PLUMBERS' AND STEAMFITTERS' LOCAL 166

HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

June 1, 2019

PLUMBERS AND STEAMFITTERS LOCAL 166
HEALTH AND WELFARE FUND

To: All Eligible Participants and Eligible Dependents:

We are pleased to distribute the Summary Plan Description (SPD) for the Plumbers and Steamfitters Local166 Health and Welfare Fund (Fund). This document summarizes the terms of the Plumbers and Steamfitters Local166 Health and Welfare Fund plan document (Plan).

This SPD is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Fund Office. If there is any conflict between this SPD and the Plan, the Plan controls. For a more detailed statement of your rights, benefits, and obligations consult the Plan document.

No statements made by any party, including the Plan Sponsor, Plan Administrator, Trustee, Third Party Administrator, Participant, or provider that are in conflict with the contents of this SPD or the Plan can alter the benefits payable as set forth in this document, nor be binding on the Fund.

The Trustees reserve the right to amend the Plan at any time. THERE ARE NO VESTED BENEFITS UNDER THIS PLAN.

Please read this SPD carefully and keep it for future reference. If you have any questions, please contact the Fund Office.

Respectfully,

BOARD OF TRUSTEES

Enrollment Forms

When you first became eligible for benefits, you should have received an enrollment form. This form requests certain basic data, such as your Social Security number, address, birthdate, name, names and ages of your Dependents, and the name of your designated beneficiary. This information is vital. Without it, the Third Party Administrator will have difficulty keeping your records updated and keeping you informed of Plan changes. If there have been any changes in your information, it is your responsibility to update this form. You will be responsible to pay back benefits paid due to incorrect information on file with the Fund Office (such as failing to inform the Fund Office of a divorce).

If you are not sure whether you have an enrollment form on file at the Fund Office, or are unsure whether the information on your form is still correct, please contact the staff at the Fund Office.

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This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

ARTICLE 1-DEFINITIONS

As used in this document, the following words have the following meanings (other terms may also be defined elsewhere in this document):

Active Employee - an individual on whose behalf contributions are required to be made by an Employer to the Fund and who is eligible for coverage under the Fund.

Administrative Staff - Non-Bargaining Unit Participants employed by the Union as administrative staff.

Alternate Recipient - a child of a Participant who is recognized under a Qualified Medical Child Support (QMCSO) order as having a right to benefits under the Plan.

Ambulance Services - transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- from the Covered Person's home, scene of accident or medical emergency to a Hospital;
- between Hospitals;
- between Hospital and Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to the Covered Person's home.

Association - the Mechanical Contractor Association of the Fort Wayne Area.

Autism Spectrum Disorder means any pervasive developmental disorders as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Autism Spectrum Disorder includes ADD, ADHD, developmental delay, learning disabilities, hyperkinetic syndromes, or behavioral problems.

Beneficiary - a person designated by the Participant or by the terms of the Plan who is or may be entitled to a benefit.

Birthing Center - a facility which meets all of the following tests:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a doctor;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times; and
- It has a written agreement with a Hospital located in the immediate geographical area of the birthing center to provide emergency admission of the Covered Person.

Board of Trustees or Trustees - the Trustees appointed under the terms of the Trust Agreement.

Cardiac Rehabilitation consists of three phases:

- **Phase I** begins approximately two-four days following a heart attack, or 24 hours post-Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.
- **Phase II** is an outpatient, Hospital-based program, usually of two-three months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.
- **Phase III** is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist.

Certificate of Creditable Coverage - a certification of coverage issued to individuals who cease to be covered under the Plan.

Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

Child/Children- a Participant's natural child, adopted child, child placed for adoption, step children or legal ward through the end of the month in which the Child attains age 26, subject to the following:

- For Plan Years beginning before January 1, 2014, a Child is not entitled to coverage under the Plan if he or she is an adult and is eligible for employer-based health care coverage under another health care plan.
- Grandchildren only if a Participant has legal guardianship or has been granted an order of custody under Indiana law for such individuals.
- A Child who upon reaching age 26 is Totally Disabled, who is dependent upon the eligible Participant for primary support and maintenance, and whose mental or physical handicap commenced prior to his attaining age 26 will remain eligible provided notification of such handicap is given to the Fund Office prior to the child attaining age 26 and the Board of Trustees makes a determination of continuing eligibility. A Participant may be required to supply proof, upon request by the Board of Trustees or the Third Party Administrator, that a Child satisfies these eligibility criteria.
- A Child for whom an eligible Participant is required to provide medical coverage in accordance with the provisions of a Qualified Medical Child Support Order is a Child under the Plan.

Collective Bargaining Agreement - an agreement between an Employer and the Union requiring contributions to the Fund.

Confinement/Confined - the period starting with a Covered Person's admission on an inpatient basis (more than 24 hours) to a Hospital or other licensed health care facility for treatment of an Illness or Injury. Confinement ends with the Covered Person's discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it is considered one Confinement.

Contributions - mean payments to the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act. Contributions become vested plan assets when they are due and owing to the Fund.

Consultation - a personal bedside examination by another Physician when requested by the Covered Person's attending Physician.

Cosmetic - Means any procedure performed primarily: to improve the physical appearance or to change or restore bodily form which is not Medically Necessary to treat an Injury or Illness; or to prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Employment - employment for which an Employer is required to make Contributions to the Fund.

Covered Person - an eligible Participant or eligible Dependent who has been properly enrolled and is covered by the Plan.

Covered Service - a Provider's service or supply as described in this document for which benefits will be provided as listed in the Schedule of Benefits.

Creditable Coverage - coverage under any previous health plan, individual or group coverage, private or public, including Medicare and military coverage.

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

- a person without medical skills or background could provide or could be trained to provide; or
- are provided mainly to help the covered individual with daily living activities, including (but not limited to):
  (a) walking, getting in and/or out of bed, exercising, and moving the covered individual;
  (b) bathing, using the toilet, administering enemas, dressing, and assisting with any other physical or oral hygiene needs;
  (c) assistance with eating by utensil, tube or gastrostomy;
  (d) homemaking, such as preparation of meals or special diets, and house cleaning;
  (e) acting as a companion or sitter; or

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

- provide a protective environment; or
- are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve injury, sickness, or functional ability; or
- are provided for convenience or are provided because arrangements are not appropriate or adequate.

Dependent - a Spouse or Child of a Participant who is eligible for coverage, excluding Illegal Aliens. “Illegal Alien” shall mean a person who: (a) is not a citizen of the United States; (b) is not lawfully admitted to the United States for permanent residence; and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General ofthe United States.

Developmental Care - services or supplies, regardless of where or by whom provided which:

- are provided to an individual who has not previously reached the level of development expected for his age in the following areas of major life activity: a) intellectual; b) receptive and expressive language; c) learning; d) mobility; e) self-direction; f) capacity for independent living; or g) economic self-sufficiency; or
- are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to
- Injury or Illness); or
- are educational in nature.

Diagnostic Services - the following services when performed for a diagnosis of a condition, disease, or InJury:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and pathology services;
- Diagnostic medical examinations such EKGs and EEGs;
- Cardiographic, Encephalographic and Radioisotope tests

Durable Medical Equipment - an item which can withstand repeated use and is:

- primarily used to serve a medical purpose with respect to an Illness or Injury;
- generally not useful to a person in the absence of an Illness or Injury;
- appropriate for use in a Covered Person’s home; and
- prescribed by a Physician.

Emergency Care - medical services provided by a health care provider to treat a medical emergency. A medical emergency occurs where the Covered Person requires immediate medical care as the result ofthe onset of sudden and unexpected severe symptom(s) and acute condition(s).

Employee - an individual on whose behalf contributions are required to be made by an Employer to the Fund.

Employer - means the following:

- An employer who is a member of, or is represented, by the Associations, and who is bound by a collective bargaining agreement with the Union requiring Contributions to the Fund.
- Any other employer who is obliged, by any collective bargaining agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;
- The Union, to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund;
- The Fund, to the extent and solely to the extent, that it acts in the capacity of an employer of administrative employees on whose behalf Contributions are made to the Fund;

- Any Welfare, Apprenticeship or related Union fund to the extent, and solely to the extent, that it acts in the capacity of an employer of its employees and makes Contributions to the Fund pursuant to a participation agreement.

Enteral or Parenteral Nutrition Therapy - is nutritional therapy which is necessary due severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength, or is necessary for an individual with a functioning gastrointestinal tract which, due to a pathologic cause or the non-function of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with the individual's general condition.

Essential Health Benefits - certain types of health care on which there can be no annual or lifetime dollar limits pursuant to the Patient Protection and Affordable Care Act, including the following:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

Expense - the cost incurred for a covered service or supply and which is ordered by a Physician. Any expense shall be considered incurred on the date the service or supply was ordered. The expense is not the amount which will be paid by the Plan.

Experimental/Investigative - any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

- The device, drug, or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug, or medicine is furnished; or
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility and the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine; or
- any treatments, services or supplies that are educational or provided primarily for research; or treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

Health Care Provider - any person, institution or other entity licensed by the state in which he/she or it is located to provide medical treatment, services or supplies to a Covered Person within the lawful scope of his/her license.

Home Health Care - Services not covered elsewhere in the Plan provided or coordinated by a licensed or Medicare-certified home health agency or certified rehabilitation agency. Such services include:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;

- Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
- Physical or occupational therapy or speech-language pathology or respiratory care;
- Medical supplies, drugs, and medications prescribed by a Physician; laboratory services by or on behalf of a Hospital is needed under the home care plan. These items are covered to the extent they would be if the Covered Person had been hospitalized;
- Nutrition counseling provided or supervised by a registered dietician; and
- Evaluation of the need for a home care plan by a registered nurse, physician extender, or medical social worker. The Covered Person's attending Physician must request or approve this evaluation.

Hospice - an agency that provides counseling, medical services and may provide room and board to a terminally ill eligible individual and which meets all of the following:

- It has obtained any required state or governmental Certificate of Need approval;
- It provides service 24 hours a day, 7 days a week;
- It is under the direct supervision of a doctor;
- It has a nurse coordinator who is a registered nurse (R.N.);
- It has a social service coordinator who is licensed;
- It is an agency that has as its primary purpose the provision of hospice services;
- It has a Full-time administrator;
- It maintains written records of services provided to the patient; and
- It is licensed, if licensing is required

Hospice Benefits - only paid if the eligible individual's attending physician certifies that:

- The eligible individual is terminally ill;
- The eligible individual is expected to die within six months or less.

Hospital - an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the requirements set forth in (a) or (b) or (c) below:

(a) It is a Hospital accredited by the Joint Commission on Accreditation of Hospitals.

(b) It is a Hospital, a Psychiatric Hospital, or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare.

(c) It is an institution which fully meets all of the following:

(1) It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians; and

(2) It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and

(3) It is operated continuously with organized facilities for operative surgery on the premises.

A Hospital does not include the following: a convalescent or extended care facility unit within or affiliated with the Hospital; a clinic; a nursing, rest or convalescent home or extended care facility; an institution operated mainly for care of the aged or for treatment of Mental Illness or Substance Abuse; a health resort, spa or sanitarium; or a sub-acute care center.

Hyperbaric and Pulmonary Therapy - introduction of high-density solutions into the lungs for treatment purposes

Illness or Sickness - any physical or mental disease or sickness, disorder or condition which requires treatment by a Physician, including pregnancy and complications of pregnancy. Mental

disease or sickness does not include benefits for conditions related to Autism Spectrum Disorders or intellectual disability.

Incur/Incurred - a charge is considered incurred on the date the Covered Person receives the service or supply for which the charge is made.

Injury - an accidental physical Injury to the body caused by unexpected external means.

Inpatient- a person who is a resident patient using and being charged for a room and board facility of the hospital.

Legend Drugs - drugs which have the following legend on the container: CAUTION, FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION.

Maternity - expenses related to pregnancy and childbirth.

Medical and Surgical Supplies - syringes, needles, oxygen, casts, surgical dressings, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. Also includes supplies prescribed by your Physician such as catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract surgery.

Medically Necessary (or Medical Necessity) - health care services, supplies or treatment that are required to identify or treat the illness or injury which a physician has diagnosed. To be medically necessary the service, supplies or treatment must be:

- Consistent with the diagnosis and treatment of the patient's condition;
- Consistent with professionally recognized standards of health care;
- Medically proven to be effective treatment of the condition;
- Not conducted for research purposes;
- Not solely for the convenience of the patient, physician or supplier; and
- The most appropriate level of services which can be safely provided to the patient.

The fact that a physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

Mental Health Benefits - are benefits for mental disorders, illnesses, and conditions as defined by generally recognized independent standards of current medical practice and in the International Classification of Diseases (ICD-10). Mental Health Benefits do not include benefits for conditions related to Autism Spectrum Disorders or intellectual disability.

Miscellaneous Hospital Expense - the regular Hospital charges (but not room and board, nursing services and ambulance services) for care for an Illness or Injury requiring inpatient hospitalization.

Newborn Care - care required for a well, but Hospital confined, Dependent newborn child but only while the mother is Hospital confined as the result of giving birth to such child.

Non-Bargaining Unit Participant - An Active Employee working for an Employer in non-bargaining unit work on whose behalf contributions are made pursuant to a participation agreement.

Non-Participating - the status of a Physician, Other Professional Provider, Hospital or Other Facility Provider that does not have a signed agreement with the Plan's PPO Network regarding payment for Covered Services.

Occupational Therapy - the treatment of a physically disabled person by means of con-structive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period oftime.

Orthotic Devices - a rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping, orthopedic braces, and crutches. Orthotics must be custom molded and prescribed by a Physician and not used only to improve comfort or appearance. These do not include special shoes unless the device is a permanent part of an orthopedic brace.

Other Provider or Other Professional Provider - entities which are licensed (where required) and provide their patients with covered services in exchange for compensation. Other Professional Providers include the following:

- Dentist
- Doctor of Chiropractic Medicine
- Certified Registered Nurse Anesthetist (CRNA)
- Laboratory (must be Medicare approved)
- Licensed Mental Health and Substance Abuse Counselors
- Licensed Social Worker
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Pharmacy (a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law)
- Physician Assistant (PA)
- Physical Therapist
- Podiatrist
- Psychologist

Other Provider Facilities - include the following institutions:

- Alcoholism Treatment Facility - a facility which mainly provides detoxification and rehabilitation treatment for Alcoholism.
- Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or horne care basis.
- Drug Abuse Treatment Facility - a facility which provides detoxification and rehabilitation treatment for Drug Abuse.
- Home Health Care Agency - a facility which:
  (a) provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
  (b) is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Outpatient - a person who receives hospital services and treatments but is not an Inpatient. Participant- an Active Employee or Retiree who is eligible for benefits under the Plan.

Physician - A qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, and practicing within the scope of his license. This does not include the Participant, or his or her spouse, parent, son, daughter, brother or sister.

Plan - the term "Plan" shall mean the plan established and maintained pursuant to this document, as amended from time to time.

Plan Year - the 12-month period beginning January 1st of each year and ending on December 31st of the following year.

Pre-Admission Tests - tests performed prior to Confinement as an Inpatient, provided:

(a) Such tests are related to the performance of scheduled surgery;
(b) Such tests have been ordered by a duly qualified Physician after a condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician; and
(c) The Covered Person is subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your Dependent's condition which precludes the surgery.

Prescription Drugs - Legend Drugs and drugs which: require a written prescription executed by a Physician according to state law; and are dispensed by a licensed pharmacist or a Hospital pharmacy for take home use.

Prosthetic Appliances - purchase, fitting, needed adjustment and necessary repairs of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ.

This benefit will also include replacements for children who, due to growth, must obtain a new prosthetic appliance.

Psychologist - a person who specializes in clinical psychology and fulfills one of the following requirements, whichever is applicable:

(a) A person who is licensed or certified as a Psychologist by the appropriate govern-mental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service.
(b) A person who is a member or fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service.

Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.

Reasonable and Customary - the term "Reasonable and Customary" refers to the designation of a charge as being the usual charge made by a Physician or Other Professional Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by Other Providers rendering or furnishing such care or treatment within the same area. The term "Area" in this definition means a county or such other area as is necessary to obtain a representative cross-section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise.

Respiratory Therapy - treatment by the introduction of dry or moist gases into the lungs, and other respiratory therapy-related services.

Retiree - an individual eligible for benefits as a Retired or Permanently Disabled Participant under Section 2.5 of this Plan.

Skilled Nursing Care - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of Physicians. Confinement in a Skilled Nursing Facility:

- must begin within two days after the Covered Person has been confined in a Hospital for at least three consecutive days for which room and board charges were paid; and
- is for treatment of the Illness causing the Hospital Confinement; and
- is one for which a Physician visits the Covered Person at least once every 30 days, and
- is not for routine Custodial Care.

Skilled Nursing Facility -

- A Skilled Nursing Facility, as the term is defined by Medicare, which is qualified to participate

and eligible to receive payments in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital; or

- An institution which fully meets all of the following:
  (a) It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
  (b) It is under the supervision of a licensed physician, or registered graduate nurse (R.N.) who is devoting Full-time to such supervision;
  (c) It is regularly engaged in providing room and board and continuously provides 24 hour a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Illness;
  (d) It maintains a daily medical record of each patient who is under the care of a duly licensed physician;
  (e) It is authorized to administer medication to patients on the order of a duly licensed physician;
  (f) It is not, other than incidentally, a home for the aged, the blind, the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill; and
  (g) It is not a Hospital or part of a Hospital.

Spouse - a Participant's legal spouse, while not divorced or legally separated from the Participant. Surgical Procedure - means only the following: a cutting procedure; suturing of a wound; treatment of a fracture; reduction of a dislocation; radiotherapy (including radioactive isotope that is used in lieu of a cutting operation for removal of a tumor); electrocauterization; diagnostic and therapeutic endoscopic procedures; or injection treatment of hemorrhoids, varicose veins, joint, tendon sheath, ligament or trigger points.

Surgical Assistance - refers to when an assistant physician who assists your surgeon while performing covered surgery when a house staff member, intern, or resident cannot be present.

Third Party Administrator - an organization which has been retained by the Fund to process claims and/or provide administrative services. The Fund's Third Party Administrator is BeneSys, Inc., P.O. Box 99485, Troy, Michigan 48099-9485, telephone 248-641-4966, or toll free 855-641-4966.

Totally Disabled (Total Disability) - a condition resulting from Illness or Injury in which, as certified by a Physician for a:

- Participant: means he/she is not engaged in any occupation for wage or profit and is unable to perform the substantial duties of a plumber, pipefitter, or metal tradesman; or
- Dependent Child age 26 or under: means he/she is substantially unable to engage in the normal activities of an individual of the same age and sex; or
- Dependent Child over age 26: means he/she is incapable of self-sustaining employment due to a mental or physical handicap and is primarily dependent upon the Participant for support and maintenance;
- Notwithstanding the foregoing, a participant who is eligible for coverage pursuant to Section 2.2 (Eligibility for Self-Employed Members and Non-Bargaining Unit Personnel), Totally Disabled (Total Disability) means such participant is unable to engage in any occupation for wage or profit.

Trust Fund or Fund - the Plumbers and Steamfitters Local 166 Health and Welfare Fund, as established by the Trust Agreement.

Trust Agreement - the Agreement and Declaration of Trust establishing the Plumbers and Steamfitters Local 166 Health and Welfare Plan Trust Fund, effective June 1, 1998, as amended from time to time.

Union - United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry ofthe U.S. and Canada, AFL-CIO, Local166.

ARTICLE 2- ELIGIBILITY RULES

2.1. Eligibility for Employees (Excluding Self-Employed Individuals, Non-Bargaining Unit Personnel, Indiana Pipes Trades Association Employees, and Northeast Indiana Building & Construction Trades Employees)

(a) Initial Eligibility

Initial Eligibility shall begin on the first day of the month following any month an Employee has completed 100 hours of Covered Employment and payment for those hours is received by the Fund Office.

In the event that an Employee's Employer(s) makes payment for fewer than 100 hours in the initial month of employment, the Employee may pay the difference in order to meet the Initial Eligibility requirements provided the Participant is on the Union's out of work list or working for a contributing Employer. Payment shall be in an amount equal to the difference in the hours reported and 100 multiplied by the applicable self contribution rate for such Employee, as established by the Trustees from time to time in their sole discretion.

(b) Establishing an Hour Bank. Once initial eligibility is established and hours in excess of 100 hours of Contributions per month equal a total of 300 hours, Contributions thereafter received for hours in excess of 300 hours per calendar quarter are placed in a participant's Hour Bank. This will continue until contributions in the Hour Bank equal 300 hours of contributions (i.e. 300 times the current applicable contribution rate).

(c) Continuing Eligibility. Provided the Participant is on the Union's out of work list or working for a contributing Employer, eligibility may be maintained by meeting the requirements set forth sections (1) or (2), below.

(1) Required Hours Per Calendar Quarter

In the calendar quarter during which eligibility is initially established under 2.1(a) and the following two calendar quarters, eligibility will continue provided 100 Hours of Contributions per month are received by the Fund Office. Effective beginning the third calendar quarter after initial eligibility is established, or sooner if eligibility has been re-established under section 2.1(e), eligibility will continue so long as 300 hours of contributions are received per calendar quarter, as follows:

Calendar Quarter of Contributions	Benefit Quarter of Coverage
300 hours of Contributions in April, May, June	Provide eligibility for subsequent September, October, and November
300 hours of Contributions in July, August, September	Provide eligibility for subsequent December, January, and February
300 hours of Contributions in October, November, December	Provide eligibility for subsequent March, April, May
300 hours of Contributions in January, February, March	Provide eligibility for subsequent June, July, August

If less than the required hours of contributions are received per month or per calendar quarter to maintain eligibility as set forth above, as applicable:

(A) on or after the beginning of the third calendar quarter after initial eligibility is established, hours needed to reach the required hours to maintain eligibility may be drawn from the participant's Hour Bank; or

(B) If eligibility cannot be maintained under (A), and the Participant is on the Union's out of work list, working for a contributing employer, or working outside the Union's jurisdiction under the collective bargaining agreement of another UA local, the Participant shall be permitted to make self-contribution payments to the Fund in an amount equal to the difference between the credited hours for the month or Calendar Quarter, as applicable, and the required hours to maintain eligibility multiplied by the applicable self-contribution rate as established by the Trustees from time to time in their sole discretion. The ability of a Participant to maintain coverage by self-paying the entirety of the required hours is limited to four consecutive Calendar Quarters.

The self-contribution payment must be made quarterly and be paid by the 20th day of the last month of the Calendar Quarter preceding the Benefit Quarter for which coverage is being requested. Payment may also be made on a monthly basis, provided that the payment is made by the 20th day of the month preceding the month for which coverage is being requested. A self-contribution payment is deemed to be made on the date it is postmarked or actually received by the Fund Office, whichever is earlier.

Failure to make a timely self-contribution payment or to make a self contribution payment, even if timely, in the correct amount shall result in a loss of eligibility and the right to make future self-contribution payments. The Trustees reserve the right to accept for good cause, not more than once, a Participant's late or incorrect self-contribution payment, provided that payment in the correct amount is received by the Fund Office no later than 30 days after the original due date.

(2) Look Back Rule. Once the Hour Bank equals 300 hours of contributions, then hours in excess of 300 hours of contributions per calendar quarter can be used for purposes of the Look Back Rule. Under the Look Back Rule, eligibility can be maintained where the following number of hours of contributions has been received by the Fund Office on behalf of a Participant:

Calendar Quarter(s) of Contributions	**Benefit Quarter of Coverage**
600 hours of Contributions January thru June **or** 900 hours of Contributions October thru June **or** 1,200 hours of Contributions July thru June	Provide eligibility for subsequent September, October, and November
600 hours of Contributions April thru September **or** 900 hours of Contributions January thru September **or** 1,200 hours worked October thru September	Provide eligibility for subsequent December, January, and February
600 hours worked July thru December **or** 900 hours worked April thru December **or** 1,200 hours worked January thru December	Provide eligibility for subsequent March, April, May
600 hours worked October thru March **or** 900 hours worked July thru March **or** 1,200 hours worked April thru March	Provide eligibility for subsequent June, July, August

Hours of contributions in the Hour Bank cannot be used for purposes of the Look Back Rule. If at any time a Participant's Hour Bank drops below 300 hours of Contributions, any subsequent hours of Contributions in excess of 300 hours per calendar quarter will be placed in the Hour Bank until it again equals 300 hours.

(d) Termination of Coverage and Loss of Reserve Credit. Notwithstanding any term of this Plan to the contrary, a Participant shall cease to be eligible under this Plan the earliest of the following:

(1) He/she becomes employed by an employer which is not obligated to make Contributions to this Plan, unless the Participant is working for an employer party to a collective bargaining agreement which requires contributions on his/her behalf to another health plan which has a reciprocity agreement with this Plan.
(2) He/she enters military service, other than service for less than 30 days.
(3) Eligibility is no longer established under Sections 2.l(b) or (c), above.
(4) He/she is terminated from the Plumbers & Steamfitters Local Union 166 Apprenticeship Training Program or any UA sponsored apprenticeship program.

Your coverage under this Plan shall terminate on the last day of the calendar month during which either of these events occurs. In addition, at that time, you shall forfeit the entire balance of your Reserve Credit Dollar Account.

(e) Reinstatement of Eligibility. In the event that eligibility is terminated, an Employee will reinstate eligibility on the first day of the third month following any calendar any calendar quarter during which the Employee completes 300 hours or more of Covered Employment for an Employer or Employers and payment for those hours is received by the Fund Office. In the event that an Employee's Employer(s) makes payment for fewer than 300 hours in the first calendar quarter following the month in which eligibility terminated, the Employee may pay the difference in order to meet these reinstatement requirements provided the Employee is on the Union's out of work list or working for a contributing Employer. Payments shall be in an amount equal to the difference in the hours reported and 300 multiplied by the applicable self contribution rate for such Employee, as established by the Trustees from time to time in their sole discretion. Once eligibility is re-established, Contributions for hours in excess of 300 hours per calendar quarter are placed in a participant's Hour Bank. This will continue until contributions in the Hour Bank equal 300 hours of contributions (i.e. 300 times the current applicable contribution rate). Coverage will thereafter continue pursuant to the terms of 2.1(c).

All other terms and conditions of eligibility set forth in section 2.1 apply once eligibility is reestablished.

(t) Contributions Subject to Reciprocity. Contributions made on behalf of Employees represented by local Unions with which the Plan has reciprocal agreements shall be returned to the appropriate home fund pursuant to the terms of the reciprocal agreement and no eligibility for benefits shall be established under this Plan. Contributions received via reciprocity on behalf of Active Employees shall be prorated to the equivalent applicable hourly contribution rate and then credited to the Active Employee on whose behalf the reciprocated contribution was received.

2.2. Eligibility for Self Employed Members and Non-Bargaining Unit Personnel

(a) Eligibility for self-employed members requires the reporting and payment of 40 hours per week (13 weeks per Calendar Quarter) or the actual number of hours worked in the case of a bargaining unit individual, whichever is greater. Failure to report the minimum of 160 or 200 hours in a Calendar Month shall result in a failure to establish initial Eligibility or to maintain eligibility.

(b) Self-employed members or other employers who desire to cover Non-Bargaining Unit Personnel may do so pursuant to a Participation Agreement and otherwise subject to the following:

(1) Coverage For All Full-Time Non- Bargaining Unit Personnel

(i) Contributions must be made for all full-time (on average at least 30 hours per week) Non-Bargaining Unit Personnel. Notwithstanding, coverage does not have to be provided for Employees who certify they have other health coverage which meets the Affordable Care Act minimum value standard (Excluded Employee). Proof of such coverage must be provided to the Fund Office upon request.

(ii) If an Excluded Employee loses his/her other health coverage, or experiences another qualifying event such as death, marriage, birth of a child or adopted, the Excluded Employee may be enrolled within 30 days of such event. If not enrolled within 30 days of loss of coverage, any Excluded Employee who no longer has other coverage must be enrolled in the next open enrollment period.

(iii) The Employer must contribute on each Non-Bargaining Unit Personnel for whom contributions are required in the amount of:

- the greater of the actual numbers of hours worked by such Employee per week or 40 hours per week multiplied by
- the then prevailing rate required to be contributed to the Fund on behalf of Local 166 Journeyman under the Local 166 Collective Bargaining Agreement.

(iv) Newly hired, Non-Bargaining Unit Personnel are eligible for enrollment in the Fund on the first of the month following 60 days of employment. New Non Bargaining Unit Personnel not enrolled when first eligible must be enrolled in the next open enrollment period.

(2) Exception For Non-Bargaining Unit Participant Alumni Who Switches Employers. Notwithstanding the requirements of (b)(l) above, a Non-Bargaining Unit Participant, who is an alumni of the Bargaining Unit, may continue participation in the Plumbers and Steamfitters Local166 Health and Welfare Fund when he switches Employers even if the new Employer does not otherwise cover Non-Bargaining Unit Personnel, provided there is no lapse in coverage and the new Employer is a party to the Local 166 Collective Bargaining Agreement (i.e. makes contributions for bargaining unit Employees).

(c) In no event will non-bargaining participation exceed 10% of the total participation.

(d) Banks for Administrative Staff: Contributions for hours received in excess of 300 per Calendar Quarter (as defined in Section 2.1, above) are placed in individual Hour Banks. Administrative Staff may use his/her Hour Bank to maintain coverage when on a leave of absence of up to 12 consecutive months authorized by the Union or necessitated by an illness ori ury incurred while in the active employ of the Union or on a leave authorized by the Union. Eligibility shall be maintained during such leave by drawing 300 hours per Calendar Quarter from his/her Hour Bank. If there are insufficient Banked Hours to maintain eligibility during such leave, Administrative Staff may maintain eligibility for a Calendar Quarter by self-paying an amount equal to the hourly contribution rate required under this Section 2.2 multiplied by (300 minus the hours remaining in his/her Bank).

2.3. Eligibility for Disabled Participants Who Are Not Retired

After an Active Participant becomes initially disabled, coverage will be continued during the period of time contributions are received by an Employer pursuant to the Family and Medical Leave Act. (The Employer is solely responsible for determining whether such contributions are owed and the Fund has no obligation to collect such contributions.)

After the Employer ceases making contributions, the Participant may continue eligibility pursuant to Section 2.1(c).

Once eligibility under Section 2.1(c) is exhausted, the Participant may continue coverage by making self-payments equal to the amount of contributions which would be required to maintain eligibility under Section 2.l(c)(1), above. However, if the Participant has applied for Social Security Disability, the self-payment will equal the self-payment rate for Medicare eligible Participants In the event he/she is denied Social Security Disability benefits after all internal Social Security Disability Administration appeals have been exhausted, the Participant must pay the Fund the difference between the amount paid and the self-payment that would have been required under Section 2.1(c) if an application for Social Security Disability benefits had not been filed.

A Participant's coverage under this section shall terminate the earlier of: (a) the date he/she fails to make a required self-payment;

(b) the date he/she becomes gainfully employed outside the trade;
(c) the date he/she becomes eligible for Retiree coverage under Section 2.5, below, or
(d) 24 months, unless an application for Social Security Disability benefits is pending, in which case coverage will continue until all internal Social Security Disability Administration appeals have been exhausted.

If coverage is terminated under this section and the Participant does not otherwise qualify for continued coverage under this Plan, he/she will be offered COBRA coverage.

2.4. Dependent Eligibility

(a) A Participant may enroll him/herself and his/her eligible Dependent(s).
(b) If both Spouses are Participants, both may elect coverage, and both may elect Dependent coverage. Either individual may be covered as a Participant or as a Dependent under the Plan. In no event may an individual be covered both as a Participant and as a Dependent under the Plan. Dependent Children may be covered as Dependents of either Spouse, or both. In no event will a Dependent's coverage become effective before a Participant's coverage.
(c) Newborn Children or adopted children of, or children placed for adoption with, Participants who have covered Dependents will be eligible as of the date of such event. However, no claims will be paid until a completed enrollment form is received by the Third Party Administrator.
Participants who have <u>not</u> previously enrolled in Dependent coverage must complete and submit an enrollment form within 31 days of the Child's birth, adoption, placement for adoption or other event giving rise to eligibility in order for the Child to be eligible for coverage as of the date of such event. Otherwise, coverage will be effective upon acceptance of the completed enrollment form by the Third Party Administrator.
(d) A Participant must provide the following to the Third Party Administrator upon request:
- documentation proving Dependent status, including, but not limited to, birth certificates, marriage records, or initiation of legal proceedings severing spousal or parental rights;
- at reasonable intervals, proof that such Child continues to be Totally Disabled and eligible for coverage beyond age 26, including an examination by a Physician of the Plan's choice, at the Plan's expense. Coverage under the Plan will cease when such Child ceases to be Totally Disabled, or earlier if such Child ceases to meet the requirements to be considered a Dependent under the Plan. Once this has occurred, the Child cannot be re-enrolled in the Plan.

(e) Coverage will be provided pursuant to a Qualified Medical Child Support Order, (QMCSO). A QMCSO means a medical child support order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and clearly specifies:

- the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient (i.e. child/ren) covered by the order (except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any alternate recipient);
- a reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined;
- the period to which such order applies; and
- the plan to which the order applies.

A medical child support order will fail to be a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 U.S.C. §1396g. The procedures for determining the qualified status of medical support orders are as follows:

- The Participant and any potential Alternate Recipients and/or their designated representatives will be immediately notified in writing that the Order has been received by the Fund and its qualified status will be determined by the Third Party Administrator within 45 days, or within any time period that may be established by federal regulations in the future. The notice will include a provision permitting an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order and a copy of the plan's procedures for determining the qualified status of the order.
- After determining the status of an Order, the Participant and Alternate Recipients and/or their designated representatives will be notified in writing. If the QMCSO is acceptable, the Alternate Recipients and/or their designated representative will be informed of the Alternative Recipient's health benefits and of the Plan's procedures to provide benefits.
- If the determination is that an Order is not a QMCSO, the Third Party Administrator will suggest necessary modifications. During this interim period, the Fund may either provide coverage or wait and provide retroactive coverage once the QMCSO is approved.

Once a Child is enrolled in the Fund pursuant to a QMCSO, the Fund cannot disenroll or eliminate coverage unless the Fund is provided with written evidence that the Court or Administrative Order is no longer in effect or that the child will be enrolled in comparable health insurance through another insurer effective no later than the date of the disenrollment.

If the Plan receives an appropriately completed National Medical Support Notice and the Notice meets the requirements of a QMCSO, the Notice shall be deemed to be a QMCSO. Where an appropriately completed National Medical Support Notice which meets the requirements of a QMCSO is issued regarding the child of a Participant who is a noncustodial parent, within 40 business days after the date of the Notice the Fund Office shall-

- notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to Section 9.I(b)(I)) to effectuate the coverage; and
- provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Neither a QMCSO nor a National Medical Support Notice shall, to provide benefits under the Plan a plan to provide any benefits not otherwise provided under the Plan. Any payment for benefits made by the Fund pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. The Plan will comply with any other requirements of §609 of ERISA regarding QMCSO.

(f) A Dependent's coverage will terminate on the earliest ofthe following dates:
(1) The Participant's coverage terminates.
(2) The Participant ceases to make the required contribution regarding Dependent Coverage.
(3) When the Child is eligible for employer-based health care coverage under another health care plan prior to May 1, 2014.
(4) The last day of the Calendar month the Child ceases to meet the eligibility rules for Dependent Children.
(5) The last day of the calendar month the Spouse is legally separated or divorced from the Participant.

2.5. Eligibility for Retired or Permanently Disabled Participants

(a) Eligibility

(1) Retired Participants

A retired Participant becomes eligible for benefits for himself and his eligible Dependents if he meets all of the following terms and conditions:

(A) The Participant applies to the Plan for coverage as of his retirement date.
(B) The Participant provides proof that he is receiving pension benefit payments from a pension plan sponsored by a local Union affiliated with the United Association of Plumbers and Pipefitters (or in the case of Administrative Staff, the Plumbers and Steamfitters Local 166 Profit Sharing Annuity Plan or the UA General Officers and Employees Pension Fund).
(C) The Participant is at least age 55.
(D) The Participant has been eligible for benefits under this Plan for at least one month in each of the ten Plan Years immediately preceding the Participant's retirement.
(E) He is a member in good standing with the Union.

(2) Disabled Participants

A disabled Participant becomes eligible for benefits for himself and his eligible Dependents if he meets all of the following terms and conditions:

(A) The Participant applies to the Plan for coverage within 30 days of receipt of a favorable disability benefit award from the Social Security Administration.
(B) The Participant provides proof that he is receiving disability benefit payments from a pension plan sponsored by a local Union affiliated with the United Association of Plumbers and Pipefitters (or in the case of Administrative Staff, the Plumbers and Steamfitters Local166 Profit Sharing Annuity Plan or the UA General Officers and Employees Pension Fund).
(C) The Participant is receiving disability benefits from the Social Security Administration.
(D) The Participant has been eligible for benefits under this Plan for at least one month in each of the ten Plan Years immediately preceding the Participant's retirement.
(E) He is a member in good standing with the Union.

(3) Continuing Coverage if a Retired Disabled Participant's Social Security Award is Revoked

(A) In the event a Retired Disabled Participant's Social Security disability award is revoked, he/she can maintain coverage under the same terms as a Retired Disabled Retiree under 2.5(a)(2), including making self-payments at the rate charged to Medicare eligible participants if such revocation includes revocation of Medicare eligibility, provided he/she:

(i) has timely filed an appeal or request for review of such revocation with the Social Security Administration, and continues to timely pursue same through exhaustion of all appeal or review rights, both administrative and judicial ("SSA Appeal Procedure");

(ii) continues to receive a disability benefit under a pension plan sponsored by a local Union affiliated with the United Association of Plumbers and Pipefitters (or in the case of Administrative Staff, the Plumbers and Steamfitters Local 166 Profit Sharing Annuity Plan or the UA General Officers and Employees Pension Fund); and

(iii) is not capable of employment in any gainful capacity.

(B) Such coverage may continue until the exhaustion of the SSA Appeal Procedure. In the event the applicant is found not to be disabled by the Social Security Administration after the exhaustion of the SSA Appeal Procedure, then

(i) continued coverage as a Disability Retiree shall terminate;

(ii) for the period of time between the date of the initial notice of revocation of benefits from the Social Security Administration until the date benefits are terminated under (i), above, the Participant must pay the Fund the difference between the self-pay rate paid by the Participant during this period oftime and the lesser of:

- the self-payment required under Section 2.1(c), or
- the self-payment that would have been required under another classification for which the Participant qualified for continued coverage under the terms of this Plan during this period of time; and

(iii) if the Participant does not otherwise qualify for continued coverage under this Plan, he/she shall be offered COBRA coverage.

(b) Self Payments

To maintain eligibility, self-payments, in an amount established in the sole discretion of the Trustees from time to time, must be made on a monthly, quarterly, or yearly basis and must be postmarked by the 1Oth day of the eligibility month or the 1Oth day of the first month of the Benefit Quarter. For Retirees receiving a monthly benefit from the Plumbers and Steamfitters Local166 AFL-CIO Pension Fund, self-payments must paid by an assignment of such benefit to the Plan, unless the self-payment is greater than the pension benefit in which case self-payment must be made via an automatic deduction from a checking account. This assignment is voluntary and revocable at any time; however, coverage will be lost upon revocation. If a Retiree chooses not to make such an assignment (or automatic deduction), he/she will be offered COBRA continuation coverage.

Failure to make timely and continuous payments as described above shall terminate the individual's right to make further payments and be covered under this Plan. NO

LATE PAYMENTS SHALL BE ACCEPTED. However, the Trustees reserve the right to accept for good cause, not more than once, a Participant's late or incorrect contribution payment, provided that payment in the correct amount is received by the Fund Office no later than 30 days after the original due date.

When a Participant initially becomes eligible as a Retiree, in lieu of self-payments, any hours which remained in his/her Bank upon retirement will be used to maintain monthly eligibility as a Retiree (at the same rate such hours are used to maintain monthly eligibility for Actives) until such hours are exhausted.

(c) Effective Date of Coverage

The initial eligibility date of coverage is the first day of the Benefit Quarter following the date the application is approved and proper payment is received. An otherwise eligible person who fails to enroll within the time limits set forth above forfeits all future rights to participate in the Fund as a Retiree.

(d) Termination of Coverage

Coverage for a Retiree terminates the earliest of:

(1) The first day of any month for which the required self-payment is not timely paid; or
(2) The last day of the month during which the Covered Person fails to meet the eligibility rules or fails to qualify as an eligible Dependent; or
(3) The last day of the month during which the Retired or Disabled Member loses membership in Plumbers and Steamfitters Local 166.

2.6. Eligibility for Surviving Spouses of Active Participants or Retirees

(a) Eligibility

A Surviving Spouse of a deceased Participant, and his/her Children eligible as of the date of the death of the Participant (or born within nine months of the death of the Participant), may continue coverage for 90 days following the death of the Participant. Thereafter, he/she may elect to maintain eligibility by making self-payments in a timely manner as set by the Trustees, provided the Surviving Spouse makes written application to the Trustees for such continued coverage no later than 90 days following the death of the Participant.

The Surviving Spouse's coverage shall commence with the first day of the month following the receipt of the written application, required self-payment, and approval by the Trustees.

(b) Self Payments

Self-payments must be made on a monthly basis. The self-payment amounts are determined from time to time in the sole discretion of the Trustees.:

In the event the Surviving Spouse is receiving a pension from the Plumbers and Steamfitters Local 166 AFL-CIO Pension Fund, self-payments must be made in the manner set forth for Retirees in Section 2.5(b).

Failure to make timely and continuous payments as described above shall terminate the individual's right to make further payments and be covered under this Plan. NO LATE PAYMENTS SHALL BE ACCEPTED. However, the Trustees reserve the right to accept for good cause, not more than once, a Surviving Spouse's late or incorrect contribution payment, provided that payment in the correct amount is received by the Fund Office no later than thirty days after the original due date.

(c) Termination of Coverage

Coverage under for a Surviving Spouse shall terminate the earliest of:

(1) The first day of any month for which the required self-payment is not timely paid; or

(2) The first day of the Benefit Quarter following the Benefit Quarter in which the Surviving Spouse remarries; or

(3) The first day of the Benefit Quarter in which the Surviving Spouse is covered for benefits under another group health care or group insurance plan.

2.7. Indiana Pipes Trades Association Employees and Northeast Indiana Building & Construction Trades Employees

A covered employee of the Indiana Pipes Trades Association or the Northeast Indiana Building & Construction Trades is eligible for coverage the first of the month following the month in which 100 hours of contributions, at a rate agreed upon by the Trustees, is received by the Fund.

Eligibility will continue thereafter provided 100 hours of contributions are received by the Fund. Contributions are due prior to the month for which coverage is sought. If contributions are not timely received, the covered employee will be offered COBRA coverage. However, in the event the Employer contributes less than 100 hours for a particular month, then up to two times per year the covered employee may self-pay the hours needed to equal 100 for that month.

Notwithstanding the above, if a covered employee under this section is unable to work for the Pipe Trades Association or the Northeast Indiana Building & Construction Trades due to sickness or disability, he/she may self-pay (in full or in part) to maintain coverage for a period of 6 months.

All self-payments under this section shall be made under the same terms and conditions, at the prevailing journeyman rate, applicable to participants to under Section 2.1(c).

2.8 Open Enrollment

Open Enrollment will occur December 1st through December 301 of each Plan Year.

ARTICLE 3- MEDICAL BENEFITS

3.1. Network

The Fund has entered into an agreement with a preferred provider organization (PPO). The agreement provides that hospitals, physicians, and other health care providers in the preferred provider organization networks will charge reduced fees to Covered Persons. Providers in the preferred provider organization are referred to as Participating Providers, or in network providers. The Fund reimburses a higher percentage of in network provider charges than out of network provider charges. However, it is always the Covered Person's choice as to which Provider to use.

The Fund's PPO Network is Anthem Blue Cross Blue Shield (Anthem). To view and print a copy of the provider directory visit the following website www.anthem.com. You may also request a printed copy of the provider directory by contacting Anthem at 1-800-331-1476. A list of Participating Providers is also available for inspection at the Fund Office.

In the following situations, services rendered by a non-PPO provider will be considered at the PPO level:

- Ancillary providers rendering care in a PPO facility (i.e.: pathologist, radiologist, and anesthesiologist, emergency room physician)

- If a Covered Person is out of the PPO service area and has a medical emergency requiring immediate care
- When a PPO provider utilizes the services of a Non-PPO provider for the reading or interpretation of x-ray or laboratory tests
- Eligible Dependent Children who reside outside of the Primary PPO service area.
- When a PPO provider refers a Covered Person to a specialist who is the exclusive provider of the only medically necessary and appropriate treatment available
- When the PPO network confirms there is no in network provider within 50 mile radius of the covered person's residence, in which case the provider charge will be paid in network and the facility charge will be paid in network only if such provider does not have privileges at an in-network facility within such area.
- Out-of-network facility charges for a surgical procedure performed by a PPO Provider when the out-of-network facility has medical equipment that in the opinion of the PPO Provider, supported by medical literature or information that is acceptable in the sole discretion of the Trustees, will increase the likelihood of the surgical procedure and such equipment is not available at an in-network facility within 50 miles of the covered person's residence.

3.2. Benefits

(a) Relevant Terms

Coinsurance - The chart below indicates the percentage of a covered expense paid by the Fund. If the percentage is less than 100%, the Covered Person is responsible for the remainder. For instance, for in-network outpatient surgery, the Fund pays 90%. This means that the Covered Person is responsible for paying the remaining 10%.

Copay/Copayment - The amount of money paid by the Covered Person each time a particular service is received.

Annual Deductible - The deductible is an amount that must be paid by the Covered Person annually before any benefits are payable. If two or more Covered Persons of a family are injured in the same accident, only one deductible will be applied toward the eligible expenses which directly resulted from injuries incurred by family members in the same accident. Any amount paid as a deductible applies to satisfying the Annual in network deductible as well as the out of network Annual Deductible set forth in the chart below.

Reasonable and Customary (R&C) - Out of network benefits are paid at a Reasonable and Customary level, which means the Fund will pay the lesser of the actual charge or a charge which is not higher than the general level of charges accepted by most providers of like service in the same area, considering the nature and severity of the condition being treated, medical complications or unusual circumstances. Please note that even if the Fund pays a Reasonable and Customary amount to an out of network provider, the provider may bill the Covered Person for amounts not paid by the Fund.

Annual Out-of-Pocket Maximum - This is the annual maximum amount of eligible medical expenses which a Covered Person has to pay for in-network benefits. Once the Out of Pocket Maximum has been met, the Fund will pay 100% of eligible expenses for in-network benefits. There is no out of pocket maximum for out of network benefits (in other words, a Covered Person will continue to have co-insurance and co-payments on out of network benefits regardless of the out of pocket amount paid by the Covered Person). Any amounts paid out of network will be used to satisfy the in-network and out of pocket maximums.

(b) Medical Benefits

The following chart sets forth the benefits provided by the Fund subject to all exclusions and limitations set forth in this Plan, including but not limited to the exclusions set forth in Section 3.3, below. All benefits are subject to applicable deductibles, unless otherwise noted.

	In-Network	**Out-of-Network**
Annual Deductible	$500/individual; $1,000/family $7,000/family Effective 1/1/2020: $1,500 individual; $3,000 family	$3,500/individual; $7,000/family
Coinsurance	10% (Plan pays 90%) Effective 1/1/2020: 20% (Plan pays 80%)	40% (Plan pays 60%) of R&C
Maximum Out-of-Pocket Medical Costs per Plan Year	$3,000/individual; $6,000/family Effective 1/1/2020: $4,000/individual; $8,000/family	No out of pocket maximum
2016 Annual TROOP, subject to annual increase [1]	$7,900/individual; $15,800 family	No TROOP Limit

[1] Set forth in the chart is the 2019 Total Real Out-of-Pocket Maximums for essential health benefits, which includes deductibles, co-insurance, and co-pays for medical and Rx. The Annual TROOP will increase annually to maximum allowed by law.

Medical Benefits	**In-Network**	**Out-of-Network**
HOSPITAL SERVICES (whether admitted as bed patient or as an outpatient to any state-approved hospital)		
Inpatient Maximum Daily Semi- Private Room Charge	90%	60%
Private Room Rate (the hospital's average semi-private room rate)	90%	60%
Special Care Unit (ICU and CCU)	90%	60%
Inpatient Miscellaneous Charges	90%	60%
Inpatient Physician Visits	90%	60%
Ancillary Services	90%	60%
Blood and Blood Plasma	90%	60%

Medical Benefits	In-Network	Out-of-Network
Diagnostic Services	90%	60%
Emergency Room (per incident or occurrence) (no deductible) If Emergency Room Visit results in admission or is for a life-threatening illness, see below.	90% with $200 copayment	90% with $200 copayment (Maximum payment for out-of-network services will be the greater of the in-network rate, out-of-network rate, or Medicare approved amount)
Emergency Room - Life Threatening Illness or Admitted (no deductible)	90%	90%
Operating room and supplies	90%	60%
Pre-admission testing (deductible does not apply)	100%	100%
Surgical Expense Benefits	90%	60%
Multiple Surgical Procedures:	If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. No additional allowance shall be made for any incidental procedures performed during the operative session.	If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. No additional allowance shall be made for any incidental procedures performed during the operative session.
Surgical Assistance	90%	60%
Second Surgical Opinion (deductible does not apply) Must be provided by a surgeon other than the first surgeon who recommended the surgery. A third opinion will be covered if the first two conflict.	100%	60%
ALCOHOL AND SUBSTANCE ABUSE	90%	60%
DENTAL SERVICES		
Accidental Injury	90%	60%

Medical Benefits	In-Network	Out-of-Network
MATERNITY BENEFITS-INPATIENT **See special notice following charts**.		
Birthing center	90%	60%
Newborn Exam	90%	60%
Surgical Sterilizations	90%	60%
MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES		
Medical and Surgical Supplies	90%	60%
Durable Medical Equipment (expenses not included in out of pocket maximum)	90%	60%
Orthotic Devices	90%	60%
Prosthetic Appliances	90%	60%
MENTAL HEALTH BENEFITS	90%	60%
AUTISM SPECTRUM DISORDER		
Screening and Diagnosis, only.	100%	100%
THERAPY SERVICES All therapy must be non-maintenance to be eligible		
Cardiac rehabilitation (coverage available only for Phase I and II)	90%	60%
Chemotherapy	90%	60%
Outpatient dialysis	90%	60%
Hyperbaric and pulmonary therapy (treatment must be provide by a Hospital)	90%	60%
Occupational therapy	90%	60%
Radiation therapy	90%	60%
Respiratory therapy	90%	60%
Speech therapy when used to regain normal speech lost due to Accident, Injury, or sickness	90%	60%
Physical Therapy	90%	60%

Medical Benefits	In-Network	Out-of-Network
PHYSICIAN VISIT- NOT IN HOSPITAL As EPO is a hospital network, the EPO network IS not applicable for physician visits outside the hospital and the in- network provider is Parkview Signature Care. Accordingly, these visits are subject to the lower preferred EPO Network Deductible and MOO (as opposed to the higher Parkview Signature Care deductibles and MOO for EPO County residents).		
Primary care visit to treat an injury or illness	n/a	60%
Specialist visit	n/a	60%
Other practitioner office visit	n/a	60%
WELLNESS BENEFITS (As EPO is a hospital network, wellness benefits generally do not apply and the in-network provider is Parkview Signature Care)		
Annual physical examination	n/a	60%
Colon/rectal screening (one per every 10 years if age 35 or older, or one per every 10 years if under age 35 and considered high risk)	100%	50%
Immunizations and inoculations for children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP). EXCEPTION: Immunizations shall be covered under prescription drug coverage and HRA not medical where that option is available. Out of pocket maximum does not apply	n/a	60%
Well baby and child care (deductible does not apply)	n/a	60%

Medical Benefits	In-Network	Out-of-Network
Gynecological exam, including the pap test and doctor visit (one per year; deductible does not apply)	n/a	60%
Prostate tests and exams, including doctor visit (one per year; deductible does not apply)	n/a	60%
Mammogram (one per year; deductible does not apply)	100%	60%
OTHER PROVISIONS		
Ambulance Services Trips must be to the closest facility that can give covered services appropriate for the Covered Person's condition. Air ambulance service is covered under the Plan when Medically Necessary.	90%	90%
Anesthesia (must be administered by a Physician or Other Provider who is not the surgeon or the assistant at surgery)	90%	60%
Chiropractic Care Calendar Year Maximum: $1,000.00 Out of pocket maximum does not apply	90%	60%
Enteral or Parenteral Nutrition Therapy	90%	60%
Home Health Care Maximum of 100 visits per calendar year. Each four hours shall be considered one visit.	n/a	60%
Skilled Nursing Facility	n/a	60%

Medical Benefits	In-Network	Out-of-Network
Confinement in the facility must begin within two days after the Covered Person has been confined in a Hospital for at least three consecutive days for which room and board charges were paid, must be for treatment of the Illness causing the Hospital Confinement, and is one for which a Physician visits the Covered Person at least once every 30 days.		
Hospice care (no deductible) A treatment plan must be developed and submitted to the Plan by the Covered Person's Physician and the Provider of Hospice Services. The treatment plan must be approved by the Plan. Benefits may exceed 6 months should the patient continue to live beyond the prognosis for life expectancy.	90%	90%
Organ Transplants	See Section 3.6, below.	See Section 3.6, below.
Mastectomy and breast reconstructive surgery in connection with a mastectomy performed related to breast cancer, which includes: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.	90%	60%

Medical Benefits	In-Network	Out-of-Network
Private Duty Nursing Services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician Prior approval is required for inpatient services	90%	60%
Wheelchair or Motorized Scooter Effective 1/1111, subject to $2000 lifetime maximum. Out of pocket maximum does not apply	90%	60%

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

3.3. Limitations and Exclusions

(a) The following are not covered by the Plan:

(1) Elective abortions, except in the case of rape, incest, or to save the life or to protect the life of the mother;
(2) Charges which would not have been made had coverage not existed;
(3) Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;
(4) Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing;
(5) Cardiac Rehabilitation that is considered part of Phase III;
(6) Charges relating to self-inflicted injuries, or threatened suicide unless due to a medical condition;
(7) Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning;
(8) Treatment or services resulting from participating in a civil insurrection or riot;
(9) Clinical trials, except for Routine Patient Costs incurred in an Approved Clinical Trial as set forth below. For purposes of this provision:
    (a) An Approved Clinical Trial is a clinical trial for which coverage is required under federal law, PHSA Sec. 2709, which is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (i.e. any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is a federally funded trial or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (or is exempt from investigational new drug application requirements); and

(b) Routine Patient Costs are items and services typically covered by the Plan for Covered Persons not enrolled in Clinical Trials. Further, Routine Patient Costs do not include:

(1) the investigational item, device, or service, itself;

(2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Where an in-network provider is participating in an Approved Clinical Trial in the Covered Person's state of residence and this participating provider will accept the Covered Person as a participant in that trial, coverage for Routine Patient Costs will only be provided for participation in such trial.

In-network and out-of-network Routine Patient Costs will be subject to the Plan's standard cost-sharing provisions for in- and out-of-network services and expenditures, which means a Covered Person may be balance billed for participating with an out-of-network provider.

(10) Service provided by a "close relative," meaning Spouse, or Covered Person's or Spouse's parent, brother, sister or child, or the Spouse of the Covered Person's parent, brother, sister or child;

(11) Completion of claim forms, or missed appointments;

(12) Care, services or treatment required as a result of complications from a treatment not covered under the Plan;

(13) Corrective Shoes;

(14) Services rendered for cosmetic purposes, unless made necessary by accidental injury. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;

(15) Charges for health care ordered by a court, (i.e. court ordered rehabilitative treatment or services);

(16) Services or supplies provided mainly as a rest cure, domiciliary or convalescent care, or Custodial Care;

(17) Services or supplies for tooth extractions or other dental care that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease, or disease of the gingival tissue, except for surgical extraction of an impacted wisdom tooth;

(18 Developmental care, as defined in this Plan, regardless of where or by whom provided;

(19) Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting;

(20) Disposable supplies, except for colostomy supplies, syringes, lancets, or chem strips;

(21) Services for educational or vocational testing or training, except for diabetic management training;

(22) Charges that exceed the Reasonable and Customary allowance, if applicable;

(23) Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;

(24) Experimental or Investigative services, procedures, treatment, prescription drugs and supplies, or substances, which have not been recognized as accepted standards of medical protocol;

(25) Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply

to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery;

(26) Services and/or supplies for treatment of an accident or illness that resulted while committing a felony, unless due to a medical condition (physical or mental). This exclusion does not include services and/or supplies Incurred by a victim of domestic violence;

(27) Routine foot care such as treatment of bunions (except open cutting operations), corns, calluses, toenails, nail trimming, and hygienic and preventative maintenance foot care, including but not limited to:

(a) Cleaning and soaking of feet.
(b) Applying skin creams in order to maintain skin tone.
(c) Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

(28) Counseling or testing concerning inherited (genetic) disorders;

(29) Genetic Testing and Surgical Procedures for Detecting and Addressing High Risk of Breast Cancer and/or Ovarian Cancer, unless a female Covered Person's risk of contracting breast cancer and/or ovarian cancer is demonstrated in medical records which identify the Covered Person as having a strong family history of breast cancer and/or ovarian cancer.

Family history is defined by any of the following criteria:

(A) Multiple relatives of the Covered Person are affected.
(B) Relatives (including self) of the Covered Person were diagnosed with breast cancer and/or ovarian cancer at comparatively younger ages than is typical (prior to age 50).
(C) Relatives of the Covered Person have multiple primary cancers.
(D) There is an autosomal dominant pattern indicating that the Covered Person is in a common genetic path with her affected relatives.

BRCA I and BRCA II testing will be covered one time per lifetime and will not include a second level of testing. BRCA testing for Covered Persons that is performed primarily for the medical management of other family members who are not Covered Persons will not be covered. Tissue samples from other family members who are not Covered Persons may be required to provide the medical information necessary for the Covered Person's proper care.

Results. A Covered Person in any of the following circumstances may be considered at high risk for contraction of breast cancer and/or ovarian cancer:

(A) a mutated BRCA gene is found by genetic testing.
(B) Lobular neoplasia (fluid type 2), also referred to as LCIS or lobular carcinoma in situ (this pertains to removal of the uninvolved breast) is found.
(C) Atypical lobular hyperplasia, type 1, is found.

Prophylactic surgery and reconstruction are covered when the results of the genetic test BRCA I or BRCA II confirm the mutation of the gene. Coverage will include a prophylactic mastectomy or oophorectomy. Coverage subject to Plan's deductible, coinsurance, copayment, and other conditions applicable to covered surgeries and other procedures.

(30) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or Medicare or when otherwise prohibited by law;

(31) Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

(32) Treatment for injuries sustained while hang gliding, bungee jumping, parachuting, or injuries sustained while racing any sort of motorized vehicle;

(33) Hearing aids or examinations for prescribing or fitting them;

(34) Home Health Care, unless a Physician certifies that (a) hospitalization or Confinement in a licensed Skilled Nursing Facility would be needed if the Covered Person didn't have home care; and (b) members of the Covered Person's immediate family, or others living with the Covered Person, couldn't give the Covered Person the care and treatment he/she needs without undue hardship. If the Covered Person was hospitalized just before home care started, the Covered Person's primary Physician during his/her Hospital stay must also approve the home care plan. If home care is covered under two or more health benefit plans, coverage is payable under only one of them, except as stated in the Coordination of Benefits section. Under no circumstances will Home Health Care covered services include:

- dietician services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- purchase or rental of dialysis equipment;
- food or home delivered meals; and
- training.

(35) Hospice services which are:

- volunteer services;
- spiritual counseling;
- homemaker services;
- food or home delivered meals;
- custodial care, rest care or care which is provided solely for someone's convenience

(36) Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service;

(37) Housekeeping, shopping or meal preparation services (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet;

(38) Hypnosis;

(39) Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease;

(40) Reproductive infertility services including but not limited to family planning; fertility tests; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations; impotence, organic or otherwise;

(41) Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment;

(42) Medical and surgical supplies usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

(43) Confinement in an institution primarily to change or control one's environment;

(44) Never Events. The Center for Medicare and Medicaid Services has determined that some events should never happen in a Hospital or surgical center setting. When such events do occur, they can cause serious Injury or death to the patient. The National Quality Forum ("NQF") has defined these events as Serious Reportable Adverse Events, commonly referred to nationally as "Never Events". Care, treatment, or services relating to these Hospital acquired Illnesses and

Injuries, if they are reported, and after investigation, are determined to fall into the following Never Event categories, are not covered by the Benefit Plan:

- an Illness or Injury that the patient did not have at the time of entering the hospital;
- an Illness or Injury that the patient did not have at the time of entering the hospital;
- a foreign object left inside patient during a Surgical Procedure;
- an air embolism;
- blood incompatibility (wrong blood transfusion);
- Stage III or IV pressure ulcers (bedsores);
- falls or trauma;
- a Surgical Procedure on the patient's wrong body part;
- a catheter-associated urinary tract infection;
- deep-vein thrombosis or pulmonary embolism following total knee and hip replacements;
- Surgical site infection-mediastnitis after coronary artery bypass graft surgery;
- Surgical site infections following certain orthopedic and bariatric surgeries; and
- certain manifestations of poor control ofblood sugar levels. (45) Services performed at an employer work site treatment facility.

(46) Expenses that are in any way reimbursable through "No-Fault" automobile msurance;
(47) Any services or supplies which are not Medically Necessary;
(48) Charges incurred for which the Covered Person has no legal obligation to pay;
(49) Any expenses incurred for any service or treatment which is not provided or recommended by a Physician;
(50) Services, treatment and supplies which are not specified as covered under the Plan;
(51) Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the Notice of Claim section;
(52) Nuclear accident;
(53) Nutritional supplements, including those prescribed by a Physician;
(54) Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion includes any bariatric surgery and complications as a result of, which includes but is not limited to:

- gastric Bypass surgery (including Laparoscopic gastric bypass);
- gastroplasty;
- gastric banding

(55) Occupational therapy that consists of diversional, recreational, and vocational therapies (such as hobbies, arts and crafts);
(56) Elective procedures performed outside the United States, or any service or supply purchased outside the United States, unless pre-authorization from the Plan has been obtained prior to treatment, the Covered Person is a resident of the United States, and the charges are Incurred while traveling on business or for pleasure;
(57) To the extent that payment is prohibited by any law at the time expenses are Incurred;
(58) Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, hot tubs or spas, whirlpools, sunbeds, waterbeds, physical fitness equipment or like items, health club or country club memberships, electric heating units, telephones, televisions, cots, newspapers, walkers, commodes, visitor's meals, orthopedic mattresses, hot tubs, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-hospital adjustable beds even though a Physician may prescribe them;

(59) Private duty nursing does not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding. Furthermore, benefits are not provided for a nurse who usually lives in your home or is a member of your immediate family;

(60) Recreational therapy, even though a Physician may prescribe it;

(61) To the extent those expenses are in any way reimbursable through any public program, except as otherwise required by law;

(62) Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits;

(63) Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan;

(64) Services rendered or billed for by a school or halfway house or by a member of its staff;

(65) Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, and medical or psychiatric treatment, both pre and post-operative care;

(66) Skilled Nursing Facility services for custodial care or care for senile deterioration;

(67) Speech therapy, except when used to regain normal speech lost due to Accident, Injury, or sickness;

(68) Care and treatment for reversal of surgical sterilization;

(69) Telephone or internet consultations;

(70) Temporomandibular Joint Dysfunction (TMJ), Myofascial treatment or repair or mandibular or maxilla osteotomy;

(71) Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically allowed by the Plan;

(72) Transportation services provided by an ambulance or wheelchair van, which includes using an ambulance where there is a Non-Life Threatening condition;

(73) Travel or flight in or descent from any type of aircraft, if you are a student pilot or member of the crew, or if you are a passenger on:

(A) any civilian aircraft not having a current and valid worthiness certificate, or piloted by a person who does not then hold a valid and current certificate of competency or a rating authorizing him to pilot such aircraft; or

(B) any type of aircraft operated by any military authority of the United States, or by any duly constituted governmental authority of any other country recognized by the United States government while in the course of any training maneuvers of any Armed Forces;

(74) An Injury or Illness resulting from the voluntary use of prescription drugs, nonprescription drugs, or alcohol where the use of such substances constitutes or contributes to the violation of any state or federal law. It will be determined by the Plan that violation of a state or federal law has occurred if:

(A) the individual is convicted or found guilty of the applicable charges; or

(B) there is sufficient evidence that a state or federal law has been violated and no charges were brought against the individual, as determined in the sole discretion of the Trustees. Sufficient evidence is deemed conclusive in such situations including, but not limited to:

(i) blood alcohol levels which exceed established state or federal minimums,

(ii) the possession of illegal nonprescription drugs, or

(iii) prescription/legend drugs used or taken without a written prescription;

(75) Disease or injury resulting from participation in a war, or act of war, whether declared or undeclared;

(76) Weight Loss Programs. Weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, etc.) or fasting programs;

(77) Care received without cost under the laws of the United States or any other country or government entity;

(78) Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers' Compensation or occupational disease policy, whether or not any such policy is actually in force. However, this exclusion only applies to persons who can elect, or could have elected for them, coverage under a Workers' Compensation act, policy or similar law;

(79) Pre-marital examination, sports physical, school physical, or an employment related or required examination; or

(80) Services or treatment for Autism Spectrum Disorders, except for screening and diagnosis.

3.4. Precertification of Benefits and Utilization Review

(a) In General

Precertification review is required for all inpatient Hospital confinements. For elective admissions, precertification is required at least five business days prior to admission and for emergency admissions precertification is required within 48 hours following admission.

An elective admission refers to a pre-planned admission to the Hospital for an overnight stay or longer. This includes pregnancies. Patients are required to give notice to the utilization review company of all elective admissions, except pregnancies, at least five days prior to the admission.

An emergency admission refers to a situation that requires immediate hospitalization. In such case, the patient must call the utilization review company by the next business day after admission and provide them with the pertinent information concerning the admission.

The utilization review company is Health Link.

(b) Pregnancy/Childbirth

Inpatient Confinement for Delivery of Child - The utilization review company must be notified only if the inpatient care for the mother or child is expected to continue beyond 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Such notice must before the end of these time periods.

Non-Emergency Inpatient Confinement Before Delivery of Child - Confinement during pregnancy but before the admission delivery, which is not Emergency Care, requires notification as a scheduled Confinement. The utilization review company must be notified prior to the scheduled admission.

(c) Failure to Obtain Required Precertification

If precertification is not utilized, benefits may be reduced.

3.5. Medicare Eligibility

(a) Effect of Medicare Eligibility

If a Covered Person is eligible for Medicare Part A or B and does not enroll for such coverage, benefits under this Plan shall be calculated as if the individual had enrolled in both Part A and B of Medicare when first eligible to do so, regardless of the fact that the individual is not enrolled in the program.

(b) Coverage for Medicare Eligible Covered Persons

(1) Retirees, Spouses and Surviving Spouses

For Medicare eligible Pensioners, Spouses and Surviving Spouses ("Medicare Eligible Participants"), Medicare is primary. The Plan shall pay eligible Plan expenses only to the extent not paid by Medicare, and only after the Plan Deductible Amount is met. The Plan will pay all deductible amounts required by Medicare when a Covered Person is initially hospitalized. If an expense is covered by Medicare and not the Plan, no payment will be made by the Plan.

All claims will be processed as if the Medicare Eligible Participant has obtained Medicare Parts A and B, even if such coverage is not in place. Thus, it is strongly recommended that a covered person contact the Social Security Administration at least four months before they will reach age 65.

(2) Disabled Employees

A Covered Person suffering from a disability becomes eligible for Medicare, regardless of age, after receiving Social Security Disability payments for two years. Such a Participant is required to apply for Medicare benefits as soon as he becomes eligible for them. Once Medicare eligibility could have been obtained, even if it is not, coverage under the Plan will be coordinated with Medicare coverage under the Plan will be coordinated with Medicare as set forth in paragraph (1), above. In other words, the Plan will not pay for benefits which would have been paid for by Medicare had it been timely applied for and obtained. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding Social Security Disability payments.

(3) Dialysis Patients

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Covered Person receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by the Medicare's Secondary Payer rules.

(4) Claims Incurred by Medicare Participants Outside of United States

Medicare does not pay for claims incurred outside of the United States and, therefore, the Fund will not provide coverage either. If a Participant or Dependent is traveling outside of the United States, he/she must obtain a private short term insurance policy to ensure coverage.

(5) Medicare Secondary Payer Rules

To the extent that Medicare Secondary Payer Rules are applicable to a Medicare eligible individual who has coverage by virtue of current employment status or is Medicare eligible due to End Stage Renal Disease, please see Article 9.

3.6. Transplants

Benefits for organ and tissue transplants are provided under a fully insured policy of insurance (AIG Policy) issued to the Fund by AIG life insurance Company, 1 Alico Plaza, Wilmington, DE 19801. The Policy is administered by Medical Excess LLC, 8777 Purdue Road, #330, Indianapolis, IN 46268, 1-888-449-2377.

All terms and conditions of the AIG Policy govern transplant coverage. The amount of coverage provided under the AIG Policy will be added to all other coverage provided by the Fund to determine if the annual limits set forth in Section 3.3, above, have been reached.

If any organ or tissue transplant is contemplated, a Covered Person must notify Medical Excess, LLC. Notification must occur before any transplant services are arranged or received. Failure to provide prior notification may result in a denial of benefits. Submit all notifications to: Medical Excess LLC, 8777 Purdue Road, #330, Indianapolis, IN 46268, Attn: Transplant Nurse Advisor, 1-888-449-2377.

An Organ and Transplant Certificate is available from the Fund Office. This certificate explains the benefits available, and limitations and exclusions from coverage. All appeals regarding any denial of benefits for organ and transplant services are handled through the insurance company, not the Fund. The applicable appeal and grievance procedures are set forth in the certificate.

3.7. Large Case Management and Disease Management

(a) Large Case Management

Large case management is a program which identifies potential high risk, high cost claims in order to direct the patient toward the most cost-effective, quality medical care available, as well as provide the patient and the patient's family with another avenue for information and options.

When a Covered Person's condition (i.e. chronic Illness, catastrophic Injury, etc.) warrants, the Plan shall have the right to initiate case management. The Case Manager, Health Link will first contact the Covered Person, attending Physician, and other medical providers to introduce themselves and to assure that all available resources are considered.

Should an alternate treatment plan be proposed, the Case Manager, attending Physician, patient, and patient's family must all agree to the alternate treatment plan. However, the patient and/or patient's family may not refuse to cooperate with the case management firm, including signing necessary authorization forms to obtain health information.

(b) Disease Management

Disease management is handled by the Activate Healthcare Family Medical Center. See Article 3.9 for information regarding the Medical Center.

3.8. Health Reimbursement Arrangement and Medical Reimbursement Account

A Health Reimbursement Arrangement is provided under which an account (HRA) is established for each Participant to be used by the Participant for reimbursement of out-of pocket health care costs incurred by the Participant or his/her Dependents effective July 1, 2014, as follows:

(a) Funding

(1) Active Employees

An HRA will be established for each Active Employees for whom a contribution is required to be made pursuant to the Collective Bargaining Agreement or participation agreement.

(2) Amounts in the HRA accumulate over time, I.e. unused amounts may accumulate and be carried over year to year.

(3) Like all other benefits provided by the Fund, the Fund may terminate the HRA at any time for any reason. Participants have no vested interests in the HRAs. At all times, amounts in the HRA are the property of the Fund. Eligibility to receive reimbursement from the HRA terminates when the Participant is no longer eligible for benefits under the Plan and any unused amounts remaining in the Participant's account at such time remain the property of the Fund.

(b) Reimbursable Expenses. To the extent that an eligible Participant has credit in his or her individual HRA, this amount may be used for reimbursement of out-of-pocket health care costs incurred by the Participant or his/her Dependents, such as:

(1) Dental co-payments and expenses;
(2) Vision expenses;
(3) Medical expenses not otherwise covered by insurance, including deductibles;
(4) Self-payments;
(5) Premiums paid for other health insurance;
(6) Prescription drug co-payments; and
(7) Other IRS approved medical expenses (pursuant to §213 of the Internal Revenue Code).

(c) Submission of Expenses for Reimbursement. To obtain reimbursement under the HRA, a claim must be filed with the Fund Office. Claims are eligible for reimbursement only if they were incurred on or after the date on which the Participant became eligible for benefits under the Plan (expenses are incurred when medical care is provided, not when billed or paid). Claims must be submitted within 12 months of the date incurred. In order for payment to be made, proof of payment satisfactory to the Trustees must be submitted.

(d) Account Balances Upon Termination of Eligibility. Upon termination of eligibility, a Participant's HRA will be suspended, to be reinstated if the Participant re-establishes eligibility within 24 months of such termination. If the Participant does not re-establish eligibility within such 24 months, the balance in the HRA will remit to the Fund.

(e) Account Balances Upon Death of Participant. Upon the death of an Active Employee, Disabled or Permanently Disabled Participant, or Retiree, any balance in his/her HRA will transfer to his/her Surviving Spouse, provided such individual otherwise qualifies for Surviving Spouse coverage, and such amounts used to reimburse qualified expenses of the Participant's Surviving Spouse or Children. Upon the death of a Surviving Spouse, his/her HRA will terminate.

(f) Retirees and Disabled Participants. Retirees and Disabled or Permanently Disabled Participants with balances in their HRAs who maintain eligibility in the Fund can continue to use such amounts for eligible medical expenses. Retirees or Permanently Disabled Participants who do not maintain eligibility in the Fund will be eligible to use the remaining balances in their HRAs so long as they are receiving a monthly benefit from the Plumbers and Steamfitters Local166 AFL-CIO Pension Plan.

(g) MRA Balances

Effective May 1, 2009, contributions to Participants' Medical Reimbursement Accounts (MRA) ceased. An amount necessary to fund one quarter of coverage was transferred from each Participant's MRA to create each Participant's Reserve Credit/ Dollar Banlc Any excess money following such transfer remained in the Participant's MRA and can continue to be used for reimbursement of medical expenses incurred while a Participant is eligible for benefits.

For individuals who are no longer eligible for benefits under the Fund, any amount which was in his/her MRA as of the date eligibility terminated will be frozen and reinstated if the Participant re-establishes eligibility by January 31, 2016. If the Participant does not re-establish eligibility by January 31, 2016, the balance in the MRA (or HRA after July 1, 2014) will remit to the Fund.

Notwithstanding the above, any individual receiving a benefit from the Plumbers and Steamfitters Local 166 AFL-CIO Pension Plan is eligible to use the balance which was in his/her MRA at the time of eligibility otherwise terminated for reimbursement of medical expenses.

To obtain reimbursement under the MRA, medical expenses (pursuant to §213 of the Internal Revenue Code) must be submitted to the Fund Office for reimbursement within 12 months of the date incurred. In order for payment to be made, proof of payment satisfactory to the Trustees must be submitted.

As of July 1, 2014, amounts remaining in the MRA transferred to the HRA.

(h) Election. On an annual basis a Participant can elect to limit expenses paid from his/her HRA to reimbursement of dental, vision, and preventive care expenses only. In addition, if at any time during the calendar year the Participant's Spouse becomes eligible for an HSA, he/she may make this election for the remainder of the calendar year.

3.9. Activate Healthcare Family Medical Center

The Activate Healthcare Family Medical Center (Medical Center), located at 2932 W. Ludwig Road, Fort Wayne, Indiana 46818, phone 260-755-1304, may be used by Participants and Dependents (Covered Person(s)) over age three for the following health and wellness services:

(a) Primary Care Services

The following primary care services are provided at the Medical Center at no cost to the Covered Person:

- For individuals age 18 and older (Adult Members), episodic care, preventive care, and urgent care (physicals available as of June 2014);
- Non-emergency convenient care for individuals under age 18, which does not include routine pediatric care such as immunizations;
- Health risk assessments for Adult Members;
- Health coaching for Adult Members, with tailored action plans;
- Disease management and care coordination; and
  Sport participation required physicals.

(b) **Labs.** Certain commonly ordered labs are available upon order of the Medical Center physician at the Medical Center at no cost to the Covered Person. A list of covered labs is available upon request from the Fund Office. Covered Persons can also bring lab orders from non-Medical Center physicians and have such labs, if available, performed at the Medical Center at no cost.

(c) **Prescription Drugs.** Many commonly ordered generic drugs are available upon order of the Medical Center physician at the Medical Center at no cost to the Covered Person. A list of covered drugs is available upon request from the Fund Office. Covered Persons can also bring prescription generic drugs orders from non-Medical Center physicians and have such prescriptions, if available, filled at the Medical Center at no cost if they are seen by the Medical Center physician or nurse practitioner and he/she confirms such order is appropriate.

(d) **Incentive Program**

A $100 incentive amount will be paid to each Participant and his/her Spouse who complete an annual physical between June and the following May provided the Trustees have approved incentives for such 12 month period.

If such Participant or Spouse participates in the health coaching program and meets tailored health goals over the 12 month period following his/her physical, he/she will receive another $100 incentive amount, provided the Trustees have approved such incentive for this period. If approved by the Trustees, such incentives can be pro-rated for partially meeting goals. Whether, when, and the extent to which tailored health goals are met shall be determined in the sole and complete discretion of the Medical Center professional staff.

The incentive amounts shall be paid by check and mailed to the home address of the Participant or Spouse. These payments are taxable to the recipient and it is the responsibility of the recipient to report such payments, if required, on his/her individual tax returns.

3.10. **Benchmark.** The Plan adopts the Utah state benchmark plan for purposes of defining essential health benefits.

ARTICLE 4- WEEKLY DISABILITY BENEFIT

4.1. The Weekly Disability Benefit is payable to Active Employees for each full week they are Totally Disabled. No partial weeks will be payable.

4.2. The amount ofthe Weekly Disability Benefit is 50% ofthe Active Employee's hourly straight time wage rate times 40 hours, up to a maximum of $450.00 per week, for a period not exceeding 15 weeks per year.

4.3. In the case of an Accident or Injury, payment will be made beginning with the first day of the Accident of Injury. In the case of a Sickness, payment will begin on the 8th day of the Sickness.

4.4. In order to qualify for additional benefits after a one year period the Active Employee must return to Covered Employment for one full week consisting of 40 hours.

4.5. Weekly Disability benefits are not payable if:

(a) The Active Employee engages in any work or gainful employment during any period for which he is claiming benefits; or

(b) The Active Employee is NOT under the regular care and treatment of a Physician or Surgeon; or

(c) The Active Employee is receiving a salary; or
(d) The disability is due to an occupational accident or sickness, including any for which any benefits are provided by a Workmen's Compensation Act or similar legislation.

4.6. In accordance with federal law, the appropriate amount of Social Security taxes (FICA) shall be withheld from each payment and forwarded to the appropriate governmental agency. In addition, an eligible Active Employee shall have the right to request additional optional withholding.

4.7. An individual eligible for coverage under Section 2.7 is not entitled to Disability Benefits.

ARTICLE 5- DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

5.1. Benefits for Active Employees

Coverage is provided pursuant to a group term life insurance policy purchased by the Fund from Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090, 1-800-644-1103. Information regarding such coverage, including limitations and exclusions, can be found in the certificates of insurance issued by the insurance company. A copy of the life insurance policy is available at the Fund Office upon request. In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

A summary of the death benefits provided are as follows:

Death:	$25,000.00
Accidental Death:	$25,000.00

The above benefits are reduced 35% at age 65, 50% at age 70 and 75% at age 75.

5.2. Benefits for Retirees

Coverage is provided pursuant to a group term life insurance policy purchased by the Fund from Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090, 1-800-644-1103. Information regarding such coverage, including limitations and exclusions, can be found in the certificates of insurance issued by the insurance company. A copy of the life insurance policy is available at the Fund Office upon request. In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

A summary of the death benefits provided are as follows:

Death:	$3,000.00
Accidental Death:	$3,000.00

ARTICLE 6 -PRESCRIPTION DRUG BENEFITS

6.1. Provider Network/Prescription Drug Card

The Fund has contracted with CaremarkPCS Health, L.L.C., 2211 Sanders Road, 101 Floor, Northbrook, Illinois 60062, (866) 885-4944, for the administration of the prescription drugs. To receive coverage, a Covered Person must obtain prescription drugs at a pharmacy in the Caremark provider network (a "Participating Pharmacy"). A list of such pharmacies is available at the Fund Office. Participants must present their identification card at participating pharmacies for benefits. If a Covered Person has a prescription filled at a non-participating pharmacy, or does do not have his/her card with you at the time the prescription is filled, he/

she must pay for the drug and complete a reimbursement form for submission to the Fund Office. Reimbursement will be limited to the amount that the Fund would have paid had the prescription been filled at a Participating Pharmacy. Reimbursement forms are available by contacting the Fund Office.

6.2. Covered Drugs

Subject to the exclusions set forth in Section 6.5, the Plan covers the following drugs with a prescription:

- Federal legend drugs that are non-injectable
- Injectable medications
- Contraceptives
- Diabetic medications, insulin, insulin needles and syringes
- Contraceptives
- Emergency allergic reaction kits
- Over the counter Claritin, Zyrtec, Prilosec, and Previcid
- Over the counter nicotine replacement drugs arid generic Zyban (Wellbutrin) and Chantix up to a maximum supply of 168 days per year.

Notwithstanding any term or condition to the contrary, the Plan will cover ADD and ADHD medications.

All prescriptions will be filled with generic equivalent if available.

Specialty and compound drugs with a cost in excess of $200 must receive prior authorization. Immunizations for children and adults as recommended by the Advisory Committee on

Immunization Practices (ACIP) will be covered as required by the Affordable Care Act.

6.3. Mail Order Program. Covered Persons can obtain drugs through a Mail Order program for maintenance drugs, which allows the Covered Person to fill a prescription drug for up to a 90 day supply from CVS Caremark, PO Box 94467, Palatine, IL 60094-4467, (866) 885-4944. Order forms are available on line at www.caremark.com, from the Fund Office, or call the number on the back of your benefit card. The prescription will be sent directly to your home.

6.4. Co-payments

A Covered Person is responsible for paying the following copayments for each prescription drug filled:

Retail Copay (for 34 day supply):

Generic:	$30.00
Formulary Brand:	$60.00
Non-Formulary Brand:	$120.00
Specialty:	$25% coinsurance not to exceed $250

Mail Order Copay (for 35--90 day supply):

Generic	$75.00
Formulary Brand:	$150.00
Non-Formulary Brand:	$300.00
Specialty:	N/A - Specialty only filled at retail

Maintenance Drugs (90-day supply): 90-day initial fills or 90-day refills of a maintenance drug must be through CVS Pharmacy, mail order, or, if available, at the Activate Family Medical Center (and if stocked and carried at the Activate Clinic, there is no copayment).

Generic Substitution: Effective October 1, 2011:

(a) If a prescription is not written "Dispense as Written" (DAW), it will be filled with a generic drug.

(b) If a Covered Person requests a brand name drug (formulary or non-formulary) where the prescription is not written DAW, the Covered Person must pay the difference between the cost of the generic and brand name drug in addition to the above copayments.

(c) Notwithstanding, the Fund will not provide any coverage for brand name drugs that are covered by the Plan's Step Therapy Program. The Step Therapy Program requires that a Covered Person use a specified generic drug before coverage will be provided for a brand name drug. If use of a brand name drug is approved under this program, the Covered Person will pay the applicable brand name copayment, but not the difference in the cost of the generic and brand name drug. Information regarding the Step Therapy Program, including the list of covered brand name drugs and specified generics, is available at the Fund Office.

Exceptions to above copayments: The following are covered for a $0 copay with a prescription: insulin needles and syringes, blood glucose monitors, diabetic testing agents for glucose testing of blood/urine, and over the counter Claritin, Zyrtec, Prilosec, and Previcid.

6.5. Exclusions and Limitations. The prescription drug program does not provide benefits for the following:

(1) All limitations for medical benefits, set forth at §3.3, apply to the prescription drug benefits.
(2) drugs obtained without a Physician's prescription or which do not require a prescription;
(3) drugs for which the provider's Reasonable and Customary charge is less than the Plan's copay amount;
(4) diabetic supplies not otherwise covered above, including alcohol swabs, non-invasive blood glucose testing devices, insulin delivery services (pens), insulin pumps and pump supplies;
(5) drugs used in connection with transplants covered under section 3.6, above;
(6) fertility drugs/agents;
(7) anabolic steroids;
(8) contraceptive jellies, ointments, creams, foams or other transdermal/intravaginal devices intended to prevent pregnancy;
(9) injectable contraceptives, contraceptive implants, and intrauterine devices;
(10) charges for growth hormones;
(11) charges for acne products for those over age 25;
(12) drugs for which the sole purpose is to promote or stimulate hair growth;
(13) any charge for therapeutic devices or appliances, regardless of their intended use (except for disposable syringes);
(14) support garments;
(15) medical supplies and equipment;
(16) non-medical items, regardless oftheir intended use;
(17) any charge for the administration of drugs or insulin;
(18) a charge for any prescription order refill in excess of the number specified by a doctor or any refill dispensed after one year from the date of the original prescription order;
(19) dietary supplements and vitamins, except prenatal vitamins with a prescription;
(20) health and beauty aids or cosmetic drugs;
(21) drugs labeled "Caution: limited by Federal law to investigational use" or experimental drugs;
(22) drugs taken or given while at a hospital, convalescent care facility, or similar institution;
(23) fluoride preparations;

(24) weight control/anti-obesity drugs and anorexients;
(25) impotency drugs;
(26) the charge for any medication for which a Covered Person is entitled to receive reimbursement under any Worker's Compensation law, or for which entitlement to benefits is available without charge from any municipal, state or federal program of any sort, whether contributory or not;
(27) drugs which do not have the required governmental approval when you receive them or are considered Experimental, Investigative, or of a research nature; and
(28) Proton Pump Inhibitors and Antihistamines; and
(29) Any other drug not specifically covered.

Notwithstanding the above exclusions, the Fund will cover any drug required by the Affordable Care Act.

6.6. Medicare Part D

Medicare Part D offers prescription drug coverage. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

If you decide to join a Medicare drug plan, your current Plumbers and Steamfitters Local 166 Health and Welfare Fund drug coverage will not be affected. You can keep your current drug coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Plumbers and Steamfitters Local 166 Health and Welfare Fund coverage, be aware that you and your Dependents will not be able to get this coverage back.

6.7 Rx Help Centers. The Fund has contracted with Rx Help Centers, LLC. (RxHC), 3905 Vincennes Road, Suite 2000, Indianapolis, IN 46268 (866) 478-9593, to provide prescription drug advocacy services to Participants and their covered dependents who choose to utilize these services. The purpose of RxHC is to help participants lower the cost of their brand name and specialty drugs.

ARTICLE 7- INTERNAL CLAIMS AND APPEALS

For benefits provided under the fully insured policies, including life insurance and the Medicare Advantage policy, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions set forth below.

7.1. Types of Claims Covered: For purposes of the procedures set forth below, the following terms are used:

- Urgent health claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- Post-service health claims: for example, Claimant or his/her Physician submits a claim after claimant receives treatment from Physician; and
- Concurrent claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination. Rescission of Coverage: retroactive cancellation of coverage.
- Disability Claims: claims for disability benefits or any rescission of coverage of a disability benefit,

7.2. Initial Submission of Claims: Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits should be submitted to the Fund Office.

7.3. Notice That Additional Information is Needed to Process Claim
After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims - 24 hours after receiving improper claim.
- For Pre-Service Health Claims - 5 days after receiving improper claim.

After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:

- For Urgent Health Claims - 48 hours after receiving notice
- For Pre-Service Health Claims - 45 days after receiving notice
- For Post-Service Health Claims - 45 days after receiving notice
- For Disability Claims - 45 days after receiving notice.

7.4. Avoiding Conflicts of Interest: The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

7.5. Initial Decision on a Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2 Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- For Urgent Health Claims - As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour Claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims - 15 days after receiving the initial claim. A 15-day extension permitted if Plan needs more information and it has provided notice of same to Claimant during initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Post-Service Health Claims - 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided

notice of same to Claimant during initial 30 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

- For Disability Claims - 45 days after receiving the initial claim. A 30-day extension permitted if Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Fund needs more information and has provided notice of same to claimant during first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

7.6. Adverse Benefit Determination: Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function;
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal; and
- the availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration, 1-866-444-3272.

With respect to adverse benefit determination involving disability claims, the adverse benefit determination must also include the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

7.7. Internal Appeals

(a) Adverse Benefit Determinations: A Claimant may appeal any Adverse Benefit

Determination received pursuant to Section 6. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; rescission of coverage; or
- A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a disability benefit or any rescission of coverage of a disability benefit.

(b) Submission ofInternal Appeals: An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal. The Fund will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal. The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted to the Fund Office.

(c) Time for Submitting Internal Appeals: A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims - 180 days after receiving denial.
- For Pre-Service Health Claims - 180 days after receiving denial.
- For Post-Service Health Claims - 180 days after receiving denial.
- For Concurrent Claims - Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims - 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

(d) Notice of Decision on Internal Appeal: The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;

- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA §502(a);
- a statement describing any contractual limitation period that applies to the
- Claimant's right to bring an action under ERISA §502(a) and the calendar date
- on which such contractual limitation expires; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be
- available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

In addition, a notice of decision on appeal regarding disability benefits, must also include the following:

- An explanation of the basis for disagreeing with any of the following:
    - The health care professionals that treated the Claimant;
    - The advice of the health professional obtained by the Plan; or
    - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

The Fund deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims - 72 hours after receiving appeal.
- For Pre-Service Health Claims - 30 days after receiving the appeal if one level appeal is applicable.
- For Post-Service Health Claims: The Trustees shall decide the appeal at a Board Meeting.*

- For Concurrent Claims - Prior to termination of previously approved course of treatment.
- For Disability Claims - The Trustees shall decide the appeal at a Board Meeting.*

  * Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third Board Meeting following receipt of appeal. The Fund shall notify the Claimant of the Trustees decision on appeal no later than 5 days after the decision is made.

7.8. Deemed Exhaustion ofInternal Claims and Appeals Processes:

- If the Fund fails to adhere to all of the requirements of the Plan with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review as set forth below. The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Fund has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.
- In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue available remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees. Notwithstanding, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Fund demonstrates that the violation was for good cause or due to matters beyond the control of the Fund and that the violation occurred in the context of an ongoing, good faith exchange of information between the Fund and the Claimant. The Claimant may request a written explanation of the violation from the Fund, and the Fund must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.
- If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Fund met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Fund shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

7.9. Discretion of Trustees: The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7.10. Limitations of Actions:

- **For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.**

- **For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided below.**
- **In the event a Claimant does not abide by the time limitations for internal or external reviews, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.**

ARTICLE 8- EXTERNAL REVIEW PROCESS

8.1. Eligibility for External Review: The external review process applies to any final internal adverse benefit determination that involves (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment), or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review. A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

8.2. Request for External Review: A Claimant must file a request for an external review with the Fund within 4 months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

8.3. Preliminary Review: Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
- The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- The Claimant has exhausted the Plan's internal appeal process; and
- The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

8.4. Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days' additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business

days. Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1) The Claimant's medical records;
2) The attending health care professional's recommendation;
3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2) the date the IRO received the assignment and the date of the IRO decision;
3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;
6) A statement that judicial review may be available to the Claimant; and
7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

(g) The external reviewer's decision is binding on the Fund and the Claimant, except to the extent other remedies are available under State or Federal law. The Fund must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Fund intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

8.5. Expedited External Review

- A Claimant can make a request for an expedited external review at the time the Claimant receives:
- An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
- A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.
- Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the Claimant.
- Upon a determination that a request is eligible for external review following the preliminary review, the Fund will assign an IRO as outlined above. The Fund must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
- The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

- The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

8.6. Discretion of Trustees: The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

8.7. Limitations of Actions: No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ARTICLE 9- FRAUD, INTENTIONAL MISREPRESENTATION, AND MISTAKES IN PROVIDING COVERAGE

Health care fraud is a felony that can be prosecuted. It is unethical, immoral and illegal, and it is costly to the Plan. Every Participant pays for the dishonesty of the person who commits health care fraud. The Fund will rescind the coverage of any person who defrauds the Plan or makes an intentional misrepresentation of material fact. A 30 day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should or would have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce or legal separation, (2) lapsed Union membership, which is required to maintain Retiree coverage, (3) a Surviving Spouse has remarried or become eligible for other coverage, (4) a Participant or Dependent is covered under another health plan, (5) employment with a noncontributing employer, (5) any other event which makes a Participant or Dependent ineligible for coverage, or (6) continuing to use the benefit cards after eligibility is terminated.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly and severally, for the full amount paid for such coverage, including all costs and attorney's fees expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the rights of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 10- COORDINATION OF COVERAGE

Individuals might be covered under two or more plans. In such event, coverage under this Plan will be coordinated with all "Other Plans" through which a Covered Person might have coverage so that

the total amount payable under all plans will not exceed the total amount that would have been paid by this Plan in the absence of coordination of benefits. In no event will this Plan pay more than the benefits otherwise provided to Covered Persons under this Plan.

"Other Plan(s)" shall mean:

- any HMO's and other group or individual plans;
- governmental programs;
- coverage under labor-management trusteed plans;
- coverage under union welfare plans;
- coverage under any other health or insurance plan; and
- coverage under employer organization Plans or Member benefit organization Plans.

If a Participant's coverage under this Plan continues after he/she has commenced working in a non bargaining unit position with a contributory Employer for which no continuing contributions are submitted to the Plan, then coverage under this Plan shall be secondary to all Other Plans.

Otherwise, the order of benefit determination and coordination will be handled as follows:

(a) If any plan lacks a coordination of benefits provision, it will be the primary plan.

(b) The primary plan for husbands or wives is that which covers the person as a Participant or as the certificate holder, rather than as a dependent.

(c) For children's expenses, the primary plan is the plan of the parent whose birthday falls earlier in the calendar year.

(d) If 1-3 do not apply, the plan covering the patient longest is primary.

(e) For children's expenses when the parents are separated or divorced:

(1) The plan of the parent who, by court decree, is responsible for providing medical coverage will be primary, and the plan of the other parent will be secondary.

(2) If there is no court decree stating who should provide benefits, then the plan of the parent with custody will be primary. If the parent with custody has remarried, then the stepparent will be the secondary plan and the plan of the parent without custody will pay last.

(f) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

Coverage for a Covered Person under this Plan will be Primary:

(1) For an Active Employee or the Spouse of an Active Employee; or

(2) For a Covered Person in the first 30 months of a regular course of dialysis treatment or a kidney transplant because of renal disease; or

(3) For a Covered Person under age 65 who has been receiving Social Security Disability Benefits for less than two years.

Coverage for a Covered Person under this Plan will be Secondary:

(1) After a Covered Person after the 30 months of a regular course of dialysis treatment or a kidney transplant because of renal disease; or

(2) For a Retired Covered Person, or his/her Dependent, over age 65.

(3) For a Covered Person who has been receiving Social Security Disability Benefits for over two years.

Notwithstanding the foregoing, in the event a Medicare-eligible Covered Person in this Plan is also eligible under any Other Plan as a dependent of an actively employed spouse:

- Medicare is secondary to the Other Plan and primary to this Plan; and
- The Other Plan is primary to this Plan.

(g) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this Plan will be secondary.

(h) This Plan is primary when Medicaid is involved as the other carrier.

(i) Notwithstanding anything in this Plan to the contrary, if the requirements to maximize coverage under any Other Plan for a Dependent Spouse or Child have not been met and this results in the Other Plan not paying the maximum amount it would have paid if such requirements had been met, then (a) this Plan will not provide any coverage for the Dependent Spouse, even on a secondary basis, and (2) this Plan will pay a pro rata share of allowable benefits under this Plan for a Dependent Child, not to exceed ½ of such allowable benefits.

For the purposes of determining the applicability of and implementing the terms of this Article of this Plan or any provision of similar purpose of any other Plan, consistent with applicable law the Fund may release to or obtain from any other insurance company or other organization or person any information, with respect to any Covered Person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Whenever payments have been made by the Fund with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payable under this section, the Fund shall have the right to recover such payments to the extent of such excess, from one or more of the following: any persons on whose behalf such payments were made; any person or entity to whom such payments were made; any other insurance companies; or any other organizations. When another plan makes payment which should have been made under this Plan, the Plan shall have the right to directly reimburse the other plan making payment.

ARTICLE 11- SUBROGATION, RESTITUTION AND REIMBURSEMENT

11.1. In General

Subrogation means the Plan has the right to recover from a Covered Person amounts paid by the Plan for medical care or other expenses due to an injury or illness caused by a third party, or by the Covered Person to the extent a third party is obligated to reimburse such expenses. To the extent benefits are paid by the Plan to a Covered Person for medical, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Covered Person may have against the third party who caused the injury or who is responsible for payment of claims arising from such injury.

The Plan's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Plan. The right of subrogation applies regardless of the method of recovery, i.e. whether by legal action, settlement or otherwise, and regardless of the payer. This includes, but it not limited to:

- payments made directly by a third party, or any insurance company on behalf of a third party or any other payments on behalf of a third party;
- any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of the Covered Person or other persons;
- any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as the result of negligence or alleged negligence of a third party.

- any worker's compensation award or settlement;
- any recovery made pursuant to no-fault insurance; and
- any medical payments made as a result of such coverage m any automobile or homeowners insurance policy.

The Plan's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Plan's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Plan right to subrogation shall not be affected, reduced or eliminated by comparative or contributory fault, or the common fund doctrine. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs.

11.2. Lien/Equitable Relief

The Plan has a first priority lien on any on any amounts recovered by a Covered Person, or amounts the Covered Person may be entitled to receive. The lien shall be in the amount of the benefits paid by the Plan for which it has a right to subrogation and/or reimbursement under this Article 10. This lien will remain in effect until the Plan is repaid in full. By accepting benefits from the Plan, the Covered Person consents to this lien.

A Covered Person and his/her attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. Constructive Trust means a trust in which any amount, compensation and/or money recovered shall be deemed to be held separate and not commingled with other funds. This Constructive Trust is subject to an equitable lien by the Plan.

The Plan shall be entitled to other equitable relief, including without limitation an injunction or any other equitable remedies available to the Plan under ERISA §502(a)(3), to the extent necessary to enforce the Plan's lien and to obtain reimbursement, or to preclude the transfer or dissipation of any recovery.

The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any recovery received from a third party.

11.3. Conditions to Payment of Benefits/Cooperation of Covered Person and Representatives

If a Covered Person sustains an injury or illness caused by a third party (or caused by himself and a third party is liable to pay benefits for such injury or illness), the Plan will only pay benefits under the Plan related to such injury or illness if all the following conditions are met:

(a) As soon as reasonably possible, the Covered Person notifies the Plan Office that he or she has an injury or illness caused by a third party, or for which a third party is liable to pay benefits.

(b) The Covered Person assigns to the Plan his or her rights to any recovery from the third party. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party.

(c) The Covered Person or his/her representative does not take any action that would prejudice the Plan's subrogation rights.

(d) The Covered Person and his/her representatives cooperate in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to:

(1) executing and delivering all necessary instruments and papers, including the execution of the Plan's subrogation, restitution and reimbursement agreement, which may be obtained from the Fund Office and may include terms and conditions binding upon the Covered Person and his/her representative beyond the scope of provisions listed in the Summary Plan Description. If a

Covered Person is represented by an attorney, the attorney is also required to sign the agreement.

(2) Segregate any recovery received (up to the amount of the Plan's first lien) in a separate account, and must preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.

(3) A Covered Person may not assign any rights to the recovery from the third party other than to the Plan.

(4) If litigation is commenced, the Covered Person and his/her attorney are required to deliver to the Plan a copy of the complaint filed in court, the name of the insurance company for the defendant(s) and any other instruments, documents or information for which the Plan requests to ensure the Plan's subrogation, restitution and reimbursement rights. The Plan shall have the right to intervene in any litigation involving to protect its subrogation, restitution and reimbursement rights. Any action taken by the Plan to protect its subrogation, restitution and reimbursement rights shall be without any charge or cost to the Covered Person. The Fund shall not be liable to pay the Covered Person's attorney fees or costs or the attorney or his/her costs. If litigation is commenced, the Fund may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a first lien on any judgment recovered less a pro rata of court costs.

11.4. Right to Pursue Claim. The Plan's subrogation rights allows the Plan to directly pursue any claims the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. In such event, by accepting benefits from the Plan, the Covered Person and his/her attorney agree to cooperate fully with the Plan in the prosecution of such claims, including depositions and court appearances if deemed necessary by the Plan.

11.5. Enforcement. If the Covered Person or his/her representative fails to cooperate with the Fund, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefit of whatever kind. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. At the Plan's option, it may enforce its right to subrogation, reimbursement, and restitution by deducting amounts owed from future benefits for the Covered Person or any member of his/her family covered by the Plan.

ARTICLE 12- FAMILY MEDICAL LEAVE ACT

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act ("FMLA"). Details concerning FMLA leave are available from the Participant's Employer. Requests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA required contributions from the Employer.

ARTICLE 13- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

13.1. Protected Health Information ("PHI"), as defined in the Health Insurance Portability and Accountability Act ("HIPAA"), will only be disclosed to the Plan Sponsor when and if

necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations. The Fund otherwise complies with the terms of HIPAA.

13.2. The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA. The Plan Sponsor shall, among other things, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

ARTICLE 14- COBRA CONTINUATION COVERAGE

14.1. Summary of Rights and Obligations Regarding Continuation of Coverage Under Plan

A federal law known as the "Consolidated and Omnibus Budget Reconciliation Act" ("COBRA") requires most employers sponsoring group health plans to offer Participants and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances in which coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this notice should be construed accordingly.

Both you (the Participant) and your Spouse should read this summary carefully and keep it with your records.

14.2. Qualifying Events

(a) If you are a Participant of the Plumbers and Steamfitters Local166 and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":
   (1) Termination (for reasons other than your gross misconduct) of your employment.
   (2) Reduction in the hours of your employment such that hours are insufficient to maintain eligibility

(b) If you are the Spouse of a Participant covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following five "qualifying events":
   (1) The death of your Spouse.
   (2) A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of covered employment.
   (3) Divorce or legal separation from your Spouse. (Also, if a Participant drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
   (4) Your Spouse becomes entitled to Medicare benefits.

(c) In the case of a Dependent child of a Participant covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

(1) The death of the Participant.
(2) The termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of covered employment.
(3) Parents' divorce or legal separation.
(4) The Participant becomes entitled to Medicare benefits.
(5) The Dependent ceases to be a "Dependent child" under the Plan.

14.3. Notices

(a) The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the participant, the employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

(b) Under the COBRA statute, you (the Participant) and your spouse have the responsibility to notify the Plan Administrator upon a divorce, legal separation, a child losing Dependent status. This notice is required to be submitted to your Plan Administrator in writing. You must contact your Plan Administrator to obtain a "Notice from Qualified Beneficiary of Qualifying Event Form" to provide proper notice. The form provides information as to whom and where the Notice is to be sent. You or your spouse must provide this notice within 60 days of the date of the qualifying event, or the date coverage is lost, whichever is later.

(c) If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

(d) If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

If you or family members fail to provide this notice to the Plan Administrator during this 60- day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fails to notify the Plan Administrator, and any claims are paid mistakenly for expenses

Incurred after the last day of coverage, then you and your qualified beneficiaries will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, a child's losing Dependent status, or a disability determination that has caused a loss of coverage, the Plan Administrator will notify the affected beneficiary of the right to elect continuation coverage.

14.4. Election Procedures

You (the Participant) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family Participant notice of the right to elect continuation coverage. If you or your qualified beneficiaries do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election is effective on the day the election is sent to the Plan Administrator.

Note: No claims will be paid until the COBRA payment is received.

A covered Participant or the Spouse of the covered Participant may elect continuation coverage for all qualified beneficiaries. The covered Participant and his or her Spouse and Dependent children each have an independent right to elect continuation coverage. Thus, a Spouse or Dependent child may elect continuation coverage even if the covered Participant does not (or is not deemed to) elect it.

You or your qualified beneficiaries can elect continuation coverage if you or the family Participant, at the time you or the family member elects continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

14.5. Type of Coverage; Payments of Contributions

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th - 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

14.6. Maximum Coverage Periods

36 Months

If you (Spouse or Dependent child) lose group health coverage because of the Participant's death, divorce, legal separation, or the Participant's becoming entitled to Medicare (only if the entitlement is the initial qualifying event), or because you lose your status as a

Dependent under the Plan, the maximum continuation coverage period (for Spouse and Dependent child) is 36 months from the date of the qualifying event.

18 Months

If you (Participant, Spouse or Dependent child) lose group health coverage because of the Participant's termination of employment (other than for gross misconduct), reduction in hours, or disability determination, the maximum continuation coverage period (for the Participant, Spouse and Dependent child) is 18 months from the date of termination or reduction in hours.

There are three exceptions:

(1) If a Participant or family Participant is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Sponsor or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

(2) If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Participant dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or Dependent child.

(3) If the Participant is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other family Participants who are qualified beneficiaries is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the qualifying event.

14.7. Children Born to, or Placed For Adoption with the Covered Participant After the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Participant and the covered Participant has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Participant or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered Participant or a family Participant must notify the Plan Administrator within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family Participants of the Participant. (The 30-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Participant or family Participant fails to so notify the Plan Administrator in a timely fashion, the covered Participant will NOT be offered the option to elect COBRA coverage for the child.

14.8. Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Participant, Spouse, and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

(1) The Plan Sponsor no longer provides group health coverage to any of its Participants.

(2) The premium for the qualified beneficiary's COBRA coverage is not timely paid.

(3) After electing COBRA, you (Participant, Spouse or Dependent child) become covered under another group health plan (as a Participant or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.

(4) After electing COBRA, you (Participant, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

(5) If you (Participant, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

(6) Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Participants or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

14.9. Other Information

If you (the Participant) or your qualified beneficiaries have any questions about this notice or COBRA, please contact the Plan Administrator at the address listed below. Also, please contact Plumbers and Steamfitters Local 166 if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions, and limitations.

If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your Spouse's address changes, you must immediately notify the Plan Administrator at Plumbers and Steamfitters Local166 Health and Welfare Fund, P.O. Box 99485, Troy, Michigan 48099-9485, Telephone: (248) 641-4966, Toll Free: (855) 641-4966.

ARTICLE 15- ABSENCE DUE TO MILITARY SERVICE

If coverage under the Plan is terminating due to military service, a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Plan Administration Office as soon as he volunteers for or is called to active duty. The cost of coverage during a USERRA prescribed leave will be absorbed by the Plan, and reserve credit will be frozen. Coverage continued during the military service will be counted toward the maximum COBRA continuation period.

Upon termination for military duty, a Participant will be reinstated under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply the following conditions must be met:

(a) The Participant has given advance written or verbal notice of the military leave to Plumbers and Steamfitters Local 166 (advance notice to Plumbers and Steamfitters

Local 166 is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);

(b) The cumulative length of the leave and all previous absences from employment do not exceed five years, however, eligibility may be extended beyond five years if certain exceptions apply;

(c) Reemployment follows a release from military service under honorable conditions; and

(d) You report to, or submit an application to, Plumbers and Steamfitters Local 166 as follows:

(1) On the first business day following completion of military service for a leave of 30 days or less; or

(2) Within 14 days of completion of military service for a leave of 31 days to 180 days; or

(3) Within 90 days of completion of military service for a leave of more than 180 days.

If you are hospitalized for, or recovering from, an illness or injury when your military leave expires, you have 2 years to apply for reemployment. If you provide written notice of your intent not to return to work after military leave, you are not entitled to reemployment benefits.

ARTICLE 16- CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), Participants and Dependents who are eligible for coverage but who are not emolled for coverage may exercise special emollment rights and emoll in the Plan if the Covered Person:

(a) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or

(b) loses coverage under State Children's Health Insurance Program ("SCRIP") under Title XXI of the Social Security Act; or

(c) becomes eligible for group health plan premium assistance under Medicaid or SCRIP.

If any of these circumstances arises and the Covered Person wishes to take advantage of these special emollment rights, the Covered Person must request to emoll for coverage within 60 days from the date:

(a) the coverage terminates under the Medicaid Plan or SCRIP; or

(b) the Participant or Dependent child is determined eligible for state premium assistance.

If you believe you are eligible for special emollment under CHIP, you must contact the Fund Office to request an election form as soon as possible. A request for emollment must be made in writing on the form provided by the Fund Office. Requests for special emollment must be made within 60 days after an event described above.

ARTICLE 17- OBTAINING CERTIFICATE OF CREDITABLE COVERAGE

A Covered Person will be provided a certificate of creditable coverage, free of charge, from the Fund Office upon losing coverage under the Plan, when he/she becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, a Covered Person may be subject to a preexisting condition exclusion for 12 months (18 months for late emollees) upon emolling in other coverage. You may request a certificate of creditable coverage by contacting the Fund Office, BeneSys, Inc., P.O. Box 99485, Troy, Michigan 48099-9485, telephone 248-641-4966, or toll free 855-641-4966.

ARTICLE 18- STATEMENT OF ERISA RIGHTS

As a participant in the Plumbers and Steamfitters Local166 Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or the

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. The nearest PWBA Office is the Chicago Regional Office, 200 West Adams Street, Suite 1600, Chicago, Illinois 60606. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE 19- GENERAL PLAN INFORMATION

Plan Name:

Plumbers and Steamfitters Local166 Health and Welfare Fund

Plan Sponsor:

Board of Trustees of Plumbers and Steamfitters Local 166 Health and Welfare Fund, 2930 W. Ludwig Road, Fort Wayne, Indiana 46818

Type of Administration/Plan Administrator/Plan Sponsor/Counsel:

Plan is administered by Board of Trustees consisting of six Trustees, of which three are designated as Employer Trustees and three are designated as Union Trustees. The current Trustees are:

Union Trustees	Employer Trustees
Kent Prosser Plumbers & Steamfitters Local166 2930 W. Ludwig Road Ft. Wayne,46818	Bill Meyer, Secretary Shambaugh & Son L.P. 7614 Opportunity Drive Ft. Wayne,46801-1287
Thomas Malott Plumbers & Steamfitters Local 166 2930 W. Ludwig Road Ft. Wayne,46818	Dan Huelsenbeck Wagner-Meinert, Inc. 7617 Freedom Way Ft. Wayne,46818
Chris Brown Plumbers & Steamfitters Local 166 2930 W. Ludwig Road Ft. Wayne,46818	Jake Schau Project Design & Piping 3615 Transportation Dr. Fort Wayne,46818
	John Rayburn, Alternate Mechanical Contractors Association of Indiana 2509 E. 54th St. Indianapolis 46220

The day-to-day responsibilities for Plan administration are performed by the Fund Liaison located at 2930 W. Ludwig Rd., Fort Wayne, Indiana 46818, (260) 497-0150, Fax (260) 490-5697. The Administrative Manager and Fund Office, BeneSys, Inc., is located at 700 Tower Dr., Ste. 300, Troy, Michigan, 48098, (248) 813-9800, Fax (248) 8130-9898. Office hours are Monday through Friday 7:30a.m. to 5:30p.m.

Employer Tax I.D. No.: 35-2030543
Plan Number: 501
Type of Plan: Self-Funded Welfare Benefit Plan- Group Health Plan
Plan Year Ends: December 31st
Effective Date of Plan: January 1, 1998

LEGALCOUNSELFORTHEPLAN

Jacqueline Kelly, Esq.
Michael J. Asher, Esq.
Sullivan, Ward, Asher & Patton, P.C.
25800 Northwestern Hwy, Suite 1000
Southfield, MI 48075
(248) 746-0700

Statutory Agent for Service of Legal Process:
Board of Trustees of Plumbers and Steamfitters Local 166, Health and Welfare Fund, 2930 W. Ludwig Road, Fort Wayne, Indiana 46818. Service of process may also be made upon Third Party Administrator or any individual Trustee.

Collective Bargaining Agreements:
The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Fund Office, or are available for examination by participants and beneficiaries at the Fund Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

Source of Plan Contributions:
The primary source of financing for the benefits provided under this Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement. Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of the Plan assets is invested and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Fund Office and may be examined at the Fund Office.

Welfare Trust Assets and Reserves:
The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations consult the Plan document.