PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE PLAN

COMBINED PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

Effective January 1, 2026[1]

[1] Unless otherwise provided herein.

PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE PLAN

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****SPECIAL NOTICE****

It is extremely important that you keep the Fund Office informed of any change in address or desired change in coverage. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits. The importance of a current, correct address on file at the Fund Office cannot be overstated! It is the only way the Board of Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

TO: ALL PARTICIPANTS AND DEPENDENTS OF THE PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE PLAN

We are pleased to distribute this revised copy of the Combined Plan Document and Summary Plan Description (the "Plan Document" or "SPD") detailing the benefits provided by the Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan. This booklet replaces and supersedes in entirety your previous booklet and related amendments. Any changes made to the Plan in the future will be mailed to you in order that you may include them in this booklet. In this way, you will have an up-to-date booklet for your Plan.

This booklet summarizes the eligibility rules for participation in the Plan, the benefits provided for those who are eligible, and the procedures that must be followed in filing or appealing a claim. In addition, the booklet provides important information concerning the administration of the Plan and your rights as a Participant.

The Board of Trustees has made several changes to the Plan. We urge you to review this booklet carefully so you are informed of the financial protection provided for those eligible for benefits under the Plan. Your specific attention is directed to the section of the booklet detailing continuation of coverage for you and your eligible Dependents under a federal law known as COBRA in certain instances where coverage under the Plan would ordinarily end.

The Board of Trustees has full, complete and binding authority to define, interpret and apply all of the terms and provisions of the Trust Agreement and this Plan Document and their amendments, as well as all contracts entered into by the Board of Trustees with any third parties. This authority to define, interpret and apply terms includes, but is not limited to, all issues relating to eligibility, the amount of and entitlement to any forms of benefit, all issues that directly or indirectly relate to covered employment, and all issues that directly or indirectly relate to benefit terminations.

Although we intend to continue the Plan and the benefits provided under the Plan, the Board of Trustees reserves the right, in its sole discretion, to amend or terminate the Plan by written amendment or resolution without prior notice to Participants and their families, except as may be required by law. Without limiting in any way the authority of the Board of Trustees recited above, the Board of Trustees has delegated that same authority to the Fund Office.

By their signatures at the end of this document, the Trustees intend that this booklet shall serve as both the Plan Document and the SPD for this Plan.

Please note the receipt of this booklet does not automatically mean you are eligible for benefits. Your eligibility will be determined in accordance with the Plan's eligibility rules, which are set forth in this booklet.

If you have questions concerning your eligibility, schedule of benefits or general provisions of the Plan, please write or call the Fund Office.

The Board of Trustees has determined, as of January 1, 2026, that this Plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As a non-grandfathered health plan, the Plan must provide certain consumer protections of the Affordable Care Act, such as the requirement for the provision of preventive health services without any cost sharing. Both non-grandfathered and grandfathered health plans must comply with certain other consumer protections of the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply to a non-grandfathered health plan can be directed to the Fund Office at BeneSys, Inc., 3660 Stutz Drive, Suite 101, Canfield, Ohio 44406. You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or at www.dol.gov/ebsa/healthreform.

Sincerely yours,

BOARD OF TRUSTEES OF THE
PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94
HEALTH & WELFARE PLAN

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ARTICLE I - SCHEDULE OF BENEFITS

A. Schedule of Benefits (for Non-Medicare Eligible Participants)

	NETWORK	NON-NETWORK
Calendar Year Deductible – Single/Family [2]	$500/$1,000	$1,000/$2,000
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family [3]	$4,500/$9,000	$9,000/$18,000
Prescription Maximum Out of Pocket – Single/Family	$5,650/$11,300	None
Combined Medical and Prescription Maximum Out of Pocket – Single/Family	$10,150/$20,300	Not applicable
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury) [4] Includes telemedicine services through Cleveland Clinic (available to out-of-state members at in-network coverage)	$15 copay, then 100%	$15 copay, then 80%
Urgent Care Office Visit [5]	$15 copay, then 100%	$15 copay, then 80%
Podiatry Service	80% after deductible	60% after deductible
Voluntary Second Surgical Opinion	80% after deductible	60% after deductible
Immunizations	80% after deductible	60% after deductible

[2] Deductible and coinsurance expenses incurred for services by **a non-network provider** will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by **a network provider** will also apply to the non-network deductible and coinsurance out-of-pocket limits. In addition, the deductibles under the Plan are "embedded." The term "embedded processing" refers to family coverage with two kinds of deductibles and maximum out-of-pocket limits: one for an individual family member and a higher one for the whole family. Payments made by any family member toward his or her individual deductible count toward the family's higher deductible. Once a covered person meets his or her individual deductible, the Plan will start paying for that person's claims, even before the family deductible is met. However, once the family deductible is met by any combination of family members' spending, the Plan will cover all subsequent medical expenses for the entire family, regardless of whether each individual's deductible was met.

[3] See footnote 2 above.

[4] The office visit copay applies to the cost of the office visit only.

[5] The office visit copay applies to the cost of the office visit only.

	NETWORK	NON-NETWORK
Certain immunizations are not covered under the Affordance Care Act. If you have questions, please contact the Claims Payor or the Fund Office. [6]		
Hepatitis B vaccine	No cost sharing	No cost sharing
Influenza shots (all causes, all ages) [7]	No cost sharing	No cost sharing
PREVENTIVE SERVICES [8]		
Office Visit/Physical Exam (Two exams per calendar year) [9]	No cost sharing	No cost sharing
WELL CHILD CARE BENEFIT (Includes exam and immunizations)		
Birth through Age 26	$15 copay then 100%	$15 copay then 60%

[6] The administrative costs of the COVID-19 vaccine will be covered at zero copay. Further, the COVID-19 vaccine will be both a medical and prescription benefit. In addition, effective March 1, 2024, the Plan was amended to provide that vaccines will be covered, at the amount in accordance with the Plan's Schedule of Benefits for vaccines, as both a medical and prescription drug benefit. Particularly, the vaccine will be covered as a medical benefit when it is administered at a doctor's office, at a hospital, or at any other medical care facility. The vaccine will be covered as a prescription benefit when it is administered at a pharmacy. The vaccines covered include flu vaccines, hepatitis, RSV, shingles, and COVID-19 vaccines. In addition, effective January 1, 2024, the Plan will no longer restrict coverage of a shingles vaccine to those Participants who are age 65 and over. Instead, the Plan will cover, at the amount in accordance with the Schedule of Benefits for vaccines, a shingles vaccine for any Participant or Dependent who receives that vaccine. Lastly, effective January 1, 2024, a Participant's out-of-pocket costs for insulin will not exceed $35.00 per purchase.

[7] The administrative costs of the COVID-19 vaccine will be covered at zero copay. Further, the COVID-19 vaccine will be both a medical and prescription benefit. In addition, effective March 1, 2024, the Plan was amended to provide that vaccines will be covered, at the amount in accordance with the Plan's Schedule of Benefits for vaccines, as both a medical and prescription drug benefit. Particularly, the vaccine will be covered as a medical benefit when it is administered at a doctor's office, at a hospital, or at any other medical care facility. The vaccine be covered as a prescription benefit when it is administered at a pharmacy. The vaccines covered include flu vaccines, hepatitis, RSV, shingles, and COVID-19 vaccines. In addition, effective January 1, 2024, the Plan will no longer restrict coverage of a shingles vaccine to those Participants who are age 65 and older. Instead, the Plan will cover, at the amount in accordance with the Schedule of Benefits for vaccines, a shingles vaccine for any Participant or Dependent who receives that vaccine. Lastly, effective January 1, 2024, a Participant's out-of-pocket costs for insulin will not exceed $35.00 per purchase.

[8] Preventive services are provided in accordance with state and federal law. Please refer to the "Preventive and Wellness Services" section for more details. In general, preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Task Force, as well as preventive immunizations and other screenings, as mandated by the Affordance Care Act.

[9] The office visit copay applies to the cost of the office visit only.

	NETWORK	NON-NETWORK
Mammogram (one per calendar year)	No cost sharing	No cost sharing
Pap Test (one per calendar year)	No cost sharing	No cost sharing
Prostate Specific Antigen test	No cost sharing	No cost sharing
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (ages 9 and over, one each per calendar year)	No cost sharing	No cost sharing
Routine Colonoscopy/Sigmoidoscopy for Participants and Eligible Dependents (ages 40 and over)	No cost sharing	No cost sharing
OUTPATIENT SERVICES		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Services	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
FDA-Approved Gene Therapy	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Physical Therapy/Occupational Therapy – Facility and Professional (maximum 64 visits per calendar year except for autism-related therapies)	80% after deductible	60% after deductible
Chiropractic Therapy – Professional only (not to exceed 36 visits)	80% after deductible	60% after deductible
Speech Therapy – Facility and Professional (maximum 40 visits per calendar year)	80% after deductible	60% after deductible
Emergency Use of an Emergency Room	80% after deductible	80% after deductible

	NETWORK	NON-NETWORK
Non-Emergency Use of an Emergency Room	80% after deductible	80% after deductible
INPATIENT FACILITY		
Semi-Private Room and Board	80% after deductible	60% after deductible
Inpatient Consultation	80% after deductible	60% after deductible
Skilled Nursing Facility (90 days per calendar year)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
ADDITIONAL SERVICES		
Allergy Testing and Treatments	80% after deductible	60% after deductible
Ambulance	80% after deductible	60% after deductible
Case Management	100%	100%
Durable Medical Equipment	80% after deductible	60% after deductible
Home Healthcare	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Organ Transplant	80% after deductible	60% after deductible
Organ Donor Expenses	80% after deductible	60% after deductible
Private Duty Nursing (90 days per calendar year)	80% after deductible	60% after deductible
MENTAL HEALTH CARE, DRUG ABUSE AND ALCOHOLISM SERVICES		
Inpatient Mental Health	80% after deductible	60% after deductible
Inpatient/Outpatient Substance Abuse Services and Alcoholism	80% after deductible	60% after deductible
Outpatient Mental Health	80% after deductible	60% after deductible

NOTE: Services requiring a copayment are not subject to the single/family deductible.

PRESCRIPTION DRUGS	NETWORK	NON-NETWORK	LIMITATIONS
Rx Max Out of Pocket	$5,650 per person, up to $20,300 per family	None	
Generic Drugs	10% coinsurance (retail and mail order)	10% coinsurance (retail)	Retail: 30 day supply Mail order: 90 day supply
Preferred Brand Drugs	20% coinsurance (retail and mail order)	20% coinsurance (retail)	
Non-Preferred Brand Drugs Coinsurance	30% coinsurance (retail and mail order)	30% coinsurance (retail)	
Specialty Drugs Coinsurance	Same as above	Same as above	

DENTAL AND VISION SERVICES

The Plan will pay eighty percent (80%) for any combination of dental/vision expenses up to a maximum payment of Two Thousand Dollars ($2,000.00) per family per calendar year ($2,500.00 in charges paid at 80%). ***Note***: Claims are payable only through the Fund Office either directly to the provider or, for expenses paid by the Participant, directly in reimbursement to the Participant. Benefits cannot be assigned. A sample form is provided in the **Addendum**.

B. No Surprises Act: Out-of-Network Emergency and Air Ambulance Services

Effective May 1, 2022, notwithstanding the Schedule of Benefits in Article I, Section A:

1) In accordance with the Title I of Division BB of the Consolidated Appropriations Act of 2021 (the "No Surprises Act"), the Plan will apply in-network cost-sharing to out-of-network air ambulance services, and emergency services for treatment of emergency medical conditions by out-of-network providers and out-of-network emergency facilities (unless the patient received proper notice and consented to the out-of-network billing rates for certain post-stabilization services, as allowed under the No Surprises Act).

2) Notwithstanding any Plan provision to the contrary, for out-of-network services covered by the No Surprises Act, the in-network coinsurance

percentage shall be applied to the lower of the billed charge or the qualifying payment amount. There will be no balance billing for services covered by the No Surprises Act.

3) Any amount paid by a covered individual under the Plan for emergency services (in-network or out-of-network) shall be applied toward any applicable deductible and cost-sharing limit.

4) The Plan shall not impose prior authorization requirements on emergency services, whether in-network or out-of-network, and shall not apply any limitation on coverage of emergency services provided by an out-of-network provider or facility that are more restrictive than the requirements that apply to in-network emergency services.

5) For services covered under the Plan and subject to the No Surprises Act, the Plan will pay the provider or facility, subject to all applicable Plan limitations and exclusions, an agreed upon amount, and if there is no agreed upon amount, an amount determined by an Independent Dispute Resolution or "IDR" process.

6) If there is a conflict between the Plan and the No Surprises Act or the Affordable Care Act, then the No Surprises Act or the Affordable Care Act shall govern, as applicable.

7) For purposes of this section and any related No Surprises Act provisions of this Plan, the following definitions shall apply:

   a) "Qualifying payment amount" means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under 29 C.F.R. § 2590.716-6(c).

   b) "Independent Dispute Resolution" or "IDR" means a process established by the No Surprises Act and its enforcing regulations to resolve a payment dispute between payers and out-of-network providers, initiated only if the parties are unable to agree on an acceptable payment rate.

   c) "Emergency service" means, with respect to an emergency medical condition, the following:

      i. An appropriate medical screening examination (as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an

independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.

ii. A medical service within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

iii. Any additional item or service for which benefits are provided or covered under the Plan and are furnished by an out-of-network provider or out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the service is furnished.

d) "Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to:

i. place the individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;

ii. result in serious impairment to the individual's bodily functions; or

iii. result in serious dysfunction of any bodily organ or part of the individual.

e) "Air ambulance service" means medical transport service by a rotary wing air ambulance, as defined in 42 C.F.R. § 414.605, or fixed wing air ambulance, as defined in 42 C.F.R. § 414.605, for patients.

f) "Emergency facility" means an emergency department of a hospital or an independent freestanding emergency department.

g) "Independent freestanding emergency department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law, and provides any emergency services as described in 29 C.F.R. § 2590.716-4(c)(2)(i).

C. No Surprises Act: Certain Services at an In-Network Hospital or Ambulatory Surgical Center

Effective May 1, 2022, notwithstanding the Schedule of Benefits in Article I, Section A, the following ancillary services provided at an in-network hospital or ambulatory surgical center (as described in § 1833(i)(1)(A) of the Social Security Act) shall be billed at the Plan's in-network cost-sharing amount even if provided by an out-of-network provider:

a) Emergency Medicine

b) Anesthesia

c) Pathology

d) Laboratory

e) Neonatology

f) Assistant Surgeon

g) Hospitalist

h) Intensivist Services

i) Radiology

1) For services provided by an out-of-network provider at an in-network facility, this Plan shall not impose cost-sharing on coverage for out-of-network services greater than cost-sharing that applies to in-network services unless the provider has complied with notice requirements pursuant to the No Surprises Act in the form and method prescribed by the Department of Health and Human Services, and the patient consents to using the out-of-network provider. However, this notice-consent exception is not available to the following providers (in other words, in-network cost-sharing shall apply):

a) The ancillary services described in Article I, Section C(1)(a)-(i) above;

b) Services provided as a result of unforeseen, urgent medical needs that arise at the time a covered service is furnished;

c) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; or

d) Such further medical examination and treatment as may be required to stabilize the patient (regardless of the department of the hospital in which the further medical examination and treatment are furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

D. No Surprises Act: Continuity of Care

Effective May 1, 2022, notwithstanding the Schedule of Benefits in Article I, Section A:

1) This Plan shall provide ninety (90) days of continued in-network coverage for a "continuing care patient" where the treating in-network provider leaves the network for any reason except a for-cause termination of the provider's in-network contract.

2) A "continuing care patient" means a person who is (1) undergoing a course of treatment for a serious and complex condition from the provider; (2) undergoing a course of inpatient care from the provider; (3) scheduled for nonelective surgery from the provider; (4) pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and receiving treatment for such illness from the provider.

3) This Plan shall provide notice to a continuing care patient as soon as administratively practicable after the applicable provider leaves the Plan's network. Said notice shall inform the continuing care patient how to elect this continued coverage.

E. No Surprises Act: External Review of Adverse Benefit Determination

Effective May 1, 2022, notwithstanding the Schedule of Benefits in Article I, Section A:

1) An adverse benefit determination involving items and services within the scope of No Surprises Act are eligible for external review as follows:

a) "External review" is a review of an adverse benefit determination by an independent review organization or external review organization ("IRO") or by the state's Insurance Commissioner, if applicable.

b) You must complete all of the levels of standard appeal described in Article XVIII of this Plan before you can request external review, other than in a case of deemed exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

c) The notice of an adverse benefit determination that you receive from the Plan will describe the process to follow if you wish to pursue an external review, and it will include a copy of the request for external review form.

d) You must submit the request for external review form to the Plan within 123 calendar days of the date you received the adverse benefit determination or final internal adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include copies of the notice and all other pertinent information that support your request.

e) If you file this voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, this appeal is voluntary and you are not required to undertake it before pursuing legal action.

f) If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

2) Preliminary Review Upon Plan's Receipt of Requests for External Review Form

a) Following the date of receipt of the request for external review, the Plan or its designee must provide a preliminary review determining:

i. you were covered under the Plan at the time the service was requested or provided;

ii. you have exhausted the internal appeals process (unless deemed exhaustion applies); and

iii. you have provided all paperwork necessary to complete the external review.

b) The Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the

Employee Benefits Security Administration (the toll-free number is 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the Plan or its designee must allow you to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3) Referral to the IRO

a) The Plan or its designee will assign an IRO accredited as required under federal law to conduct the external review. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, and it will provide an opportunity for you to submit in writing, within ten (10) business days following the date of receipt, additional information that the IRO must consider when conducting the external review. The IRO must notify you, the Plan and its designee.

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

i. the applicable medical records;

ii. the attending health care professional's recommendations;

iii. reports from appropriate health care professionals and other documents submitted by the covered person, the Plan, its designee or the treating health care providers;

iv. the relevant terms of the Plan to ensure that the IRO's decision is not contrary to those terms, unless the terms are inconsistent with applicable law;

v. 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;

vi. any applicable clinical review criteria developed and used by the industry, unless the criteria are inconsistent with the terms of the Plan

or applicable law; and

vii. the opinion of the IRO's clinical reviewer or reviewers after considering the information described in the notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

c) The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the covered person and the Plan.

d) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process. An IRO must make such records available for examination by the claimant, the Plan, and the state or federal oversight agencies upon request, except where such disclosure would violate state or federal privacy laws.

e) Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

4) Expedited External Review

a) The Plan must allow the covered person to request an expedited external review at the time he or she receives:

i. An adverse benefit determination, if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the covered person's life or health or would jeopardize his or her ability to regain maximum function and he or she has filed a request for an expedited internal appeal; or

ii. A final internal adverse benefit determination, if he or she has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize his or her life or health or would jeopardize his or her ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, health care item or service for which he or she received emergency services, but has not been discharged from a facility.

b) Immediately upon receipt of the request for expedited external review,

the Plan or its designee will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan or its designee must immediately send the covered person a notice of its eligibility determination.

5) Referral of Expedited Review to IRO

a) Upon a determination that a request is eligible for external review following preliminary review, the Plan or its designee will assign an IRO. The IRO shall render a decision as expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the covered person and the Plan.

6) Appeal to the Plan

a) If the covered person chooses to appeal to the Plan or its designee following an adverse determination by external review, he or she has the right to do so under Article XVIII, Section D.

ARTICLE II - RULES OF ELIGIBILITY

A. Eligible Classes of Participants

Classes of Participants eligible for benefits provided by the Plan include the following:

1) Active Participants, as well as their spouses and Dependents, who are working under the terms of an applicable collective bargaining agreement.

2) Full-time employees of the Union, including its Business Manager and Business Representatives.

3) Retired Participants who have satisfied the eligibility provisions of the Retiree Program set forth in this SPD.

4) Surviving spouses and Eligible Dependents of deceased Participants.

B. Eligibility of Active Participants (DOES NOT INCLUDE APPRENTICES) Working Under the Terms of an Applicable Collective Bargaining Agreement

1) **Initial Eligibility.** A Participant will be eligible for benefits under the Plan, provided the following conditions are met:

   a) The Participant is covered under the terms of an applicable collective bargaining agreement entered into between the Union and his or her Employer, or the Participant is covered under the terms of a participation agreement between the Plan and his or her Employer;

   b) The Participant is a member of the Union, or the Participant is covered under the terms of a participation agreement between the Plan and his or her Employer; and

   c) The Participant has worked a total of 600 hours within five (5) consecutive preceding calendar months for which contributions to the Fund have been made on his or her behalf.

2) After a Participant has met the above requirements and becomes eligible, the Participant will be eligible for two (2) months of coverage starting on the first day of the month following the month in which the Participant has accumulated a total of 600 hours of employment within five (5) consecutive preceding calendar months and all contributions for such hours are due.

3) **Initial Eligibility of MES and Residential Active Participants Entering the Plan from the State Plan.** An MES employee or a Residential Active Participant who first comes into this Plan after June 1, 2017 will be eligible for benefits under the Plan as follows:

a) The Participant is covered under the terms of an applicable collective bargaining agreement entered into between the Union and his or her Employer.

b) The Participant is a member of the Union.

c) The Participant has worked a total of 600 hours within three (3) consecutive calendar months for which contributions to the Fund have been made on his or her behalf.

After this Participant has met the above requirements and becomes eligible, the Participant will be eligible for two (2) months of coverage starting on the first day of the month following the month in which the Participant has obtained 600 hours. However, for this MES Active Participant who has worked less than the 600 hours within this initial eligibility period, and in order to receive immediate coverage, the Participant will have the option to receive negative bank hours at the outset in the amount of the difference necessary to give him or her the requisite 600 hours during the period.

The amount of reserve work hours accumulated during these two (2) months will first be used to pay off the number of negative bank hours extended to reach the initial 600-hour requirement. Then, the number of hours of employment in those two (2) months in excess of the pay-off amount will be credited to the Participant's Reserve Bank pursuant to Article II, Section D below. Hours of employment after these two (2) months will then be applied toward this Participant's Continuation of Eligibility pursuant to Article II, Section C below.

It is expected that any Participant who elects to receive negative bank hours, as provided above, will "pay back" those hours as soon as possible but, at the latest, within three (3) years from the receipt of the negative bank hour(s). Failure to pay back can result in the Participant being assessed each pay an appropriate pay back amount until full pay back is completed.

C. Continuation of Eligibility

Once the Participant becomes eligible, his or her continued eligibility will be based on the continuation of contributions being made on the Participant's behalf, with the amount of contributions as established by the Board of Trustees to be deducted monthly from the Participant's Reserve Bank. For each calendar month the Participant is credited with contributions which are less than sufficient to maintain monthly eligibility, the Participant will lose eligibility for one month unless the Participant has accumulated sufficient contributions in the Participant's Reserve Bank to make up the difference between the actual contributions and the required amount for maintenance of eligibility, or the Participant makes the required self-payment.

D. Accumulations of Reserve Dollars

A Participant may accumulate Credited Reserve Dollars as follows:

1) During the initial eligibility period, all contributions in excess of those required to purchase initial eligibility.

2) All contributions paid to the Fund on the Participant's behalf following the effective date of his or her coverage which is in excess of the amount set by the Board of Trustees to maintain eligibility will be credited to the Participant's Reserve Bank, up to a maximum reserve dollar accumulation equivalent to thirty-six (36) months of coverage based on the current hourly rate times 150 hours.

E. Self-Contributions

If the Participant's eligibility for benefits under the Plan terminates, the Participant may arrange with the Board of Trustees to continue eligibility at the Participant's own expense subject to the following conditions:

1) If the Participant has an amount in the Participant's Reserve Bank which is less than the required amount to continue the Participant's eligibility, the Participant will be permitted to make self-payments representing the difference between the amount of contributions in the Participant's Reserve Bank and the contributions required for maintenance of eligibility. Self-contributions shall be limited to a maximum of 18 consecutive months of full self-payment, except that eligibility can be retained for up to an additional twelve (12) consecutive full self-payment months if the Participant become disabled so as to be prevented from performing his or her normal duties and that disability continues after the 18-month period.

2) A Participant may preserve his or her eligibility, as set forth above, if he or she satisfies one or more of the following:

   a) if laid off or unemployed but is actively seeking work, meaning the Participant maintains his or her membership in the Union and registers his or her continued availability for work;
   b) if on an authorized strike;
   c) if by reason of Union activities or governmental service or activity related to the construction industry, the Participant may preserve his or her eligibility during the leave of absence period; or
   d) if the Participant becomes disabled so as to be prevented from performing his or her normal duties and remains disabled after the 18 consecutive full self-contribution period. In that case, as noted above, the Participant can retain eligibility for up to an additional twelve (12)

consecutive full self-contribution months. However, such eligibility period will terminate upon the occurrence of the first of one of the following events during the additional 12-month full self-contribution period:

(i) the 12-month period ends;
(ii) the disability ends; or
(iii) the Social Security Administration holds during this 12-month period that the Participant's disability has made him or her eligible for Medicare.

All self-contributions become the property of the Plan the day received and will not be refunded. Hours received relative to the work month for which the self-contribution was made, whether as a result of a late payment or reciprocity agreement, will be credited in their entirety to the Participant's Reserve Bank.

F. Reinstatement of Eligibility

A Participant who fails to maintain eligibility as set forth above will be reinstated in the Plan on the first day of the month following the month in which the Fund Office receives 150 hours of credited service for the Participant with one or more contributing Employers. The 150 hours of credited service shall be calculated by adding the Participant's credited hours of service in each month following the month in which the Participant lost eligibility.

G. Initial Eligibility and Negative Bank Option for Non-MES, Non-Residential Active Participants and for Active Apprentice Participants, Effective June 1, 2017

Effective June 1, 2017, any non-MES, non-Residential Active Participant or Active Apprentice Participant who:

1) first enters the Plan after June 1, 2017;
2) is covered under the terms of an applicable collective bargaining agreement or participation agreement; and
3) is a member of the Union (and, for an Apprentice, is a registered Apprentice with the Union),

then he or she will have the option to receive up to 300 negative bank hours at the outset in order to be entitled to immediate coverage.

Note that any Active Apprentice Participant who is directed into the Plan by the International after May 1, 2020, will have the option to receive an advance of up to 150 bank hours to use toward the threshold of 300 hours to satisfy initial eligibility for Plan coverage. Otherwise, any other Active Participant who is directed into the Plan by the International after May 1, 2020 will not have the option to receive advance negative bank

hours toward the threshold of 300 hours to satisfy initial eligibility for Plan coverage.

Any reserve work hours accumulated at any time in accordance with Article II, Section D will be first used to pay off the number of negative bank hours extended to reach the initial 300-hour requirement. The number of hours of employment in excess of the payoff amount will be credited to the Participant's Reserve Bank pursuant to Article II, Section D and can then be applied toward the Participant's continuation of eligibility pursuant to Article II, Section C.

It is expected that any Participant or Active Apprentice Participant who elects to receive negative bank hours, as provided above, will "pay back" those hours as soon as possible but, at the latest, within three (3) years from the receipt of a negative bank hours. Failure to pay back can result in the Participant being assessed each pay an appropriate pay back amount until full pay back is completed.

H. Eligibility of Full-Time Employees of the Union, Including the Business Managers and Business Representatives

A full-time employee of the Union, including the Business Manager and Business Representatives, shall become eligible for benefits under the Plan, provided the following conditions are met:

1) The Participant is a full-time employee working at least a minimum of thirty (30) hours per week, as reflected in the payroll records of the Union.

2) The Union signed a participation agreement with the Plan.

3) Contributions at a monthly rate established by the Board of Trustees are payable to the Fund by the fifteenth (15th) day of the month pursuant to the participation agreement.

I. Participants Serving in Armed Forces

In the event a Participant enters the Armed Forces of the United States on a full-time basis, coverage under the Plan shall be extended in accordance with Article II, Section N below.

J. Eligibility of Retired Participants Under the Retiree Program

1) Eligibility for the Retiree Program shall be restricted to the following Retired Participants:

   a) Participants who are at least age fifty-five (55), who are no longer actively employed and who are receiving retirement benefits from a qualified pension plan acceptable to the Board of Trustees.

b) Participants under age fifty-five (55) and considered to be totally and permanently disabled and who are eligible to receive retirement benefits provided through the Social Security Administration and are enrolled in Medicare, including Part B, if eligible to do so and/or are receiving pension benefits from a qualified pension plan acceptable to the Board of Trustees.

c) Participants who are retired Office and Salary Employees and who have been "grandfathered" in their eligibility.

2) A Retired Participant meeting the eligibility rules stated above must have been continuously covered under the Plan for at least twelve (12) months prior to the month the Retired Participant ceased work. Within thirty-one (31) days following the Retired Participant's eligibility to participate, he or she must satisfactorily complete a Retiree Program application and must remit the necessary contributions as required by the Board of Trustees. Retired Participants who were working under the terms of the applicable collective bargaining agreement or participation agreement, after having made the necessary arrangements, shall be provided the opportunity to exhaust, at the rates applicable to Active Participants, any amounts remaining in their accumulated Reserve Banks.

3) Coverage will be automatically transferred to the Retiree Program effective on the effective date of his or her retirement as determined by the Plumbers and Pipefitters National Pension Fund. Furthermore, a Retired Participant who is maintaining coverage while exhausting his or her Reserve Bank will be entitled to the Plan's accident and sickness benefit only to the extent necessary to finish such entitlement which was commenced prior to his or her retirement and only up to a total of twenty-six (26) weekly benefits as calculated from the start of that commencement of use of this benefit prior to retirement.

4) **Payment of Premium.** The amount of payment which those Participants under the Retiree Program shall be required to make shall be determined by the Board of Trustees and may be adjusted from time to time. Any payments required by the Retired Participants must be received by the Plan prior to the beginning of the period for which coverage is to be effective.

5) **Eligible Dependents of Retired Participants**. An Eligible Retired Participant shall be entitled to coverage under the Plan for his or her Eligible Dependents. Such coverage shall become effective on the later of the following dates:

a) On the date the Eligible Retired Participant's coverage became effective; or

b) On the date the Participant first acquires an Eligible Dependent.

6) **Termination of Coverage.** If the coverage of a Retired Participant lapses due to the Retired Participant's non-payment of premiums or a request by the Participant to terminate coverage, the Participant shall be able to reinstate such coverage within one (1) year of such termination. However, the Participant shall only be eligible for such reinstatement one time. **Furthermore, if a Retired Participant ceases or loses coverage and enrolls in the Medicare Part D prescription plan, the Participant will not be eligible to re-enroll for prescription coverage through this Plan.**

7) **Special Rule for Married Participants.** A Participant who is the spouse of another Participant, and who retires from active service (hereinafter, the first retiring spouse shall be referred to as Participant A), shall be entitled to be carried as a Dependent under the Plan by the spouse who remains as an active Participant (the remaining active spouse shall be referred to as Participant B). Participant A shall not be required to draw down Participant A's Reserve Bank while being carried as a Dependent by Participant B. If Participant A becomes Medicare eligible, Participant A shall no longer be carried as a Dependent by Participant B. If Participant B retires from active service while carrying Participant A as a Dependent, Participant B shall be required to begin drawing upon Participant B's Reserve Bank for coverage under the Plan. During such time, Participant A will continue to be carried by Participant B as a Dependent under the terms of the Plan. When Participant B exhausts Participant B's Reserve Bank, Participant A will be required to draw down Participant A's Reserve Bank and carry Participant B as a Dependent. When Participant A and Participant B have each exhausted their Reserve Banks, and prior to becoming Medicare eligible, Participant A or Participant B will be required to self-pay to the Plan in order to maintain eligibility and may carry the other participant as a Dependent. Reserve Banks shall be drawn down, and self-payments shall be made, at the full rate required by the Board of Trustees. It is the intention of the Board of Trustees that Participant A and Participant B be treated as Retired Participants at the time when each becomes Medicare eligible. To be eligible for the benefits under this Paragraph (7), each married Participant must have had contributions made to the Plan for ten (10) consecutive years prior to the retirement of one of the Participants. The benefits described in this Paragraph (7) shall be available to married Participants notwithstanding any apparently contrary provisions of the Plan.

K. Eligibility of Surviving Spouses and Eligible Dependents of Deceased Participants

The surviving spouse and each Eligible Dependent of a deceased Participant shall be eligible for benefits under the following conditions:

1) The surviving spouse or Eligible Dependent may utilize any Reserve Bank Dollars accumulated by the deceased Participant to continue his or her benefit coverage under the Plan. A surviving spouse who remarries shall have the right to continue to draw down the Reserve Bank, provided, however, that the surviving spouse's new spouse shall not be eligible for coverage under this Plan as a Dependent. The preceding disqualification shall not apply if the new spouse has independently established eligibility for coverage under the Plan as a Participant.

2) The surviving spouse or Eligible Dependent shall be entitled to the same benefit coverage that was extended to him or her under the Plan immediately prior to the Participant's death. However, the Death Benefit offered by the Plan is not a benefit to which the surviving spouse or Eligible Dependent is entitled.

3) Upon exhaustion of the Reserve Bank accumulated by the deceased Participant account, the surviving spouse or Eligible Dependent shall be entitled to continue coverage under the Plan by making the self-payment that otherwise is required of Retired Participants under the Plan.

L. Special Enrollment Rights

If a Participant or Eligible Dependent previously declined enrollment for himself for herself or for another Eligible Dependent, such Participant or Eligible Dependent may enroll for coverage under this Plan if the individual later loses that other health care coverage, so long as the following conditions are met:

1) The Participant or Eligible Dependent was covered under a group health plan or had health insurance at the time coverage was previously offered to the Participant or Dependent.

2) The Participant stated in writing at such time that coverage under the group health plan or health insurance was the reason for declining enrollment and provided a copy of such written statement to the Fund Office.

3) The Participant's or Dependent's coverage:

   a) either was under a COBRA continuation provision and the coverage under such provision was exhausted, or was not under such COBRA provision and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or the employer's contributions toward such coverage were terminated; and

   b) The Participant or Dependent requested such enrollment under the Plan

no later than thirty (30) days after the date of such exhaustion of coverage, termination of coverage, or termination of Employer contributions (as applicable).

Notwithstanding the foregoing, a Participant or Eligible Dependent shall have the right to special enrollment in the Plan after a marriage, birth, adoption or placement for adoption. If any of the preceding events occurs, the Participant or Eligible Dependent must request special enrollment within ninety (90) days of the event that triggered the special enrollment right.

M. Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (the "FMLA") guarantees certain employees a minimum of twelve (12) weeks of coverage under this Plan based on premium payment provisions in effect immediately prior to such leave.

1) Notwithstanding any provision in this Plan to the contrary, the following provisions shall apply to an Eligible Participant who requests, and receives, a leave of absence pursuant to the FMLA:

a) If the Eligible Participant is covered by an applicable collective bargaining agreement negotiated by the Union, the Plan shall continue eligibility for the Participant and credit contributions on behalf of the Participant who is using FMLA leave as though the Participant had been continuously employed for a maximum of twelve (12) weeks as allowed by law.

b) If the Eligible Participant is a full-time employee of the Union, the Employer of such Participant shall continue to make contributions on behalf of the Participant using FMLA leave as though the Participant had been continuously employed.

c) For the duration of the Participant's FMLA leave, coverage by the Plan and benefits provided pursuant to the Plan shall continue at the level of coverage that would have continued if the Participant had remained actively employed.

d) A Participant using FMLA leave shall not be required to use his or her Reserve Bank or pay any greater premiums than the Participant would have been required to pay if the Participant had been continuously employed.

e) A Participant, upon returning from an FMLA leave, shall be reinstated in the Plan to the same status as provided when the leave began, subject to benefit changes that affect all Participants in the Plan. The Participant shall not be subjected to any restrictions, waiting periods, physical

examinations or other pre-existing condition exclusions that would not have been imposed upon the Participant had he or she not taken the FMLA leave.

f) Effective January 28, 2008, Participants with members in the Armed Services are entitled to FMLA leave under the following circumstances:

i. When leave is needed so that the Participant can care for an injured or ill family member in the Armed Services; and

ii. When such leave is required due to "any qualifying exigency" related to a family member's service or call to duty.

The Participant must be a spouse, parent, child or nearest blood relative of the member in the Armed Services. A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single twelve (12) month period.

N. Participants Serving in the Armed Forces

A Participant who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his or her Reserve Bank, if any, until discharged from active full-time military duty; or utilizing his or her Reserve Bank, if any, to continue coverage under the Plan, as provided hereafter.

In the event a Participant who enters into full-time military duty of the United States has no Reserve Bank, has an insufficient Reserve Bank to maintain coverage while serving in the military service, or does not elect to utilize said Participant's Reserve Bank to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan for the Participant and said Participant's Eligible Dependents can be continued for eighteen (18) months upon receipt of a timely application and required contributions established by the Board of Trustees.

If a Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the Participant and Eligible Dependents at the Plan's expense. For military service that exceeds thirty-one (31) days, the Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

A Participant shall notify the Fund Office as soon as said Participant knows or understands that said Participant will be entering the military service of said Participant's desire to purchase continuation health care coverage for that period of time when said Participant is in active military service, not to exceed five (5) years. This notice requirement shall be adhered to by the Participant unless giving such notice is precluded

by military necessity or is otherwise impossible or unreasonable.

Upon a Participant's honorable discharge from military service, the Participant's eligibility status under the Plan will be restored to the status that existed when said Participant entered military service, with the exception of any Reserve Bank Dollars that the Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Participant must notify the Fund Office, in writing, within sixty (60) days of his or her discharge of his or her intent to return to covered employment. In addition to such written notice, the Participant shall also supply the Fund Office copies of said Participant's discharge papers showing the date of said Participant's enlistment in military service and the date of said Participant's discharge. Failure on the part of the Participant to file such notice and documentation with the Fund Office may be deemed an indication that the Participant does not wish to restore said Participant's eligibility status under the Plan.

O. Termination of Coverage

1) Coverage for Active Participants working under the terms of an applicable collective bargaining agreement or a participation agreement shall terminate when any of the following events occurs:

   a) Termination of the Plan as to Active Participants;

   b) Modification of the Plan to terminate coverage for the class to which the Participant belongs;

   c) Plan modification to terminate a particular type of benefit or coverage under the Plan;

   d) The Participant fails to maintain the eligibility requirements as set forth above;

   e) The date the Participant is no longer employed by any contributing Employers;

   f) The date the Participant fails to make any required self-payment or COBRA payment;

   g) The date of the Participant's termination of membership in the classes eligible for coverage;

   h) The Participant enters the Armed Forces on full-time active duty;

   i) The Participant allows a non-covered or ineligible person to use the said Participant's benefit card to obtain or attempt to obtain benefits from this

Plan; or

j) The Participant materially misrepresents information provided to the Plan or commits fraud or forgery.

2) If the Participant voluntarily:

a) terminates membership in the classes eligible for coverage;
b) voluntarily leaves the trade; or
c) voluntarily terminates membership in the Union,

then Plan coverage will terminate and any accumulated bank hours will be forfeited to the Plan. Furthermore, the Participant must notify the Fund Office within sixty (60) days of such action in order to preserve rights under COBRA.

3) Retired Participant coverage shall terminate when any of the following events occurs:

a) Termination of the Plan;

b) The date the Retiree Program terminates;

c) The date of expiration of the period for which the last contribution is made to the Plan, as required, to the account of the Retired Participant;

d) The date the Retired Participant ceases to be within the classes of persons eligible for coverage under the Retiree Program;

e) The date the Retired Participant dies;

f) The date the Plan is discontinued;

g) The date the Eligible Retired Participant allows a non-covered or ineligible person to use said Participant's benefit card to fraudulently obtain or attempt to obtain benefits under the Plan;

h) The date the Eligible Retired Participant materially misrepresents information provided to the Plan or commits fraud or forgery. or

i) Any additional reasons for termination of coverage as listed in Article II, Section J(5) above.

4) Surviving spouse and Dependent coverage shall terminate when any of the following events occurs:

a) Termination of the Plan;

b) Termination of the supporting Participant's coverage;

c) The date on which the surviving spouse becomes covered under another plan other than for coverage under Medicare;

d) When the Dependent ceases to be an Eligible Dependent;

e) Termination of surviving spouse or Dependent benefits under the Plan;

f) The date on which the surviving spouse or Eligible Dependent fails to make a required self-payment under the Plan;

g) The surviving spouse or surviving Dependent enters the Armed Forces on a full-time active duty basis;

h) The surviving spouse or surviving Dependent allows a non-covered or ineligible person to use his or her benefit card to fraudulently obtain or attempt to obtain benefits under the Plan; or

i) The surviving spouse or surviving Dependent materially misrepresents information provided to the Plan or otherwise commits fraud or forgery in connection with the Plan.

P. Eligibility of Employees of Newly Organized Employers

1) An employee of a newly organized Employer who is a member of a bargaining unit represented by the Union shall be eligible for benefits under the Plan on the following terms:

a) The employee is accepted into the Plumbers & Pipefitters Local Union 94 Joint Apprenticeship and Training Program or is registered by the Union as a journeyman.

b) If the employee is accepted as an apprentice, his or her eligibility benefits shall be determined by Article II, Section G.

c) If the employee is registered by the Union as a journeyman, the employee shall be entitled to immediate coverage. However, the employee shall initially have a negative Reserve Bank equivalent to 600 hours. Once the negative Reserve Bank is paid off by contributions made on the employee's behalf, the provisions of this Plan applicable to active Participants shall apply.

ARTICLE III - MEDICAL BENEFITS

If a covered person incurs expenses as the result of a non-occupational illness or injury, the Plan will provide the benefits described below, subject to the applicable maximums, deductibles and co-insurance as set forth in the Plan's Schedule of Benefits.

This section describes the services and supplies covered if provided and billed by providers. All covered services must be medically necessary unless otherwise specified.

Allergy Tests and Treatment

Allergy tests and treatment that are performed and related to a specific diagnosis are covered services. Desensitization treatments are also covered.

Ambulance Services

Transportation for conditions other than emergency medical conditions via ambulance must be certified by your physician. Transportation services are subject to medical review to determine medical necessity. Ambulance services include local ground transportation by a vehicle equipped and used only to transport the sick and injured:

- from your home, scene of an accident or emergency medical condition to a hospital;
- between hospitals;
- between a hospital and a skilled nursing facility;
- from a hospital or skilled nursing facility to your home; or
- from a physician's office to a hospital.

Trips must be to the closest facility that is medically equipped to provide the covered services that are appropriate for your condition. Transportation for emergency medical conditions will also be covered when provided by a professional ambulance service for other than local ground transportation, such as air and water transportation, only when special treatment is required and the transportation is to the nearest hospital qualified to provide the special treatment.

Transportation services provided by an ambulette or a wheelchair van are not covered services.

Autism Spectrum Disorders

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders. Covered services include:

- Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist.

- Clinical therapeutic intervention, which includes, but is not limited to, applied behavior analysis. This intervention must be provided by, or be under the supervision of, a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform such services in accordance with a treatment plan.

- Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist or physician providing consultation, assessment, development, or oversight of treatment plans.

- Prescription drugs.

Treatment for autism spectrum disorders means evidence-based care and related equipment prescribed or ordered for a covered person diagnosed with autism spectrum disorder by a licensed physician who is a developmental pediatrician or a licensed psychologist trained in autism who determines the care to be medically necessary. All covered services must be prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism spectrum disorders and require preauthorization.

Cancer Clinical Trial Programs

Benefits are provided for routine patient care administered to a covered person participating in any stage of an eligible cancer clinical trial if that care would be covered under the Plan if the covered person were not participating in a clinical trial.

The phrase “eligible cancer clinical trial” means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes;
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- The trial does one of the following:

    - Tests how to administer a health care service, item, or drug for the treatment of cancer;
    - Tests responses to a health care service, item, or drug for the treatment of cancer;
    - Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
    - Studies new uses of a health care service, item, or drug for the treatment of cancer;

- The trial is approved by one of the following entities:

    - The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    - The United States Food and Drug Administration;
    - The United States Department of Defense; or
    - The United States Department of Veterans' Affairs.

The phrase "routine patient care" means all health care services consistent with the coverage provided under the Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

The phrase "subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An experimental or Investigational drug or device that has not been approved for market by the Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, a family member, or a companion of the patient associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsor free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by a person or entity other than the Plan, including the sponsor of the cancer clinical trial.

Case Management

Case management is an economical, common-sense approach to managing health care benefits. The case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment. In such instances, benefits not expressly covered by the Plan may be approved. All case management programs are voluntary for the patient. Coverage for these services must be approved in advance and in writing. To learn more about these services, you may contact your case management staff.

Dental Services for an Accidental Injury

Dental services will only be covered for initial injuries sustained in an accident. The accidental injury must have caused damage to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

The above exclusion for injuries as a result of biting or chewing shall not apply if such injury was the result of domestic violence or if an underlying medical condition caused the biting or chewing-related injuries. For example, a covered person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure. The underlying illness must cause the chewing or biting accident that results in injury to the jaw, sound natural teeth, mouth or face. If a covered person has an underlying Illness that causes the teeth to be more susceptible to injury, dental services related to such injury will not be covered as an injury sustained in an accident.

Diagnostic Services

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your condition. It must be ordered by a physician or other professional provider. Covered diagnostic services are limited to the following:

- radiology, ultrasound and nuclear medicine;
- laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

Drug Abuse and Alcoholism Services

Detoxification and rehabilitation services are provided for the treatment of drug abuse or alcoholism. In addition, the following services are covered for the treatment of drug abuse or alcoholism:

- inpatient treatment, including rehabilitation and treatment in a residential treatment facility;
- outpatient treatment, including partial hospitalization and intensive outpatient services;
- detoxification services;
- individual and group psychotherapy;
- psychological testing; and
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for covered services only for those family members who are considered covered persons under the Plan. Charges will be applied to the covered person who is receiving family counseling services, not necessarily the patient receiving treatment for drug abuse or alcoholism.

Inpatient admissions to a hospital provider or residential treatment facility provider must be preauthorized. The telephone number for preauthorization is listed on the back of your

identification card. Contracting providers in Ohio will assure this preauthorization is done; and since the provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For non-contracting providers or providers outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize these admissions and it is later determined that the admission was not medically necessary or not covered for any reason, you will be responsible for all billed charges.

Drugs and Biologicals

You are covered for prescription drugs and biologicals that cannot be self-administered and are furnished as part of a physician's professional service, such as antibiotics, joint injections and chemotherapy, in the course of the diagnosis or treatment of a condition. Other drugs that can be self-administered or that may be obtained under drug coverage, if applicable, are not covered but the administration of the drug may be covered.

Drugs that can be covered under your supplemental prescription drug plan need to be obtained under your pharmacy coverage.

Specialty prescription drugs require prior approval. The Claims Payor, along with your physician, will determine which setting is most appropriate for these drugs and biologicals to be administered to you.

The Plan may establish quantity limits and/or age limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits and/or age limits established by the Board of Trustees, the Claims Payor, or the utilization guidelines.

The Claims Payor may require other utilization programs, such as step therapy and prior authorizations, on certain prescription drugs. The medical necessity decisions are made by going through a coverage review process.

Step therapy is a program to determine whether you qualify for coverage based on certain information, such as medical history, drug history, age and gender. The program requires that you try another drug before the target drug will be covered under this Plan unless special circumstances exist. If your physician believes that special circumstances exist, he or she may request a coverage review.

Emergency Services

You are covered for medically necessary emergency services for an emergency medical condition. Emergency services are available 24 hours a day, 7 days a week. In the event of an emergency:

- call 911 or go to the nearest hospital or independent freestanding emergency department; and
- notify the Claims Payor by calling Customer Care at the phone number shown on your identification card, within 24 hours, or as soon as medically possible, if the

nearest hospital or independent freestanding emergency department is not in the Claims Payor's network.

Emergency services do not require prior authorization and are payable at the PPO network level of benefits shown in the Schedule of Benefits, regardless of whether these services are obtained from a PPO network provider, a non-PPO network provider or a non-contracting provider.

Services are no longer considered "emergency services" when all of the following conditions are met:

- The covered person's provider determines the covered person is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO network provider located within a reasonable travel distance, taking into consideration the covered person's medical condition.

- The covered person's provider satisfies the notice and consent criteria of the applicable federal or state law prohibiting balance billing as well as any guidance subsequently issued thereto.

- The covered person is in a condition to receive the notice and consent information and provide an informed consent, thereby giving up his or her rights to be protected from balance billing for the emergency services.

Gender Affirming Surgery

The Plan will cover medically necessary services for gender affirming surgery, subject to accepted medical clinical guidelines and the Claims Payor's applicable corporate medical policies.

Health Education Services

Benefits are provided for educational, vocational and training services while the covered person is an inpatient of a hospital or other facility provider.

Outpatient diabetic self-management training and education services are covered services when provided under the supervision of a licensed health care professional with expertise in diabetes. These services help to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diet and medical nutrition therapy.

Home Health Care Services

The following are covered services when you receive them from a hospital or a home health care agency:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- prescription drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section of this SPD. Examples include, but are not limited, to the following:

- homemaker services;
- food or home delivered meals; and
- custodial care, rest care or care which is only for someone's convenience.

All home health care services must be certified initially by your physician and your physician must continue to certify that you are receiving skilled care and not custodial care as requested by the Plan. All services will be provided according to your physician's treatment plan and as authorized as medically necessary by the Claims Payor.

Hospice Services

Hospice services consist of health care services provided to a terminally ill covered person. Hospice services must be provided through a freestanding hospice facility or a hospice program sponsored by a hospital or home health care agency. Hospice services may be received by the covered person in a private residence.

Benefits for hospice services are available when the prognosis of life expectancy is six (6) months or less.

The following covered services are considered hospice services:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- prescription drugs, limited to a two-week supply per prescription order or refill (these prescription drugs must be required in order to relieve the symptoms of a condition or to provide supportive care);
- oxygen and its administration;
- medical social services, such as the counseling of patients;
- home health aide visits when you are also receiving covered nursing or therapy services;
- acute inpatient hospice services;
- respite care;

- dietary guidance, counseling and training needed for a proper dietary program;
- durable medical equipment; and
- bereavement counseling for family members.

Non-covered hospice services include, but are not limited to, the following:

- volunteer services;
- spiritual counseling;
- homemaker services;
- food or home delivered meals;
- chemotherapy or radiation therapy if other than to relieve the symptoms of a condition; and
- custodial care, rest care or care which is only for someone's convenience.

Inpatient Hospital Services

The covered services listed below are benefits when services are performed in an inpatient setting, except as specified. The following bed, board and general nursing services are covered:

- a semiprivate room or ward;
- a private room, when medically necessary; if you request a private room, the Plan will provide benefits only for the hospital's average semiprivate room rate;
- newborn nursery care; and
- a bed in a special care unit approved by the Claims Payor. The unit must have facilities, equipment and supportive services for the intensive care of critically ill patients.

Covered ancillary hospital services include, but are not limited to, the following:

- operating, delivery and treatment rooms and equipment;
- prescription drugs;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing (the Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of surgery, but charges for the blood are excluded; autotransfusions or cell saver transfusions occurring during or after surgery are not covered);
- anesthesia, anesthesia supplies and services;
- oxygen and other gases;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services;
- therapy services; and
- surgically inserted prosthetics, such as pacemakers and artificial joints.

Non-covered hospital services include, but are not limited to, the following:

- gowns and slippers;
- shampoo, toothpaste, body lotions and hygiene packets;
- take-home drugs;
- telephone and television; and
- guest meals or gourmet menus.

Coverage is not provided for an inpatient admission, the primary purpose of which is:

- diagnostic services;
- custodial care;
- rest care;
- environmental change;
- physical therapy; or
- residential treatment.

Coverage for inpatient care is not provided when the services could have been performed on an outpatient basis, and it was not medically necessary, as determined by the Claims Payor, for you to be an inpatient to receive them.

Inpatient admissions to a hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting hospitals in Ohio will assure this preauthorization is done; and since the hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For non-contracting hospitals or hospitals outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize a hospital admission and it is later determined that the admission was not medically necessary or not covered for any reason, you will be responsible for all billed charges. However, if your inpatient stay is for an organ transplant, please review the requirements under the Organ Transplant Services section of this SPD.

Maternity Services, Including Notices Required by the Newborns' and Mothers' Protection Act

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and routine nursery care for a well newborn are covered.

Coverage for the inpatient postpartum stay for the mother and the newborn child in a hospital will be, at a minimum, forty-eight (48) hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in its Guidelines for Perinatal Care. Please note that neither you nor your provider is required to obtain prior approval of an inpatient maternity stay that falls within these timeframes.

Physician-directed, follow-up care services are covered after discharge, including the following:

- parent education;
- physical assessments of the mother and newborn;
- assessment of the home support system;
- assistance and training in breast or bottle feeding;
- performance of any medically necessary and appropriate clinical tests; and
- any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending physician or the nurse midwife, as applicable, determines further inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

- In the opinion of the attending physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:

    - the antepartum, intrapartum and postpartum course of the mother and infant;
    - the gestational stage, birth weight and clinical condition of the infant;
    - the demonstrated ability of the mother to care for the infant after discharge; and
    - the availability of post-discharge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, at home post-delivery follow up care visits are covered for you at your residence by a physician or nurse when performed no later than seventy-two (72) hours following your and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to, the following:

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At the mother's discretion, this visit may occur at the facility of the provider.

Medical Care

Concurrent Care: You are covered for care by two or more physicians during one hospital stay when you have two or more unrelated conditions. You are also covered for care for a medical condition by a physician who is not your surgeon while you are in the hospital for surgery.

Inpatient Consultation: A bedside examination by another physician or other professional provider is covered when requested by your attending physician.

If the consulting physician takes charge of your care, consultation services are not covered. When this occurs, the consulting physician is considered to be the new attending physician. Coverage is not provided for both the new attending physician and the physician who was initially treating you for services rendered at the same time.

Staff consultations required by hospital rules are not covered.

Inpatient Medical Care Visits: The examinations given to you by your physician or other professional provider while you are in the hospital are covered services. Benefits are provided for one visit each day you are an inpatient.

If the Board of Trustees changes your health care benefits, causing an increase or decrease in your inpatient medical care visits allowed, the number of inpatient medical care visits already used will be deducted from the number of visits available under your new coverage.

Intensive Medical Care: Constant medical attendance and treatment is covered when your condition requires it.

Newborn Examination: Your coverage includes the inpatient medical care visits to examine a newborn. Please refer to the Eligibility section of this SPD for information about enrolling for family coverage.

Office Visits: Office visits to examine, diagnose and treat a condition are covered services.

Medical Supplies and Durable Medical Equipment

This section describes supplies and equipment that are covered when prescribed by a physician. These supplies and equipment must serve a specific, therapeutic purpose in the treatment of a condition.

Medical and Surgical Supplies: Disposable supplies which serve a specific therapeutic

purpose are covered. These include:

- syringes;
- needles;
- oxygen; and
- surgical dressings and other similar items.

Items usually stocked in the home for general use are not covered. These include, but are not limited to, the following:

- elastic bandages;
- thermometers;
- corn and bunion pads; and
- Jobst stockings and support/compression stockings.

Durable Medical Equipment ("DME"): Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, the physician must provide a written treatment plan that shows how the prescribed equipment is medically necessary for the diagnosis or treatment of a condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your physician may be required to recertify that continued use is medically necessary.

Be sure to contact the Claims Payor before selecting your DME so that you understand the rental and/or purchase options available under this Plan.

Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds;
- crutches;
- mastectomy bras; and
- augmentive communication devices, when approved by the Claims Payor, based on the covered person's condition.

Deluxe: If the supplies, equipment and appliances include comfort, luxury or convenience items or features which exceed what is medically necessary in your situation or needed to treat your condition, reimbursement will be based on the maximum allowable charge for a standard item that is a covered service, serves the same purpose and is medically necessary. Any expense that exceeds the maximum allowable charge for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair/Warranty/Misuse: Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Claims Payor. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a covered service;
- The continued use of the item is medically necessary; and
- There is reasonable justification for the repair, adjustment, or replacement. (Warranty expiration is not a reasonable justification.)

In addition, replacement of purchased equipment, supplies or an appliance may be covered if:

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- A covered person's clinical needs have changed and the current equipment is no longer usable. For example: due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired. Benefits for repairs and replacement do not include the following:

    - Repair and replacement due to misuse, malicious breakage or gross neglect.
    - Replacement of lost or stolen items.

Non-covered equipment includes, but is not limited to, the following:

- rental costs if you are in a facility which provides such equipment;
- physician's equipment, such as a blood pressure cuff or stethoscope; and
- items not primarily medical in nature, such as:

    - an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
    - items for comfort and convenience;
    - disposable supplies and hygienic equipment;
    - self-help devices, such as bed boards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units; and
    - other compression devices.

Orthotic Devices: These are rigid or semi-rigid supportive devices used: 1) to support, align, prevent or correct deformities; 2) to improve the function of movable parts of the body; or 3) which limit or stop motion of a weak or diseased body part. These devices

include, but are not limited to, the following:

- Cervical collars;
- Ankle foot orthosis;
- Corsets (back and surgical);
- Splints (extremity);
- Trusses and supports;
- Slings;
- Wristlets;
- Built-up shoes; and
- Custom-made shoe inserts.

Covered services for orthotic devices are:

- The initial purchase, fitting and repair of the device.
- The cost of casting (if billed with the orthotic device and not separately), molding, fittings and adjustments.
- One replacement per year when medically necessary. Benefits may also be provided for covered persons under age 18, due to rapid growth, or for any covered person when an appliance is damaged and cannot be repaired.

Non-covered orthotic devices include, but are not limited to, the following:

- Orthopedic shoes (except therapeutic shoes for diabetes);
- Non-custom-made foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
- Standard elastic stockings and garter belts; and
- Corn and bunion pads.

Prosthetic Appliances: Your coverage includes the purchase, fitting, adjustment, repair, and replacement of prosthetic devices, which are artificial substitutes and necessary supplies that:

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

Covered prosthetic appliances include:

- intraocular lens implantation for the treatment of cataract, aphakia or keratoconus;
- soft lenses or sclera shells for use as corneal bandages when needed as a result of eye surgery;
- artificial hands, arms, feet, legs and eyes, including permanent lenses;
- appliances needed to effectively use artificial limbs or corrective braces; and
- mastectomy prosthetics.

Non-covered appliances include, but are not limited to, the following:

- dentures, unless as a necessary part of a covered prosthesis;
- dental appliances;
- eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
- replacement of cataract lenses, unless needed because of a lens prescription change;
- taxes included in the purchase of a covered prosthetic appliance;
- deluxe prosthetics that are specially designed for uses such as sporting events; and
- wigs and hair pieces.

Mental Health Care Services

Covered services for the treatment of mental illness include:

- inpatient treatment, including treatment in a residential treatment facility;
- outpatient treatment, including partial hospitalization and intensive outpatient services;
- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a hospital or psychiatric hospital;
- psychological testing; and
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for covered services only for those family members who are considered covered persons under the Plan. Charges will be applied to the covered person who is receiving family counseling services, not necessarily the patient.

In addition, as provided in the Claims Payor's applicable medical policy guidelines, certain behavioral assessment and intervention services for individual, family and group psychotherapy will also be covered for a medical condition.

Services for learning disabilities, other than those necessary to evaluate or diagnose these conditions, are not covered. Services for the treatment of attention deficit disorder are covered.

Inpatient admissions to a hospital provider or residential treatment facility provider must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting providers and PPO network providers will assure that preauthorization is done; since the provider is responsible for obtaining preauthorization, there is no penalty to you if this is not done. If a non-contracting provider is utilized, you are responsible for obtaining preauthorization. If you do not obtain preauthorization and

it is later determined that the admission was not medically necessary or not covered for any reason, you will be responsible for all billed charges.

Organ Transplant Services

Coverage includes benefits for the following medically necessary human organ transplants:

- bone marrow;
- cornea;
- heart;
- heart and lung;
- kidney;
- liver;
- lung;
- pancreas; and
- pancreas and kidney.

Additional organ transplants will be considered for coverage provided that the transplant is medically necessary, not experimental, and is considered accepted medical practice for the covered person's condition.

Organ Transplant Preauthorization: In order for an organ transplant to be a covered service, the inpatient stay must be preauthorized. In addition, the proposed course of treatment must be approved by the Claims Payor. In the event you do not obtain preauthorization, and your organ transplant is determined to not be medically necessary or is determined to be experimental/investigational, you may be responsible for all billed charges for that organ transplant.

After your physician has examined you, the physician must provide the Claims Payor with:

- the proposed course of treatment for the transplant;
- the name and location of the proposed transplant center; and
- copies of your medical records, including diagnostic reports for the Claims Payor to determine the suitability and medical necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ. You may also be required to undergo an examination by a physician chosen by the Claims Payor. You and your physician will then be notified of the Claims Payor's decision.

Obtaining Donor Organs: The following services will be covered services when they are necessary in order to acquire a legally obtained human organ:

- evaluation of the organ;
- removal of the organ from the donor; and

- transportation of the organ to the transplant center.

Donor Benefits: Benefits necessary for obtaining an organ from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if medically necessary as determined by the Claims Payor. Such coverage is available only so long as the recipient's coverage is in effect.

The Plan does not provide organ transplant benefits for services, supplies or charges:

- that are not furnished through a course of treatment which has been approved by the Claims Payor;
- for other than a legally obtained organ;
- for travel time and the travel-related expenses of a provider; or
- that are related to other than a human organ.

Outpatient Institutional Services

The covered services listed below are covered when services are performed in an outpatient setting, except as specified.

Covered institutional services include, but are not limited to, the following:

- operating, delivery and treatment rooms and equipment;
- whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation and blood processing of your own blood in anticipation of surgery, but charges for the blood are excluded. Autotransfusions or cell saver transfusions occurring during or after surgery are not covered;
- anesthesia and anesthesia supplies and services; and
- surgically inserted prosthetics, such as pacemakers and artificial joints.

Pre-Admission Testing: Outpatient tests and studies required before a scheduled inpatient hospital admission or outpatient surgical service are covered.

Post-Discharge Testing: Outpatient tests and studies required as a follow-up to an inpatient hospital stay or an outpatient surgical service are covered.

Outpatient Therapy Services

Therapy services are services and supplies used to promote recovery from a condition. Therapy services must be ordered by a physician or other professional provider to be covered. Covered services are limited to the therapy services listed below.

Cardiac Rehabilitation Services: Benefits are provided for cardiac rehabilitation services which are medically necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning.

Chemotherapy: Treatments of malignant disease by chemical or biological antineoplastic agents are covered.

Dialysis Treatments: Treatments of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine, are covered.

Hyperbaric Therapy: Pressurized oxygen for treatment purposes is covered. These services must be provided by a hospital.

Radiation Therapy: The treatment of disease by X-ray, radium or radioactive isotopes is covered.

Respiratory/Pulmonary Therapy: Treatments by the introduction of dry or moist gases into the lungs are covered.

No benefits will be provided for the following therapy services once the covered person can no longer significantly improve from treatment for the current condition unless it is determined to be medically necessary by the Claims Payor, and in no event will treatment be covered if the number of visits exceeds the limit set forth in the Schedule of Benefits, even if it is medically necessary.

- **Chiropractic Visits:** This treatment is given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part, by a chiropractor. These covered services include, but are not limited to, office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and devices. Braces and molds are not covered under this benefit.

- **Occupational Therapy:** Occupational therapy services are covered if it is expected that the therapy will:

    - result in a significant improvement in the level of functioning; and
    - that improvement will occur within sixty (60) days of the first treatment.

    All occupational therapy services must be performed by a certified, licensed occupational therapist. Occupational therapy services are not covered services when the patient suffers a temporary loss or reduction of function which is expected to improve on its own with increased normal activities.

- **Physical Therapy:** This is treatment given to relieve pain, restore maximum

function and to prevent disability following disease, injury or loss of a body part. These covered services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and devices. Braces and molds are not covered under this benefit. All physical therapy services must be performed by a certified, licensed physical therapist.

- **Speech Therapy:** In order to be considered a covered service, this therapy must be performed by a certified, licensed therapist and be medically necessary due to a medical condition such as:

    - a stroke;
    - aphasia;
    - dysphasia; or
    - post-laryngectomy.

Physical Medicine and Rehabilitation Services

Coverage is provided for acute inpatient care from a provider for physical rehabilitation services received in a rehabilitation facility.

Preventive and Wellness Services

Preventive services will be covered under the Plan as required under federal and state law. In accordance with those laws and their associated guidance, limitations on coverage may apply, based upon the covered person's actual condition, age, gender and the frequency of the service.

The following categories of preventive services are covered without application of a deductible, copayment or coinsurance, when provided by a PPO network provider:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

- Immunizations for preventive use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved.

- With respect to covered persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration ("HRSA").

- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Examples of preventive services that fall within the above categories are the following:

Health Education Services

- behavioral counseling to promote a healthy diet;
- intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases;
- gynecological services;
- mammogram services; and
- PAP tests.

Physical Examinations

Screenings

- blood glucose screenings and screening for type 2 diabetes;
- bone density screenings for women;
- chlamydia screenings, limited to pregnant and sexually active women;
- cholesterol screenings;
- colorectal cancer screenings, using fecal occult blood testing, sigmoidoscopy or colonoscopy; and
- hepatitis B virus screenings, limited to pregnant women in their first prenatal visits.

Smoking Cessation Services

Well Child Care Services

Women's Preventive Services

- These services include, but are not limited to, well-woman visits; screening for gestational diabetes, human papillomavirus (or HPV), human immunodeficiency virus (or HIV) and sexually transmitted disease; contraceptives and counseling for contraceptives for women with reproductive capacity; sterilization procedures; breastfeeding; and domestic violence.

These no-cost benefits also include the following:

- Medicine and supplements to prevent certain health conditions for adults, women and children;
- Medicine and products for quitting smoking or chewing tobacco (also known as tobacco cessation);
- Medicine used prior to screenings for certain health conditions in adults;
- Vaccines and immunizations to prevent certain illnesses in infants, children and adults; and
- Contraceptives for women.

The Plan's PBM will work with you to provide these drug benefits and explain:

- which medicines, supplements, health-related products or vaccines are covered;
- who they are covered for (such as children up to age 6 or adults age 65 or older); and
- what health conditions or illnesses they help prevent.

In addition, preventive services newly added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one (1) year after the new recommendations or guideline went into effect. You will be notified at least sixty (60) days in advance if any item or service is removed from the list of eligible services.

For more information about the preventive services available under the Plan, please contact the Fund Office, the Claims Payor, or the Plan's PBM. Please refer to the phone number on the back of your identification cards if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/coverage/preventive-care-benefits.

Private Duty Nursing Services

The services of a registered nurse, licensed vocational nurse or licensed practical nurse when ordered by a physician are covered. These services include skilled nursing services received in the patient's home or as an inpatient. The physician must certify all services initially and continue to certify that the patient is receiving skilled care and not custodial care as requested by the Claims Payor. All covered services will be provided according to the physician's treatment plan and as authorized by the Claims Payor.

Inpatient private duty nursing services include services that the Claims Payor decides are of such a degree of complexity that the provider's regular nursing staff cannot perform them. When private duty nursing services must be received in the patient's home, nurse's notes must be sent in with the claim.

Private duty nursing services do not include care which is primarily nonmedical or custodial in nature, such as bathing, exercising or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in the patient's home or is a member of the patient's immediate family.

All private duty nursing services must be certified by a physician initially and every two weeks thereafter, or more frequently if required by the Claims Payor, for medical necessity.

Skilled Nursing Facility Services

The benefits available to an inpatient of a hospital listed under the Inpatient Hospital Services section are also available to an inpatient of a skilled nursing facility. These

services must be skilled care, and the physician must certify all services initially and continue to certify that the patient is receiving skilled care and not custodial care as requested by the Claims Payor. All covered services will be provided according to the physician's treatment plan and as authorized by the Claims Payor.

No benefits are provided:

- once a patient can no longer significantly improve from treatment for the current condition unless it is determined to be medically necessary by the Claims Payor; and
- for custodial care, rest care or care which is only for someone's convenience.

Surgical Services

Surgery: Coverage is provided for surgery. In addition, coverage is provided for the following specified services:

- sterilization, regardless of medical necessity;
- therapeutic abortions;
- removal of bony impacted teeth;
- maxillary or mandibular frenectomy;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- reconstructive surgery following a mastectomy, including coverage for reconstructive surgery performed on a nondiseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas; and
- surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by the Claims Payor, subject to any appeal process. Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered, unless such coverage is required under the mental health parity laws.

Diagnostic Surgical Procedures: Coverage is provided for surgical procedures to diagnose a condition while the patient is in the hospital. The diagnostic surgical procedure and medical care visits, except for the day the surgical procedure was performed, are covered.

Multiple Surgical Procedures: When two or more surgeries are performed through the same body opening during one operation, the patient is covered only for the most complex procedure. However, if each surgery is mutually exclusive of the other, the patient will be covered for each surgery. Incidental surgery is not covered.

When two or more surgical procedures are performed through different body openings during one operation, the patient is covered for the most complex procedure, and the allowed amount for the secondary procedures will be half of the allowed amount for a

single procedure.

If two or more foot surgeries (podiatric surgical procedures) are performed, the patient is covered for the most complex procedure, and the allowed amount will be half of the allowed amount for the next two most complex procedures. For all other procedures, the allowed amount will be one-fourth of the full allowed amount.

Assistant at Surgery: Another physician providing help to the surgeon performing the covered surgery when a hospital staff member, intern or resident is not available is a covered service.

Anesthesia: Coverage includes the administration of anesthesia, performed in connection with a covered service, by a physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty surgery.

Second Surgical Opinion: A second surgeon's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by a surgeon are covered but are not required.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery. This benefit is not covered while the patient is an inpatient of a hospital.

If the first and second surgical opinions conflict, a third opinion is covered. The surgery is a covered service even if the physicians' opinions conflict.

Urgent Care Services

Health problems that require immediate attention and which are not emergency medical conditions are considered to be urgent care claims. Determination as to whether urgent care services are medically necessary will be made by the Claims Payor.

Examples of urgent care are:

- minor cuts and lacerations;
- minor burns;
- sprains;
- severe earaches or stomachaches;
- minor bone fractures; or
- minor injuries.

Women's Health and Cancer Rights Act Coverage

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Fund Office for more information.

ARTICLE IV - PRESCRIPTION DRUG BENEFITS

A. Eligibility for Coverage

1) All covered persons are eligible to receive the Plan's prescription drug benefits. The prescription drug benefits cover charges for drugs prescribed by a physician, dispensed by a pharmacist, and not available over-the-counter without a prescription. The benefit is administered by the Plan's current pharmacy benefits manager (the "PBM"), CVS/Caremark.

2) Under the medical portion of this Plan, each covered person is eligible for prescription drugs and other biologicals that cannot be self-administered and that are furnished as part of a physician's professional service, such as antibiotics, joint injections, and chemotherapy in the course of a diagnosis or treatment of a medical condition. Other drugs that can be self-administered, except for cancer oral chemotherapy, or that may be obtained under drug coverage, if applicable, are not covered as a medical benefit under the Plan, but the administration of the drugs may be covered. Also, those same drugs may be covered by the Plan's prescription drug benefit.

B. Covered Expenses

1) Coverage for prescription drugs includes self-administered drugs and medicines requiring a physician's written prescription, insulin (including Omnipod disposable insulin pumps purchased at a CVS pharmacy) and syringes without a physician's written prescription (provided the Plan is advised in advance of the prescribed dosage). Prescription drugs include pre-natal vitamins during pregnancy.

2) Effective August 28, 2014, coverage is provided for prescription contraceptives to the same extent as coverage is provided for prescription drugs, devices, and services that are used to prevent the occurrence of medical conditions other than pregnancy.

3) Effective October 15, 2015, covered expenses do not include PCSK9 Inhibitor drugs.

4) The percentage copay for brand name drugs without a generic equivalent is 20% for both retail and mail order prescriptions. The percentage copay for generic drugs is 10% for both retail and mail order prescriptions. If you choose to use a brand name drug when a generic equivalent is available, the percentage copay will be 30%.

5) For maintenance medications that have been filled at a non-CVS/Caremark retailer, any fill after the first three (3) refills shall only be available through CVS/Caremark mail order or at a CVS/Caremark retailer.

6) The formulary link of the current PBM is here:

http://www.caremark.com/portal/asset/caremark_recaprxclaimsdruglist.pdf

This link is updated on a quarterly basis. You will be notified sixty (60) days in advance of any changes to the PBM's formulary. If the drug is not listed on the formulary, it is not covered by the Plan.

7) For a list of the clinical programs available under the Plan, please contact the PBM. For additional information about the coverage of specific drugs, please contact the PBM.

C. Prior Authorization Drugs

Prior authorization is required for some prescriptions. For the latest list of drugs needing prior authorization, please contact the PBM.

D. Mail Order Prescription Drug Program

Each covered person will be allowed to receive up to a 90-day supply of his or her prescription, if prescribed by his or her physician, through the PBM's mail order program. To obtain a prescribed medication through the mail order program, the covered person should inform his or her physician that he or she is participating in the Plan's mail order program. Then the covered person should request two (2) prescriptions for the medication and take one to the pharmacy and get the medicine right away. Then he or she should complete the PBM's mail service order form, fill out the patient profile section the first time he or she orders the medicine, and send the completed form, along with the second prescription and payment, to the PBM's mail service.

E. Additional Information

For additional information about the following prescription drug topics, please contact the PBM:

- Rx coverage information
- Rx deductibles, copayments, coinsurance, and out-of-pocket maximums
- Patient advocacy programs
- Rx utilization review and step therapy procedures
- Clinical trials coverage and procedures
- Prior authorization procedures
- Dispense as written (or "DAW") information
- Exclusivity of access to specialty drugs
- Accessing online benefit information

- Paper claim submission requirements and contact information
- Mail order address and telephone number
- Appeals procedures and contact information
- Exclusions and limitations of the available drug programs
- Supply method issues under the available drug programs
- Coverage offering options and alternatives

ARTICLE V - BASIC PLAN FOR RETIREES AND DEPENDENTS

A. Retired Participants and Eligible Dependents Who Are Not Medicare Eligible

1) The Schedule of Benefits of the Active Program will apply and will be provided to retired Participants and Eligible Dependents who are not Medicare eligible. Vaccines for shingles and whooping cough that are provided to eligible Medicare Participants shall not be subject to the copayment requirements in Article I, Schedule of Benefits. The Plan also will provide coverage for the Shingrex and Zostavax shingles vaccines for Medicare Retiree Participants. The Plan will pay 100% of the cost of the vaccine for these retired Participants.

B. Retired Participants and Eligible Dependents Who Are Medicare Eligible

1) The following benefit features shall apply:

- Prescription drug benefit: prescription drugs, as provided in the Prescription Drug Program Policy

- Other Benefits: Medicare Supplemental Coverage, as provided below.

C. Medicare Supplemental Coverage

1) Medicare Supplemental Coverage shall be provided by the Plan to Eligible Retired Participants and their Dependents. The Board of Trustees has elected to provide these benefits on a self-insured basis. This election may be changed or cancelled at any time by the Board of Trustees. The following benefits are provided to all Eligible Retired Participants and their Dependents who are eligible for, and enrolled in, Medicare Parts A and B:

Medicare Part A Expenses (inpatient hospital charges)	Medicare Deductible Amounts
Medicare Part B Expenses	Applicable Deductible Amounts
Other Benefits	As provided by the individual policy issued to the Retired Participant under the Retiree Program

IF YOU, AS A RETIRED PARTICIPANT, CEASE OR LOSE COVERAGE UNDER THE PLAN AND ENROLL IN MEDICARE PART D PRESCRIPTION COVERAGE, YOU WILL NOT BE ELIGIBLE TO RE-ENROLL IN THE PLAN TO OBTAIN PRESCRIPTION COVERAGE.

IF A PARTICIPANT IS ELIGIBLE FOR BUT NOT ENROLLED IN MEDICARE PARTS A AND B, THE RETIREE INSURANCE PROGRAM WILL MAKE ITS PAYMENTS

BASED UPON THE BENEFITS WHICH WOULD HAVE BEEN PAYABLE ON THE PARTICIPANT'S BEHALF UNDER THE MEDICARE PROGRAM.

ARTICLE VI - PLAN EXCLUSIONS AND LIMITATIONS

A. Plan Exclusions. Eligible or covered expenses do not include any charges which are excluded under the general provisions of the Plan, including the following. No duplication of payments will be made by the Plan.

1) Not prescribed by or performed by or under the direction of a physician or other professional provider.

2) Not performed within the scope of the provider's license.

3) Not medically necessary.

4) Received from other than a provider.

5) For experimental or investigational drugs, devices, medical treatments or procedures.

6) To the extent that the U.S. government, federal or state governmental units, or their agencies provide benefits, except Health Departments, as determined by the Claims Payor.

7) For a condition that occurs as a result of any act of war, declared or undeclared.

8) For any loss incurred while attempting or during the commission of a felony.

9) For which the patient has no legal obligation to pay in the absence of this Plan or like coverage.

10) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

11) Received from a member of the patient's immediate family.

12) Incurred after the patient stops being a covered person, except as specified in the Benefits After Termination of Coverage section.

13) For the following:

- physical examinations or services required by an insurance company to obtain insurance;
- physical examinations or services required by a governmental agency, such as the FAA or DOT;
- physical examinations or services required by an Employer in order to

begin or to continue working;
- premarital examinations;
- screening examinations, except as specified; or
- X-ray examinations with no preserved film image or digital record.

14) For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the covered person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a covered person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.

15) For which benefits are payable under Medicare Parts A, B and/or D or would have been payable if the covered person had applied for Parts A, B and/or D, except, as specified elsewhere in this SPD or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the covered person has not enrolled in Medicare Part B, the Claims Payor will calculate benefits as if he or she had enrolled.

16) Received in a military facility for a military service-related condition.

17) For surgery and other services primarily to improve appearance or to treat a mental or emotional condition through a change in body form (including cosmetic surgery following weight loss or weight loss surgery), except as otherwise specified in this SPD.

18) For surgery to correct a deformity or birth defect for psychological reasons where there is no function impairment.

19) For the removal of tattoos.

20) For dietary and/or nutritional counseling or training, except as may be specified.

21) For outpatient educational, vocational or training purposes, except as may be specified.

22) For recreational travel, even if it is prescribed by a physician.

23) Rest care, custodial care or otherwise medically unnecessary care relating to routine daily activities (e.g., bathing, feeding, etc.).

24) For treatment of learning disabilities, other than treatment necessary to evaluate or diagnose these conditions.

25) For routine minor nonoperative endoscopic procedures, except as may be specified.

26) For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.

27) For weight loss surgery and any repairs, revisions or modifications of such surgery, including weight loss device removal, unless determined by the Claims Payor to be a covered service in accordance with its corporate medical policy.

28) For marital counseling.

29) For the medical treatment of sexual problems not caused by a biological condition.

30) For contraceptives, except as may be specified.

31) For contraceptive devices which include, but are not limited to, IUDs, diaphragms and cervical caps.

32) For reverse sterilization.

33) For elective abortions or abortions that are not medically necessary as a life-sustaining measure or as a result of a criminal act.

34) For the treatment of infertility and impotency, including, but not limited to, artificial insemination, in vitro fertilization, Gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT).

35) Incurred as a result of any covered person acting as or contracting to be a surrogate parent.

36) For oral implants considered part of a dental process or dental treatment, including preparation of the mouth, for any type of dental prosthetic, except when due to trauma, accident or as deemed medically necessary by the Claims Payor.

37) For treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including orthognathic (jaw) surgery, except as may be specified.

38) For treatment with intraoral prosthetic devices or by any other method to alter vertical dimension.

39) For treatment of the vertebral column, unless related to a specific

neuromusculoskeletal-related diagnosis.

40) For personal services, personal hygiene, supplies, and other convenience items.

41) For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of surgery.

42) For any surgical procedure for the correction of a visual refractive problem, including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).

43) For all services related to hearing loss, including hearing aids or examinations for prescribing or fitting them, except as may be specified.

44) For immunizations, other than those specified as covered in the Routine and Wellness Services section of this SPD.

45) For massotherapy or massage therapy.

46) For hypnosis and acupuncture.

47) For blood which is available without charge.

48) For outpatient blood storage services.

49) For prescription drugs, except as may be specified.

50) For non-prescription items (except for inulin and related supplies and where specifically included herein), over the counter drugs, vitamins or herbal remedies.

51) For weight loss drugs.

52) For charges related to weight loss and treatment of obesity, except for bariatric surgery, provided that the Claims Payor deems the surgery to be medically necessary pursuant to its medical policy protocol applicable to bariatric surgery. A copy of the policy protocol will be provided on request. As clarification, although the Plan excludes coverage for charges relating to weight loss and treatment of obesity, the Plan does cover charges related to treatment for eating disorders. This includes coverage for changes related to treatment of anorexia nervosa, bulimia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and nutritional counseling as treatment for eating disorders.

53) For topical anesthetics.

54) For routine services, except as may be specified and in accordance with state and federal law.

55) For arch supports and other foot care or foot support devices only to improve comfort or appearance, which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone surgery), calluses and toenails.

56) For non-covered orthotics, such as garter belts, arch supports, corsets, corn and bunion pads; corrective shoes, except with accompanying orthopedic braces; and other foot care or foot support devices only to improve comfort or appearance.

57) For specialized camps.

58) For treatment at sleep disorder centers.

59) For water aerobics.

60) For afterhours care.

61) For missed appointments, completion of claim forms or copies of medical records.

62) For any oral, written or electronic communications or consultations by a provider with a covered person or another provider that do not involve in-person contact with the covered person.

63) For charges incurred during confinement in a hospital owned or operated by a state, province or political subdivision, unless there is an unconditional requirement to pay these charges.

64) For charges incurred to the extent that benefits are payable therefor by any plan which this Plan replaces.

65) For charges incurred for any service or treatment which is not recommended by a physician.

66) For fraudulent or misrepresented claims.

67) For charges for which the covered person is not required to pay or for which he or she may not be legally billed.

68) For a particular health service in the event that a non-PPO network provider waives copayments, coinsurance and/or the deductible per benefit period, no benefits are provided for the health service for which the copayments, coinsurance and/or the deductible per benefit period are waived.

69) For non-covered services or services specifically excluded under the terms of this SPD.

70) For any services or treatments rendered in facilities outside the United States for which Medicare will not pay (retired Participants only).

71) For any expense that Medicare does not cover, unless a specific extension of such benefits is provided under the Plan (retired Participants only).

72) Prior to March 21, 2024, charges relating to temporomandibular joint dysfunction ("TMJ"). Effective March 21, 2024, the Plan provides coverage for charges relating to the treatment of TMJ at the amount in accordance with the Plan's Schedule of Benefits.

B. Mental Health Parity. The Plan provisions applicable to coverage of surgical expense benefits and mental disorder benefits coverage will be and are amended to provide Plan coverage, pursuant to the MHPAEA, for gender affirming surgery in accordance with the Plan's Claims Payor's policy protocol; for Applied Behavior Analysis Services with no restrictions as to the age of the patient or the number of hour of treatment; and for Autism Spectrum Disorder Services, with any applied limits to not be more stringent than limits on medical services.

ARTICLE VII - DEATH AND DISMEMBERMENT BENEFITS

A. Death Benefits for Active and Retired Participants

1) In the event of an active hourly and retired Eligible Participant's death while covered under this Plan, the Plan will provide a payment of twelve thousand dollars ($12,000) to the person who has been designated as the Active Hourly or Retired Participant's Beneficiary. This benefit is not available to a surviving spouse or a Dependent.

B. Dismemberment Benefits

1) The Plan will provide a benefit to Eligible Participants for losses resulting from injuries sustained in an accident, provided:

   a) The losses occur within ninety (90) days following the date of the accident, and are a direct result of such injuries; and

   b) The injuries are evidenced by a contusion or visible wound.

C. Benefits Payable for Loss of Limbs

1) **Benefit Amounts.** The following benefits are payable for the variable losses of limbs:

Life	Principal sum	($12,000)
Both Hands or Both Feet	Principal sum	($12,000)
Sight of Both Eyes	Principal sum	($12,000)
One Hand	One half of Principal sum	($6,000)
One Foot	One half of Principal sum	($6,000)
Sight of One Eye	One half of Principal sum	($6,000)

Loss of a hand or foot means actual severance through or above the wrist or ankle joint. Loss of an eye means the entire and irrevocable loss of sight of the eye.

2) **Maximum Benefit.** The maximum benefit which shall be payable for all losses resulting from injuries sustained in any one accident shall be the largest benefit which is specified in the above Schedule.

3) **Limitations on Dismemberment Benefits.** No benefits shall be payable for any loss resulting from:

   a) Disease or infection, except an infection resulting from an accidental cut or wound; or

b) Declared or undeclared war, or an act of war.

4) **Designation of Beneficiary.** The Eligible Participant's Beneficiary shall be the person who has been designated by the Participant on a form satisfactory to the Plan. The Participant may change his or her Beneficiary at any time by filing a written notice that is satisfactory to the Board of Trustees. The new designation shall take effect on the date the Eligible Participant signs the notice of change. When a new Beneficiary is designated, the interest of any previously designated Beneficiary shall cease.

5) **Alternate Beneficiaries.** If, at the death of the Eligible Participant, no named Beneficiary is surviving, the amount of the benefit will be paid, in a single sum, to the Eligible Participant's spouse, if living; otherwise, in equal shares to the then living children of the Eligible Participant, if any; or if none, in equal shares to the father and mother of the Eligible Participant or to the survivor of them; if none, then to the estate of the Eligible Participant. All other benefits provided by the Plan shall be payable to the Eligible Participant or Eligible Retired Participant as the eligible person.

ARTICLE VIII - WEEKLY ACCIDENT AND SICKNESS BENEFITS
(Excludes Retired Participants, Except as Provided in Article II)

A. Available Benefits. Subject to the limitations and exclusions below, the Plan shall pay the Eligible Participant the following benefits:

1) For the first day of a disabling accident, heart attack, or a condition which requires hospital confinement from the outset. Otherwise, the benefit will commence on the eighth (8th) day of disabling illness in the amount of $580/week (rate effective as of January 1, 2026) based on a 7 days per week basis.

2) To receive any benefit described in this Article VIII, an Eligible Participant must file an application for benefits no later than one hundred eighty (180) days following the onset of a disabling illness described in this Article VIII and as substantiated by sufficient documentation, to be determined by the Board of Trustees, provided by the Eligible Participant's treating provider.

B. Maximum Benefits. A maximum benefit of twenty-six (26) weeks in any calendar year shall be applied for each period of disability. However, should the Participant's treating provider submit sufficient documentation to the Plan that the Participant's same-cause disabling condition still exists after the twenty-six (26) weeks and will likely continue to exist thereafter, then the Participant can remain eligible for this disability benefit for the duration of that condition but only for up to 13 more weeks.

C. Period of Disability. Successive periods of disability due to unrelated causes which are separated by the eligible Participant's return to full-time employment for at least one (1) day shall be considered separate periods of disability for purposes of determining maximum benefits.

D. Successive Periods of Disability. Successive periods of disability related to the same cause shall be considered as one period of disability unless the subsequent disability is separated from the prior disability by at least eighty (80) or more hours of active employment.

E. Exceptions and Limitations

1) Payment under this Plan provision shall be made over and above all other payments provided under the Plan and shall not be coordinated with any other Plan or benefit provided by this Plan.

2) No payment shall be provided by the Plan for those disabilities which result from the Employee's occupation or employment and which are considered eligible for payment under any workers' compensation laws or similar laws.

3) The Participant must be under the care of a legally qualified physician in

order to be eligible for weekly benefits provided by the Plan, with acceptable certification of the disabling illness/accident provided to the Fund Office by the physician.

4) The Participant shall not be eligible for any benefit described in this Article VIII unless the Participant files a timely application for benefits as set forth in this Article VIII.

ARTICLE IX - DENTAL AND VISION BENEFITS
(Includes Retiree Participants)

The dental and vision benefits provided by the Plan will be a maximum combined benefit of $2,000.00 for coverage to Eligible Participants and their Eligible Dependents for dental and vision expenses. The Plan will pay 80% of dental and vision expenses up to a maximum payment of $2.000.00 per family per calendar year for combined vision and dental benefits, provided, however, that, effective January 1, 2012, pediatric dental and vision essential benefits shall not be subject to the $2,000.00 per family per calendar year limitation.

Claims are payable through the Fund Office either directly to the provider or, for expenses already paid by the Participant, directly in reimbursement to the Participant upon Participant's submission of proof of payment to the Fund Office. Benefits cannot be assigned. Dental benefits are not subject to the Plan's Coordination of Benefits provisions.

ARTICLE X - CONTINUATION COVERAGE ("COBRA")

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage, called "continuation coverage" or "COBRA coverage," in certain instances where 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 the entire premium for your continuation coverage.

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

A. Qualifying Events

If you are an Active Participant covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1) Termination of your employment for reasons other than your gross misconduct.

2) Reduction in the hours of your employment.

If you are the spouse of an Active Participant or Retired Participant covered by the Plan, you have the right (if you have not waived such right) to elect continuation coverage if you lose coverage under the Plan because of any of the following four "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 employment with the Employer.

3) Divorce or legal separation from your spouse. Also, if an Employee 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 divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Fund Office within sixty (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.

In the case of a dependent child of an Active 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 Active Participant.

2) The termination of the Active Participant's employment for reasons other than gross misconduct or reduction in his or her hours of employment with the Employer.

3) The parents' divorce or legal separation.

4) The Active Participant becoming entitled to Medicare.

5) The Dependent ceases to be a "dependent child" under the Plan.

B. Notices and Election

The Plan provides that your spouse's coverage terminates and, thus, is lost as of the last day of the month in which a divorce or legal separation occurs. A dependent child's coverage terminates the last day of the month in which he or she ceases to be an Eligible Dependent under the Plan (for example, after attainment of a certain age). Under COBRA, the Participant or a family member has the responsibility to notify the Fund Office upon a divorce, legal separation, or a child losing dependent status. You or a family member must provide this notice no later than sixty (60) days after the last day of the month of the divorce, legal separation, or a child losing dependent status. If you or a family member fails to provide this notice to the Fund Office within 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 timely notify the Fund Office and any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing dependent status, then you and your qualifying family members will be required to reimburse the Plan for any claims so paid.

If the Fund Office is provided timely notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, the Fund Office will notify the affected family member of the right to elect continuation coverage.

Please Note: Claims may not be paid until the COBRA payment is received.

An Active Participant or the spouse of the covered Active Participant may elect continuation coverage for all qualifying family members. The covered Active 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 Active Participant does not or is not deemed to elect it.

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

C. Type of Coverage; Premium Payments

Ordinarily, you or your qualifying family member will be offered COBRA coverage that is the same coverage that you, he, or she had on the day before the qualifying event. Therefore, a person (Active Participant or Retired Participant, spouse or dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce.

If the coverage for similarly situated employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you and any qualifying family member by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received, whichever is earlier.

D. Maximum Coverage Periods

36 Months. If a spouse or dependent child loses group health coverage because of the Active Participant's death, divorce, legal separation, or the Active Participant becoming entitled to Medicare, or because the dependent child loses status as a Dependent under the Plan, the maximum coverage period for the spouse or dependent child is 36 months from the date of the qualifying event.

18 Months. If the Active Participant, spouse or dependent child loses group health coverage because of the Active Participant's termination of employment other than for gross misconduct or reduction in hours, the maximum continuation coverage period for the Active Participant, spouse or dependent child is 18 months from the date of termination or reduction in hours. There are three exceptions:

1) If an Active Participant or Retired Participant or family member is disabled at any time during the first sixty (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 Fund Office both within the 18-month coverage period and within sixty (60) days after the date of the determination.

2) If a second qualifying event that gives rise to a 36 month maximum coverage period, i.e., the Employee dies or becomes divorced, occurs

within the 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.

3) If the qualifying event occurs within 18 months after an individual becomes entitled to Medicare, the maximum coverage period for the spouse and dependent child ends 36 months from the date the individual became entitled to Medicare.

E. Children Born to or Placed for Adoption with the Active 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 Active Participant and the Active Participant has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The Active Participant or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable eligibility requirements (e.g., age). The Active Participant or a family member must notify the Fund Office within thirty (30) days of the birth, adoption, or placement to enroll the child, and COBRA coverage will last as long as it lasts for other family members of the Active Participant. The 30-day period is the Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption. If the Active Participant or family member fails to so notify the Fund Office in a timely fashion, the Active Participant will not be offered the option to elect COBRA coverage for the child.

F. Extension of the Length of Continuation Coverage

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund Office of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

G. Disability

As noted above, an 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration to be disabled. The disability has 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. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by Social Security Administration to no longer be disabled, you must notify the Fund Office of that fact within thirty (30) days of the Social Security Administration's determination.

H. Second Qualifying Event

As noted above, an 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying event may include the death of the covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Fund Office within sixty (60) days after a second qualifying event occurs.

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

Continuation coverage of the Active Participant, Retired 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 no longer provides group health coverage.

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

3) After electing COBRA, the Active Participant, Retired Participant, spouse or dependent child becomes covered under another group health plan as an Employee or otherwise that has no exclusion or limitation with respect to any preexisting conditions. If the other plan has applicable exclusions or limitations, COBRA coverage will terminate after the exclusion or limitation no longer applies, i.e., 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, the Active Participant, Retired Participant, spouse or dependent child becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

5) If the Active Participant, Retired 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. Continuation coverage will not end until the month that begins more than thirty (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 the covered Employee or the spouse or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

J. Retired Participants

1) Pre-65. If you retire prior to age 65 and have exhausted your Reserve Bank, you shall be offered COBRA coverage to the extent you have not already received retiree coverage from the Plan. Any period of retiree coverage from the Plan shall be counted against the applicable continuation coverage.

2) 65 and older. If you retire at age 65 or older, you shall have the option to receive retiree medical coverage through the Plan or COBRA. However, if you chose retiree medical coverage at retirement, then you will cease to be a qualified beneficiary once the COBRA election period has expired and you will not be eligible for any COBRA coverage.

K. Election of Continuation Coverage

To elect continuation coverage, you must complete an election form and furnish it according to the direction on the form. You may obtain a copy of the election form from the Fund Office. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Employee's spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The Employee or the Employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by another group health plan if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the rights to request special enrollment in another group health plan for which you are otherwise eligible such as a plan sponsored by your spouse's employer within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

L. Cost for Continuation Coverage

Generally, each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% or, in the case of an extension on continuation coverage due to a disability, 150% of the cost to the group health plan for coverage of a similarly situated Participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each option is described below.

M. First Payment for COBRA Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage no later than forty-five (45) days after the date of your election. This is the date the election notice is post-marked if mailed. If you do not make your first payment for continuation coverage in full no later than forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Fund Office to confirm the correct amount of your first payment.

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

Fund Office
Plumbers & Pipefitters Local 94 Health & Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406

N. Periodic Payments for COBRA Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in the election notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Fund Office
Plumbers & Pipefitters Local 94 Health & Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406

O. Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of its grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated going back to the due date if the periodic payment is made before the end of the grace period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan.

P. Can You Elect Other Health Coverage Besides Continuation Coverage?

Yes. Under the Plan, if you have exhausted your COBRA continuation of coverage, you have the right to elect additional coverage for a period of one (1) year at the same cost as the COBRA continuation coverage rates set by the Board of Trustees. Such coverage is limited to a maximum benefit of $60,000.00 and is conditioned upon the Participant actively pursuing alternative coverage. You must contact the Fund Office if you wish to elect such additional coverage.

Please be reminded that if your marital status changes, or an Eligible Dependent or Eligible Retiree Dependent ceases to be a dependent eligible for coverage under the Plan, or you or your spouse's address change, you must immediately notify the Fund Office.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), the Affordable Care Act, and other laws affecting group health plans, please contact the Fund Office or the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA's web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.

ARTICLE XI - COORDINATION OF BENEFITS

A. Applicability

If an eligible person has coverage with any other insurance carrier or medical benefit plan and all or a portion of the cost thereof shall directly or indirectly have been payable by an Employer or paid by or through payroll deductions or payable by or through a group or association, and if such other coverage provides to such eligible person any of the services and supplies or reimbursement for any part of the cost thereof for which benefits are payable to or on behalf of such eligible person hereunder, then this Plan will coordinate its Schedule of Benefits with the other health plan. However, such coordination of benefits shall not apply to dental or vision benefits under this Plan.

B. Definitions

The term “another plan” or “other plan” includes any plan providing benefits or services for or by reason of hospital or medical treatment, and such benefits or services are provided by:

1) Group, blanket or franchise insurance coverage.

2) Any coverage under labor management trusted plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group.

3) Any other plan which has a coordination provision within that plan.

4) Any other plan which provides coverage arising out of any claim or cause of action which might accrue because of an alleged negligent action of a third party.

5) Any governmental plan or program created by federal or state statute or regulations for the purpose of providing some or all of the benefits as set forth in this Plan, including but not limited to Medicare, whether enrolled in or applied for.

6) The term “plan” shall be considered separately for each plan and also between that part of any plan which applies to the anti-duplication provision and that part which does not.

7) The term “allowable expense” means any necessary, reasonable and customary item of expense for hospital or medical treatment which is covered under at least one of the plans covering the person for whom a claim is made. If both spouses are Participants, 100% of all covered expenses shall be paid.

C. Provision for Allowable Expenses

Benefits payable for allowable expenses incurred during a claims determination period shall be paid subject to the following limitations:

1) If an Eligible Participant is covered as an eligible participant under another plan, this Plan will pay initially one-half (1/2) of the allowable expenses, and after the other plan has paid a share equal to this Plan's initial contribution, the Plan will pay the remaining allowable expenses, if any.

2) If a Dependent of an Eligible Participant is covered for benefits under another plan as a dependent of an individual who is not an Eligible Participant of this Plan, the plan covering the parent whose birthday occurs earlier in the calendar year will pay first as the primary payor on behalf of the child, subject to this Plan's Schedule of Benefits (providing the parents are not separated or divorced). In the event the other parent's plan is not required to follow this provision (the so-called Birthday Rule), this Plan will pay its pro rata share, up to one-half (1/2) of the allowable expenses as determined by benefits provided under this Plan and the remaining allowable expenses, if any, after the other plan has paid all it can pay and its share becomes less than the share paid by this Plan.

3) If the Dependent fails to comply with the requirements of the other plan, fails to utilize the requirements of the other plan, or fails to utilize a health maintenance organization ("HMO") which has been selected by the individual who is a participant under the other plan which would have been the primary provider, then this Plan will pay its pro rata share, up to one-half (1/2) of the allowable benefits provided under this Plan.

4) If a Dependent of an Eligible Participant is covered for benefits as a participant under another plan, this Plan will not pay any benefits toward the Dependent's claim until that Dependent's benefits under the other plan are exhausted. If there are additional bills payable toward that claim, this Plan shall pay any remaining allowable expenses, if any. If the Dependent, as a participant in the other plan, fails to comply with the requirements of the other plan or fails to utilize an HMO which has been selected by the participant under the other plan which would have been the primary provider, this Plan will not pay any portion of the allowable expenses incurred by the individual.

5) In the event of any payment for services by this Plan, the Plan shall to the extent of such payment be subrogated to all the rights of recovery of the Eligible Participant and/or Eligible Dependent arising out of any claim or cause of action which may accrue because of the alleged negligent conduct of a third party. The Eligible Participant and/or Eligible Dependent shall reimburse the Plan for any benefits paid out of any monies recovered from

any third party as the result of judgment, settlement or otherwise. The Eligible Participant and/or Eligible Dependent shall furnish such information and assistance, and execute and deliver all necessary instruments, as the Plan may require in order to facilitate the enforcement of its rights.

D. Coordination with Governmental Programs and Programs Required by Statute

Benefits payable for allowable expenses included during a claims determination period shall be paid subject to the following limitations:

1) **Medicare.** This Plan will pay its benefits before Medicare for the following individuals:

   a) An actively employed Eligible Participant who is of Medicare qualifying age or an actively employed Eligible Participant's spouse who is of Medicare qualifying age.

   b) A disabled Eligible Participant who is of Medicare qualifying age and who has a relationship with a participating Employer indicative of an employee status, or the Active Participant's disabled spouse or Dependent who is of Medicare qualifying age and who is eligible for benefits under Medicare.

   c) This Plan will be considered the primary payor of benefits for an Eligible Participant and/or Dependent under Medicare qualifying age who is disabled due to end-stage renal disease for the first thirty (30) months following the date of Medicare entitlement.

2) **Medicare-Eligible Participants and Retirees.** For all other Eligible Participants, Retirees or Dependents eligible for Medicare, whether or not enrolled in or applied for benefits, are to be paid first by Medicare, after which this Plan will make its coordinated benefit payment. The amount of benefits payable under this Plan will be coordinated so that the aggregate amount of benefits paid will not exceed the Medicare determined regular and customary expenses. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other Plan were involved.

3) **Other Governmental Programs.** For all Eligible Participants, Retirees or Dependents eligible for benefits under a governmental program or eligible for benefits as a result of any state or federal statute or regulation (other than Medicare), this Plan will pay its pro rata share up to one-half (1/2) of the allowable expenses as determined by benefits provided under the Plan. If after the other plan has paid its allowable share, its share is less than the share paid by this Plan and it would leave a balance for the individual, then

this Plan will pay the remaining allowable expenses, if any.

E. Eligible Dependent Children of Divorced or Separated Parents

In the case of children whose parents are divorced or separated and who are eligible for coverage under this Plan, the primary payor shall be the plan which covers the child as a Dependent of the Parent who:

1) by the Qualified Medical Child Support Order, is responsible for the child's health care expense;

2) has custody of the child, and if the parent has remarried, the spouse (stepparent) of such parent; or

3) does not have custody of the child.

If none of the above applies, the program in effect the longest is the primary program. An individual who is an Eligible Participant of the Plan cannot also be an Eligible Dependent under the Plan.

F. Participants or Dependent Children of Both Spouses Who Are Both Participants in the Plan

In the case of children whose parents are both Eligible Participants under the Plan, the Plan will pay 100% of the Eligible Participant's and child's health care expenses.

G. Liability of the Plan

In the event benefits are reduced, as provided above, each benefit otherwise payable shall be reduced proportionately, and only the reduced amount shall be charged against any applicable benefit limit under the Plan. If benefits have been paid under any other plan which should have been reduced in accordance with an anti-duplication provision, the Plan may pay at its option, to such other plan to the extent required to offset the reduction required by the existence of the Plan, and such payment shall reduce the liability of the Plan to the extent of such payment. If payment has been made by the Plan in excess of that permitted by this provision, the Plan shall have the right to recover such excess from any party acquiring same.

ARTICLE XII - SUBROGATION AND REIMBURSEMENT

A. Subrogation

1) The Plan will use its right of subrogation if a covered person is paid benefits under this Plan for expenses due to injuries or illness for which a third party may be obligated to pay the covered person for any reason.

2) This subrogation provision applies when the covered person is sick or injured as a result of the act or omission of a third party. The term "subrogation" means the Plan's right to recover any payments made to the covered person by a third party. The term "third party" includes, but is not limited to, a person, organization, corporation, insurance carrier, governmental agency, uninsured and/or underinsured insurance coverage and/or the covered person's own insurance company. The Plan's subrogation right shall extend to first-party and third-party contracts and claims.

3) The Plan reserves the right of subrogation. This means that, to the extent the Plan provides and pays for benefits and expenses, the Plan assumes the covered person's legal rights to recover the value of those benefits and expenses from any person, entity, organization or insurer, including the covered person's own insurer and any underinsured or uninsured coverage that may be legally obligated to pay the covered person the value of those benefits and expenses.

4) The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for covered services. The Plan's right of subrogation shall have priority over the covered person's or anyone else's rights until the Plan recovers the total amount the Plan paid for covered services. The Plan's right of subrogation for the total amount the Plan paid for covered services is absolute and applies whether or not the covered person receives, or is entitled to receive, a full or partial recovery, or whether or not the covered person is "made whole" by reason of any recovery from any other person or entity. **This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that the covered person be "made whole" before the Plan may be entitled to assert its right of subrogation.**

B. Reimbursement

1) The Plan reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for covered services, the covered person must repay any amounts recovered by lawsuit, claim, settlement or otherwise, from any third party or his or her insurer and any underinsured or uninsured coverage, as well as from any other person,

entity, organization or insurer, including the covered person's own insurer, from which he or she receives payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for covered services. The Plan's right of reimbursement shall have priority over the covered person's or anyone else's rights until the Plan recovers the total amount the Plan paid for the covered services. The Plan's right of reimbursement for the total amount the Plan paid for covered services is absolute and applies whether or not the covered person receives, or is entitled to receive, a full or partial recovery, or whether or not the covered person is "made whole" by reason of any recovery from any other person or entity. **This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require the covered person be "made whole" before the Plan may be entitled to assert its right of reimbursement.**

2) The covered person shall have the following responsibilities to the Plan:

a) The covered person must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which the Plan benefits have been or will be paid.

b) The covered person must provide the Fund Office or its designee any information requested by the Plan or its designee within five (5) business days.

c) The covered person must execute any assignments, liens, subrogation agreements, and any other documents or information that the Plan may request.

d) The covered person or his or her designee must complete forms providing information as to how the injuries occurred; the identity of any potentially responsible third parties; the disclosure of any applicable insurance coverage; and an acknowledgement of the Plan's subrogation and reimbursement rights.

e) The covered person or his or her designee must sign any other documents and do whatever else is reasonably necessary to secure the Plan's rights of subrogation and reimbursement, including, but not limited to, executing a written acknowledgement of the lien in favor of the Plan that may be delivered to the third party, or that may be filed with a court having jurisdiction in the matter; allowing intervention by the Plan; and/or allowing joinder of the Plan in any claim and action against the responsible third party.

f) The covered person must not settle or compromise any claims

unless the Fund Office or its designee is notified as soon as possible before such settlement or compromise is finalized and the Plan or its designee agrees to the settlement or compromise. **The covered person's benefits and those of his or her family members may be suspended until the Plan receives the requested documents or information**.

3) In consideration of this Plan's covering his or her expenses and medical claims, which may be the responsibility of the third party, the Participant and/or Dependent agree to acknowledge and abide by the subrogation lien and reimburse this Plan directly to the extent of any benefits paid. The Participant and/or Dependent must not do anything to impair or negate this right of subrogation. This prohibition, includes, but is not limited to, the following: the Participant and/or Dependent may not release and/or discharge any claim and/or responsible party, effect any settlement, or dismiss any legal action against another source that may be responsible for paying damages or providing compensation, nor will the covered person effect satisfaction of any judgment resulting from any legal action without first notifying the Plan and tendering to the Plan's attorneys the full amount of reimbursement due to the Plan.

C. Enforcement

1) If the covered person does not attempt a recovery of the benefits paid by the Plan or for which the Plan may be obligated, the Plan shall, at its sole discretion, be entitled to institute a legal action and/or claim against the third party in the name of the Plan or the Board of Trustees so that the Plan may recover all amounts paid on behalf of the covered person or his or her family members.

2) In the event the covered person obtains a recovery by judgment, settlement or otherwise against the third party, the Plan's subrogation interest, to the full extent of benefits or claims paid and/or due as a result of the occurrence causing the injury or illness, shall be deducted from the covered person's total recovery. The remainder of the balance of any recovery shall then be paid to the covered person and/or his or her attorneys, if applicable. Once a settlement or judgment is reached, additional claims may not be submitted with respect to the same injury covered by said settlement.

3) To the extent of the aforesaid payments made or to be made by the Plan, any money that may be recovered by the covered person as a result of such payments by the Plan, or otherwise, from any third party with respect to the matter giving rise to the above-referenced loss, whether by judgment, settlement or otherwise, together with such costs as are allowed by law, shall be repaid to the Plan. The Plan, however, shall not be obligated to share, set off or reimburse any portion of the covered person's attorney

fees, court costs or expenses associated with any lawsuit, judgment, settlement, or otherwise which preceded such recovery by the covered person.

4) If the covered person's acts or omissions compromise the Plan's right of subrogation and recoupment, the Plan will seek reimbursement of all appropriate benefits paid directly to the covered person and/or will offset benefits otherwise payable to the covered person under the Plan.

5) The completion and/or execution of any documents requested by the Fund Office or its designee shall be a condition to the covered person receiving coverage for any present or future claims. Furthermore, the Plan shall have the right to suspend all benefit coverage if the covered person fails to complete, provide or execute such requested documentation.

ARTICLE XIII - MEDICAL REIMBURSEMENT ACCOUNTS

A. Overview

The Medical Reimbursement Account ("MRA") benefit was established as of May 1, 2007, for all active Participants. Employer contributions to the MRA must be made in accordance with the applicable collective bargaining agreement or participation agreement. The MRA is an individual sub-account of the Plan for each Participant for whom such contributions are made. These contributions and accounts shall not create or constitute a vested benefit for any Participant, Dependent or Beneficiary.

When a Participant, or his or her Eligible Dependent, has eligible unreimbursed medical expenses and an existing balance in his or her individual MRA, the Participant may use a "debit pre-paid card" to automatically pay for prescriptions and eligible over-the-counter ("OTC") expenses, copayments, deductibles, self-pays, vision services, dental and orthodontia services, and co-insurance. The card, which the Fund Office will provide, can only be used if the Participant has a balance in the MRA and only for so long as the MRA exists. The Participant may instead submit, on a form provided by the Fund Office, proof of such expenses and apply for reimbursement from his or her individual MRA. Reimbursement checks shall be issued to Participants on a monthly basis.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant under any health insurance policy or plan provided through any employer of the Participant. Reimbursement, to the extent the Participant has funds in his or her individual MRA, can be made for deductibles, copayments and expenses in excess of benefit maximums applied to covered medical expenses under this Plan or another qualified plan for which the Participant or Dependent receives medical benefits; for self-payments to maintain eligibility under this Plan or another qualified plan or arrangement; or for premiums or other payments required to maintain coverage under his or her spouse's plan.

B. Reimbursable Expenses

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the individual under any health insurance policy or plan provided through any employer. Reimbursement, to the extent there are funds in the his or her MRA, will be made for the following types of expenses in accordance with Internal Revenue Code § 213:

- Deductibles, copayments and expenses in excess of benefit maximums applied to covered medical expenses under this Plan or another tax-qualified plan for which the Participant of Dependent receives medical benefits.

- Self-payments to maintain eligibility under this Plan or the tax-qualified health plan of the employee's spouse.

- Unreimbursed prescription medicines (prescribed by a physician) and insulin, including copayments.

- Over-the-counter medicine bought with a prescription.

The following specific items (in alphabetical order) **are reimbursable** under the MRA, subject to change by the IRS and the Board of Trustees:

- Abortion
- Acupuncture
- Alcoholism, including expenses for an inpatient's treatment at a therapeutic center for alcohol addiction and meals and lodging provided by the center during treatment. This also includes medical expense amounts paid for transportation to and from local alcohol recovery support organization (for example, Alcoholics Anonymous) if attendance is pursuant to competent medical advice that membership in the alcohol recovery support organization is necessary for the treatment of a disease involving the excessive use of alcohol.
- Ambulance
- Annual physical examinations
- Artificial limbs
- Artificial teeth
- Bandages and other medical supplies
- Birth control pills, if prescribed by a doctor
- Body scan (i.e., medical expenses related to the cost of an electronic body scan)
- Braille books and magazines (for use by a visually impaired person that is more than the cost of regular printed editions)
- Breast pumps and supplies that assist lactation (this does not include the costs of excess bottles for food storage)
- Breast reconstruction surgery or breast prosthesis following a mastectomy for cancer
- Capital expenses (i.e., expenses for special equipment installed in a home, or for improvements, if their main purpose is medical care for the Participant, spouse, or Dependent). The cost of permanent improvements that increase the value of the property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of the property. The difference is a medical expense. If the value of the property is not increased by the improvement, the entire cost is included as a medical expense.
- Capital improvements made to accommodate a home to a disabled person's condition, or that of his or her spouse or Dependent who lives with the person (improvements do not usually increase the value of the home), and the cost can be included in full as medical expenses. Examples include the following:
    - Constructing entrance or exit ramps for the home

- Widening doorways at entrances or exits to the home
- Widening or otherwise modifying hallways and interior doorways
- Installing railings, support bars, or other modifications to bathrooms
- Lowering or modifying kitchen cabinets and equipment
- Moving or modifying electrical outlets and fixtures
- Installing porch lifts and other forms of lifts (but elevators generally add value to the house)
- Modifying fire alarms, smoke detectors, and other warning systems
- Modifying stairways
- Adding handrails or grab bars anywhere (whether or not in bathrooms)
- Modifying hardware on doors
- Modifying areas in front of entrance and exit doorways
- Grading the ground to provide access to the residence.

Only reasonable costs to accommodate a home to the disabled person's condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.

- Car repairs and improvements, if the expense is for special hand controls and other special equipment installed in a car for the use of a person with a disability. The allowable expense can include the difference between the cost of a regular car and a car specially designed to hold a wheelchair.
- Chiropractic medical care
- Christian Science practitioner care (if the expense is for medical care)
- Contact lenses, if used for medical reasons. The expense can include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaners.
- Crutches (both to buy or rent them)
- Dental treatments, including amounts paid for the prevention and alleviation of dental disease. Preventive dental treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatments to alleviate dental disease include services of a dentist for procedures such as x-rays, fillings, braces, extractions, dentures, and other dental ailments. Teeth whitening is not covered.
- Diagnostic devices used in diagnosing and treating illness or disease (e.g., a blood sugar test kit to monitor a diabetic's blood sugar level)
- Disabled dependent care expenses
- Drug addiction amounts for inpatient treatment at a therapeutic center for drug addiction. This includes meals and lodging provided by the center during treatments. Also included are amounts paid for transportation to and from the drug treatment meetings if attendance is pursuant to competent medical advice that the membership is necessary for the treatment of a disease involving the excessive use of drugs.

- Eye examinations
- Eyeglasses
- Eye surgery to treat defective vision (such as laser eye surgery or radial keratotomy)
- Fertility enhancement, including procedures such as in vitro fertilization (including temporary storage of eggs or sperm) and surgery, including an operation to reverse a prior surgery that prevented the person operated on from having children.
- Guide dog or other service animal expenses, including the costs of buying, training, and maintaining a guide dog or other service animal to assist a visually impaired or hearing disabled person, or a person with other physical disabilities. In general, this includes any costs, such as food, grooming, and veterinary care, incurred in maintaining the health and vitality of the service animal so that it may perform its duties.
- Health institute expenses, but only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental disability or illness of the individual receiving the treatment.
- Health maintenance organization ("HMO") expenses to receive medical care from an HMO
- Hearing aids, including the cost of the hearing aid, batteries, repairs, and maintenance needed to operate it
- Hospital services if a principal reason for being in the hospital is to receive medical care
- Insurance premiums paid for policies that cover medical care. This does not include insurance premiums that were paid and for which the person claims a tax credit or deduction. Medical care policies can provide payment for treatment that includes:
    - Hospitalization, surgical services, x-rays;
    - Prescription drugs and insulin;
    - Dental care;
    - Replacement of lost or damaged contact lenses; and
    - Long-term care (subject to additional limitations discussed below).

  If the policy provides payments for other than medical care, it can still be included if the premiums for the medical care part of the policy are reasonable, and only if the cost of the medical part is separately stated in the insurance contract or given in a separate statement.
- Laboratory fees
- Lactation expenses
- Lead-based paint removal expenses
- Legal fees that are necessary to authorize treatment for mental illness. However, this does not include legal fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not

necessary for medical care.

- Lifetime care advance payments or “founder’s fees” paid either monthly or as a lump sum under an agreement with a retirement home.
- Lodging at a hospital or similar institution if a principal reason for being there is to receive medical care.
- Long-term care and related services that are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance and personal care services, and that are required by a chronically ill individual, and provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- Maintenance and personal care services, with its primary purpose of providing a chronically ill individual who needed assistance with his or her disabilities (including protection from threats to health and safety due to severe cognitive impairment).
- Meals at a hospital or similar institution if a principal reason for being there is to get medical care.
- Medical conferences if the amounts are for admission and transportation to a medical conference that concerns the chronic illness of the Participant, his or her spouse, or his or her Dependent. The costs of the medical conference must be primarily for and necessary to the medical condition, and the majority of the time spent at the conference must be spent attending sessions on medical information. The cost of meals and lodging while attending the conference are not allowable as a medical expense.
- Medical information plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.
- Medicines
- Nursing home and nursing services
- Operations that are not for cosmetic surgery
- Optometrist services
- Organ transplants
- Osteopathy
- Oxygen and oxygen equipment to relieve breathing problems caused by a medical condition
- Physical examination and diagnostic tests by a physician
- Pregnancy test kits
- Prostheses
- Psychiatric care
- Psychoanalysis
- Psychologist for medical care
- Special education fees based on a doctor’s recommendation for a child’s tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous

system disorders.

- Smoking cessation programs, although not for drugs that do not require a prescription, such as nicotine gum or patches, which are designed to help stop smoking.
- Sterilization
- Surgery
- Telephone and related special telephone equipment that lets a person who is deaf, hard of hearing, or has a speech disability to communicate over a regular telephone. This includes teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment, including the cost of repairing the equipment.
- Television and related equipment that displays the audio part of a television program as subtitles for a person with a hearing disability. This may be the cost of an adapter that attaches to a regular set. It also may be part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.
- Therapy received as medical treatment
- Transplants
- Transportation primarily for, and essential to, medical care
- Trips primarily for, and essential to, receiving medical services
- Tuition in medical expenses. A lump-sum fee which includes education, board, and medical care without distinguishing which part of the fee results from medical care is not considered an amount payable for medical care. However, it can include charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school.
- Vasectomy services
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees paid for membership in a weight reduction group as well as fees for attendance at periodic meetings. This does not include membership dues in a gym, health club, or spa as medical expenses, but it can include separate fees charged there for weight-loss activities. It also does not include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. It can include the cost of special food in medical expenses only if:
    - The food does not satisfy normal nutritional needs;
    - The food alleviates or treats an illness; and
    - The need for the food is substantiated by a physician.

  The amount included in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.
- Wheelchair used for the relief of a sickness or disability. The cost of operating and maintaining the wheelchair is also a medical expense.

- Wig purchased on the advice of a physician for the mental health of the patient who has lost all of his or her hair from disease.
- X-ray and related medical expenses paid for medical reasons.

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. For additional information, please contact the Fund Office.

C. Unreimbursable Expenses

The following specific items (in alphabetical order) are **not** subject to reimbursement:

- Baby sitting, childcare, and nursing services for a normal, healthy baby
- Controlled substances (such as marijuana, laetrile, etc.) that are not legal under federal law, even if such substances are legalized by state law.
- Cosmetic surgery or any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. These include face lifts, hair transplants, hair removal (electrolysis), and liposuction. However, amounts paid for cosmetic surgery are allowable if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.
- Dancing lessons, swimming lessons, etc., even if they are recommended by a doctor, if they are only for the improvement of general health.
- Diaper services, unless they are needed to relieve the effects of a particular disease.
- Electrolysis, hair removal, and hair transplants
- Flexible spending amounts for which the person is fully reimbursed
- Funeral expenses
- Future medical care
- Health club dues and other amounts paid to improve one's general health or to relieve physical or mental discomfort not related to a particular medical condition. These include membership costs in any club organized for business, pleasure, recreation, or other social purposes.
- Health savings account contributions
- Household help, even if such help is recommended by a doctor
- Illegal operations and treatments, even if rendered or prescribed by licensed or unlicensed practitioners.
- Insurance premiums
- Maternity clothes
- Medical savings account contributions
- Medicines from other countries brought in (or ordered and shipped) from another country, unless the drug is imported legally.
- Nonprescription drugs and medicines
- Nutritional supplements, vitamins, herbal supplements, natural medicines, etc., unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician.

- Personal use items ordinarily used for personal, living, or family purposes, unless they are used primarily to prevent or alleviate a physical or mental disability or illness.
- Swimming lessons
- Teeth whitening expenses
- Veterinary fees
- Weight-loss programs, if the purpose of the weight loss is the improvement of appearance, general health, or sense of well-being.

D. Procedural and Administrative Issues

Please note that eligible OTC products that are medicines or drugs (e.g., acne treatments, allergy and cold medicines, antacids, etc.) will only be eligible for reimbursement with a physician's prescription that includes his or her address and license number. The only exception is insulin, which will not require a prescription.

Claims for medical expense reimbursements shall be filed no later than one (1) year following the end of the calendar year in which the services were rendered. Please contact the Fund Office for a reimbursement claim form. A sample form is provided in the **Addendum**.

Any monies deposited in a Participant's individual MRA will remain in such account so long as the Participant is actively employed (or available for such employment) pursuant to the applicable collective bargaining agreement requiring contributions to the Plan and for a period of time not to exceed twelve (12) months after the Participant has terminated employment (other than due to retirement or disability retirement) with an Employer that is required to make contributions to the Plan. After termination of such employment and twelve (12) months have expired since such termination, any monies in the individual MRA shall first be used to pay off any negative bank hours owed, and thereafter, any amounts remaining shall revert to the general assets of the Plan and shall no longer be a benefit available to the Participant or his or her Dependents.

In the event of a Participant's death, his or her individual MRA balance shall be placed in an individual MRA for his or her spouse, or if unmarried or widowed, for his or her Dependent(s) as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder. This individual MRA may only be used for reimbursement purposes and shall not be paid directly to the surviving spouse or the Dependent other than for reimbursement for eligible expenses.

The Plan may assess an administrative fee against the Participant's MRA for the administrative costs of processing such reimbursement claims.

Effective January 1, 2017, all contributions to a Participant's Reserve Bank, in excess of the amount that is necessary to maintain three (3) years of coverage under the Plan for the Participant, shall first be used to pay off any negative bank hours owed, and, thereafter, any such excess amounts remaining shall be directed to the Participant's

MRA. Such excess contributions shall terminate if the amount in the Participant's Reserve Bank is less than the amount required to maintain coverage for the Participant for a three (3) year period of time.

Effective with any Employer contributions received after June 26, 2023, all contributions to a Participant's Reserve Bank in excess of the amount that is necessary to maintain three (3) years of coverage under the Plan for the Participant shall first be used to pay off any negative bank hours owed. Thereafter, and effective with any Employer contributions received after June 26, 2023, any such excess amounts remaining shall not be directed to the Participant's MRA but, instead, shall be directed to and become part of the general assets of the Fund. Lastly, such excess contributions to the general assets shall not occur if and for so long as the amount in the Participant's Reserve Bank is less than the amount required to maintain coverage for the Participant for a three (3) year period of time.

Effective May 1, 2014, and as directed by the Affordable Care Act, the Participant will be given the opportunity once each year to opt-out of and waive future reimbursement from the MRA. Further, the Participant will have that same opportunity upon termination of employment, and upon ceasing to work or being unavailable for work in covered employment. Any opt-outs and waivers of future MRA reimbursements are permanent. When a Participant opts out of the MRA, all funds in the MRA account will revert to the general assets of the Plan and the Participant will be deemed to have permanently forfeited and waived benefits, including those for Eligible Dependent(s).

Effective January 1, 2026, if the Participant's MRA has had no activity for a period of 365 consecutive days (i.e., there have been no contributions received by the account and no claims processed through the account in the past year) and the balance in the account is less than $100.00, such account will be canceled and any remaining account balance shall be permanently forfeited and revert to the Plan.

ARTICLE XIV - GENERAL PROVISIONS AND LIMITATIONS

A. Guarantee of Benefits

All benefits under the Plan shall be payable through employees or agents of the Board of Trustees acting under its authority. Benefits as authorized under the Plan shall be paid as long as the Plan can operate on a sound financial basis. No benefits shall be payable except those that can be provided under the Plan, and no person shall have any claim for benefits against the Union, the Association, any Employer or the individual Trustees. The Board of Trustees, the individual Trustees, the Employers, and the Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Union. The Board of Trustees reserves the right to change or eliminate the benefits of all Participants (including the benefits of Retired Participants) in accordance with the amendment procedures in this SPD and the Trust Agreement.

B. Physical Examination and Autopsy

No medical examination shall be required of any Eligible Participant or Eligible Dependent to secure coverage initially. However, the Board of Trustees shall have the right through its medical examiner to examine an Eligible Participant or Eligible Dependent whose injury or sickness is the basis of a claim as often as may be reasonably required during the pendency of a claim hereunder, and the right to order an autopsy in case of death, where it is not forbidden by law.

C. Illegal Occupation or Commission of Felony

The Plan shall not be liable for any loss directly or indirectly related to the commission of, or the attempt to commit, a felony by the person whose injury or sickness is the basis of the claim or directly or indirectly related to such person's being engaged in an illegal occupation or undertaking.

D. Assignment

Benefits under the Plan may be assigned by the Participant only to a participating physician or provider (except as noted in the dental and vision benefit sections).

E. Facility of Payment

Whenever payments that should have been made under this Plan have been made by another plan, the Plan shall have the right, exercisable alone and in its sole discretion, to pay an organization making the payments any amounts it determines are warranted to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits payable under this Plan, and the Plan will be fully discharged from liability to the extent of such payment.

F. Right to Recovery

Whenever payments have been made by the Plan with respect to allowable expenses in an amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan will have the right to recover the excess payments from among one or more of the following, as determined by the Board of Trustees: (1) any persons to or from whom the payments were made; (2) any insurance companies; and (3) any other organizations.

G. Right to Receive and Release Necessary Information Consistent with the Plan's Obligations Under HIPAA

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan, or any provision of similar purpose of any other plan, the Plan may, with the consent of the Eligible Participant or Eligible Dependent, release to or obtain from any insurance company or other organization or person any information with respect to any person which the Board of Trustees deems to be necessary for these purposes. Any person claiming benefits under this Plan shall furnish to the Board of Trustees any information necessary to implement this provision.

H. Word Usage

Whenever words are used in this SPD in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

I. Amendments

The Board of Trustees can amend the Plan at any time and to any extent in its sole discretion. Such amendments shall be effective when approved by a majority of the individual Trustees, provided such amendments are in writing and consistent with the objectives and purposes of the Plan. Whenever an amendment is adopted in accordance with this section, all necessary parties shall be notified in a reasonable manner within a reasonable time.

J. Authority of the Board of Trustees

The Board of Trustees has full, complete and binding authority to define, interpret and apply all of the terms and provisions of the Plan, the Trust Agreement, the SPD, the amendments, the Plan's policies, and all contracts entered into by the Board of Trustees with any third parties. This authority to define, interpret and apply includes, but is not limited to, all issues that relate to eligibility, the amount of and entitlement to any forms of benefit, all issues that directly or indirectly relate to covered employment, and all issues that directly or indirectly relate to benefit terminations. Without limiting in any way the authority of the Board of Trustees as recited above, the Board of Trustees may delegate that same authority to the Fund Office, to another agent, or to another Plan representative.

ARTICLE XV - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A. Overview

ERISA requires the Plan to honor court orders or administrative court directives (i.e., medical child support decrees) to provide medical plan coverage to children and/or other "alternate recipients" and to begin such coverage while the covered person is working.

However, these orders must meet the qualified medical child support order ("QMCSO") rules, which require that certain federal standards be satisfied. The Plan will deny medical coverage under any judgment, decree or order unless it satisfies all of the requirements set forth below. Assuming such court order meets these federal requirements, the Plan will follow the terms of the QMCSO if this Plan is the proper party to the legal proceeding from which the QMCSO has been issued.

The Plan will follow court orders or administrative court orders that meet all of the following requirements:

1) The order must be a judgment, order or decree (including approval of a settlement agreement) that provides for child support or health benefit coverage for a child of the Participant under this Plan, is made pursuant to a state's domestic relations law, and relates to benefits under the Plan.

2) The order must include the names and last known mailing addresses of the Participant and each alternate recipient, i.e., each child of the Participant who is recognized under the order as having a right to enroll under the Plan.

3) The order should either provide a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or indicate the manner in which the type of coverage is to be determined. The order would satisfy this requirement by designating the alternate recipient's coverage to be the same as the coverage elected each year by the Participant.

4) The order must indicate the period to which it applies, although it need not include a specific ending date. Note that coverage under a QMCSO need not continue beyond the age for which coverage is available for Dependents generally.

5) The order may not require the Plan to provide a type or form of benefit or option not otherwise provided under the Plan.

Upon request to the Fund Office, the covered person will be provided a copy of the Plan's procedures for processing QMCSOs.

ARTICLE XVI - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan is required by law to take reasonable steps to ensure the privacy of each covered person's personally identifiable health information and to inform him or her about the following:

- the Plan's uses and disclosures of PHI;
- his or her rights to privacy with respect to his or her PHI;
- the Plan's duties with respect to his or her PHI;
- his or her right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- the person or office he or she should contact for further information about the Plan's privacy practices.

A. Definition of "Protected Health Information" or "PHI"

The term "protected health information" or "PHI" refers to all information relating to the covered person's past and present health conditions that individually identifies him or her or could reasonably be used to identify the covered person, and which is transferred to an individual or entity or maintained by the Plan in oral, written, electronic, or any other form.

B. When the Plan May Disclose PHI

The Board of Trustees has amended this SPD to protect PHI as required by federal law. Under federal law, the Plan may disclose PHI without the covered person's consent or authorization in the following cases:

1) **Upon Request:** If the covered person requests it, the Plan is required to give the covered person access to certain PHI to allow him or her to inspect and copy it.

2) **As Required by an Agency of the Government:** The HHS or other government agency may require the disclosure of the covered person's PHI to investigate or determine the Plan's compliance with the privacy regulations.

3) **For Treatment, Payment, or Health Care Operations:** The Plan and its business associates will use PHI without the covered person's consent, authorization, or opportunity to agree or object in order to carry out treatment, payment, or health care operations. The phrase "treatment, payment, or health care operations" is defined in the next subsection.

C. Definition of "Treatment, Payment, or Health Care Operations"

The phrase "treatment, payment, or health care operations" is defined as follows.

1) The term “treatment” means the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of the covered person’s health care providers.

2) The term “payment” includes, but is not limited to, making coverage determinations and payments. These actions include billing, claims management, subrogation, reimbursement, and reviews for medical necessity and appropriateness of care, utilization review, and preauthorization.

3) The phrase “health care operations” includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical reviews, legal services, and auditing functions, including fraud and abuse compliance programs, business funding and development, business management, and general administrative activities.

D. When the Disclosure of PHI Requires Written Authorization

The Plan will not use or disclose the covered person’s PHI for any purpose not outlined in this SPD, unless the covered person gives the Plan his or her written authorization to do so. The Plan does not make disclosures of information to any other companies that may want to sell their products or services to the covered person. If the covered person gives the Plan his or her written authorization, the covered person may revoke that authorization at any time, unless the Plan is taking action in reliance on his or her authorization. To receive an authorization form, the covered person should contact the Fund Office. If a family member calls with knowledge of his or her claim, the Fund Office may confirm certain information about it, unless the covered person has previously informed the Fund Office in writing of a need for confidential communications.

E. Use or Disclosure of PHI that Requires the Covered Person Be Given an Opportunity to Agree or Disagree before the Use or Release

Disclosure of PHI to family members, other relatives, and the covered person’s close personal friends is allowed under federal law if:

- the information is directly relevant to the family member’s or friend’s involvement with the covered person’s care or payment for that care; and
- the covered person has either agreed to the disclosure or has been given an opportunity to object and has not objected.

F. Use or Disclosure of PHI for which Consent, Authorization, or Opportunity Is Not Required

The Plan is allowed under federal law to use and disclose PHI without the covered person's consent, authorization, or request under the following circumstances:

1) When required by law.

2) If the disclosure is to an authorized public health authority and required by law for public health and safety purposes. If authorized by law, PHI also may be used or disclosed if the covered person has been exposed to a communicable disease or is at risk of spreading a disease or condition.

3) If the disclosure is to public authorities and relates to abuse, neglect, or domestic violence, and if a reasonable belief exists that the covered person may be a victim of abuse, neglect, or domestic violence. In this case, the Plan will promptly inform the covered person that such a disclosure has been or will be made, unless such notice would cause a risk of serious harm.

4) If the disclosure is to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions (e.g., to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (e.g., to investigate Medicare or Medicaid fraud).

5) If the disclosure relates to a legal proceeding and is in response to a subpoena or discovery request that is accompanied by a court order.

6) If the disclosure is for law enforcement health purposes, such as to report certain types of wounds.

7) If the disclosure relates to law enforcement emergency purposes, such as the following:

   - identifying or locating a suspect, fugitive, material witness, or missing person; or
   - disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8) If the disclosure is related to determining the cause of death or for organ donation. The Plan also may disclose PHI for cadaveric organ, eye, or

tissue donation purposes.

9) If the disclosure is required to be given to a funeral director to carry out his or her duties with respect to a decedent.

10) If the disclosure is made when, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11) If the disclosure is necessary to comply with workers' compensation or similar programs established by law.

Except as otherwise indicated in this SPD, the use or disclosure of PHI will be made only with the covered person's written authorization, and subject to his or her right to revoke the authorization.

G. Other Uses and Disclosures

The Plan may contact the covered person to provide information about treatment alternatives or other health-related benefits and services that may be of interest to him or her. The Plan also may disclose PHI to the Board of Trustees and its designees (e.g., the Fund Office, Fund Counsel, etc.) for the purpose of reviewing the covered person's appeal of a benefit claim or for other reasons relating to the administration of the Plan.

H. Restrictions on PHI Uses and Disclosures

The covered person may request that the Plan:

1) Restrict the uses and disclosures of his or her PHI to carry out treatment, payment, or health care operations.

2) Restrict the uses and disclosures to family members, relatives, friends, or other persons identified by the covered person who are involved in his or her medical care.

The Plan is not required to agree to such a request if the Board of Trustees, in its sole discretion, determines that the request is unreasonable.

The Plan will accommodate a reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the covered person. In that case, the covered person or his or her personal representative would be required to submit a form to the Fund

Office requesting such restrictions on the uses and disclosures of his or her PHI.

I. The Right to Amend PHI

The covered person has the right to request that the Plan amend his or her PHI or a record about the covered person in a designated record set for as long as the PHI is maintained in the designated record set, subject to certain exceptions. The Plan has sixty (60) days after receiving such a request to act on it. The Plan is allowed a single 30-day extension if it is unable to comply with this 60-day deadline. If the Plan denies the request in whole or in part, it must provide the covered person a written denial explaining the basis for the decision. The covered person or his or her personal representative then may submit a written statement disagreeing with the denial and have that statement included with any future disclosures of the PHI.

J. The Right to Inspect and Copy PHI

The covered person has the right to inspect and obtain a copy of his or her PHI for as long as the Plan maintains his or her PHI. The Plan will provide the requested information within thirty (30) days if the information is maintained on site, or within sixty (60) days if the information is maintained offsite. A single 30-day extension would be allowed if the Plan is unable to comply with the applicable 30-day or 60-day deadline. The covered person or his or her personal representative would be required to submit a form to the Fund Office requesting access to the PHI in the designated record set. If access is denied, the covered person or his or her personal representative would be provided a written denial setting forth the basis for the denial, a description of how the covered person may exercise his or her review rights, and a description of how the covered person may complain to the Board of Trustees or the Secretary of the HHS.

K. The Right to Receive an Accounting of the Plan's PHI Disclosures

Upon request, the Plan is required to provide the covered person an accounting of disclosures by the Plan of his or her PHI. This accounting period starts as of April 14, 2003, and it allows the covered person to request an accounting for up to six (6) years of disclosures after that date. The maximum period that the covered person can request is six (6) years. The Plan then has sixty (60) days to provide such an accounting. It would be allowed an additional thirty (30) days if the Plan is unable to comply with the applicable 60-day deadline, but it must give the covered person a written statement of the reasons for the delay and the date by which the accounting would be provided. If the request is for more than one accounting within any 12-month period, the Plan would be entitled to charge a reasonable, cost-based fee for each subsequent accounting.

L. The Right to Receive a Paper Copy of the Plan's PHI Notice upon Request

The covered person has the right to receive a paper copy of the Plan's PHI notice upon request. To obtain a copy of the notice, the covered person or his or her personal representative should contact the Fund Office. If the covered person disagrees with the

record of his or her PHI, the covered person can amend it. If the Plan denies his or her request to amend his or her PHI, the covered person can require the Plan to include with the PHI his or her written statement disagreeing with that denial.

M. The Right to a Personal Representative

The covered person may exercise his or her PHI rights through a personal representative. His or her personal representative will be required to produce evidence of authority to act on his or her behalf before the personal representative would be given access to his or her PHI or be allowed to take any action on his or her behalf. Proof of such authority would be a completed, signed, and approved "Appointment of Personal Representative" form. The covered person may obtain this form by contacting the Fund Office.

The Plan retains sole and complete discretion to deny the personal representative access to the PHI to protect those vulnerable persons who depend on others to exercise their PHI rights or who may be subject to abuse or neglect. On the other hand, the Plan will recognize certain individuals as personal representatives even without completed appointment forms. For instance, the Plan will automatically consider covered spouses to be the personal representatives for each other. Additionally, the Plan will consider a covered parent, guardian, or other person acting in loco parentis as the personal representative of any dependent child covered by the Plan, unless applicable laws require otherwise. A parent may act on a child's behalf, including requesting access to that child's PHI. Dependents, including a spouse, however, may request that the Plan restrict information going to family members. Additionally, the Plan will automatically consider any person designated under a power of attorney on file with the Fund Office to be the personal representative.

The covered person or his or her spouse may elect not to have each other as their personal representatives. The covered person or his or her spouse would need to submit an "Opt-out of Personal Representation" form to the Fund Office. Dependent children also have the right to submit an "Opt-out of Personal Representation" form if they do not wish to have one or both of their parents as their deemed personal representatives. All requests will be reviewed by the Board of Trustees, which may deny the requests, especially for those based on or subject to state law restrictions.

N. Maintaining Privacy

The Plan is required by law to maintain the privacy of PHI and to provide the covered person with notice of its legal duties and privacy practices. Since April 14, 2003, the Plan has been required to comply with these federal PHI laws. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of the Plan's PHI notice will be provided to the covered person and to all past and present Participants, Dependents, Retirees, and Beneficiaries for whom the Plan still maintains PHI. The revised notice will be mailed to each such person

within sixty (60) days of the effective date of any material change to the following:

- the uses or disclosures of PHI;
- the recipient's individual rights;
- the duties of the Plan; or
- other privacy practices stated in the Plan's PHI notice.

O. Disclosing Only the Minimum Necessary PHI

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses and disclosures made to the individual to which the PHI applies;
- disclosures made to the Secretary of the HHS pursuant to its enforcement activities under federal law;
- uses and disclosures required by law; and
- uses and disclosures required for the Plan's compliance with federal laws and regulations.

PHI restrictions do not apply to information that has been de-identified, which is information that does not identify the person in question and with respect to which there is no reasonable basis to believe that the information can be used to identify that person.

In addition, the Plan may use or disclose "summary health information" for obtaining premium bids or for modifying, amending, or terminating the Plan. Summary information summarizes the claims history, claims expenses, and types of claims experienced by individuals for whom the Plan has provided health care benefits.

P. Additional Rights

Certain uses and disclosures of PHI require the covered person's authorization, including uses and disclosures for marketing purposes, disclosures that constitute "sales" of PHI, and most uses and disclosures of psychotherapy notes. No use or disclosure may be made without his or her authorization for a purpose that is not explicitly described in this SPD and/or applicable federal laws. Covered persons also have the right to be notified of any cybersecurity breaches that have or may have compromised the privacy of their PHI.

Q. The Right to File a Complaint with the Plan or HHS

If the covered person believes that his or her privacy rights have been violated, the

covered person may file a complaint with the Fund Office at the following address:

Privacy Officer of the
Plumbers & Pipefitters Local Union 94 Health and Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, Ohio 44406

The covered person also may file a complaint with the federal government at the following address:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

The Plan and its Board of Trustees will not retaliate against the covered person for filing such a complaint.

R. Substance Use Disorder Treatment Records

Substance use disorder treatment records received from programs subject to 42 C.F.R. Part 2 or testimony relaying the content of such records shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 C.F.R. Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed. The Plan will never use this information to raise funds for its benefit. But if it were to do so, the Plan would first provide you a clear and conspicuous opportunity to elect not to receive any fundraising communications.

S. Federal Law

Uses and disclosures of PHI by the Plan are regulated by federal law, including HIPAA. The HIPAA regulations are found in Title 45, Code of Federal Regulations, Parts 160 and 164. Those laws and regulations will supersede this SPD if there are any discrepancies between the information provided herein and the applicable federal laws and regulations.

ARTICLE XVII - CLAIMS FILING AND BENEFIT DETERMINATION

A Participant, a Dependent or an authorized representative may file a claim for benefits under the Plan. The claim shall be in writing, stating the basis of the claim and authorizing the Plan or its representatives to conduct all necessary investigations into the claim. A claim is not filed until it is received by the Plan. Such claims shall be sent to the following addresses:

Medical Claims

Medical Mutual
P.O. Box 6018
Cleveland, Ohio 44101

Prescription Claims

Normally you will take your prescription card to an appropriate pharmacy to obtain your prescriptions or obtain your prescription via mail order. However, if you need reimbursement for any prescription you paid for, you may file a claim for reimbursement by sending the receipt, along with a request for reimbursement, to:

CVS/Caremark
1 CVS Drive
Woonsocket, RI 02895

Death and Dismemberment, and Weekly Accident and Sickness Benefit Claims

Plumbers & Pipefitters Local Union No. 94
Health & Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406

If the Plan, upon receipt of a claim for benefits, needs additional information or the claim does not follow the Plan's procedures, the Plan will notify you within twenty-four (24) hours (for an urgent care benefit claim) and thirty (30) days (for non-urgent post-service benefits claims) of receipt of the claim that such additional information is necessary. In the case of an urgent care claim, notification of additional information may be oral, unless you request written notification. The Plan shall allow you a minimum period of forty-eight (48) hours (for urgent care benefit claims) or forty-five (45) days (for non-urgent benefit claims) to furnish such additional information.

For those claims where additional information is requested by the Fund Office, any partial or total denial of the claim shall be made by the Plan of a notice of adverse benefit determination within forty-eight (48) hours (for an urgent care benefit claim) or thirty (30) days (for a non-urgent post-service benefit claim) from the date the Plan receives the

information requested from you. If additional information is requested, the time period for making a benefit decision is tolled from the date on which the notice is sent to you until the date you respond to the request. In the case of non-urgent care benefit claim, the period for a benefit determination to be made may be extended for a period of fifteen (15) days (for post-service claims) if it is due to circumstances beyond the Plan's control. However, you will be given notice of such extension prior to the original deadline for a determination.

The term "urgent care claim" is defined as any claim for medical care or treatment which cannot be decided under normal timeframes because:

- it can seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition it would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

For those claims where additional information is not necessary, the Plan shall make any determination regarding the validity of the claim and, upon any partial or total denial of the claim, the Plan shall deliver a notice of adverse benefit determination within seventy-two (72) hours (for an urgent care benefit claim) or thirty (30) days (for a non-urgent care post-service benefit claim) of the filing of the claim.

If the request that the Plan extend a previously approved course of treatment by increasing either the number of treatments or the period of time for treatments, any determination on such request will be provided within twenty-four (24) hours after receipt of the claim, when the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes. However, if the request does not involve urgent care, the request shall be treated as a new benefit claim and decided within the non-urgent care timeframes. If the Plan decides to reduce or terminate a previously approved course of treatment, such a decision shall be treated as a Notice of Claim Denial. In such case, the Fund Office shall provide reasonable advance notice of the reduction or termination to allow the claimant to appeal and obtain a determination before the benefit is reduced or terminated.

The Notice of Claim Denial shall be in writing and contain the following information:

- The specific reasons for the denial.

- The specific reference to pertinent provisions of this SPD or other documents on which the adverse benefit determination was based.

- A description of any additional materials or information necessary for the claimant

to perfect the claim and an explanation of why such material or information is necessary.

- A description of the Plan's claims and review procedures and the time limits applicable to such procedures.

- A notice of any internal guidelines or protocols used in making the decision, if applicable, and the claimant's right to receive a copy of such guidelines or protocols.

- In the case of an adverse benefit determination by a group health plan involving a claim for urgent care, a description of the expedited review process applicable to such claims.

The following table summarizes the deadlines for notifying claimants of the applicable benefit decisions:

Claims Procedures	**Group Health (Urgent)**	**Group Health (Post-Service)**
Initial Benefit Determination	72 hours	30 days
Plan Notifies Claimant if Additional Information Is Necessary	24 hours	30 days
Minimum Time for Claimant to Furnish Information after Plan's Information Request Is Received	48 hours	45 days
Determination Is Required after Claimant Submits Additional Information	48 hours	30 days

ARTICLE XVIII - APPEALS PROCEDURES

A. Review Procedures for Medical Claims: Mandatory Standard Appeals

A claimant may file an appeal if he or she is dissatisfied with any of the following:

- a benefit determination;
- a medical necessity determination;
- a determination of eligibility to participate in the Plan or to obtain health insurance coverage; or
- a decision to rescind coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums).

To submit an appeal of a medical claim electronically to Medical Mutual, the appellant should go to Medical Mutual's website, www.medmutual.com/members, complete all required fields, and submit the form, or call the Customer Service telephone number on the identification card for more information about how to file an appeal. He or she also may write a letter with the following information:

- the appellant's full name;
- the patient's full name (if different from the appellant's name);
- the identification number;
- the claim number (if the claim has been denied);
- the reason for the appeal;
- the date of service;
- the name of the provider or facility; and
- any supporting information or medical records, documents, dental x-rays, or photographs to be considered in the appeal.

The appellant should send or fax the letter and records to:

Medical Mutual
Member Appeals Unit
P.O. Box 94580
Cleveland, Ohio 44101-4580
Fax: (216) 687-7990

The request for review must come directly from the patient unless he or she is a minor or has appointed an authorized representative. The appellant may choose another person to represent him or her during the appeals process if the Claims Payor has a signed and dated statement from the appellant authorizing that person to act on his or her behalf. However, in the case of a claim involving urgent care, a health care professional with knowledge of the relevant medical condition may function as the authorized representative without a signed and dated statement from the appellant.

B. Mandatory Internal Appeal: First Level of Appeal

The Plan offers a mandatory internal appeal. The appellant must complete this mandatory internal appeal before any additional action is taken, except when exhaustion is unnecessary, as described in the following subsections.

Mandatory internal appeals must be filed within 180 days of receipt of the notice of the adverse benefit determination. All requests for appeal may be made by submitting an electronic form, by calling Customer Service, or in writing, as described elsewhere in this SPD.

Under the Plan's appeals process, there will be a full and fair review of the claim in accordance with applicable laws. The internal appeals process is a review by an appeals specialist, a physician consultant, and/or other licensed health care professionals. The review will consider all comments, documents, medical records, and other information submitted by the appellant and the provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

All determinations that involve, in whole or in part, issues of medical necessity, whether services are experimental or investigational, or any other medical judgments are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment.

The health care professionals who review the appeal will not have made any prior evaluations about the claim and will not be a subordinate of the professional who made the initial evaluation of the claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote, or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits.

Upon specific written request, the Claims Payor will provide the identification of the medical or vocational expert whose advice was obtained on behalf of the Claims Payor in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The appellant may submit written comments, documents, records, testimony, and other information relating to the claim that is the basis for the appeal. These documents should be submitted at the time the appellant sends in the request for an appeal. Upon written request, he or she may have reasonable access to and copies of documents, records, and other information used to make the decision on the claim for benefits that is the subject of the appeal.

If, during the appeal, the Claims Payor considers, relies on, or generates any new or additional evidence, the appellant will be provided free of charge copies of that evidence before the notice of final adverse benefit determination is issued. The appellant will have an opportunity to respond before issuance of the notice of adverse benefit determination

expires. Additionally, if the Claims Payor decides to issue a final adverse benefit determination based on a new or additional rationale, the appellant will be provided that rationale free of charge before the notice of final adverse benefit determination is issued. The appellant will have an opportunity to respond before the timeframe for issuing a notice of final adverse benefit determination expires.

The appellant will receive continued coverage pending the outcome of the appeals process. For this purpose, the Claims Payor may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

C. Mandatory Internal Appeal Procedures

1) Appeal of a Claim Involving Urgent Care

The appellant or his or her authorized representative may request an appeal of a claim involving urgent care. The appeal does not need to be submitted in writing. The appellant or authorized representative should call the Care Management telephone number listed on the identification card as soon as possible.

Appeals of claims involving urgent care typically involve those claims for medical care or treatments with respect to which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the patient, or could affect the ability of the patient to regain maximum functions; or
- in the opinion of the physician with knowledge of the patient's medical condition, would subject him or her to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

The appeal must be decided as soon as possible, considering the medical exigencies, but no later than seventy-two (72) hours after receipt of the appeal request. The expedited appeals process does not apply to prescheduled treatments, therapies, surgeries, or other procedures that do not require immediate action.

When he or she requests an internal appeal for an urgent care claim, the appellant or authorized representative also may simultaneously request an expedited external review.

2) Pre-Service Claim Appeal

The appellant or authorized representative may request a pre-service claim appeal. A pre-service claim appeal is requested in advance of obtaining

medical care for approval of a benefit, as it relates to the terms of this SPD. The pre-service claim appeal must be decided within a reasonable period appropriate to the medical circumstances, but no later than thirty (30) days after receipt of the request, and it must be requested within 180 days of the date the appellant received notice of the adverse benefit determination.

3) **Post-Service Claim Appeal**

The appellant or authorized representative may request a post-service claim appeal. A post-service claim appeal is requested for payment or reimbursement of the cost of medical care that has already been provided. The post-service claim appeal must be decided within thirty (30) days of the request, and it must be requested within 180 days of the date the appellant received notice of the adverse benefit determination.

All notices of a final adverse benefit determination after an appeal will be culturally and linguistically appropriate and will include the following information:

- the specific reason(s) for the adverse benefit determination;
- reference to the specific provision(s) of this SPD on which the adverse benefit determination is based;
- sufficient information to identify the claim or health care service involved, including the date of service, the health care provider, and the claim amount (if applicable);
- a statement that the appellant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to his or her appeal;
- a notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- a notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act § 2793, if one is available;
- if an internal rule, guideline, protocol, or similar criterion was relied on in making the adverse benefit determination, this will be disclosed, or the appellant will be advised that information about the rule, guideline, protocol, or similar criterion will be provided free of charge upon written request;
- if the adverse benefit determination was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to the circumstances will be disclosed, or the appellant will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures; and

- a statement of the appellant's right to bring a civil action under ERISA following an adverse benefit determination on review.

If the appeal is denied at the internal mandatory appeal level, there are two different voluntary review options available. The appellant is eligible for either the voluntary internal review process or the external review process. These two processes and the eligibility requirements are discussed in the following subsections.

D. Voluntary Internal Review Process: Second Level of Appeal

If the mandatory internal appeal is denied and the claim does not qualify for an external review, the appellant has the option of a voluntary internal review. All requests for appeal may be made by calling the Claims Payor's Customer Service or by writing to the Member Appeals Unit. The appellant should submit additional written comments, documents, records, dental x-rays, photographs, and other information that were not submitted for the mandatory internal appeal.

A voluntary internal review may be requested at the conclusion of the mandatory internal appeal. The request for the voluntary internal review must be received by the Claims Payor within sixty (60) days of the receipt of the mandatory internal appeal decision. The Claims Payor will complete its review of the voluntary internal review within thirty (30) days of receipt of the request.

The voluntary internal review provides a full and fair review of the claim. The appeal will consider all comments, documents, records, and other information submitted by the appellant and/or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the mandatory internal appeal.

E. External Review Process: Second Level of Appeal

In most situations, the appellant must complete two levels of appeals before he or she can pursue arbitration, litigation, or any other type of administrative proceeding.

Sometimes, however, the appellant does not have to complete both levels of appeals before he or she may take other actions. These situations are as follows:

1) He or she has an urgent claim or a claim that involves ongoing treatment, in which case the appellant can have the claim reviewed internally and simultaneously through the external review process.

2) The Plan did not follow all the claim determination and appeal requirements. However, the appellant will not be able to proceed directly to external review if the rule violation was minor and not likely to influence the decision or harm the appellant; the violation was for a good cause or beyond the Plan's control; or the violation was part of an ongoing, good faith exchange

between the appellant and the Plan.

External review is done by an organization independent of the Plan and the Claims Payor. Such an organization is called an independent review organization ("IRO"). The appellant has a right to external review only if:

- the claim decision involved medical judgment;
- the service or supply was found not to be medically necessary or appropriate;
- the service or supply was found to be experimental or investigational; or
- the appellant received an adverse benefit determination from the Plan.

The appellant or authorized representative will receive a notice of adverse benefit determination describing the external review process. It will include a copy of the request for external review form at the final adverse determination level. The appellant or authorized representative must submit the request for external review form within 123 calendar days, or about four (4) months, from the date he or she receives the decision. He or she must include a copy of the notice and all other important information that supports the external appeal request. At this point, the Claims Payor will:

- contact the IRO that will conduct the external review;
- assign the appeal to one or more independent clinical reviewers who have the proper expertise to perform the review;
- consider appropriate credible information that the appellant provided;
- follow the contractual documents and the Plan's requirements; and
- send notification of the decision within forty-five (45) calendar days of the date the Plan receives the request form and all the necessary information.

The Plan will stand by the IRO's decision, unless the Plan or Claims Payor can show a conflict of interest, bias, or fraud. When an appeal is not eligible for IRO review or when the appeal is upheld at the IRO level, the Plan will inform the appellant or authorized representative of his or her right to appeal to the Board of Trustees for a voluntary level of review. The Plan will inform him or her in writing of the IRO's decision not more than forty-five (45) calendar days after the Plan receives the notice of external review form and related information from the appellant or authorized representative.

An adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect. An adverse benefit determination eligible for internal claims and appeals also includes compliance with the surprise billing protections under the No Surprises Act.

The Plan is required to provide the appellant or authorized representative (free of charge) any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with the appeal, as well as any new or additional rationale for the denial at the internal appeals stage, and a reasonable opportunity for the appellant or authorized representative to respond to such new evidence or rationale.

The Plan also must ensure that all appeals are adjudicated in a manner designed to ensure the independence and impartiality of the people involved in making the decisions. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as a claims adjudicator or medical expert) must not be based on the likelihood that the individual will support the denial of benefits.

If the Plan fails to strictly adhere to all the requirements of the applicable regulations under ERISA as they pertain to the appeal, the appellant is deemed to have exhausted the Plan's appeals processes and procedures, regardless of whether the Plan asserts that it had substantially complied, and he or she may initiate any available external remedies available under ERISA. However, the appeals processes and procedures will not be deemed to have been exhausted based on a de minimis violation.

F. Standard External Review Procedures

The appellant or authorized representative may file a request for an external review with the Plan within 123 calendar days, or about four (4) months, after the date of receipt of the notice of adverse benefit determination.

After receipt of the external review request, the Fund Office will complete a preliminary review of the request to determine whether:

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

After completion of the preliminary review, the Fund Office will issue a notification informing the appellant or authorized representative whether the appeal is eligible for external review. If the request is complete but not eligible for external review, the notification will include the reasons for ineligibility and the contact and support information from the DOL. If the request is incomplete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow the appellant to perfect the request for external review within the four-month filing period or forty-eight (48) hours of the appellant receiving the notification, whichever is later.

The Plan will then assign an IRO that is accredited to conduct an independent external review. The assigned IRO will timely notify the appellant of the claim's acceptance for external review. He or she will be given ten (10) business days to submit additional information to the IRO, and the IRO will consider that information in making its

determination on the appeal. The IRO is not required to but may accept and consider additional information submitted after the ten (10) business days.

Within five (5) business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the parties.

Upon receipt of any information submitted by one party, the assigned IRO must within one business day forward the information to the other party. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration of the Plan will not delay the external review. The external review may be terminated because of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day of making such a decision, the Plan will notify the appellant and the IRO, and the IRO will then terminate the external review.

The IRO will review all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and will not be bound by any decision or conclusions reached during the Plan's internal claims and appeals procedures.

In addition to the documents and information provided, the assigned IRO, to the extent the information and documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- the appellant's medical records;
- the attending health care professional's recommendations;
- reports from appropriate health care professionals and other documents submitted by the Plan, the appellant, or the treating provider;
- the terms of the 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;
- 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;
- 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
- the opinion of the IRO's clinical reviewer(s) after considering all the available information to the extent such information and the related documents are available and the clinical reviewer considers appropriate.

The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to both parties.

The assigned IRO's decision notice will contain the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- 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;
- the date the IRO received the assignment to conduct the external review and the date of the decision;
- references to evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
- a discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under applicable law; and
- a statement that judicial review may be available to the appellant.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. The IRO also must make such records available for examination by the Plan, the appellant, and the state and federal oversight agencies upon request, except where such disclosures would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

G. Expedited External Review Procedures

The appellant will be permitted to request an expedited external review for either an adverse benefit determination or a final internal adverse benefit determination if:

- an adverse benefit determination involves a medical condition of the appellant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the appellant's life or health or would jeopardize the appellant's ability to regain maximum function and the appellant has filed a request for an expedited internal appeal; or
- a final internal adverse benefit determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the appellant's life or health or would jeopardize the appellant'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 service for which the appellant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will determine whether the request is eligible for expedited external review and will immediately send the appellant a notice regarding whether the claim is eligible for such review.

Upon a determination that the request is eligible for expedited external review following this preliminary review, the Plan will assign an IRO for review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by telephone, by facsimile, or by any other expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider such information or documents under the procedures for standard external review. In reaching its decision, the assigned IRO must review the claim de novo and is not bound by any decision or conclusion reached during the Plan's internal claims and appeal process.

The assigned IRO will provide notice of the final external review decision as expeditiously as the medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to both parties.

H. Medical Claims Review Guidelines

1) **Consent to Release Medical Information; Denial of Coverage**
The covered person consents to the release of medical information to the Claims Payor when he or she enrolls in the Plan and/or signs an enrollment form. When the covered person presents the identification card for covered services, he or she also gives consent to release medical information to the Claims Payor. The Claims Payor has the right to refuse to reimburse for covered services if the covered person refuses to consent to the release of any medical information.

2) **Right to Review Claims**
When a claim is submitted, the Claims Payor will review the claim to ensure that the service was medically necessary and that all other conditions for coverage are satisfied. The fact that a provider may recommend or prescribe treatment does not mean that it is automatically a covered service or that it is medically necessary. As part of its review, the Claims Payor may refer to corporate medical policies and guidelines to assist in reviewing the claim.

The Claims Payor may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Claims Payor determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of the covered person.

3) **Physical Examination**

The Plan may require the covered person to have one or more physical examinations at the Plan's expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services the covered person had previously received and for which he or she has submitted claims. These examinations will not have any effect on his or her status as a covered person or for eligibility under the Plan.

I. Review Procedures for Prescription Claims

1) **Overview**

According to the Plan's PBM, there is no generic language for a prescription drug appeal. A covered person may file an appeal if he or she is dissatisfied with a benefit determination by the PBM. The appeal process differs for each covered person and the reason(s) for the denial of his or her drug claim. But the appeals procedures for prescription benefit denials are similar to the procedures for medical claims. For more information, please contact PBM using the telephone number provided on the back of the identification card. In addition, the treating physician may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.

For clinical review requests, mail or fax this information to the following address:

CVS Caremark Inc
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Rx Claim Platform Fax Number for Appeals: (866) 443-1172

Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.

For administrative review requests, mail or fax this information to the following address:

CVS Caremark Inc
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Rx Claim Platform Fax Number for Appeals: (866) 443-1172.

J. Legal Action

No legal action regarding a covered person's benefits may be commenced or filed against the Board of Trustees or the Plan more than one (1) year after the mailing of the final decision on appeal.

ARTICLE XIX - FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (the "FMLA") requires a covered employer to provide up to twelve (12) weeks of unpaid leave during any 12-month period for specified family and medical reasons. During this period, the employer must provide health coverage for the covered person on the same terms and conditions that the covered person would have received if he or she had continued to work.

To be eligible for leave under the FMLA, the "eligible employee" must work for the same contributing employer for at least twelve (12) months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, his or her employer is obligated to provide family and medical leave only if the employer employs fifty (50) or more employees each working day during twenty (20) or more work weeks during the current or preceding calendar year. During an FMLA leave, the employer must make contributions to the Plan on the covered person's behalf so that his or her health coverage under the Plan will continue. Federal law also requires that the covered person receives continued eligibility under the Plan.

A "covered employer" must grant an eligible Participant up to a total of twelve (12) work weeks of unpaid leave during any 12-month period, or twenty-six (26) work weeks for Participants with members in the Armed Forces, for one or more of the following reasons:

- for the birth or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the covered person is unable to work because of a serious health condition.

Upon return from his or her FMLA leave, the covered person must be restored to his or her original job or to an equivalent job. In addition, his or her use of FMLA leave cannot result in the loss of any employment benefits that the covered person earned or was entitled to before using FMLA leave.

If the covered person returns to work within twelve (12) or twenty-six (26) weeks, as applicable, the covered person will not lose health care coverage. If the covered person does not return to work within twelve (12) or twenty-six (26) weeks, as applicable, the covered person may then qualify to continue coverage under COBRA.

If the covered person takes a leave under the FMLA and fails to return to his or her employer for any reason after such absence, his or her employer has the right to collect all contributions made on his or her behalf during such leave of absence under the FMLA.

Furthermore, the covered person and his or her family members in any regular component of the Armed Forces, including the National Guard, Reserves, and Veterans, are entitled to FMLA leave under the following circumstances:

1) When leave is needed so that the covered person can care for a seriously injured or ill family member who is a “covered service member” (as defined under the FMLA) of the Armed Forces, including the National Guard, Reserves, and Veterans.

2) When such leave is required due to “any qualifying exigency” related to a family member’s service or call to covered active duty. This “qualifying exigency leave” extends to family members of individuals in any regular component of the Armed Forces, including National Guard, Reserves, and Veterans.

3) “Covered active duty” means (a) in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and (b) in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in § 101(a)(13)(B) of Title 10, United States Code.

4) A “covered service member” means (a) a member of the Armed Forces (including a member of the National Guard, Reserves, or Veterans) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or (b) a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard, Reserves, or Veterans) at any time during the period of five (5) years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

5) A “serious injury or illness” means (a) in the case of a member of the Armed Forces (including a member of the National Guard, Reserves, or Veterans), an injury or illness that was incurred by the member in the line of duty and on active duty in the Armed Forces (or existed before the beginning of the member’s active duty and was aggravated by service in the line of duty and on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating; and (b) in the case of a veteran who was a member of the Armed Forces (including a member of the National Guard, Reserves, or Veterans) at any time during such period, a qualifying injury or illness (as defined by the Department of Labor) that was incurred by the member in the line of duty and on active duty in the Armed Forces (or existed before the beginning of the member’s active duty and was aggravated by service in the line of duty and on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran.

6) The term “veteran” has the meaning given the term in § 101 of Title 38, United States Code.

7) “Qualifying exigencies” include:

a) Issues arising from a covered military member’s short notice deployment (i.e., deployment on 7 or less days of notice) for a period of 7 days from the date of notification.

b) Military events and related activities, such as official ceremonies, programs, or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to active duty or call to active duty status of a covered military member.

c) Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member.

d) Making or updating financial and legal arrangements to address a covered military member’s absence.

e) Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member.

f) Taking up to five (5) days of leave to spend time with a covered military member who is on short-term temporary rest and recuperation leave during deployment.

g) Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of ninety (90) days following the termination of the covered military member’s active duty status and addressing issues arising from the death of a covered military member.

h) Any other event that the employee and employer agree is a qualifying exigency.

8) The eligible employee must be the spouse, parent, child, or nearest blood relative of the member in the Armed Forces. An employee who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single 12-month period.

9) Questions relating to FMLA and military service leaves should be addressed to the Fund Officer.

ARTICLE XX - GENETIC INFORMATION

This section of the Plan is intended to implement the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA"). Pursuant to GINA, the Plan:

- may not adjust premium or contribution amounts based on genetic information;
- shall not request or require an individual or a family member of such individual to undergo a genetic test;
- shall not request, require, or purchase genetic information for "underwriting purposes," as that term is defined by ERISA § 733(d)(9); or
- shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment in the Plan or coverage in connection with such enrollment.

Notwithstanding the foregoing, the Plan may use genetic information as otherwise allowed by GINA.

"Genetic information" means, with respect to any individual, information about:

- such individual's genetic tests;
- the genetic tests of family members of such individual; and
- the manifestation of a disease or disorder in family members of such individual.

ARTICLE XXI - STATEMENT OF RIGHTS UNDER ERISA

Each Participant of the Plan is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Participants under this Plan shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and the local union halls, all of the Plan's written documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports and plan descriptions.

- Upon written request to the Fund Office, obtain copies of all documents and other Plan information, including insurance contracts and collective bargaining agreements, copies of the latest annual report, and updated SPDs. The Fund Office may make a reasonable charge for such copies.

- Receive a summary of the Plan's annual financial report. The Fund Office is required by law to furnish each Participant a copy of the summary annual report.

In addition to creating rights for Participants under the Plan, ERISA imposes duties upon people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and Beneficiaries. No one, including a contributing employer, a local union, or any other person or entity, may fire a Participant or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

If his or her claim for a welfare benefit is denied in whole or in part, the Participant must receive a written explanation of the reason for the denial. The Participant has the right to have the Plan review and reconsider his or her claim.

Under ERISA, there are steps the Participant can take to enforce these rights. For instance, if the Participant requests materials from the Plan and does not receive them within thirty (30) days, he or she may file a lawsuit in a federal court. In such a case, the court may require the Plan to provide the Participant the materials and pay the Participant up to $110 a day until he or she receives those materials, unless the materials were not sent because of reasons beyond the Plan's control. If the Participant has a claim for benefits that is denied or ignored, in whole or in part, he or she may file a lawsuit in a state or federal court. If the Plan's fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her ERISA rights, he or she may seek assistance from the U.S. Department of Labor, or he or she may file a lawsuit in a federal court. The court will decide who should pay the court costs and legal fees. If the

Participant is successful, the court may order the defendant to pay for the court costs and fees. If the Participant loses, the court may order him or her to pay those costs and fees, for example, if it finds the claim is frivolous.

If the Participant has any questions about the Plan, he or she should contact the Fund Office. If the Participant has any questions about this statement or about his or her rights under ERISA, he or she should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, 1885 Dixie Highway, Suite 210, Ft. Wright, Kentucky 41001-2664, (606) 578-4680, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

ARTICLE XXII - ADDITIONAL INFORMATION REQUIRED BY ERISA

1) Name of Plan: Plumbers and Pipefitters Local Union No. 94 Health and Welfare Plan.

2) Plan Established and Maintained by:

Board of Trustees
Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan
BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8874
Fax: (330) 270-0912

3) Sponsoring Employers: Upon written request to the Fund Office, the Participant and/or Dependents/Beneficiaries may obtain a complete list of Employers sponsoring the Plan. Additionally, upon written request to the Fund Office, Participants and/or Dependents/Beneficiaries may receive from the Administrator information as to whether a particular Employer is a sponsor of the Plan and, if the Employer is a sponsor, its address.

4) Internal Revenue Service Employer Identification Number (EIN): 34-6594978

5) Plan Number: 501

6) Type of Plan: This Plan is a welfare plan under ERISA and is maintained for the purpose of providing death and dismemberment, weekly income, hospitalization, surgical, medical and other related benefits.

7) Type of Administration of the Plan: Although this Plan technically is administered and maintained by the Board of Trustees, the Board of Trustees has delegated certain administrative functions to the Fund Office.

8) Address all communications with the Board of Trustees to:

Board of Trustees
Plumbers & Pipefitters Local Union No. 94 Health & Welfare Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8874

9) Agent for Service of Legal Process: Service of legal process may be made upon the Board of Trustees through Fund counsel at the following address:

Thomas J. Griffith, Esq.

Macala & Piatt, LLC
601 South Main Street
North Canton, Ohio 44720

Additionally, service of legal process may be made upon Fund Counsel or the Fund Office.

10) Name, Title and Address of Principal Place of Business of each Trustee:

Brett McElfresh
3919 13th Street S.W.
Canton, Ohio 44710

Todd Peel
3919 13th Street S.W.
Canton, Ohio 44710

Dave Poole
3919 13th Street S.W.
Canton, Ohio 44710

Eric Seifert
11197 Cleveland Ave. NW
Uniontown, OH 44685

Ben Griffith
7257 Fulton Dr. NW
Canton, OH 44718

Todd McKeever
950 Keynote Circle #40
Cleveland, Ohio 44131

11) Collective Bargaining Agreement: This Plan is maintained pursuant to the applicable collective bargaining agreement between the Union and the various participating Employers. You may obtain a copy of the collective bargaining agreement by writing to the Fund Office or you may examine it at the Fund Office.

12) Sources of Contributions: This Plan is funded as follows:

a. Contributions by the Employers on behalf of their employees under the terms of the applicable collective bargaining agreement.

b. Contributions of the Employers on behalf of the full-time employees of the Union under the terms of a participation agreement.

c. Self-contributions by Participants.

d. Investment income.

13) The Plan is subject to periodic actuarial review to assure that the relationship between income and benefit costs meets the funding standards required by ERISA.

14) Funding Medium for the Accumulation of Plan Assets: Assets are accumulated and medical benefits are provided by the Plan. Some Plan assets are invested in accordance with the investment directives by the Board of Trustees.

15) Date of the Plan's Fiscal Year End: April 30th.

16) Network/Provider information: Accidental death and dismemberment benefits are self-insured and administered by the Plan, 3660 Stutz Drive, Suite 101, Canfield, OH 44406, Phone: 330-779-8874.

17) The vision and dental benefits provided to Participants in the active plan and to retired participants are self-insured and administered by the Plumbers and Pipefitters Local Union No. 94 Health and Welfare, 3660 Stutz Drive, Suite 101, Canfield, OH 44406 Phone: 330-779-8874.

18) The prescription drug benefits are self-insured and administered by the Plan. The preferred pharmacy network and mail order services are provided through the Plan's PBM, which is CVS/Caremark, 1 CVS Drive, Woonsocket, RI 02895, Phone: (401) 765-1500. Website: www.caremark.com.

19) Weekly accident and sickness benefits are self-insured by the Plan at 3660 Stutz Drive, Suite 101, Canfield, OH 44406, Phone: 330-779-8874.

20) All medical benefits for eligible Participants are self-insured and administered by the Plan. The hospital (facility), medical and surgical benefits are administered through a provider network operated by Medical Mutual of Ohio, 2060 East Ninth Street, Cleveland, Ohio 44115. Medical claims are administered by Medical Mutual Services, LLC, a wholly owned subsidiary of Medical Mutual of Ohio ("Medical Mutual"), P.O. Box 6018, Cleveland, Ohio 44101-1018. The Plan provides Participants with the option of seeking medical/surgical and other major medical care through providers that have contracted with Medical Mutual. As you know, a PPO is a network of doctors, diagnostic facilities and other health care providers who discount their charges in exchange for prompt payment of claims and more patient volume. Your Plan is not an HMO. There are no referrals nor is it necessary to select a primary care physician. Medical Mutual was added to our Plan in an effort to save hard earned contribution dollars and to reduce your out-of-pocket expenses. If you seek care from a provider that is participating in Medical Mutual's PPO on the date of service, the provider's charge will be discounted in accordance with the PPO allowance.

- Medical claims are to be submitted via electronic submission or paper claims by the provider of service or you may submit them directly to Medical Mutual of Ohio, P.O. Box 6018, Cleveland, Ohio 44101-1018.

- You may obtain a provider list (free of charge) upon your request to Medical Mutual. However, Medical Mutual's provider network is always growing. Therefore, new providers are regularly being added to the program. It is also possible that a provider is listed in the directory but since the print of that directory may not have renewed their contract with Medical Mutual. As such, providers are advised to call Medical Mutual at (800) 362-1279 before providing medical procedures. In addition, if a provider is not listed in your directory, you may obtain a more current list of medical care providers by accessing Medical Mutual's website at www.medmutual.com or by calling the Medical Mutual over-the-phone directory ordering system at (888) 241-2583.

ARTICLE XXIII - GENERAL DEFINITIONS

Accidental Bodily Injury and Sickness - An unanticipated or unintentional occurrence which results in bodily harm, injury, damage or loss. The terms “Accidental Bodily Injury,” “Sickness,” and “Illness,” with respect to an Eligible Participant or Dependent. do not include accidental bodily injury, sickness or illness which arises out of or in the course of employment, except that this provision shall not apply to death benefits and dismemberment benefits.

Affordable Care Act - The Patient Protection and Affordable Care Act of 2010, also known as the ACA, the PPACA, and Obamacare.

Amendments - The provisions of the Trust Agreement and this SPD may be amended from time to time by the Board of Trustees. Such amendments shall be effective when approved by a majority of the Board of Trustees, provided such amendments are in writing and consistent with the objectives and purposes of the Trust.

Benefit - The term “benefit” shall mean the payment or reimbursement of a medical expense incurred by a Participant or a Participant’s Dependents, the establishment and crediting of a Reserve Bank for Participants, and any death and dismemberment benefits payable under the Plan. However, the death benefit offered by the Plan is not a benefit to which a surviving spouse and/or an Eligible Dependent is entitled. The term “benefit” also includes reimbursements or payments by this Plan or any other plan, including federal or state government plans and employers’ plans.

Claims Payor - The term “Claims Payor” shall mean a third-party administrator that is responsible for the receipt, administration and payment of claims.

Coinsurance - A payment that represents the portion of the allowed charges that you are responsible to pay to any out-of-network providers after you have met your deductible or made your copayment. The covered services which require a coinsurance payment are specified in the Schedule of Benefits, subject to Article I, Sections B-E, which apply to you and your Dependents.

Collective Bargaining Agreement - The applicable collective bargaining agreement between the Union and the various participating Employers. You may obtain a copy of the collective bargaining agreement by contacting the Fund Office or the Union, or you may examine the applicable collective bargaining agreement at the offices of the Fund Office.

Contracting - The status of a hospital or other facility provider which has an agreement with the Claims Payor about payment for covered services or which is designated by the Claims Payor as a contracting [provider.

Copayment - A copayment is an out-of-pocket charge paid by you directly to the provider or physician at the time the services are rendered. The covered services which require a

copayment are specified in the Schedule of Benefits, subject to Article I, Sections B-E, which apply to you and your Dependents.

Covered Charges - The billed charges for covered services, except that the Claims Payor reserves the right to limit the amount of covered charges for non-emergency covered services provided by a non-contracting institutional provider, subject to Article I, Sections B-E.

Covered Service - A provider's service or supply for which the Claims Payor will provide benefits, as listed in the Schedule of Benefits and subject to Article I, Sections B-E.

Deductible - A deductible is an amount, usually stated in dollars, for which the covered person is responsible during each benefit period before the Plan will start to provide benefits.

Eligible Dependent - The term "Eligible Dependent" or "Dependent" shall mean the following members of the Eligible Participant's family:

1) The Participant's spouse, which shall refer to the lawful wife of a male Participant or the lawful husband of a female Participant. In addition to the foregoing, the term "spouse" includes any individuals who are lawfully married under any state law, including any individuals married to a person of the same gender who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. The term "marriage" as used in the preceding sentence includes a same-gender marriage that is legally recognized as a marriage under any state law, provided, however, the terms "spouse" and "marriage" do not include individuals in a formal relationship recognized by a state where that relationship is not designated a marriage under state law, such as a domestic partnership or a civil union, regardless of whether the spouses are same-gender or opposite-gender.

2) The Participant's child or stepchild in any of the following categories:

   - From date of birth until the end of the month the child reaches age 26.

   - A child over the age of 26 who is incapable of self-sustaining employment, regardless of age, due to mental or physical disability prior to attainment of the maximum age, provided the Participant furnishes proof of the child's incapacity within thirty-one (31) days of the child's attainment of such maximum age.

   - A legally adopted child or a child placed for adoption from the date of birth until the end of the month the child reaches age 26 (in the event the child is placed in the home within sixty (60) days) or from the date the child is placed in the home of the Eligible Participant by a state

agency or order of a court of competent jurisdiction if the child is not placed in the home within sixty (60) days.

- Any other child until the end of the month the child reaches age 26 and for whom the Eligible Participant or his or her spouse is the legal guardian.

3) Coverage for a stepchild shall not be effective unless and until the Plan has been given written notice by the Eligible Participant that the stepchild is not covered through another plan and until the Eligible Participant furnishes to the Plan certified copies of pertinent divorce orders and/or death certificates to aid the Plan in the determination of eligibility. If the natural parents of the eligible stepchild are divorced, the Plan shall be subrogated to the rights of the reimbursement pursuant to the court order and/or separation agreement through which the stepchild's natural parents were divorced. No coverage shall be effective for the stepchild by the Plan until a subrogation agreement acceptable to the Board of Trustees has been provided.

4) A child/stepchild shall not be entitled to coverage under the Plan for so long as the child/stepchild is eligible for coverage under a plan provided by the child's/stepchild's employer which is not also an employer of the child's/stepchild's parent.

Eligible Member or Eligible Participant or Participant - The term "Eligible Member" or "Eligible Participant" or "Participant" shall mean any person eligible for benefits as set forth in the eligibility rules adopted by the Board of Trustees.

Emergency Service - The term "emergency service" refers to a medical screening examination as required by federal law that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as are required under § 1867 of the Social Security Act, 42 U.S.C. § 1395dd, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished; and appropriate transfers undertaken prior to an emergency medical condition being stabilized.

Emergency services also include services for which benefits are provided under the Plan and that are furnished by a non-PPO network or non-contracting provider (regardless of the department of the hospital in which such items or services are furnished) after the covered person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services are furnished.

Employer or Participating Employer - The term "Employer" or "Participating Employer" shall mean an employer that is, or has been, obligated under the applicable collective

bargaining agreement or participation agreement to make payments to the Plan for health and welfare benefits.

Expense Incurred - The term “expense incurred” includes those charges made for services and supplies which a prudent person would consider to be reasonably priced and reasonably necessary for the injury or sickness being treated.

Fiscal Year - The Fiscal Year shall be May 1 to April 30.

Formulary - A list of FDA-approved generic and brand-name prescription drugs that are provided under the Plan’s prescription drug coverage. The formulary consists of the following:

- a ranking of covered drugs into preferred and non-preferred tiers;
- a listing of non-covered drugs; and
- associated utilization review programs pursuant to the PBM’s standard clinical criteria, which may include, but is not limited to, prior authorizations, step therapy and/or quantity limits for one or more covered drugs.

The above-referenced utilization review programs may be conducted prospectively or retrospectively.

Fund or Trust Fund - The term “Fund” or “Trust Fund” shall mean the Trust Fund established for this Plan under the terms of the Trust Agreement. The term “Trust Fund” also refers to the amounts contributed by the Employers; such additional sums as the Fund receives as dividends; rate refunds and/or recoveries on insurance policies held by the Fund, either paid to the Trust or left by the Trust with an insurance company; all investments of the Trust selected by the Board of Trustees and income thereon; and any other money or property received by the Fund in connection with the administration of the Trust Agreement.

Funding Medium for the Accumulation of Plan Assets - Assets are accumulated and medical benefits are provided by the Plan. Commercial insurance may be secured to provide any or all benefits under the Plan. Some Plan assets are invested in accordance with the investment directives established by the Board of Trustees.

Hospital - The word “hospital” shall mean any institution which meets one of the following requirements:

1) An approved and accredited hospital recognized by the American Hospital Association and is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics.

2) Any institution which meets all of the following requirements:

- It maintains permanent and full-time facilities for bed care of five (5) or more resident patients.
- It has a physician in regular attendance.
- It provides continuous 24-hour-per-day nursing service by registered nurses.
- It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics.
- It is operating lawfully in the jurisdiction where it is located.

Illness - The term "illness" shall mean a sickness, injury, pregnancy, or accidental bodily injury. For purposes of the Plan's weekly accident and sickness benefits coverage, illness is a disabling accident or sickness.

Immediate Family - A Participant's spouse, parent, child, brother, sister, mother-in-law or father-in-law, stepparents, stepchildren, foster parents and children, grandparents and any bona fide member of a Participant's household.

Incurred Date - The "incurred date" of a claim shall be the first date on which the Eligible Participant or Eligible Dependent is under the care of a physician and/or has expenses which would be payable by the Plan.

Injury - Any bodily harm or damage.

Inpatient - The term "inpatient" means a person who is a resident patient using and being charged for room and board by a hospital.

Medically Necessary (or Medical Necessity) - A covered service, supply or prescription drug that is required to diagnose or treat a condition and which the Claims Payor determines is:

- appropriate with regard to the standards of good medical practice and not experimental or investigational;
- not primarily for the covered person's convenience or the convenience of a provider; and
- the most appropriate supply or level of service which can be safely provided to the covered person.

When applied to the care of an inpatient, this means that the medical symptom or

condition requires that the services cannot be safely or adequately provided on an outpatient basis. When applied to prescription drugs, this means the drug is cost-effective compared to alternative prescription drugs which will produce comparable effective clinical results.

Negotiated Amount - The term “negotiated amount” refers to the amount the provider or pharmacy has agreed with the Claims Payor to accept as payment in full for covered services, subject to the limitations set forth below.

- The negotiated amount may include performance withholds or payments to providers for quality or wellness incentives that may be earned and paid at a later date. The covered person’s copayment, deductible and/or coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

- The negotiated amount for providers does not include adjustments or settlements due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. In addition, the negotiated amount for prescription drugs does not include pharmacy rebates, volume-based credits or refunds or discount guarantees. In certain circumstances, the Claims Payor may have an agreement or arrangement with a vendor that purchases the services, supplies or products from the provider instead of the Claims Payor contracting directly with the provider itself. In these circumstances, the negotiated amount will be based on the agreement or arrangement the Claims Payor has with the vendor and not on the vendor’s actual negotiated price with the provider, subject to the further conditions and limitations set forth herein.

Non-Contracting - The status of a provider that does not have a contract with the Claims Payor or one of its networks.

Other Professional Provider - The following persons or entities which are licensed as required:

- advanced nurse practitioner;
- ambulance services;
- certified dietician;
- certified nurse-midwife;
- certified nurse practitioner;
- clinical nurse specialist;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be approved by Medicare);
- licensed independent social workers;

- licensed practical nurse;
- licensed professional clinical counselor;
- licensed professional counselor;
- licensed vocational nurse;
- mechanotherapist (licensed or certified prior to November 3, 1975);
- occupational therapist;
- ophthalmologist;
- optometrist;
- osteopath;
- pharmacy or pharmacist;
- physical therapist;
- physician assistant;
- podiatrist;
- psychologist;
- registered nurse;
- registered nurse anesthetist; and
- urgent care provider.

Covered services provided by an other professional provider not listed above also will be considered for reimbursement if the provider is acting within the scope of his or her license or certification under state law.

Out-of-Pocket Maximum - A specified dollar amount of deductible, coinsurance and copayment expense, including any applicable prescription drug deductibles, coinsurance and copayments, incurred in a benefit period by a covered person for covered services.

Outpatient - The term "outpatient" means a person who receives services and treatments at an approved medical facility, but not as an inpatient.

Physician or Surgeon - The term "physician" or "surgeon" shall mean a person who is duly licensed to prescribe and administer all drugs and/or to perform surgery, and shall include osteopaths, chiropractors, optometrists, podiatrists, dentists, psychologists and physical therapists when operating within the scope of their licenses.

Plan - The term "Plan" shall mean the Plan established and maintained pursuant to this SPD or any predecessor documents which set forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which the Plan's fiduciaries may be identified.

PPO Network - A limited panel of providers as designated by the Claims Payor known as a preferred provider organization.

Sources of Contributions - This Plan is funded as follows:

1) Contributions by Employers on behalf of their employees, under the terms

of the applicable collective bargaining agreement.

2) Contributions by the Employer on behalf of the full-time employees of the Union under the terms of a participation agreement.

3) Self-contributions by Eligible Participants.

4) Investment income.

Step Therapy - The term “step therapy” refers to a program designed to help a covered person with certain health conditions that may require maintenance medications to save money by using the most cost effective treatments. It requires that a newly diagnosed individual first try a generic drug to treat his or her medical condition. Then, based on his or her doctor’s review, if necessary, he or she would move to a brand name drug. Please contact the Fund Office or the PBM for more specific information on the program.

Telehealth Services - The term “telehealth services” means health care services provided through the use of information and communication technology by a health care professional within the professional’s scope of practice, who is located at a site other than the site where either of the following is located:

- the patient receiving the services; or
- another health care professional with whom the provider of the services is consulting regarding the patient.

Traditional Amount or “TA” - The Traditional Amount means the maximum amount determined and allowed for a covered service based on factors, including the following:

- the actual amount billed by a provider for a given service;
- CMS’s Resource Based Value Scale (RBRVS);
- other fee schedules;
- input from participating physicians and wholesale prices (where applicable); and
- other economic and statistical indicators and applicable conversation factors.

Transplant Center - The term “transplant center” refers to a facility approved by the Claims Payor that is an integral part of a hospital and that:

- has consistent, fair and practical criteria for selecting patients for transplants;
- has a written agreement with an organization that is legally authorized to obtain donor organs; and
- complies with all federal and state laws and regulations that apply to transplants covered by this Plan.

Trust Agreement - The term “Trust Agreement” shall mean the Agreement and

Declaration of Trust as originally entered into between the Local Union No. 94 of the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Refrigeration Industry of the United States and Canada and the Stark Association of Plumbing, Heating and Cooling Contractors, and as from time to time amended.

Trustees - The term “Trustees” shall mean the individuals who from time to time function as Trustees of the Board of Trustees and as appointed in accordance with the terms of the Trust Agreement.

Union - The term “Union” shall mean the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Refrigeration Industry of the United States and Canada, Local Union No. 94. The Union shall also be deemed an “Employer” under this Plan for purposes of extending coverage hereunder to its employees.

United States - All the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

Urgent Care - Any condition that is not an emergency medical condition that requires immediate attention.

Urgent Care Provider - An “other professional provider” that performs services for health problems that require immediate medical attention that are not emergency medical conditions.

THE BOARD OF TRUSTEES OF THE PLUMBERS & PIPEFITTERS LOCAL UNION NO. 94 HEALTH & WELFARE FUND HAS ADOPTED AND APPROVED THIS COMBINED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ON THIS 19TH DAY OF NOVEMBER, 2025, TO BE EFFECTIVE JANUARY 1, 2026.

EMPLOYER TRUSTEES	UNION TRUSTEES
_____	_____
_____	_____
_____	_____

ADDENDUM

Plumbers and Pipefitters Local Union No. 94 Health & Welfare Fund

3660 Stutz Drive, Ste. 101
Canfield, Ohio 44406
Phone (800) 435-2388
Fax (248) 731-5603

THIS FORM IS NOT TO BE USED FOR YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIMS

DENTAL / VISION REIMBURSEMENT CLAIM FORM

Dental/Vision Benefit Reimbursement Account **E-mail: local94DV@benesys.com**

Instructions: Please complete **ONE FORM per claim/per individual**, along with the following information:

Reimbursement for:

☐ **Dental/Vision Services**

Requirements:

Attach copy of the itemized billing. This billing must include the date of service, procedure code for services performed as well as the patient's name. This is your Dental/Vision Plan that reimburse eligible expenses up to a maximum payment of $2,000 per Family/Per Calendar year.

☐ Dental/Vision balance - Please pay any remaining balance using my MRA funds.

IMPORTANT NOTICE: A submission of a claim that has already been reimbursed under the Dental/Vision Plan may result in the suspension of your Benny Card.

Member's Name: _____ Member's SS# or Alternate ID: _____

Address: _____

Phone Number: (Home) _____ (Work)_____

Patient Name: _____ Relationship: _____

Type of Service	Provider Name	Date of Service	Amount of Claim
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Plumbers and Pipefitters Local Union No. 94 Health & Welfare Fund Account requirements and limitations established by the Board of Trustees.
Note: Unreimbursed Dental and Vision expenses are subject to limitations specified in your Summary Plan Description.
(See the reverse side of this form for a brief description of covered benefits)

Member's Signature: _____ Date: _____

*****Not valid unless signed and dated by employee*****

Revised 12/2024 tw

The Dental/Vision Reimbursement is available to actives, early retirees and retired members and their dependents.

What do I have to do to request reimbursement for my Benefit?

You must send a completed Reimbursement Benefit Claim Form along with the following information attached: (Please Note: BALANCE DUE STATEMENTS ARE **NOT** ACCEPTABLE).

Reimbursement for:	**Information Required**
Dental/Vision Claims	Attach a copy of the itemized billing. This billing must include the date of service, procedure code for services performed as well as the patient's name. This is your Dental/Vision Plan that reimburse eligible expenses up to a maximum payment of $2,000 per Family/Per Calendar year. **Orthodontic services will be paid once services are rendered.**

Where do I obtain Reimbursement Claim Forms?

You may print the **Dental/Vision claims** Reimbursement Form from the **Participant Website: www.UaLocal94Benefits.org**

Click on Documents, select Health Care – Health Care Documents, select **Dental / Vision** Reimbursement Form. You may also contact the Fund office at (800) 435-2388 to have a claim form mailed to you.

Where do I send my Reimbursement claim requests?

You have (3) options to submit your claim(s).

By MAIL:	**By FAX:**	**By EMAIL:**
Plumbers and Pipefitters Local No. 94 Health and Welfare Fund 3660 Stutz Drive, Ste 101 Canfield, Ohio 44406	Fax: 1 (248) 731-5603	e-mail: **local94DV@benesys.com**

Is there a time limit to file for Reimbursement Benefits?

YES: **Dental/Vision claims** must be filed within one year from the date of service.

What information should I keep?

Please keep a copy of all items submitted in case of a Fund Audit or IRS documentation requirement.

Plumbers and Pipefitters Local Union #94

Health and Welfare Fund

P.O. Box 1129 Troy, MI 48099-1129 Toll Free: (800) 435-2388
Email: flexclaims@benesys.com Fax: (248) 731-5603

AUTHORIZATION FOR DISBURSEMENT FROM MRA ACCOUNT

Instructions: To receive reimbursement from the Medical Reimbursement Account (MRA), you must complete ONE FORM per patient, along with the following information:

Reimbursement for:	**Information Required – please attach:**
Medical Co-Payments	**Copy of your EOB** (Explanation of Benefits Form) *Balance due statements are not acceptable.*

PLEASE NOTE: You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the member.

Member's Name:_____ **Member SSN:** xxx-xx-_____

Address:_____

_____

Telephone:_____

Patient Name:_____ **Relationship:**_____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming on Federal Income Tax Deduction.

Type of Service Medical	**Providers Name**	**Date of Service**	**Amount of Claim**

****Please make a copy for yourself of all charges submitted in the event of loss****

By signing this form, I understand that benefits shall be paid in accordance with the Medical Reimbursement Account Plan eligibility requirements and limitations established by the Board of Trustees.

Member's *Signature:*_____ Date:_____

Not Valid Unless signed and dated by Employee

MAIL TO: Plumbers & Pipefitters Local #94
P.O. Box1129 Troy, MI 48099-1129
FAX: 1-248-731-5603 or EMAIL: flexclaims@benesys.com

What do I have to do to request reimbursement for my Benefit?

You must send a completed Reimbursement Benefit Claim Form along with the following information attached:

Reimbursement for:	**Information Required**
Medical Reimbursement	A copy of the Explanation of Benefits form (EOB) from your medical carrier which shows the member responsibility and matches the amount being requested below. Receipts showing payment was made for expenses not covered by the Health and Welfare Plan. Unreimbursed medical, dental, vision and prescription expenses are subject to limitations specified in your Summary Plan Description. ***(Please note: Balance due statements are not acceptable.)***
Self-Payment	A copy of the self-payment notice must be attached.

Where do I obtain Reimbursement Claim Forms?

You may print the Medical Reimbursement Claim Form from the **Participant Website at www.UaLocal94Benefits.org**

Click on Documents, select Health Care – Health Care Documents, select Medical Reimbursement Form.

You may also contact the Fund office at (800) 435-2388 to have a claim form mailed to you.

Where do I send my Reimbursement claim requests?

You have (3) options to submit your claim(s).

By MAIL:	**By FAX:**	**By EMAIL:**
Plumbers & Pipefitters Local #94 Health and Welfare Fund PO Box 1129 Troy, MI 48099-1129	Fax: (248) 731-5603	E-mail: flexclaims@benesys.com

Is there a time limit to file for Reimbursement Benefits?

Yes, Reimbursement Benefit claims must be filed within one year from the end of the calendar year in which the services were rendered for the Medical Reimbursement Account.

What information should I keep?

Please keep a copy of all items submitted in case of a Fund Audit or IRS documentation requirement.