining the maximum time self-payments are allowed (eight consecutive coverage quarters).

CONTINUATION OF COVERAGE (COBRA)

You and your dependents may be able to continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called “**COBRA continuation coverage**,” named for the law that sets forth the rules for it. COBRA continuation coverage is identical to the health care coverage provided under this Plan and is available to you and your dependents. However, it does not include weekly accident and sickness benefits. You must pay the premium for this coverage, not to exceed 102% of the group rate, as determined by the Consultant. In the event the covered person is determined to be disabled for Social Security purposes, the cost shall not exceed 150% of the group rate.

MAXIMUM PERIOD OF COVERAGE

As a covered employee, you have the right to continue coverage for yourself and your spouse and dependent children for 18 months if it otherwise would end because of the following:

- you leave covered employment for reasons other than gross misconduct on your part; or
- your hours of employment are reduced.

If you do not elect COBRA continuation coverage for your spouse or dependent children, they may do so for themselves.

If you lose coverage for any one of the above reasons and you and/or one of your family members becomes totally disabled (as determined by Social Security) at any time during the first 60 days of the continuation coverage, you have the right to continue coverage for the disabled individual(s) for a maximum of 29 months. This extension only applies if you notify the Plan within 60 days of the determination by Social Security and before the 18-month maximum coverage period expires. This special 11-month extension does not apply to non-disabled family members.

Your spouse and dependent children also may continue health care coverage for themselves for 36 months if their health coverage otherwise would end as a result of:

- your death;
- your divorce or legal separation;
- your becoming entitled to (that is covered by) Medicare;
- for a dependent child, no longer qualifying as a dependent under this Plan; or
- your employer filing for reorganization under Chapter 11 of the Bankruptcy Code.

Even if two or more of the events just described occur, the maximum period of COBRA continuation coverage for your spouse and dependent children is 36 months.

Note: If you were enrolled in Medicare prior to your termination of employment or reduction in hours, your dependents may be eligible to continue coverage for up to 36 months after the date on which you become entitled to Medicare, or 18 months (29 months if there is a disability extension) from the date your coverage ceased, whichever is later.

COORDINATION OF SELF-PAYMENT RULES AND COBRA CONTINUATION

The calculation of the maximum period of coverage for COBRA includes any period of self-payment; for example, if you choose to self-pay for twenty-four consecutive months, COBRA does not begin after self-payment stops. Any period of self-payment counts towards the maximum continuation period under COBRA. In fact, in this example, the twenty-four months of self-payment fully satisfies the COBRA requirements and coverage would cease. Any self-payments on behalf of (or by) dependents also count towards the maximum period of COBRA continuation for such dependents.

NOTIFICATION REQUIREMENTS

You or your dependent must inform the Administrator in writing of a divorce, legal separation or loss of dependent status of a child within 60 days after the event occurs. Your employer must notify the Administrator of your death, termination of employment or reduction in hours within 30 days after such event occurs.

Within 14 days of receipt of notice that a qualifying event has occurred, the Administrator will notify you and any eligible dependents, including those not living with you (whose address is known to the Administrator), of the right to elect COBRA continuation coverage. The Administrator also will provide instructions about how to elect and pay for COBRA continuation coverage.

ELECTION OF CONTINUATION COVERAGE

To elect COBRA continuation coverage, you must complete an election form (provided by the Administrator) and submit it to the Administrator within 60 days of the later of

the date coverage would be lost as a result of the event or the date of the notice sent to you by the Administrator of your right to elect COBRA continuation coverage.

PAYMENT OF CONTINUATION COVERAGE

Timely payment of the initial premium is 45 days after the election is made, and every 30 days after that.

TERMINATION OF CONTINUATION COVERAGE

Your COBRA continuation coverage may terminate earlier than the maximum period described if:

- all health care coverage offered by the Plan terminates;
- the required premium is not paid on time;
- for each person, he or she becomes covered by another group plan (after the date of election) that does not contain any exclusion or limitation with respect to any pre-existing condition (or the exclusion or limitation does not apply to, or would be satisfied by, the covered person because of HIPAA rules);
- for each person, he or she becomes entitled to Medicare; or
- an individual who receives extended coverage for 29 months due to disability has been determined for Social Security purposes to be no longer disabled.

Once COBRA continuation coverage terminates, it cannot be reinstated.

CONTINUATION OF COVERAGE FOR ELIGIBLE MILITARY LEAVE

You will be eligible for up to 24 months of continuation coverage under the Uniformed Service Employment and Reemployment Rights Act (USERRA) if you are called to active military duty while you are eligible for coverage from this Fund. You are required to notify the Administrator when you are called to military service, and if you are eligible, you will receive an election form from the Fund, as required by law.

All of the cost, payment, election and other procedures that apply to COBRA coverage as described in this Section shall apply to continuation of coverage for military leave. The only difference is that you are eligible for 24 months of continuation coverage, rather than 18 months, as provided for traditional COBRA coverage.

MAJOR MEDICAL EXPENSE BENEFIT

Coverage under the Major Medical Expense Benefit provides substantial coverage for injuries or illnesses that involve hospital, surgical or medical expenses. The Plan reimburses you for “covered medical expenses” incurred during a calendar year in an amount equal to 80% of the amount which exceeds the “Major Medical Expense Deductible” up to \$2,500; and 100% thereafter. This means you will pay 20% of the eligible expenses (after the deductible) up to \$500 per year. There is also a family maximum on the coinsurance amount (the 20% you pay) which is twice the individual amount, or \$1,000 per family per year. The most you will have to pay for these benefits in a calendar year, for the deductible and coinsurance combined (other than amounts over the usual, customary and reasonable limits or expenses which are not eligible), is \$600 for an individual and \$1,200 for a family.. Note that if a participant receives payment under the Major Medical portion of the Plan, an amount equal to such payment, but not to exceed \$1,000, is automatically restored to the participant’s lifetime benefit on January 1st each year. No lifetime maximum will apply with regard to “essential benefits,” as set forth in the Patient Protection and Affordable Care Act (“PPACA”). In the absence of regulations defining said essential benefits, the determination of what is an essential benefit shall be based upon the Trustees’ good faith interpretation of PPACA.

For examples of how Major Medical Expense Benefits work, see Appendix C.

MAJOR MEDICAL EXPENSE DEDUCTIBLE

The “**Major Medical Expense Deductible**” is the amount of charges incurred for “covered medical expenses” which you must pay before the Plan pays any benefits. The Major Medical Expense Deductible must be satisfied each calendar year. The Major Medical Expense Deductible for each eligible person is \$100. However, there is a \$200 maximum family deductible. It works this way: when the total covered medical expenses for all family members combined (but not counting expenses above \$100 for any individual) equals \$200, the deductible is considered satisfied by all family members. Furthermore, covered medical expenses incurred during the last three months of a calendar year and used to satisfy that year’s Major Medical Expense Deductible are applied towards the Major Medical Expense Deductible for the following year. Additionally, if two or more covered individuals who are members of the same family sustain bodily injuries in the same accident, a single \$100 deductible requirement is applicable to all the individuals for the total “covered medical expenses” incurred as a result of that accident.

COVERED MEDICAL EXPENSES

“**Covered Medical Expenses**” are the usual, customary and reasonable charges for services and supplies that are rendered or prescribed by a legally qualified physician, surgeon or licensed chiropractor. A charge is usual, customary and reasonable if the level charged does not exceed the fees a physician charges most of his or her patients for a similar service, and if the level is within the range of fees charged by physicians with similar training and experience for the same or similar services within the locality. Also taken into account are your condition and any additional time or skills needed by your physician to treat you. The decision of whether a charge is usual, customary and reasonable is made by the Trustees, and is conclusive and binding.

Covered Medical Expenses include the following charges:

- hospital room and board up to the average semi-private rate or special care unit charges, if required, and any necessary hospital services furnished by the hospital;
- the usual, customary and reasonable fees of a physician or surgeon for diagnosis, treatment and surgery;
- licensed registered nursing fees for private duty nursing services, fees of licensed practical nurses for private duty nursing services rendered in a hospital to a registered bed patient;
- fees for treatment by a licensed physiotherapist other than a nurse or physiotherapist who ordinarily resides in the same household with you or who is related by blood, marriage, or legal adoption to you or your spouse;
- fees of a licensed physical, speech or occupational therapist if therapy is prescribed by a legally qualified physician; limit of fifty (50) combined therapy visits per person per calendar year;
- diagnostic x-rays and laboratory examinations;
- X-ray, radium and radioactive therapy and administration of chemotherapy;
- blood and other fluids to be injected;
- casts, splints, trusses, braces, artificial limbs and crutches and surgical dressings, rental of hospital-type equipment, including wheelchair, hospital bed, and other mechanical equipment for the treatment of respiratory paralysis and equipment for the administration of oxygen;
- anesthesia and oxygen;
- professional ambulance service when used to transport an individual from the place where he or she is injured in an accident or stricken by an illness to the first hospital where treatment is given;
- room and board for confinement in an extended care facility subject to the conditions, limitations and definitions outlined in the section dealing with the “**Extended Care Facility Expense Benefit**” (see page 18); and
- hospital and other medical services rendered while confined in a hospital in

connection with necessary dental work for the repair of natural teeth or other body tissues and required as a result of a non-occupational accidental bodily injury occurring while the individual is covered. Such covered dental expenses must be incurred within 90 days of the accident;

- treatment or diagnosis of psychiatric (mental health) conditions; and
- treatment of substance abuse.

ADDITIONAL INFORMATION REGARDING COVERED MEDICAL EXPENSES

Hospital Room and Board

The Plan pays for hospital charges for semi-private room and board accommodations. Successive hospital confinements will be considered one confinement unless (1) they are due to entirely unrelated causes or (2) the individual has completely recovered from the illness or injury causing the first confinement before the second confinement begins; but the two confinements will be considered one if they are separated by less than 90 days.

Room and board charges include any charges for other hospital services, such as general nursing services, which are made by the hospital as a result of confinement or on a regular daily or weekly basis.

Hospital Miscellaneous Expenses

The Plan provides benefits for necessary hospital charges to the extent usual, customary and reasonable, in addition to charges for room and board.

Hospital charges for an operating room, anesthesia, X-ray examinations in hospital (excluding X-ray of teeth), laboratory analysis, drugs, medication, dressings and blood transfusions are covered. A hospital must charge for room and board, however, for hospital miscellaneous expenses to be covered by the Plan. If the only charges are for surgical operation or for emergency treatment of a non-occupational accident within 48 hours of the accident, a room and board charge is not required.

To be recognized as a "hospital" for Plan purposes, an institution regularly must keep patients overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24-hour nursing service by registered, graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, and places of rest for the aged, drug-addicts or alcoholics do not qualify as hospitals.

Hospital Pre-Certification Program

The Hospital Pre-Certification Program requires that you call the service provider chosen by the Trustee prior to any elective, non-emergency hospital admission. For emergency admissions, you must notify such service provider within 48 hours of

admission. The Plan reserves the right to deny coverage for any admissions (or portions of admissions) which are determined to be unnecessary.

Inpatient Substance Abuse Treatment

Effective April 1, 2018, inpatient substance abuse treatment will only be a covered expense if provided by a facility that participates in the Preferred Provider Organization.

Effective September 1, 2011, Conifer Health Solutions is the utilization management provider for pre-certification of hospital admissions. You will contact Conifer Health Solutions at (866) 308-7335 to pre-certify all non-emergency hospital stays and within 48 hours after an emergency admission. You must certify all hospital stays in order for the Fund to pay any benefits.

Call Conifer Health Solutions at (866) 308-7335 to certify the following procedures:

- All elective (non-emergency) hospital admissions
- All inpatient rehabilitation care
- All inpatient care in an Extended Care Facility
- Within 48 hours of emergency admission to a hospital

Physician Visits

The Plan pays usual, customary and reasonable charges for physician's visits. The benefit payment begins with the first treatment in connection with an accident, for an illness that requires hospital confinement, or for illnesses not requiring hospital confinement.

In addition to the General Limitations and Exclusions on page 26, benefits for physician's visits are not payable for:

- more than one treatment on any one day;
- any treatment which is not personally rendered by or prescribed by a physician or surgeon;
- treatment received on the day of any surgical operation or during convalescence from surgery if payment is made for such operation under the Surgical Expense Benefit (benefits are not payable for dentistry); and

"Physician" means a person licensed to practice medicine and surgery acting within the scope of his or her practice. Also, a "physician" may be a licensed chiropractor in the administration of physical therapy.

Surgical Expense Benefit

The Plan pays the usual, customary and reasonable charge for surgical procedures, whether a surgical procedure is performed in a hospital, doctor's office or elsewhere, but the procedure must be performed by a legally qualified physician while coverage is in force.

Multiple Surgical Procedures

When two or more surgical procedures are performed during the same operation through the same incision or in the same operative area, they are considered one

procedure and the maximum benefit payable is the largest of the benefits payable for the individual procedures. If multiple or bilateral procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total payment available shall be the amount payable for the procedure for which the largest amount is payable plus fifty percent (50%) of the amount payable for the procedure for which the smaller amount is payable.

Reconstructive Breast Surgery

As specified in the Women's Health and Cancer Rights Act of 1998, an eligible participant who elects breast reconstruction in connection with a mastectomy also will be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Definition of Surgical Procedure

The term "**surgical procedure**" means any procedure listed in the Schedule of Procedures and any of the following:

- the incision, excision, or electrocauterization of any organ or part of the body;
- the manipulative reduction of a fracture or dislocation;
- the suturing of a wound; and
- the removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter.

Diagnostic X-ray and Laboratory Expense Benefit

The Plan pays usual, customary and reasonable charges for expenses incurred for X-ray or laboratory examinations for diagnosis of an illness. Mammograms are a covered expense as part of the diagnostic x-ray benefits.

Charges Not Covered

In addition to the General Limitations and Exclusions on page 26, benefits are not payable for:

- dental x-rays, except in the case of an accidental bodily injury (see below);
- examinations that are not recommended or approved by a legally qualified physician or surgeon;
- eye examinations.

Maternity Benefit

Maternity benefits are provided to the eligible dependent spouse of an eligible active or retired employee as well as to the active or retired employee. This includes prenatal

coverage as well as labor and delivery charges. Prenatal benefits and related preventative care are provided to eligible dependent children of an eligible active or retired employee as well as to the active or retired employee. Labor and delivery benefits for pregnancies of dependent children are not provided by the Plan. All hospital charges for room and board and miscellaneous services are covered the same as for any other illness. The fee charged by the physician for any obstetrical procedures is reimbursed up to the amount shown in the Schedule of Benefits.

Extended Care Facility Benefit

The plan provides benefits for charges incurred for room and board and routine nursing services for confinement in an extended care facility. The confinement must begin within 14 days following a hospital confinement that lasts at least three consecutive days.

Such a facility shall be considered a “**hospital**” for the purposes of this Plan if it is an institution duly licensed to keep patients overnight and regularly provides 24-hour skilled nursing care by a licensed nurse under the direction of a registered nurse or physician. The institution must keep full medical records on their patients and, if part of the institution meets this definition, that part will be considered an eligible institution. Further, the institution must provide a review committee as outlined under the appropriate provisions of the Social Security Act effective July 1, 1973. Institutions which provide solely custodial care or institutions such as clinics, nursing homes, places for the rest for the aged, drug addicts or alcoholics do not qualify as extended care facilities.

Emergency Expense Benefit

The Plan pays usual, customary and reasonable charges for expenses incurred as a result of emergency illness providing the expenses are incurred within 12 hours of the onset of the illness.

Please be advised that reimbursements for services rendered in a hospital emergency room are limited to those directly related to emergency care. There will be no reimbursement for routine services obtained in a hospital emergency room.

Emergency care is defined as “a condition which poses a serious threat to the well being of the patient if not treated immediately.”

Examples of conditions which would be classified as emergency care include, but are not limited to:

Heart Attacks	Severe Hemorrhage
Unexplained Fainting	Poisonings
Acute Allergic Reactions	Respiratory Distress
Convulsions	Diabetic Coma

Visits for colds, flu, childhood diseases and nausea would not be considered emergency care within the intent of the Plan.

.WELL CHILD CARE

Well Child Care will be covered through age 6. Well Child Care will be covered at 100% according to the recommended office visits and immunizations as listed below. The recommended schedule of well child care that was approved by the Trustees was established by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics.

Age	Procedure	Immunization
Initial Visit	Heredity and metabolic screening for disorders of the thyroid, PKU (a metabolic digestive disorder), and galactosemia (a form of diabetes)	
2 months	Physical exam to include measurement of height, weight, check of vision and hearing, measurement of head circumference	DTP (diphtheria, tetanus, pertussis), polio, and HBCV (Haemophilus B conjugate vaccine)
4 months	Physical exam to include measurement of height, weight, check of vision and hearing, measurement of head circumference	DTP, polio, HBCV
6 months	Physical exam to include measurement of height, weight, check of vision and hearing, measurement of head circumference, urinalysis	DTP, HBCV
9 months	Physical exam to include measurement of height, weight, check of vision and hearing, measurement of head circumference, hematocrit or hemoglobin tests	
12 months	Physical exam to include measurement of height, weight, check of vision and hearing, measurement of head circumference, tuberculin test	
15 months	Physical exam to include measurement of height, weight, check of vision and hearing	DTP, polio, MMR (measles, mumps rubella), HBCV booster
18 months	Physical exam to include measurement of height, weight, check of vision and hearing	
Age 2	Physical exam to include measurement of height, weight, check of vision and hearing, urinalysis, hematocrit or hemoglobin tests, tuberculin tests	

Age 3	Physical exam to include measurement of height, weight, check of vision and hearing, blood pressure, initial dental referral	
Age 4	Physical exam to include measurement of height, weight, check of vision and hearing, blood pressure	Ages 4-6 years [DTP booster, polio booster, measles (second dose)]
Age 5	Physical exam to include measurement of height, weight, check of vision and hearing, blood pressure	
Age 6	Physical exam to include measurement of height, weight, check of vision and hearing, blood pressure	

PEDIATRIC HEARING AID BENEFIT

The Plan provides coverage for hearing aids for a minor child (age 21 or younger) if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. The amount of the benefit is \$1,400 per hearing aid for each hearing-impaired ear every 36 months.

PREFERRED PROVIDER ORGANIZATION

The Plan participates in a “Preferred Provider Organization” (PPO). A PPO is a group of select physicians, specialists, hospitals, and other treatment centers which have agreed to provide their services to Plan participants for a discount. A PPO can be used for routine or emergency medical problems. It is not mandatory, so you do not need to change your doctor or the hospital you use, even if the doctor or hospital does not participate in the PPO program. However, if you use the PPO, both you and the Plan will save money, as explained below.

By using the PPO, there are considerable savings for both you and the Plan. The PPO has special arrangements with health care providers, such as doctors and hospitals, to discount substantially their normal fees. Because you usually pay a percentage of billed charges, this will result in your paying a percentage of a smaller amount. Use of a PPO physician or hospital for medical benefits means a direct **out-of-pocket** cost savings to you.

Of course, the Plan’s costs are reduced as well, which means that your contribution dollars will be used more efficiently.

Check to see if your current physician already participates. In fact, there is a good possibility that you are already using a PPO physician. New physicians are being added weekly so if you do not find your physician listed, call the number of the PPO which is on your ID card.

Your identification card verifies your participation in the PPO. When you go to a participating hospital or physician, identify yourself as a PPO participant by presenting the ID card. You then complete and sign the claim form as usual.

The hospital or physician will submit your claim directly to the PPO which will discount the bill and forward it to the Administrator for payment.

You should let your current physician know that the Plan is participating in the PPO.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Copayment

The Prescription Drug Benefit is available to all eligible participants who do not choose an HMO for medications that are prescribed by a doctor and bear the label "Caution, Federal Law Prohibits Dispensing Without A Prescription." You must pay a copayment per prescription or refill (see the Schedule of Benefits).

Identification Card

Once you become eligible for prescription drug benefits, the Administrator will send you a plastic identification card. If a participating pharmacy is not available in your area, you may pay for the prescription and submit the charges to the Administrator for payment. Your ID card is very important to you. It should be used only by a person covered by the program. The unauthorized or fraudulent use of this card to obtain prescription drugs results in cancellation of this benefit.

Receiving A Prescription

Follow these simple steps to receive a prescription under the program:

- Present your ID card to the pharmacist along with the prescription to be filled. The pharmacist has the forms necessary to provide you with your prescription benefit. Your pharmacist will ask you the age and relationship to the patient and will require the person picking up the prescription to sign the claim form. Your card covers all the eligible members of your family.
- Pay only the copay, which depends on whether the drug is a brand-name or generic drug (see the Schedule of Benefits). The plan pays any additional cost.

Formulary and Non-Formulary Drugs

Optum Rx (the Plan's Pharmacy Benefit Manager) maintains a Formulary Drug List, which is a list of preferred prescription medications that are selected based on their quality and overall cost. This list contains medications that are chemically and therapeutically equivalent and have the same medical effect as other more expensive drugs. Drugs that are not on this list are considered "Non-Formulary" drugs. In addition, effective February 1, 2018, certain

medications are excluded from coverage altogether. There will, however, always be alternative, covered medications to treat your condition.

Mail Order Option

If you take maintenance prescriptions you must have the prescription filled by mail. With mandatory mail order for maintenance medications, you receive a larger supply (usually 90 days) for the same copayment you would have paid at the pharmacy (see the Schedule of Benefits).

The Administrator will provide you with the form you need to complete to receive prescriptions through the mail. You simply need to complete the form and send it with payment (using check or credit card) to the prescription vendor. For new prescriptions, you can even have your doctor send the information by fax.

Opioid Management Program

Effective February 1, 2018 Optum Rx is implementing an Opioid Management Program. This program is a comprehensive solution that uses evidence-based clinical rules to help prevent opioid misuse, identify and intervene with at-risk and high-risk members, and support those with dependency through successful recovery. The program has the following components:

- Minimizing early exposure: since opioid dependence can start in just a few days, it's important to stop opioid abuse before it starts. The program limits the dose and duration of the first fill for a new prescription. The limits are aligned with the Centers for Disease Control and Prevention (CDC) prescribing guidelines.
- Reducing inappropriate supply: the program reviews ongoing usage of opioid medications by chronic users to ensure safe fill limits and to monitor proper dosing. This part of the program also follows CDC guidelines. Optum Rx will monitor opioid prescriptions to prevent unnecessary refills and screen for medications that may cause overdoses or serious side effects when combined with other medications.
- Treating at-risk and high-risk members: Optum Rx clinical pharmacists will work with members to provide intensive case management which includes consultations with prescribing physicians to prevent abuse and misuse and ensure the most appropriate treatment regimen.
- Supporting chronic populations and recovery: Optum Rx will review prescriptions treatment guidelines are followed. This may include blocking opioid claims, and monitoring claims for opioid prescription "shopping" through multiple prescribing physicians or pharmacies.

Charges Not Covered

Prescription Drug benefits are not payable for:

- any non-legend drug, except insulin;
- vitamins, minerals, dietary supplements, cosmetics or beauty aids;
- any medication which is to be taken by or administered while you or your dependent is confined in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- more than a 34-day supply unless specifically authorized by a physician;
- any drug labeled "Caution - Limited by Federal Law to Investigational Use" or experimental drugs whether or not a charge is made to the patient
- injectible drugs, with the following exceptions:
 - Methotrexate
 - Enbrel, for the treatment of rheumatoid arthritis
 - Testosterone Enanthate (on a case by case basis only) for the treatment of sexual dysfunction
 - Lupron Depot (on a case by case basis only) for the treatment of fibroids
 - Rebetrone, to treat Hepatitis C
 - Avonex, for the treatment of multiple sclerosis
 - Humira

HMO BENEFIT

ACTIVE EMPLOYEES/RETIREES NOT ELIGIBLE FOR MEDICARE

The Plan offers alternative health care coverage through one or more Health Maintenance Organizations (HMO). This coverage may be elected instead of the Major Medical and Prescription Drug Benefits previously described in this booklet. The HMO plans available all include a Prescription Drug Benefit as part of the HMO coverage.

There are several advantages to receiving health care through an HMO. You and your dependents can receive complete care through one plan. This care includes preventive care such as annual checkups. Also, HMO coverage generally results in lower out-of-pocket expenses. Finally, a simplified claim filing procedure has been established for this coverage that does not involve the Administrator.

During the month of November each year, you have the opportunity to elect HMO coverage for yourself and your eligible dependents to be effective on January 1. This is called "**open enrollment.**" New employees will have the opportunity to elect HMO coverage when they become eligible under the rules of this Plan. For more information regarding open enrollment and HMO coverage, contact the Administrator.

Remember - if you choose an HMO, this takes the place of the Basic, Major Medical, and Prescription Benefits described previously. The Weekly Accident and Sickness Benefit is

a separate benefit available to eligible employees regardless of the choice made for medical coverage.

SUPPLEMENTAL MEDICARE BENEFIT

COVERED EXPENSES

The Supplemental Medicare Benefit extends your Medicare benefits and provides you and your eligible dependents with additional coverage.

Upon receipt of due proof that any participant eligible for Medicare has incurred charges for a covered medical expense, as defined under Medicare, the Plan will pay, subject to the exclusions as defined under Medicare, the benefits described below up to the maximum benefit indicated:

- the deductible of eligible hospital charges incurred during the first 60 days of confinement;
- the deductible of eligible hospital charges incurred daily during the 61st through 90th day of confinement;
- the deductible of eligible hospital charges incurred after 90 days of confinement and during the “lifetime reserve” of 60 additional days of hospital benefit;
- the deductible of eligible hospital charges from the 21st through 100th day of confinement in a participating skilled nursing facility; and
- the deductible of eligible charges for physician’s services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, speech pathology and other health care services and 20% of the Medicare approved charges for such services following the initial deductible charges.

ENROLLMENT

Medicare coverage includes hospital insurance benefits (called Part “A”) and supplementary medical insurance (called Part “B”). All active employees and retirees over age 65 and their spouses over age 65 and all disability retirees must enroll and maintain enrollment in the hospital and voluntary medical insurance programs of Medicare. You should enroll as soon as possible, because you are considered by the Plan to be insured under Part A (Hospitalization) and Part B (Voluntary Medical) of Medicare whether or not you have actually enrolled in either.

HOW TO FILE A CLAIM

It is your responsibility to provide the Administrator with Medicare statements showing claims paid by Medicare when you incur charges for Medicare premiums. Please consult the Administrator for additional information.

DENTAL BENEFIT

Dental benefits are available for all eligible participants (regardless of the medical plan chosen). The Administrator has made special arrangements with a number of dentists to participate in the Plan. These dentists have agreed to substantially reduce their normal fees. This arrangement works much like the PPO for the self-insured medical plan. Using dentists on the list (which can be obtained from the Administrator) can save you money. A list of dental procedures is included in Appendix E. The list includes many common procedures, but is not intended to be all-encompassing; benefits may be available for procedures not shown on the list. For each procedure, you will see two numbers. The column "Negotiated Fee" shows the reduced fee the dentist has agreed to accept as full payment for that service. The column "Plan Payment" shows the amount the Plan will pay towards that fee. For most services, the Plan pays 100% of the negotiated fee. For some of the more expensive services, the plan pays 50% and you will be responsible for paying the dentist the difference.

Two situations may cause you to have to pay an amount in addition to the difference between the negotiated fee and the plan payment. Some dentists who participate in the program charge copayment amounts over and above the negotiated fee for items such as dentures, root canals, crowns and pontics. You will be responsible for the difference. Dentists who are not on the list will likely charge an amount over and above the negotiated fee for all procedures, and you are responsible for that difference.

Since the discount negotiated by the Plan is significant, the amount above the negotiated fee you would have to pay to a dentist not on the list could be substantial. So make sure you consult the list of participating dentists and use them whenever possible.

For each eligible participant, there is a calendar year maximum dental benefit of \$1,250. However, to the extent that dental benefits for dependents under age 19 are considered to be pediatric oral care, this limitation shall not apply to pediatric oral care. Once the plan has paid \$1,250 in benefits for an individual in a calendar year, no further benefit is available under the dental provisions. Additional expenses not paid under the dental benefit are not eligible Major Medical expenses, but may be submitted to the Flexible Spending Account if available. There is a separate lifetime maximum for orthodontic benefits of \$1,500 per person (the \$1,250 annual limit does not apply to orthodontia). Dental benefits are NOT provided for:

- Treatment excluded under General Exclusions or by any other limitation in this booklet
- Dentures, bridges and crowns delivered more than 60 days after your coverage ends or ordered before your coverage begins
- Replacing lost or stolen dentures, bridges or crowns
- Professional fees to someone who is not a licensed dentist
- Replacements of dentures, bridges or crowns more than once every two years
- Engraving of dentures or cosmetic work

WEEKLY ACCIDENT AND SICKNESS BENEFIT

The Plan provides a Weekly Accident and Sickness Benefit to eligible employees, even if you are self-paying, while you are disabled and prevented from working because of a non-occupational sickness or injury. However, if you are self-paying, you must have been employed in covered employment for the five days prior to the disability.

The amount of the Weekly Accident and Sickness Benefit is shown in the Schedule of Benefits (see Appendix A). This benefit begins on the first day of disability resulting from an accident. For disability resulting from an illness requiring hospital confinement, the weekly benefit begins on the first day of such an illness. However, benefits begin on the eighth day of an illness that does not require hospitalization.

Benefits are payable for a maximum of 26 weeks for any one disability. Successive periods of disability that are separated by less than two weeks of continuous active employment are considered one continuous period of disability unless arising from different and unrelated causes.

Claims Procedure

To claim a benefit from the Fund, you must:

- Obtain a Weekly Accident and Sickness Claim Form from the Fund Office.
- Complete the Participant Section of the form and sign.
- Have your Physician complete the Doctor's Statement Section in full and sign.
- Claim Form must be completed in full or the form will be returned for completion.
- Mail the completed claim form to:

Plumbers & Steamfitters Local 486 Medical Fund
P.O. Box 1064
Sparks, MD 21152-1064

Claims must be received by the Fund Office within 24 months from the date your disability began.

GENERAL LIMITATIONS AND EXCLUSIONS

The following charges are not covered under this Plan; therefore, the amount of benefits payable under the Plan is determined after these charges are deducted from covered expenses:

- charges incurred while not covered under this Plan;
- charges that would not have been made if coverage did not exist;
- charges that you or your dependents are not required to pay;
- charges for services or supplies which are furnished, paid or otherwise provided for by reason of the past or present service of any person in the armed forces unless otherwise required by law;
- charges for nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of your family or your spouse's family;
- charges for services or supplies which are paid for or otherwise provided for under any laws of a government unless required by federal law;
- charges for services or supplies which are not medically necessary for treatment of an injury or illness or are not provided or prescribed by a legally-qualified surgeon, physician or licensed chiropractor;
- charges to the extent that they are not usual, customary and reasonable;
- charges for an injury or illness covered by workers' compensation laws;
- charges for the purchase or fitting of a hearing aid for adults and dependent children over age 21;
- charges for hearing examinations
- charges for blood plasma;
- charges by an intern of a hospital;
- charges for transportation or travel unless explicitly mentioned in this SPD;
- vision care for adults and dependent children over age 21;
- medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury;
- charges for custodial care; charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;
- charges for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;
- charges resulting from the labor and delivery resulting from a pregnancy incurred by a dependent child ;
- charges incurred as a result of war, declared or undeclared, including armed aggression;

- cosmetic procedures and associated expenses;
- the services of private duty registered and licensed practical nurses, unless medically necessary;
- physical or psychiatric examinations or psychological testing for purposes of obtaining or maintaining employment, licensure, legal proceeding, registration or insurance, or conducted for purposes of medical research. Physical examinations for camp, school, sport, or other similar activities;
- any elective surgical procedure including all associated expenses, intended primarily for treatment of morbid obesity, with the exception of minimally invasive gastric bypass surgery deemed medically necessary;
- any surgical procedure, including all associated health services, for the reversal of voluntary sterilization;
- services related to sex transformations or sexual dysfunction inadequacies unless medically necessary;
- in-vitro fertilization and embryo transplants; and
- charges for services or supplies for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ) and any related disorders or procedures regardless of medical necessity.

The term “custodial care” means services and supplies, including room and board and other institutional services, primarily to assist a person in the activities of daily living - whether or not he or she is disabled. However, room and board and skilled nursing care for a person in a hospital are not considered custodial care if they must be combined with therapeutic services needed to improve his or her medical condition.

The Plan only covers treatments, services or supplies that are necessary, reasonable and recommended or approved by the attending physician.

COORDINATION OF BENEFITS

The benefits payable to you under this Plan are coordinated with benefits payable to you or your covered dependents from “other benefit plans” for the same expenses. It is intended to permit full payment of actual allowable expenses without duplication of benefits.

Coordination means that benefits payable from this Plan and from other benefit plans can equal but not exceed 100% of “allowable expenses.” It also determines the priority of payment between or among different plans.

The term “**allowable expenses**” means the usual, customary and reasonable charges for necessary services and supplies that are covered in full or in part under this Plan or any other plan under which the person making the claim is covered.

The term “**other benefit plans**” means any group health plan or policy (insured or self-insured) such as your spouse’s employer’s plan or Medicare.

The following determines the priority of payment of benefits under this Plan and any other benefit plan:

- This Plan always pays after a plan that does not have a coordination of benefits provision.
- A plan covering you as an employee pays benefits before a plan covering you as a dependent.
- A plan covering you as a laid-off or retired employee pays benefits after any other plan covering you as an employee.
- If the other plan has a coordination of benefits provision, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year covers dependent children first.
- If priority still is not established, the coverage that has been in effect for the longer period of time pays benefits first.
- The following special rules apply for dependent coverage in case of legal separation or divorce:
 - If the parent with custody has not remarried, the plan covering the parent with custody pays first. The plan covering the parent without custody pays second.
 - If the parent with custody has remarried, the plan covering the parent with custody pays first. The stepparent’s plan pays second. The plan of the parent without custody pays third.

If you or your dependents are also covered under a health maintenance organization (“HMO”), any benefits you receive under the HMO are coordinated with benefits provided under this Plan in accordance with the above coordination rules.

MEDICARE COORDINATION

Because this Plan may coordinate its coverage with your Medicare benefits, it would be wise to visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn all about Medicare. For additional information or for help in comparing benefits offered by this Plan and Medicare, please contact the Administrator.

ACTIVE EMPLOYEES AND DEPENDENTS AT AGE 65

Upon reaching age 65, you are entitled to coverage under Medicare even if you don’t retire (see page 24). As an active employee, even though you are covered under Medicare, this Plan will pay your claim before Medicare does.

RETIRED DISABLED EMPLOYEES AND DEPENDENTS

When active employees or covered dependents become entitled to Medicare because they are totally and permanently disabled, coverage under this Plan is primary to Medicare coverage. It is important to remember that this rule applies whether or not you or your covered dependent is enrolled in Medicare.

RETIREES

When any retired employee or his or her spouse reaches age 65 and is eligible for Medicare benefits, coverage under this Plan is coordinated with Medicare coverage, whether or not such person is enrolled under Medicare. After your enrollment in Medicare, all medical claims are submitted to Medicare first. In order for expenses to be covered under this Plan, they must be Medicare-eligible expenses.

SUBROGATION

If you or one of your Dependents and/or Dependent Parent(s) is injured directly or indirectly by a third party, the Plan will pay covered benefits under the following circumstances. If you receive a payment from the third party, and/or from an insurance company, employer, or other agent, assign, or relative of the third party as a result of settlement or award for your injuries, the Plan will have the right to an equitable lien over the payment, and the Plan will have a right of first recovery from the payment, without deduction of attorneys' fees or costs, up to the full amount of the recovery. The Plan's right of first recovery shall apply regardless of whether the award is designated for medical benefits, damages, pain and suffering or any other designation related to the injuries. The common fund and make whole doctrines are specifically rejected, for the purposes of this section. No benefits will be paid by the Plan under this section until a fully executed Subrogation Agreement is completed by the participant, the injured party and the injured party's attorney, if applicable. The Subrogation Agreement requires, among other things, that you and your attorney must cooperate with the Plan and provide all information regarding your lawsuit or settlement to the Plan's Administrator and/or Plan Counsel. Benefits will not be provided under this section unless you and the attorney representing the injured party sign the Subrogation Agreement.

For example, suppose that you and your spouse are injured in an automobile accident that was another person's or entity's fault and that the Plan pays \$1,000 in benefits to you for injuries resulting from the accident. If you and your spouse receive money from the other person or entity, or from the insurer of that person or entity, as a result of a legal suit or settlement, the Plan is entitled to receive up to \$1,000 of the money awarded to you as reimbursement for the benefits provided by the Plan.

If you file a claim for workers' compensation benefits and your claim is contested, you may receive benefits from the Plan until your workers' compensation claim is resolved. In order to receive these benefits from the Plan, you must sign an Indemnity Agreement, stating that if you later are awarded temporary total workers' compensation benefits or workers' compensation medical benefits, you must repay all benefits you received from the Plan for any period to which your workers' compensation award applies. If you fail to reimburse the Fund under this section, the amount owed to the Fund may be offset by future benefits owed to you and your dependents.

CLAIMS PROCEDURES

OBTAINING AND COMPLETING CLAIM FORMS

1. The prompt filing of any required claim form will result in faster payment of your claim.
2. You may get the required claim forms from the Administrator. All fully completed claim forms and bills should be sent directly to the Administrator.
3. Your claim must be submitted to the Administrator in writing. It must give proof of the nature and extent of the loss. All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss. If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible, but not later than 24 months from the date incurred, unless you are legally incapacitated. Otherwise, late claims will not be covered.
4. *Hospital Confinement:* If possible, get a claim form from the Administrator before you are admitted to the hospital. This form will make your admission easier, and any cash deposit usually required will be waived.
5. *Doctor's Bills:* Complete the "patient & insurer information" section. Then have the bottom portion completed by your doctor, or attach a bill/receipt to a completed form, making sure the following information is on the bill/receipt:
 - a. employee's full name, patient's full name,
 - b. diagnosis for each date,
 - c. type of services or treatment (using CPT procedure code number),
 - d. date of service or treatment,
 - e. itemization of all charges,
 - f. name of doctor, and
 - g. other insurance coverage.

All benefits are payable to you or your eligible dependents. For your convenience, the Plan may pay medical benefits directly to the provider of service. This will be done if you elect this option when you file the claim.

6. *Laboratory & X-ray:* Send an itemized bill to the Administrator, and have the physician

who sent you to have the tests complete the “Physician or Supplier” form with their own charges and referral. THIS MUST BE DONE IN ORDER TO PAY FOR YOUR TESTS.

7. *Hospital Pre-Certification:* If you are admitted more than one day prior to surgery or admitted for an outpatient procedure, your surgeon MUST complete a hospital pre-cert. form and return it to the Administrator prior to your admission. Otherwise, your benefit will be reduced.
8. *Medicare:* If payment is to be sent to you, only send your Explanation of Medicare Benefits that Medicare sends to you. If you don’t receive the statement, you need to contact Medicare at 561-4160 (Maryland residents) and request a “duplicate” copy. When you want payment made directly to the provider of services, you need to have them complete a physician/supplier form and have them bill us directly.

SEND ALL COMPLETED CLAIM FORMS TO THE ADMINISTRATOR:

Plumbers And Steamfitters Local 486 Medical Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Phone: (888) 494-4443

For information or assistance, contact the Administrator.

GENERAL RULES TO REMEMBER

1. When to file a claim?
File the completed claim form as soon as possible. You have 90 days from the time you incur covered medical expenses to file a claim.
2. Time for processing claims?
Allow the Administrator time to process claims before making inquiry as to non-receipt of benefit checks. You will be notified in writing when the claim will be delayed for additional information or further review.
3. Fraud.

If a participant purposely supplies wrong information to the Administrator or causes, or conspires with someone else to cause, wrong information to be supplied to the Administrator, in connection with the filing of a claim, the participant may be subject to the loss of eligibility and other severe penalties.

REMEMBER - The sooner your completed Claim Form is received by the Administrator, the sooner your claim can be paid!

HOW TO APPEAL A DENIAL OF CLAIM

If a claim is wholly or partially denied, written notice of the decision will be furnished to the claimant by the Administrator in accordance with the timetable at the end of this section.

The notice will contain:

1. the specific reason(s) for the denial;
2. the specific reference to the Plan provision(s) on which the denial is based;
3. a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. information on your right to appeal the denied claim to the Trustees.

You may appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denied claim; however, you must notify the Plan in advance in writing the name, address, and phone number of the authorized representative.

If the Administrator relied on an internal rule, guideline, protocol or similar criterion in making its decision to deny your claim, the notice will also include this information, or a statement of such, along with a notice of your right for a free copy of the internal rule, guideline, protocol or similar criterion upon request.

If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit the Administrator will provide you with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided to you free of charge should you request it.

A claimant whose claim has been denied may take an appeal to the Trustees, in accordance with the timetable on the following chart. Your appeal need not be formal but must be in writing and delivered or mailed to the Administrator or the Trustees at the Office of the Administrator. The appeal must state in clear terms the reason(s) for the appeal, and must include any pertinent documents not already furnished to the Plan, such as written comments, records, and other information relating to the claim for benefits.

As part of the appeal, if you want to review the Plan's pertinent documents, and make a request to the Administrator, you may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge. A document, record or other information is "relevant" if it: (1) was relied upon in making the benefit determination; (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination; (3) demonstrates compliance with the

administrative processes and safeguards required under federal law; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Board of Trustees will also provide the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your benefit denial, whether or not the advice was relied upon in making the adverse decision.

The Board of Trustees will provide an impartial review that takes into account all comments, documents, records, and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental or investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Should it be necessary for the Board of Trustees to consult with a health care professional, the health care professional will be an individual who was not consulted in connection with the initial denial, and who is not a subordinate of that individual.

The Board of Trustees will make a decision on the appeal within the time frames included in the chart in this section. If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board of Trustees will rule on the appeal within the time required by law. If such an extension of time is required because of special circumstances, the Plan will provide you with written notice of the extension before the extension period begins, describing the special circumstances and the date on which the appeal will be decided.

The Plan will notify you of the Trustee's decision in writing. The notice will include: (1) the specific reason(s) for the decision; (2) the specific references to the pertinent Plan provisions on which the decision is based; (3) a statement that you are 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 (4) a statement explaining your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination upon appeal.

The denial of an application or claim to which the right of review has been waived or the decision of the Board of Trustees with respect to a petition for review, shall be final and binding upon all parties, including the applicant, claimant or petitioner and any person claiming under the application claimant or petitioner, subject only to judicial review. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless

of the bases asserted for the claim, regardless of when the act of omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" of "Beneficiary" of the Plan. You will have a period of one (1) year after the date of the written decision of the Board of Trustees, to commence legal action in a Court of appropriate jurisdiction to review the decision of the Trustees. If you fail to commence such an action under ERISA Section 502(a) or other applicable law within one (1) year of the Trustees' decision to deny plan benefits, you will be barred from further review.

Urgent Health Care Claim		
<i>Type of Claim</i>	<i>Action on Claim</i>	
Pre-service emergency claims (for conditions that could jeopardize life, health or ability to regain maximum function) as determined by the treating physician or a physician with knowledge of your medical condition	Step 1:	The Medical Fund's Administrator has 72 hours after receiving your initial claim to approve or deny the claim.
	Step 2:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 3:	The Board of Trustees has 72 hours after receiving your appeal to notify you of its decision.

<i>If Your Claim Is Not Proper or Complete</i>		
	Step 1:	The Medical Fund's Administrator has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2:	You have 48 hours after receiving notice from the Administrator to correct or complete your claim.
	Step 3:	The Administrator has 48 hours to notify you if your claim is denied.
	Step 4:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 5:	The Board of Trustees has 72 hours after receiving your appeal to notify you of its decision.

Pre-Service Health Care Claim		
<i>Type of Claim</i>	<i>Action on Claim</i>	
Claims filed prior to treatment, such as those that must be	Step 1:	The Medical Fund's Administrator has 15 days after receiving your initial claim to approve or deny the claim.

pre-approved, or pre-certified under hospital pre-certification requirements or under the Fund's utilization review requirements		
	Step 2:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 3:	The Board of Trustees has 30 days after receiving your appeal to notify you of its decision.

<i>If Your Claim Is Not Proper or Complete</i>		
	Step 1:	The Medical Fund's Administrator has 5 days after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2:	You have 45 days after receiving notice from the Administrator to correct or complete your claim.
	Step 3:	If the Administrator needs more information or provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision.
	Step 4:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 5:	The Board of Trustees has 30 days after receiving your appeal to notify you of its decision.

Post-Service Health Care Claim		
<i>Type of Claim</i>	<i>Action on Claim</i>	
Claims filed after treatment, when you request benefits after medical services have been rendered to you	Step 1:	The Medical Fund's Administrator has 30 days after receiving your initial claim to approve or deny the claim.
	Step 2:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 3:	The Board of Trustees has 60 days after receiving your appeal to notify you of its decision.

<i>If Your Claim Is Not Proper or Complete</i>		
	Step 1:	The Medical Fund's Administrator has 30 days after receiving your initial claim to notify you that your claim is improper or incomplete.

	Step 2:	You have 45 days to provide information after receiving notice from the Administrator to correct or complete your claim.
	Step 3:	If the Administrator needs more information or provides an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you of its decision.
	Step 4:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 5:	The Board of Trustees has 60 days after receiving your appeal to notify you of its decision.

Disability Claim		
Type of Claim	Action on Claim	
Claims for short term disability benefits, including weekly accident and sickness benefits	Step 1:	The Medical Fund's Administrator has 45 days after receiving your initial claim to approve or deny the claim.
	Step 2:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
	Step 3:	The Board of Trustees has 45 days after receiving your appeal to notify you of its decision.
<i>If the Fund Needs An Extension or More Information</i>		
	Step 1:	The Medical Fund's Administrator has 45 days after receiving your initial claim to notify you that it needs more information or an extension.
	Step 2:	You have 45 days to provide information after receiving notice from the Administrator to correct or complete your claim.
	Step 3:	If the Administrator needs more information or provides an extension notice during the initial 45-day period, the Plan 75 days after receiving the claim to notify you of its decision. If the Fund needs more time, it may notify you that a further extension of 30 days is necessary to approve or deny your claim.
	Step 4:	If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.

	Step 5:	The Board of Trustees has 45 days after receiving your appeal to notify you of its decision, or if more time is necessary, 90 days after receiving your appeal.
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All Other Claims		
<i>Type of Claim</i>	<i>Action on Claim</i>	
Other claims, such as eligibility to self-pay, or eligibility for retiree coverage	Step 1:	The Medical Fund's Administrator has 90 days after receiving your initial claim to approve or deny the claim.
	Step 2:	If the Fund denies your claim, you have 60 days after receiving the denial to appeal the Administrator's decision.
	Step 3:	The Board of Trustees has 60 days after receiving your appeal to notify you of its decision.
<i>If the Fund Needs An Extension</i>		
	Step 1:	The Medical Fund's Administrator has 90 days after receiving your initial claim to notify you that it needs an extension.
	Step 2:	If the Administrator provides an extension notice during the initial 90-day period, the Plan 180 days after receiving the claim to notify you of its decision.
	Step 3:	If the Fund denies your claim, you have 60 days after receiving the denial to appeal the Administrator's decision.
	Step 4:	The Board of Trustees has 60 days after receiving your appeal to notify you of its decision, or if more time is necessary, 120 days after receiving your appeal.

INFORMATION OR CLAIM FORMS

For information or claim forms call or write:

Plumbers and Steamfitters Local 486 Medical Plan
 911 Ridgebrook Road
 Sparks, MD 21152-9451
 Telephone: (888) 494-4443

WHEN TO NOTIFY THE ADMINISTRATOR:

You should notify the Administrator whenever:

1. You change your mailing address;
2. You are receiving worker's compensation benefits or are eligible to recover damages from, or settle for damages with, a person or organization which caused you expenses paid for by the Plan;
3. You enter, or are discharged from, the Armed Services;
4. Your dependency status changes - you marry or are divorced; a new dependent is added;
5. You apply for retirement benefits with the Plumbers and Steamfitters Local 486 Pension Plan;
6. You become disabled or return to employment after ceasing to be disabled;
7. You or your spouse reach age 65;
8. You desire to make a self-payment into the Medical Plan;
9. Your spouse changes employment; or
10. You or your spouse become eligible for Medicare.

GENERAL INFORMATION

BOARD OF TRUSTEES' DISCRETION

The Board of Trustees has full and exclusive authority and discretion to determine all questions of coverage, eligibility for and entitlement to benefits, methods of providing or arranging for benefits, and other related matters.

AMENDMENT OR TERMINATION OF THE PLAN

Neither this Plan nor any of its benefits is guaranteed. Although the Plan is intended to be permanent, the Board of Trustees may amend or terminate the Plan, in whole or part, as it finds necessary. The nature and amount of Plan benefits always are subject to the actual terms of the Plan as it exists at the time the claim occurs.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN

Plumbers and Steamfitters Local 486 Medical Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(888) 494-4443

TYPE OF ADMINISTRATION OF THE PLAN

The Plan is administered by a joint Board of Trustees. The daily administrative duties are performed under a contract with Associated Administrators, LLC.

NAMES AND ADDRESSES OF THE TRUSTEES

Union Trustees

William Welsh
Plumbers And Steamfitters Local 486
8100 Sandpiper Circle
Baltimore, MD 21236

Eric Eckstein
Plumbers And Steamfitters Local 486
8100 Sandpiper Circle
Suite 200
Baltimore, MD 21236

Anthony M. George
Plumbers And Steamfitters Local 486
8100 Sandpiper Circle
Suite 200
Baltimore, MD 21236

Kenneth Kahl
Plumbers And Steamfitters Local 486
8100 Sandpiper Circle
Suite 200
Baltimore, MD 21236

Employer Trustees

Stephen J. Weissenberger
MCA of Maryland, Inc.
3600 O'Donnell Street
South Tower - Suite 800
Baltimore, MD 21224

Kari Cordell
MCA of Maryland, Inc.
3600 O'Donnell Street
South Tower - Suite 800
Baltimore, MD 21224

David Fisher
MCA of Maryland, Inc.
3600 O'Donnell Street
South Tower - Suite 800
Baltimore, MD 21224

Shannon Shagoury
MCA of Maryland, Inc.
3600 O'Donnell Street
South Tower - Suite 800
Baltimore, MD 21224

LEGAL PROCESS

The name and address of the person designated as agent for the service of legal process is as follows:

Plumbers and Steamfitters Local 486 Medical Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451

Service may also be made on any Trustee at the address shown above.

IRS PLAN IDENTIFICATION NUMBER

The Employer Identification Number (EIN) issued to the Plan by the IRS is 52-1059733.

PLAN NUMBER

The Plan Number assigned by the Board of Trustees is 501.

PLAN YEAR

The end of the Plan Year is December 31st. Plan records are maintained on a calendar year basis.

FUNDING MEDIUM

Benefits under the Plan are provided from the Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreement, participation agreements, and the Trust Agreement. These assets are invested upon the advice of an independent investment consultant and held in a Trust Plan for the purpose of providing benefits to covered participants and paying reasonable administrative expenses.

SOURCE OF CONTRIBUTIONS

All contributions are made by participating employers on behalf of each eligible employee in accordance with Collective Bargaining Agreements between the Union and the Employers and participation agreements. In order to determine whether your employer is a contributing employer, you may contact the Administrator.

PLAN DOCUMENTS AND REPORTS

You may examine the following documents at the Administrator during regular business hours, Monday through Friday, except holidays:

- Trust Agreement
- Collective Bargaining Agreements
- Plan documents and all amendments
- Form 5500, a full Annual Report filed with the Internal Revenue Service and the Department of Labor

YOUR ERISA RIGHTS

The following statement of your rights under the Employee Retirement Income Security Act of 1974 (ERISA) is furnished in compliance with ERISA Section 104(c).

As a participant in the Plumbers and Steamfitters Local 486 Medical Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and summary plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, call "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan 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 these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court. If you believe that the Plan fiduciaries have misused the Plan's money or that you have been 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. The court also may impose sanctions against you 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 or about your rights under ERISA, you should contact the nearest office of the Labor-Management Services Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical

Plumbers and Steamfitters Local 486 Medical Plan

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, DC 20210.

APPENDIX A
SCHEDULE OF BENEFITS

ELIGIBLE ACTIVE EMPLOYEES

Weekly Accident and Sickness Benefit¹ \$300

ELIGIBLE ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS

Prescription Drugs – Retail Pharmacyin full, after
\$15 copayment (generic drugs) \$35
copayment (formulary drugs)
\$50 copayment (non-formulary drugs)

Prescription Drugs – Mail Order.....in full, after
\$30 copayment (generic drugs) \$70 copayment (formulary drugs) \$100 copayment (non-
formulary drugs) Major Medical

Deductible (per calendar year)
Per individual\$100
Per family\$200
Coinsurance80% of the next \$2,500
per calendar year; 100%

ELIGIBLE RETIRED EMPLOYEES UNDER AGE 65 AND THEIR DEPENDENTS UNDER AGE 65

The same benefits are provided to eligible retired employees under age 65 and their dependents under age 65 as for eligible active employees and their dependents under age 65, except that the Weekly Accident and Sickness Benefit is not provided.

ELIGIBLE RETIRED EMPLOYEES AGE 65 AND OVER AND THEIR DEPENDENTS AGE 65 AND OVER

Eligible retired employees age 65 and over and their dependents age 65 and over are offered the Supplemental Medicare Benefit and the Prescription Drug Benefit. These are the only benefits provided to members of this group.

¹ Those eligible to self-pay must have been employed within five working days of disability.

ELIGIBLE DISABLED EMPLOYEES UNDER AGE 65 AND DISABLED DEPENDENTS UNDER AGE 65

The same benefits are provided to eligible disabled employees under age 65 and their disabled dependents under age 65 as for eligible active employees and their dependents under age 65, except that the Weekly Accident and Sickness Benefit is not provided.

APPENDIX B
How Major Medical Works

Example 1: Case Not Requiring Hospitalization or Surgery

A participant develops a heart condition that requires treatment and care from time to time; however, hospital confinement is not necessary. It is assumed that both periods of treatment occurred during the same calendar year.

	Covered Expenses	Provided By Basic Coverage	Major Medical Expense
First Treatment Period:			
Physician's Charges (7 visits)	\$300	\$140	\$160
Registered Graduate Nurse's Charge	150	0	150
Charges for Diagnostic X-ray and Lab Tests	100	100	0
Second Treatment Period:			
Physician's Charges (5 visits)	300	100	200
Registered Graduate Nurse's Charge	100	0	100
Total Expenses	\$950		
Amount of Basic Coverage			\$340
Major Medical Expenses			\$610
Deductible (payable by patient)			(200)
Charges to which Major Medical Benefits apply			\$410
Amount of Major Medical Coverage (80% of \$410)			\$328
Total of Basic and Major Medical Coverage under Plan			\$668*

Thus, in this example, the participant would receive benefits of \$340 under Basic Benefits and \$328 under Major Medical, leaving him only \$282 to pay out of the \$950 total.

*After the Initial Plan Deductible is met (see page 16).

Example 2: Case Requiring Hospitalization and Surgery for a Kidney Removal

	Covered Expenses	Provided By Basic Coverage	Major Medical Expense
Inpatient Expenses:			
Hospital Charges for Board and Room (80 days at \$500 per day)	\$40,000	\$35,000	\$5,000
Hospital Charges for Miscellaneous and Supplies	48,000	42,000	6,000
Registered Graduate Nurse's Charges	400	0	400
Physician's Charges (20 visits)	1,600	900	700
Surgeon's Charges	2,500	960	1,540
Outpatient Expenses:			
Physician's Charges	200	0	200
Registered Graduate Nurse's Charge	100	0	100
Total Expenses	\$92,800		
Amount of Basic Coverage			\$78,860
Major Medical Expenses			\$13,900
Deductible (payable by patient)			(200)
Charges to which Major Medical Benefits apply			\$13,740
Amount of Major Medical Coverage (80% of \$2,500; then 100% of \$11,240)			\$13,240
Total of Basic and Major Medical Coverage under Plan			\$92,100*

Thus, in this example, the participant will receive Basic Benefits of \$78,860 and \$13,240 under Major Medical, leaving him only \$700 to pay out of the \$92,800 total.

*After the Initial Plan Deductible is met (see page 13).

APPENDIX C
SCHEDULE OF DENTAL PROCEDURES

Procedure Code	Name of Procedure	Negotiated Fee	Plan Payment
Class I - Diagnostic			
Clinical Oral Examinations			
0110	Initial Oral Examination	28	28
0120	Periodic Oral Examination	22	22
Emergency Treatment			
0130	Emergency Oral Examination	22	22
X-Rays, Tests & Laboratory Examinations			
0210	Intra-Oral/Complete Series	56	56
0220	Periapical - First Film	10	10
0230	Periapical - Each Add'l film	8	8
0240	Occlusal Film	18	18
0250	Extra-Oral/First Film	14	14
0260	Extra-Oral/Each Add'l Film	8	8
0270	Bitewing - Single Film	8	8
0272	Bitewing - Two Films	16	16
0273	Bitewing - Three Films	21	21
0274	Bitewing - Four Films	28	28
0290	Extra-Oral/Posterior-Antero	44	44
0321	TMJ - Single Film	104	104
0330	Panoramic/Single Film	47	47
0460	Pulp Vitality Tests	18	18
Class II - Preventive			
Dental Prophylaxis			
1110	Prophylaxis - 14 years of age or older	39	39
1120	Prophylaxis - 14 years of age or younger	30	30
Topical Fluoride Treatment			
1203	Topical Application of Fluoride - child	16	16
1210	Topical Application of Sodium Fluoride	28	28
1220	Topical Application of Stannous Fluoride	16	16
1230	Topical Application of Acid Fluoride	16	16
1351	Sealants	20	20
Space Maintainers			
1510	Fixed - Unilateral	134	134
1520	Removable - Unilateral	146	146
1525	Removable - Bilateral	200	200

Class III - Restorative

Amalgam Restorations & Silicate

2110	Amalgam - one surface, primary	44	44
2120	Amalgam - two surfaces, primary	59	59
2130	Amalgam - three surfaces, primary	72	72
2140	Amalgam - one surface, permanent	53	53
2150	Amalgam - two surfaces, permanent	64	64
2160	Amalgam - three surfaces, permanent	81	81
2161	Amalgam - four surfaces, permanent	92	92
2190	Pin Retention, Exclusive of Amalgam	17	17
2210	Silicate Cement - per restoration	25	25

Filled or Unfilled Resin Restorations

2310	Acrylic/Plastic Restorations	35	35
2330	Resin - one surface, anterior	56	56
2331	Resin - two surfaces, anterior	67	67
2332	Resin - three surfaces, anterior	85	85
2335	Resin - four or more surfaces	92	92
2337	Composite w/Ultra Violet - one surface	42	42
2338	Composite w/Ultra Violet - two surfaces	60	60
2339	Composite w/Ultra Violet - three surfaces	84	84
2340	Acid Etch	24	24
2380	Resin - one surface, posterior, primary	42	42
2385	Resin - one surface, posterior, permanent	49	49

Crowns - Single Restoration

2710	Crowns - Plastic/Acrylic	162	81
2740	Crowns - Porcelain	529	265
2751	Crowns - Porcelain fused to metal base	494	247
2752	Crowns - Porcelain fused to metal	512	256
2790	Crowns - Full cast gold	469	235
2791	Crowns - Full cast with metal base	376	188
2830	Crowns - Stainless Steel	200	100
2891	Cast Post & Core in Addition to Crown	135	68
2910	Recement Inlays	38	38
2920	Recement Crown	37	37
2940	Sedative Filling	38	38
2950	Crown Buildup Including Any Pins	107	107
2954	Prefabricated Post & Core in Addition to 125		125

Class IV - Endodontics

Pulp Capping

3110	Direct Pulp Cap	27	27
3120	Indirect Pulp Cap	19	19

	Pulpotomy		
3220	Vital Pulpotomy	74	74
	Root Canal Therapy		
3310	Root Canal - One canal, no apicoectomy	300	300
3320	Root Canal - Two canals, no apicoectomy	370	370
3330	Root Canal - Three canals, no apicoectomy	459	459
	Periapical Services		
3410	Apicoectomy	279	279
	Class V - Periodontics		
	Surgical Services		
4210	Gingivectomy/Gingivoplasty, per quadrant	222	222
4220	Gingival Curettage & Root Planing, per quadrant	75	75
4260	Osseous Surgery, per quadrant	444	444
4261	Osseous Graft, Single Site	282	282
4262	Osseous Graft, Multiple Site, per quadrant	300	300
	Adjunctive Periodontal Services		
4330	Occlusal Equilibration - Limited	50	50
4331	Occlusal Equilibration - Complete	265	265
4340	Periodontal Scaling - 12 or more teeth	130	130
4341	Periodontal Scaling - Less than 12 teeth	88	88
4910	Periodontal Prophylaxis	56	56
	Class VI - Prosthodontics		
	Complete Dentures		
5110	Denture - complete, upper	547	274
5120	Denture - complete, lower	494	247
5130	Denture - Immediate, upper	529	265
5140	Denture - immediate, lower	529	265
	Partial Dentures		
5211	Partial - acrylic, upper	368	184
5212	Partial - acrylic, lower	382	191
5213	Partial - cast base, upper, with acrylic saddles	582	291
5214	Partial - cast base, lower, with acrylic saddles	582	291
5230	Partial - lower, gold clasps & lingual bar	445	223
5250	Partial - upper, gold clasps & lingual bar	440	220
5280	Partial - removable, unilateral	200	100

	Adjustments to Dentures		
5410	Adjustments to Complete Denture, upper	28	28
5421	Adjustments to Partial Denture, upper	28	28
	Repairs To Partial Dentures		
5610	Repair Acrylic Saddle or Base	56	56
5620	Repair Cast Framework	85	85
5630	Replacement of Additional Teeth, per tooth	71	71
5650	Add Tooth to Existing Partial Denture	54	54
5660	Add Clasp to Existing Partial Denture	70	70
5670	Damaged Clasps	141	141
5680	Replace With New Clasp - first clasp	73	73
5690	Each Additional Clasp, With Rest	58	58
	Denture Reline Procedures		
5730	Reline Complete Denture - upper, chairside	122	122
5750	Reline Complete Denture - upper, laboratory	139	139
5751	Reline Complete Denture - lower, laboratory	139	139
5760	Reline Partial Denture - upper, laboratory	139	139
5850	Tissue Conditioning, per denture unit	68	68
	Class VII - Prosthodontics, Fixed		
	Bridge Pontic		
6210	Pontic - cast gold	469	235
6211	Pontic - cast metal	376	188
6240	Pontic - porcelain fused to gold	529	265
6242	Pontic - porcelain fused to metal	508	254
6545	Cast Metal Retainer for Acid Etch Bridge	392	196
6610	Replace Broken Pin Facing	286	286
6620	Replace Broken Pin Facing When Post is Intact	286	286
6630	Replace Broken Pin Facing When Post is Broken	286	286
6650	Replace Broken Slotted Facing	300	300
	Bridge Retainers - Crowns		
6750	Crowns, porcelain w/ gold	529	265
6751	Crowns, porcelain fused to metal base	459	230
6780	Crowns, 3/4 cast gold	445	223
6790	Crowns, full, cast gold	469	235
6791	Crowns, full, base metal	412	206
6792	Crowns, full, metal	421	211

	Other Fixed Prosthetic Services		
6930	Recement Bridge	48	48
6960	Dowel Pin, per tooth	48	48
	<u>Class VIII - Oral Surgery</u>		
	Extractions - Includes Anesthesia		
7110	Simple extractions - First tooth	52	52
7120	Simple extractions - Each Additional Tooth	44	44
	Surgical Extractions - Includes Local Anesthesia		
7210	Surgical Extractions - Erupted	92	92
7220	Impacted Tooth - Soft Tissue	119	119
7230	Impacted Tooth - Partially Bony	152	152
7240	Impacted Tooth - Completely Bony	172	172
7250	Surgical Removal of Residual Tooth Roots	106	106
	Other Surgical Procedures		
7285	Biopsy of Oral Tissue - hard	176	176
	Alveoloplasty - Surgical Preparation of Ridge for Denture		
7310	Alveoloplasty with Extractions, per quad	95	95
7320	Alveoloplasty Not With Extractions per quad	94	94
	Surgical Incision		
7510	Incision & drainage of abscess - intraoral	64	64
	Other Repair Services		
7960	Frenulectomy - separate procedure	220	220
	<u>Class IX - Adjunctive General Services</u>		
	Unclassified Treatment		
9110	Emergency treatment of dental pain, minor	30	30
	Anesthesia		
9220	General Anesthesia	123	123
9230	Analgesia (gas)	39	39
	Miscellaneous Services		
9940	Occlusal guards	212	212

