SECOND AMENDMENT TO THE PLUMBERS LOCAL 98 INSURANCE FUND PLAN DOCUMENT DATED JUNE 21, 2019

WHEREAS, the Trustees of the Plumbers Local 98 Insurance desire to amend the Plan Document dated October 16, 2023 (Plan); and

WHEREAS, the Plan and Trust authorize the Trustees to amend the Plan from time to time;

NOW THEREFORE, the Plan is amended as follows effective 4/10, 2024:

1. Article 3, Health Reimbursement Account, Section 3.3(h), Account Balances Upon Termination of Eligibility, is amended as follows:

(h) Account Balances Upon Termination of Eligibility

Upon termination of eligibility, a participant's HRA will be suspended, to be reinstated if the participant reestablishes eligibility within 12 months of such termination. If Contributions are not received on behalf of the Participant within 12 months, the balance in the HRA will remit to the Fund.

Notwithstanding, the balance in the HRA will be remitted to the Fund, and not be reinstated if eligibility is subsequently restored, the earlier of the date:

(i) eligibility is terminated under Section 2.3; or

(ii) the Participant works for a noncontributing employer in the plumbing and pipefitting industry; or

(iii) the Participant works for a noncontributing employer performing work of the type for which Contributions would be required to be paid to the Fund if performed for a contributing Employer under the Collective Bargaining Agreement.

~~Notwithstanding, if eligibility terminated under Section 2.3, the balance in the HRA will be remitted to the Fund and will not be reinstated if the Participant reestablishes eligibility.~~

This Amendment was adopted on 4/10, 2024.

UNION TRUSTEES

EMPLOYER TRUSTEES

Christopher J. Freeman

W2715185

FIRST AMENDMENT TO THE PLUMBERS LOCAL 98 INSURANCE FUND PLAN DOCUMENT DATED OCTOBER 16, 2023

WHEREAS, the Trustees of the Plumbers Local 98 Insurance desire to amend the Plan Document dated October 16, 2023 (Plan); and

WHEREAS, the Plan and Trust authorize the Trustees to amend the Plan from time to time;

NOW THEREFORE, the Plan is amended as follows effective January 1, 2024, unless otherwise indicated:

1. Article 3, Health Reimbursement Account, Section 3.3(e), Annual Benefit Amount, is amended as follows:

Participant Classification	Annual HRA Benefit
Active Employee on Medical/Rx Plan	No benefit, unless Unrestricted Journeyman, Light Rate Journeyman, or Apprentice who receives amount specified in Collective Bargaining Agreement.
Active Employee on Opt-Out Plan	Effective 6/1/19, $3.00 per hour of Contributions received, plus amount received as designated in Collective Bargaining Agreement for Unrestricted Journeyman, Light Rate Journeyman, or Apprentice.
Non-Medicare Pensioner on Medical/Rx Plan	No benefit
Non-Medicare Pensioner on Opt-Out Plan or Medicare Pensioner on Opt-Out Plan who opted out of coverage under Article 21	$600.00
Non-Medicare Surviving Spouse on Medical/Rx Plan	No benefit
Non-Medicare Surviving Spouse on Opt-Out Plan or Medicare Surviving Spouse on Opt-Out Plan who opted out of coverage under Article 21.	$600.00
Medicare eligible Participant, Spouse or Surviving Spouse	On an annual basis, the Trustees may, at their discretion, provide an additional credit to the HRA. For 2024, a credit of $300 per Medicare eligible Participant, Spouse, or Surviving Spouse will be given.

2. **Article 4, Section 4.1, Enrollment, is amended as follows:**

In addition to the benefits set forth in Article 3, above, non-Medicare eligible Participants may choose between the following coverage Options: Medical/Rx coverage, or Opt-Out coverage. ~~A or B~~. A Participant is automatically enrolled in Medical/Rx coverage for the Calendar Year unless at the time of initial enrollment or during the open enrollment months of November and

December (during which changes may be made for the next Calendar Year), he executes an Opt-Out Enrollment Form. This Enrollment Form is available at the Fund Office. A Participant can only decline Medical/Rx coverage if:

(1) The Participant is actually enrolled in a group health plan that does not consist solely of excepted benefits (e.g. can be a spouse's plan) (Other Coverage); and

(2) The Other Coverage meets the Affordable Care Act minimum value standard.

Medicare is not "Other Coverage" for purposes of this provision.

There are 3 plans available under Medical/Rx coverage – Full, Standard, and Basic. If a Participant does not elect one of the coverage plans for which he/she is eligible, coverage will be provided under the Standard Plan.

Notwithstanding, Apprentice Applicants, Apprentices 1 and 2, Metal Trades Helpers, and Irrigation Workers only have coverage under the Basic Plan.

Except as provided below, a Participant may not switch between Options during a Calendar Year. The Participant's Dependents are enrolled in the same Option as the Participant.

See Article 5 for Medical/Rx Coverage and Article~~s~~ 6 ~~and 7~~ for Opt-Out Coverage.

3. Article 4, Section 4.2(a) is amended as follows effective August 4, 2023:

A Participant may switch coverage Options during a Calendar Year only as follows:

(a) A Participant's acquisition of a new Dependent as a result of marriage, birth, adoption, or placement for adoption, if a request to change an election is made within ~~30~~ 60 days of such event. An election change for marriage shall be effective the first day of the first month following the requested change. An election change for birth, adoption, or placement for adoption shall be effective the date of birth, adoption, or placement for adoption. Notwithstanding, effective August 4, 2023, if a Child is not enrolled within this 60-day period, coverage shall be effective the date such person became a Child as defined in Article 1 upon receipt of completed enrollment materials (this exception does not apply to an individual who is a Child due to status as a stepchild or legal guardianship).

4. Article 6 is amended as follows:

ARTICLE 6 – SCHEDULE OF BENEFITS – OPT-OUT ~~A~~ COVERAGE

Opt-Out coverage is available to: (1) Active Participants, non-Medicare eligible Pensioners, and non-Medicare eligible Surviving Spouses who opt-out of Medical/Rx coverage under Article 5, and (2) Medicare eligible Participants and Medicare eligible Surviving Spouses who have opted out of coverage under Section 21.2.

Opt-Out ~~A~~ coverage provides the following:

* * *

6.3 Health Reimbursement Account (HRA)

Pensioners and Surviving Spouses who have elected Opt-Out ~~A~~ coverage receive a $600.00 annual credit to their Health Reimbursement Account. Active Participants who have elected Opt-Out coverage ~~A~~ receive an additional $3.00 per hour of Contributions received. On an annual basis, the trustees may, in their discretion, provide an additional credit to the HRA. For 2024, a credit of $300 per Medicare eligible Participant, Spouse, or Surviving Spouse with be given. Use of the HRA is governed by Section 3.3. Annually, a Participant is permitted to permanently opt-out of and waive HRA benefits provided under this Opt-Out coverage.

6.4 Other Coverage

Opt-Out Participants are eligible for benefits set forth in Article 3 subject to the terms and conditions set forth therein.

6.5 Aflac BenExtend Insurance

Aflac BenExtend Insurance, a fully insured policy (Aflac Policy), pays set dollar amounts when a Participant, Spouse, or Covered Dependent are in the hospital, are injured, or have a critical illness. Benefits are subject to the Aflac policy's terms and conditions.

(a) Hospital Indemnity Benefits

Hospital Confinement (Per day) within 6 months of accident	**Benefit Amount**
Days 1-4	$200
Days 5-10	$150
Days 11-31*	$50

*Confinement after 31 days is not covered.

(b) Accident Benefits

	Benefit Amount
Initial Treatment - once per accident, within 7 days of accident	$100
Ambulance – once per day. Within 90 days of the accident	$200

Major Diagnostic Testing – within 6 months of the accident -1 test per covered accident or sickness.	$200
Lacerations – within 7 days of the accident. 1x per accident.	$75

Fracture Benefit Schedule	**Benefit Amount**
Hip/Thigh	$1,500
Vertebrae/Sternum	$1,350
Pelvis	$1,200
Skull (Depressed)	$1,125
Leg	$900
Forearm/Hand/Wrist	$750
Foot/Ankle/Kneecap	$750
Shoulder Blade/Collar Bone	$600
Lower Jaw	$600
Skull (Simple)	$525
Upper Arm/Upper Jaw	$525
Facial Bones (except teeth)	$450
Verebral Processes/Sacrum	$300
Coccyx/Rib/Toe	$120

Appliances -within 6 months of accident.	**Benefit Amount**
Cane	$10
Ankle Brace	$10
Walking Boot	$25
Walker	$25
Crutches	$25
Leg Brace	$25
Cervical Collar	$25
Wheelchair	$100
Knee Scooter	$100
Body Jacket	$100

Back Brace	$100

(c) Critical Illness Benefits

Covered Critical Illness	Benefit Amount - Percent of $2000
Cancer	100%
Heart Attack	100%
Major Organ Transplant*	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer	25%
Coronary Artery Bypass Surgery	25%
Skin Cancer, 1 time per calendar year	$250

***25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant.**

5. **Article 7, Schedule of Benefits – Opt-Out B Coverage, is deleted in its entirety.**

6. **Article 21 Medicare Eligible Participants and Dependents, Section 21.2, Opt-Out, is amended as follows:**

A Medicare eligible Participant may opt-out of coverage under the Fund and receive the Opt-Out benefits set forth in Article 6. Medicare eligible Participants who Opt-Out may ~~and~~ re-enroll at a later date under the following conditions:

* * *

This Amendment was adopted on 1/5, 2024.

UNION TRUSTEES

EMPLOYER TRUSTEES

W2689901

PLUMBERS LOCAL 98 INSURANCE FUND PLAN

2023

PREFACE

The Board of Trustees (Trustees) of the Plumbers Local 98 Insurance Fund (Fund) set forth the benefits provided by Fund by this document, the Plumbers Local 98 Insurance Fund Plan (Plan). It is intended that this Plan shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that Act applies to employee welfare benefit plans. If any portion of this Plan does now, or in the future, conflict with ERISA or applicable federal regulations, ERISA and/or such regulations will govern.

Although the Trustees expect to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, or eliminate an entire category of benefits, at any time and/or for any reason. There are no vested benefits under this Plan.

The Fund is subject to all terms, provisions and limitations stated on the following pages of the Plan.

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ARTICLE 1 – DEFINITIONS

As used in this document, the following words are defined as follows:

Active Employee means a Journeyman, Apprentice, Irrigation Plumber, Working Principal, Union Employee, Apprenticeship Fund Employee, or other person on whose account an Employer has made Contributions to the Fund.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Ancillary Services means emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a participating or nonparticipating provider; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests per federal guidance or rulemaking).

Apprentice means a person learning the trade and designated as an Apprentice under the Collective Bargaining Agreement.

Apprenticeship Fund Employee means an instructor or other employee of the Metropolitan Detroit Plumbing Industry Training Trust Fund ("Apprenticeship Fund") on whose behalf the Apprenticeship Fund makes Contributions to the Fund.

Association means the Mechanical Contractors Association of Detroit (formerly Metropolitan Detroit Plumbing and Mechanical Contractors Association, Inc., or the Plumbing, Heating & Cooling Contractors Association of Southeastern Michigan, Inc.).

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

Children or **Child** means:

(a) Any person up until the first of the month following the month in which he/she turns age 26 and either:

(1) is a Participant's natural child or adopted child; or

(2) has been placed with a Participant for adoption; or

(3) is a Participant's step-child, which means he/she is the child of his/her Spouse; or

(4) is the legal ward of the Participant and/or his Spouse, who is dependent upon the Participant for support, is claimed by the Participant on his federal tax return, has no health coverage under any other health plan, if between the ages of 19 and 25 meets the requirements of Section 2.5(a), and no person other than the Participant or his/her spouse is legally responsible to provide medical care for such child (however, this latter requirement may be waived upon submission of evidence satisfactory to the Trustees that appropriate steps have been taken on the child's behalf to attempt to make the person legally responsible for his medical coverage provide same); or

(b) A person who would qualify as a "child" under paragraph (a) but for the age limitations, who by reason of mental or physical handicap is incapable of sustaining employment and the Participant has submitted proof of such to the Fund Office prior to December 31 of the year in which he/she attains 26 years of age and as further requested by the Trustees; or

(c) An alternate recipient under a Qualified Medical Child Support Order of a Participant.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Collective Bargaining Agreement means any contract entered into between the Union and the Association or any Employer under which the Employer has agreed to contribute to the Fund.

Consent to Out of Network Services means:

(a) a covered person provided informed consent under applicable law to receive either:

(1) post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or

(2) nonemergency services from an out-of-network provider at an in-network facility; and

(b) the Plan receives notice of such consent.

Notwithstanding, Consent to Out of Network Services does not include Ancillary Services or items or services provided as a result of unforeseen, urgent medical needs that arise at the time an items or service is furnished.

Continuing Care Patient means a Covered Person who, with respect to a provider or facility—

(a) is undergoing a course of treatment for a serious and complex condition;
(b) is undergoing a course of institutional or inpatient care;
(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery;
(d) is pregnant and undergoing a course of treatment for the pregnancy; or
(e) is or was determined to be terminally ill (i.e., a medical prognosis that the individual's life expectancy is 6 months or less).

Contributions mean payments to the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act.

Covered Person means the Participant or Dependent who is eligible for a particular benefit.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help with walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dependent(s) means a Participant's Spouse and Children.

Disability means a physical or mental condition, which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit as a plumber, any work related to the plumbing trade, and/or work performed by the person for which contributions were received by the Plan prior to his/her disability; provided, however, that no person shall be deemed to have a Disability if such incapacity was contracted, suffered or incurred while he was engaged in an illegal activity or from service in the Armed Forces of any country.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Effective Date means the first day of coverage.

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 that the absence of immediate medical attention would result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition means:

(a) a 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 such emergency medical condition, and

(b) medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department as required to Stabilize the patient (regardless of the department of the hospital in which such items or services are furnished), and

(c) unless Consent to Out of Network Services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after the Covered Person is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Employer means:

(a) a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;

(b) any other employer engaged in work coming within the jurisdiction of the Union who is obliged, by a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;

(c) the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund;

(d) the Fund, to the extent and solely to the extent that it acts in the capacity of an employer of administrative employees on whose behalf Contributions are made to the Fund;

(e) the Building Trades Council to the extent they contribute to this Fund on behalf of their Employees; and

(f) the Metropolitan Detroit Plumbing Industry Training Trust Fund, to the extent and solely to the extent that it acts in the capacity of an employer of employees on whose behalf Contributions are made to the Fund.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or **Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government

oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental or nonexperimental standings of specific technologies. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

(b) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(c) If evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(d) If evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Care Agency means an organization whose main function is to provide Home Health Care Services and Supplies; is federally certified as a Home Health Care Agency and is licensed by the state in which it is located, if licensing is required.

Home Health Care Services and Supplies means part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.), part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services), physical, occupational and speech therapy, medical supplies, and laboratory services by or on behalf of the Hospital.

Hospice Agency means an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan means a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies means services and supplies provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit means a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" also includes the following:

(a) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

(b) A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder, including Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

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

Insurance Fund/Fund means the Plumbers Local No. 98 Insurance Fund.

Intensive Care Unit means a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving

equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Irrigation Plumber means a person covered by a Collective Bargaining Agreement between the Union and Employers engaged in irrigation for whom an Employer is obligated to contribute to the Fund.

Journeyman/Journeymen means persons who have attained journeyman status pursuant to the terms of a Collective Bargaining Agreement.

Lifetime means the cumulative time during which a person is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary (or Medical Necessity) – health care services, supplies or treatment that are required to identify or treat the Illness or Injury which a Physician has diagnosed. To be Medically Necessary the service, supplies or treatment must be:

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

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

Medicare means The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Nervous Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Occupational means with respect to Injury or Disease, an Injury or Disease for which the person is not entitled to benefits under any worker's compensation law or similar legislation or does not arise out of or in the course of any employment or occupation for compensation or profit.

Occupational means, with respect to Injury or Disease, an Injury or Disease for which the person is entitled to benefits under any workers' compensation law or similar legislation, or which arises out of and in the course of any employment or occupation for compensation or profit.

Out-of-Network Rate means: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; (3) if neither (1) or (2) apply, the amount agreed upon; (4) if there is no agreement, then the amount determined by IDR

Outpatient Care means treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participant means an Active Employee, Pensioner, or Surviving Spouse entitled to coverage under the Fund.

Pensioner means either:

(a) A person, other than a Working Principal, who has been granted an early, normal, or disability pension by Plumbers Local 98 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, is a member in good standing with the Union, and

(1) Was eligible for benefits under the Fund at least one month in each of the ten consecutive years immediately preceding the date upon which he/she received his/her first pension check (the purpose of this Rule is to establish that the Pensioner was available for work as a plumber through the Union for a contributing contractor during this time period); or

(2) Does not meet the requirements of Paragraph (1) above, but establishes to the satisfaction of the Trustees that he was actually available for work as a plumber through the Union for contributing contractors during such period of time (i.e. he was continually available for work for contributing employers and did not work for non-contributing employers in the plumbing and pipefitting industry); or

(3) Does not meet the requirements of Paragraph (1) above, but retired on or after April 1, 2000, and establishes to the satisfaction of the Trustees that:

A. it was not possible for him to meet these requirements due to a Disability that occurred while he was actively working as a plumber for a contributing Employer or was available for work as a plumber through the Union;

B. during the time he was Disabled, he had continuous coverage under either the Fund or another comprehensive insurance plan; and

C. either (i) retired after incurring such Disability, or (ii) recovered from the Disability (which means that he/she was capable of working as a plumber), upon such recovery returned to work under the Collective Bargaining Agreement, and was eligible for benefits in at least one month in the year he/she so returned to work and each successive year until the year in which he/she received his/her first pension check; or

(4) Does not meet the requirements of Paragraph (1) above, but

A. Has been employed as a Plumbing Inspector (Mechanical Inspector), or by the Detroit Board of Education, The City of Detroit, Wayne County, Wayne State University, or by any other governmental employer as a plumber,

B. Upon termination of employment with such employer does not have employer paid health and hospitalization insurance coverage;

C. Is over age 55 or credited with 25 or more years of credited service under the 98 Defined Benefit Pension Plan; and

D. Submits a written request to the Trustees seeking coverage under the Fund as a Pensioner and upon such request the Trustees determine that his failure to satisfy the requirements of Paragraph (1), above, was caused by his taking employment specified in Paragraph (4)(A), above; or

(b) A Working Principal, who has been granted an early, normal, or disability pension by Plumbers Local 98 Defined Benefit Pension Plan or its predecessor, Plumbers Local No. 98 and Pipefitters Local No. 636 Pension Fund, is a member in good standing with the Union, and has had continuous coverage under the Fund for the 10-year period immediately preceding the date upon which he/she received his/her first pension check; or

(c) A Metal Trades Division Plumber, who is a member in good standing with the Union and has had continuous coverage under the Fund for the 10-year period immediately preceding his/her retirement.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nurse Practitioner, or Physician Assistant.

Plan means this document, i.e., the Plumbers Local 98 Insurance Fund Benefit Plan.

Plan Administrator means the Trustees of the Fund.

Plan Office or Fund Office means BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800.

Plan Year means the fiscal year September 1 of one year through August 31st of the following year.

Pregnancy means childbirth and conditions associated with Pregnancy, including complications.

Qualifying Payment Amount (QPA) for an item or service means, the median in- network rate for (a) the same or similar services; (b) furnished in the same or a similar facility; (c) by a provider of the same or similar specialty; and (d) in the same or similar geographic area, adjusted as required by applicable regulations for inflation and base billing units, if applicable.

Recognized Amount with respect to an item or service furnished by a nonparticipating provider is: for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; or (3) if neither of the above apply, the lesser of (a) the amount billed by the provider or facility or (b) the Qualifying Payment Amount (QPA).

Serious and Complex Condition means:

(a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Sickness means a person's Illness, disease, or pregnancy (including complications).

Skilled Nursing Facility means a facility that fully meets all of these tests:

(a) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse.

Services to help restore patients to self-care in essential daily living activities must be provided.

(b) Its services are provided for compensation and under the full-time supervision of a Physician.

(c) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(d) It maintains a complete medical record on each patient.

(e) It has an effective utilization review plan.

(f) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, Custodial or educational care, or care of Mental Disorders.

(g) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility meeting the above tests which refers to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. It does not include aromatherapy, art therapy, photo therapy, hypnosis, herbal therapies, spiritual therapies, nutritional therapy, yoga, bee sting venom therapy, aura therapy, or touch therapy.

Spouse means the Participant's legal spouse who has met all requirements of a valid marriage contract in the state of marriage.

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Abuse means a condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surviving Spouse means that person who was married to the Participant on the date of the Participant's death.

Trustees mean the Trustees of the Plumbers Local 98 Insurance Fund.

Turned Out means the time an Apprentice becomes a Journeyman. Such time is also referred to as the "Turn Out Date."

Union means Plumbers Local No. 98 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

Union Employee means a business representative or other employee of the Union on whose behalf the Union makes Contributions to the Fund.

Usual, Reasonable, and Customary Charge (UCR) means a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. The Plan will reimburse the actual charge billed if it is less than the Usual, Reasonable, and Customary Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual, Reasonable, and Customary.

Working Principal means those persons covered by Article 5 of the Collective Bargaining Agreement who are proprietors, partners, or corporate officers of an Employer and who work with the tools of the trade.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Eligibility Requirements for Active Employee (Excluding Working Principals)

(a) Dollar Bank System

(1) The Fund shall maintain a bookkeeping account for each Active Employee. The account shall be credited with Contributions received on behalf of each Active Employee, and the cumulative amount credited to the account shall be referred to as the Active Employee's "Bank." The Bank shall be credited to a maximum of $6,200.

(2) The cost of coverage for all benefits provided for which an Active Employee is eligible under the Plan shall be deducted monthly from each Active Employee's Bank. The cost of coverage shall be determined from time to time in the sole and exclusive discretion of the Trustees.

The cost of coverage shall vary based upon the plan of medical benefits covering the Active Employee, as set forth in Articles 4 and 5, or Opt-Out benefits set forth in Articles 6 and 7.

Notwithstanding anything in this Article 2 to the contrary, if an Active Employee serves on jury duty, the cost of coverage shall be prorated based upon the total number of days served on jury duty during a month. For example, if a participant serves six days on jury duty during the month of June, the cost of coverage will be reduced 20% for that month (i.e., six days of jury duty divided by 30 total days in the month of June).

(3) An Active Employee has no right or title to any amounts credited to his/her Bank. All amounts in the Bank are at all times Plan assets. The Bank shall be used exclusively for determining eligibility for benefits. The Trustees may at any time and for any reason terminate the Bank and any

credit in any Active Employee's Bank at such time will remain a Plan asset.

(b) Initial Eligibility

A person will become eligible for benefits the first day of the second month following the month in which his Bank is equal to three times the monthly benefit cost of Basic Coverage for a single participant, provided such amount was accumulated in a consecutive 12-month period.

For example, if as of January an Active Employee's Bank is equal to or greater than three times the monthly benefit cost of Basic Coverage for a single participant, then he/she will be provided enrollment information and be eligible for coverage as of March.

Special Initial Eligibility Rule for Apprentices: In lieu of the above:

(1) Individuals who are indentured into the Apprentice Fund training program and have begun the Early Start Program (Bootcamp) shall be eligible for coverage on the first day of the month following the month s/he commences Bootcamp, and such coverage shall continue until the end of the third month following the month Bootcamp began. During this period of time, no deductions will be made from Dollar Banks accumulated by any individual who worked as an apprentice applicant.

Once coverage ends under this Special Eligibility Rule, an Apprentice is subject to all eligibility rules set forth in Section 2.1.

Notwithstanding the foregoing, if prior to successful completion an individual's participation in Bootcamp is terminated, voluntarily or involuntarily, all coverage will be terminated under this Plan. COBRA will be offered provided the termination from Bootcamp is not for gross misconduct.

(2) All other Apprentices shall become eligible for coverage on the first day of the month following the month in which he/she becomes an Apprentice under a Collective Bargaining Agreement.

Special Initial Eligibility Rule for Newly Organized Active Employees: In lieu of the above, upon approval of the Trustees, an individual who is newly organized shall become eligible for coverage on the first day of the month following the earlier of:

i. The date the individual is organized and becomes employed by an Employer for at least 160 hours per month, or

ii. The date a collective bargaining agreement requiring contributions to the Fund on behalf of the individual is executed with the Union.

Coverage will continue under this Special Eligibility Rule until the first day of the month that such individual's Dollar Bank is equal to three times the monthly benefit cost of Basic Coverage for a single participant, but in no event beyond the end of the third full month following the first day of eligibility. Once coverage ends under this Special Eligibility Rule, such individual is subject to all eligibility rules set forth in Section 2.1.

An individual who is organized individually (i.e. not through his/her employer) may not elect Full Coverage for the first six months of his/her eligibility.

(c) Continuing Eligibility

Eligibility will continue so long as an Active Employee's Bank is sufficient to pay the cost of coverage. For such purposes, Contributions will be credited as follows:

Contributions Received for Work Month of:*	Will be Credited to the Bank for Eligibility Month of:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

*Contributions are required to be paid the month following the work upon which they are based. Thus, for example, Contributions for the work month of January should be received in February to provide eligibility for March.

(d) Self-Payments

In the event an Active Employee's Bank is not sufficient to cover the applicable cost of coverage for a particular month, coverage may be maintained by way of self- payment, as follows:

(1) The self-pay amount shall be determined from time to time in the sole and

exclusive discretion of the Trustees.

(2) Full Self-Payments: For any month in which the difference between the applicable monthly benefit cost and an Active Employee's Bank is greater than the self- pay amount:

A. An Active Employee with no contributions received for a work month may maintain coverage by paying the full self-pay amount.

B. Any Contributions received for a work month in which the Employee made such a self-payment will be placed in his/her Bank.

C. An Active Employee can maintain coverage under this provision for six consecutive months and thereafter will be offered COBRA coverage.

(3) Partial Self-Payments: For any month in which the difference between the applicable monthly benefit cost and an Active Employee's Bank is less than the self-pay amount, the Active Employee may pay this difference to maintain coverage.

(4) Any payments made to maintain coverage under (2) or (3), above, must be received by the Fund Office within 15 days after receipt of notice that eligibility in the Fund will terminate unless self-payment or COBRA coverage is elected. Thereafter, to continue eligibility by self-payment, self-payments must be made continuously, month after month, as necessary to maintain coverage. If a self-payment is missed, an Active Employee will not be permitted to resume eligibility by making self-payments. Once the ability to make self-payments is exhausted and eligibility is not otherwise re-established, the Active Employee will be offered COBRA.

(5) An Active Employee maintaining coverage under Section 2.1(d)(2)(A), i.e., full self-payments, is not entitled to weekly disability benefits. An Active Employee maintaining coverage under Section 2.1(d)(3), i.e., partial self- payments, is entitled to weekly disability benefits.

(6) It is the Active Employee's responsibility at all times to keep track of his eligibility and he can always inquire about eligibility at the Fund Office by telephone, e-mail, or in writing.

(7) The privilege of self-payment is available only to Active Employees who do not hold an active contractor's license and who are working as plumbers or are available for work as plumbers for a contributing employer and not working for a non-contributing employer in the

plumbing and pipefitting industry.

(8) An Active Employee who has failed to obey a strike notice recommended by the Joint Administrative Committee and issued by the Union will not be entitled to maintain eligibility by way of self-payments.

(9) While on self-pay, an Active Employee can only switch between Options as described in Article 4.

(e) Re-establishing Eligibility

Once an Active Employee loses eligibility under this Section 2.1, he will reestablish eligibility the first day of the second month following the month his Dollar Bank has sufficient credit to pay for the Active Employee's selected plan option. However, if no contributions have been received for 12 consecutive months, an Active Employee must meet the rules for initial eligibility to resume coverage.

2.2 Eligibility for Working Principals

A Working Principal's eligibility is not based upon a Bank. Eligibility for Working Principals is determined strictly according to the rules set forth in this Section.

(a) Initial Eligibility

If a person has never been eligible as a Working Principal, he may elect coverage when he becomes a Working Principal provided:

A. the company for which he works is incorporated;

B. his participation in the Fund will not result in more than two Working Principals from the same company participating in the Fund;

C. he complies with the hourly contribution requirements of the Collective Bargaining Agreement; and

D. he elects participation in the Fund within 30 days of the termination of his eligibility under the classification he held immediately prior to becoming a Working Principal, or 30 days after receipt of notice that such eligibility will terminate, whichever is later. (If a Working Principal does not elect participation in the Fund within these time limitations, he may subsequently elect to participate in the Plan as a Working Principal only on the anniversary date of the Collective Bargaining Agreement.)

(b) Continuation of Eligibility

To continue eligibility, a Working Principal must continue to comply with the hourly contribution requirements of Article 6 of the Collective Bargaining Agreement and remit the current monthly rates on or before the tenth day of each month. Once eligibility is established, a Working Principal will become ineligible on the first day of the month following any month in which he fails to comply with the requirements set forth above in section (a), above.

(c) Reinstatement of Eligibility

Once a Working Principal becomes ineligible, in order to re-establish eligibility as a Working Principal it is required that he comply with the hourly contribution requirements of the Collective Bargaining Agreement for three consecutive months. The Working Principal will become eligible on the first day of the month following completion of these requirements.

(d) Available Coverages

A Working Principal may select single or family coverage under the plans set forth in Article 5 upon payment of the current monthly rates as determined by the Trustees. The Trustees are authorized and reserve the right to change such rates at any time.

(e) Coverage Under Previous Classification

In the event a Working Principal no longer desires coverage under the Fund as a Working Principal, he may resume coverage under the classification he held immediately prior to becoming a Working Principal without incurring a break in coverage provided: (i) he has had continuous coverage under either the Fund or his spouse's comprehensive insurance plan from the last day of the month in which had coverage under the Fund pursuant to the classification he held immediately prior to becoming a Working Principal until the time he resumes coverage pursuant to this classification, and (ii) he makes application to resume coverage under this classification within 30 days after the end of the last month in which he had coverage as a Working Principal. At such time, the credit he/she had in his Bank immediately prior to becoming a Working Principal will be restored and to maintain and continue coverage he must meet the eligibility rules set forth for his classification. In the event that there was no prior Bank, the initial eligibility rules for Active Employees will have to be met to continue coverage.

2.3 Exceptions to Eligibility Rules

Notwithstanding any eligibility rule set forth above:

(a) eligibility shall immediately terminate for an individual who:

i. works for a noncontributing employer in the plumbing and pipefitting industry, or

ii. works for a noncontributing employer performing work of the type for which Contributions would be required to be paid to the Fund if performed for a contributing Employer under the Collective Bargaining Agreement.

Any such individual will not be entitled to continue coverage by way of Bank or self-payments and will be offered COBRA continuation coverage.

(b) If (a), above, does not apply, eligibility shall immediately terminate for an individual who works for an employer who is not in the plumbing and pipefitting industry if such individual is not available for work for a contributing employer. Such individual will not be entitled to continue coverage by way of Bank or self-payments and will be offered COBRA continuation coverage.

(c) If (a) or (b), above, do not apply, eligibility shall immediately terminate if a participant is maintaining coverage by using the Bank or self-payments and is not working for a contributing Employer or is not on the Union's out of work list. Despite registering on the out of work list, an individual will not be treated as on the Union's out of work list where they have turned down two jobs, for which they are qualified, for a contributing Employer within six months. Such individual will be offered COBRA coverage. This provision shall not apply to a participant who is Disabled and using their Bank to maintain eligibility after exhaustion of coverage under Section 2.4.

If eligibility is terminated under any of the above provisions, the participant's Bank shall be extinguished (as well as the HRA under section 3.3(h)) and to be eligible for coverage in the future he/she must re-establish initial eligibility under section 2.1(b).

2.4. Disability

If, while eligible, an Active Employee suffers a Disability, his eligibility under Section 2.1 will be frozen, to be restored upon cessation of Disability unless otherwise exhausted as set forth below. Eligibility while Disabled will be determined by this section.

A Disabled Active Employee will be eligible for benefits for up to 26 weeks from the first day of such continuous Disability.

While covered under this section, an Active Employee may elect to switch Options as set forth in Article 4.

Once an Active Employee has had coverage under this provision for 26 weeks, he may continue coverage by way of the Bank under Section 2.1 based upon the credit existing immediately prior to becoming disabled or self- payments as set forth in Section 2.1(d) for so long as the Active Employee remains Disabled. After an Active Employee has had

coverage under this provision for 26 weeks, he/she will not be eligible for any further coverage under this section for the same Illness or Injury until credited with 80 or more hours of work as a plumber for a contributing Employer.

Social Security Extension: If an Active Employee remains Disabled after a 26-week period of continuous Disability, provided he/she has applied for Social Security Disability benefits, has 10 years of service under the Plumbers Local 98 Defined Benefit Fund, and has applied for a disability pension with the Plumbers Local 98 Defined Benefit Fund, he may apply, in writing, to the Trustees to continue eligibility for an additional 26-week period. After an Active Employee receives this extension, if he/she subsequently returns to work, no extended coverage for disability will be provided under any portion of section 2.4 for one year following the last day eligibility was provided under section 2.4.

Extended eligibility while Disabled as provided under this section is not available to Irrigation Plumbers. Once an Irrigation Plumber's eligibility terminates, he/she will be offered COBRA coverage.

2.5 Dependents

Dependents are eligible for benefits under the Fund when the Participant of whom they are a Dependent is eligible.

(a) Children Under Legal Guardianship Between the Ages of 19 and 25

A Participant may continue coverage for a child who is between 19 and 25 years of age, resides in the Participant's home, and is a student, upon submitting an application for such coverage to the Fund Office and making a monthly payment for such child. The monthly rates for such continued coverage are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time.

The Fund Office must receive the self-payment no later than the tenth day of the month immediately preceding the month for which the payment is made. If a payment is missed, a Participant will not be permitted to resume eligibility for such persons by making self-payments.

Coverage for a Dependent who reaches the age of 19 who does not otherwise qualify for continued coverage under this Plan shall terminate on the last day of the calendar month in which such person turned 19. The Participant is obligated to notify the Fund Office of this event.

Coverage will terminate for a Dependent under legal guardianship between the ages of 19 and 25: one (1) year after the first day of a Medically Necessary Leave of Absence, provided the student was covered as a Child under the Plan

immediately before the first day of the Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence means a leave of absence (or other change of enrollment) from an Accredited Educational Institution, or any other change in enrollment of such child at such an institution, that:

(i) commences while such child is suffering from a serious illness or injury;

(ii) is medically necessary, as confirmed in writing by a treating physician of the child which states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary; and

(iii) causes such child to lose student status for purposes of coverage under the terms of the Plan.

(b) Effect of Divorce/Legal Separation/Judgment or Order of Separate Maintenance on Dependent Coverage

If a Participant is subject to a Judgment or Order of Separate Maintenance, divorces, becomes legally separated from his/her Spouse, both the Spouse and the Participant have an obligation to inform the Fund Office of the event within 60 days of the occurrence.

A Participant's former, legally separated, or separately maintained spouse is entitled to continue his/her coverage under the Fund pursuant to COBRA Continuation Coverage. In the event that the Judgment/Order requires the Participant to provide health insurance coverage for his/her former spouse, it is the Participant's responsibility to arrange for this coverage. A divorced, legally separated, or separately maintained spouse cannot be covered as a Dependent under the Fund.

(c) Initial Enrollment of New Dependents

To become effective in the current Calendar Year, a Participant must request that a new Dependent be enrolled in the Plan within 60 days of the date that such person first qualifies as a Dependent. Coverage for a Spouse shall be effective the first day of the first month beginning after the date a completed request for enrollment is received. Coverage for a Child shall be effective the date such person became a "Child" as defined in Article 1. If a Dependent is not timely enrolled under this section, he/she will not be able to enroll until the next open enrollment period, as set forth below in (d). Notwithstanding, if a Child is not enrolled within this 60-day period, coverage shall be effective the date such person became a Child as defined in Article 1 upon receipt of completed enrollment materials (this exception does not apply an individual who is a Child due to status as a stepchild or legal guardianship).

(d) Open Enrollment

During the open enrollment month of November and December, Participants will have the opportunity to enroll eligible Dependents who were not previously enrolled.

If during open enrollment the Participant states in writing that the reason for declining coverage for a Dependent is because such Dependent has Other Coverage, then if the Other Coverage involuntarily terminates during the Calendar Year, the Dependent may enroll in the Plan the first of the month following the date a request to enroll is received, provided this request is made within 30 days of such termination. For purposes of this section:

(1) Other Coverage involuntarily terminates when:

(A) the other coverage was COBRA coverage, and it has been exhausted; or

(B) the other coverage was non-COBRA coverage and it has been terminated as a result of loss of eligibility for the coverage, including due to a judgment/order of separate maintenance, legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, cessation of dependent status, relocation from HMO service area, termination of the plan/coverage for similarly situated individuals or employer contributions toward such coverage were terminated (and the Dependent had no control over such termination of contributions).

(C) Notwithstanding the above, a Dependent may enroll in the Plan during the Calendar Year if the Dependent loses eligibility for Medicaid or State Children's Health Insurance Program ("CHIP"); or the Dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP provided this request is made within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

(2) Other Coverage is coverage under a group health plan or health insurance coverage, not including accident or disability only policies, coverage issued as a supplement to liability insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits.

2.6 Surviving Spouse

A Surviving Spouse who desires to continue eligibility for insurance under the Fund must notify the Fund Office of his/her election to continue such coverage for herself/himself and any Dependents promptly after the death of the Participant. A monthly payment must be made for this coverage. The monthly rates for Surviving Spouses are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this rate at any time. Payment must be received by the Fund Office on or before the first day of each month. If a self-payment is missed, a Surviving Spouse will not be permitted to resume eligibility by making self-payments. The Surviving Spouse may make an election to have self-payments paid from his/her HRA. In the absence of this election, or after any such HRA balance is depleted, if the Surviving Spouse is receiving or will receive a benefit from the Plumbers Local 98 Defined Benefit Pension Plan, the self-payment must be made by way of deduction, via an assignment to the Fund, from this pension benefit. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation and cannot be reinstated.

If a Surviving Spouse remarries, insurance coverage for the Surviving Spouse and any dependent child/children will terminate. Upon termination of coverage, the Surviving Spouse will be offered COBRA continuation coverage.

A Surviving Spouse is not entitled to disability or death benefits.

Coverage is limited for all Participants and Dependents who are Medicare eligible. See Article 21.

2.7 Pensioner

A person who meets the definition of Pensioner set forth in Article 1, and his Dependents, are eligible for coverage under the Fund.

(a) Self-Pay

All Pensioners are required to make a monthly payment for coverage. The monthly rates for Pensioners are as established by the Trustees from time to time. Information regarding current rates is available at the Fund Office. The Trustees are authorized and reserve the right to change this monthly amount at any time. If a self-payment is missed, Pensioner will not be permitted to resume eligibility by making self-payments. At the time of retirement, the Pensioner may make an election to have self-payments paid from his/her HRA. In the absence of this election, or after any such HRA balance is depleted, if the Pensioner is receiving or will receive a benefit from the Plumbers Local 98 Defined Benefit Pension Plan, the self-payment must be made by way of deduction, via an assignment to the Fund, from this pension benefit. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation and cannot be

reinstated. If a Pensioner chooses not to make such an assignment, he/she will be offered COBRA continuation coverage.

For each month a Pensioner has made a self-payment to maintain coverage and performs bargaining unit work at the request of the Union, he shall be reimbursed in the amount of the Contributions received by the Fund for such hours worked, not to exceed one month's self-payment. Such reimbursement shall be made quarterly. A Pensioner may decline such reimbursement if he/she seeks to re-establish eligibility as an Active Employee under the Fund.

At retirement, the Bank will be extinguished and thus cannot be used to make self- payments. An amount equal to the credit in the Participant's Bank at the time of retirement shall be deposited on a one-time basis into the Pensioner's HRA.

(b) Special Rule for Disabled Plumbers Who Have Been Granted an Early, Normal, or Disability Pension Benefit by Plumbers Local 98 Defined Benefit Pension Plan but do not Qualify for Pensioner Coverage Under this Plan.

For those plumbers who:

(1) became Disabled while actively working as a plumber for a contributing Employer or while available for work for contributing employers (a person is not considered available for work for contributing employers if he/she is working for a non-contributing employer in the plumbing and pipefitting industry);

(2) have been granted an Early, Normal, or Disability pension by Plumbers Local 98 Defined Benefit Pension Plan;

(3) have at least ten years of credited service under the Plumbers Local 98 Defined Benefit Pension Plan; and

(4) who do not qualify for Pensioner coverage under this Plan,

for each year of credited service, he/she has under the Plumbers Local 98 Defined Benefit Pension Plan, he/she shall be allowed two months of coverage under this Plan under the same terms and conditions granted to Pensioners.

(c) The coverage of a Pensioner who returns to work in the construction industry in any geographical area will be terminated and not reinstated at any time thereafter. Upon such occurrence, no COBRA coverage will be available for such Pensioner and/or his/her Dependents. This provision will not apply to terminate the coverage of any Pensioner who performs work in a capacity which in the sole discretion of the Trustees is deemed not adverse to the interests of the unionized plumbing and pipefitting industry. In the latter event, if the Pensioner had coverage as a Pensioner, he/she must continue to make self-payments as a Pensioner until

he/she establishes eligibility as an Active Employee. If he/she did not have coverage as a Pensioner immediately prior to returning to work, but has been approved for a benefit from the Plumbers Local 98 Defined Benefit Fund, he/she must meet the initial eligibility requirements for an Active Employee to be eligible for coverage and upon termination of employment must meet the definition of Pensioner to be entitled to continued coverage.

(d) **Medicare:** Coverage is limited for all Participants and Dependents who are Medicare eligible. See Article 21.

2.8 Termination

Coverage terminates for all Participants on the first day of the month following the month in which a Participant was last eligible, or the date the plan terminates, whichever is earliest.

Dependent coverage terminates on the date he/she ceases to be a Dependent as defined herein, the date the plan terminates, or on the date the Participant's coverage terminates, whichever is earliest.

ARTICLE 3 – SCHEDULE OF BENEFITS AVAILABLE TO ALL PARTICIPANTS

3.1 Weekly Disability

Subject to all Plan provisions, if an Active Employee while eligible for benefits under the Fund becomes disabled by sickness or accident, which is not work-related, and becomes and remains unemployed as a Plumber because of this continuous sickness or injury, the Active Employee will be entitled to a self-funded benefit of $300.00 per week, less FICA tax, for up to 26 consecutive weeks from the first day of such continuous disability, payable only after he has been unable to work for at least a week due to this disability. After 26 consecutive weeks of payment of disability benefits, an Active Employee is not eligible for any further disability payments for the same illness or injury until he has been credited with 80 or more hours of work as a plumber for a contributing Employer.

An Active Employee who remains disabled after 26 weeks, if approved by the Trustees, can receive an additional 26 weeks of benefits if approved for a Social Security Extension of Eligibility under Section 2.4.

This benefit is available to Journeymen, Metal Trades Division Plumber, Apprentice Applicants, and Apprentices only.

3.2 Death Benefit

(a) Insured Basic Life and Accidental Death and Dismemberment Benefits

Active Employees and Pensioners on either the Medical/Rx or Opt-Out Plan are

eligible for coverage under a fully insured life insurance policy purchased by the Fund. The amount of coverage is:

- $50,000 life and accidental death and dismemberment for Building Tradesman Journeyman classification,
- $8,000.00 life and accidental death and dismemberment for all other active employees; and
- $8,000.00 life for Pensioners.

Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy.

(b) Insured Optional Life and Accidental Death and Dismemberment for Active Employees

Active Employees have the option to purchase Optional Life Insurance and Accidental Death and Dismemberment Insurance. Details regarding such coverage are available at the Fund Office and are subject to the terms and conditions of coverage set forth in the applicable insurance policy(ies).

(c) Beneficiary Designation

The Death Benefit is payable to the beneficiary(ies) designated by the Participant on the Beneficiary Designation card. Each Participant shall have the right to change his beneficiary at any time by written notice, submitted directly to the Fund Office or the insurance company, and the change shall become effective on the date of receipt by the Plan or insurance company. Notwithstanding, upon a divorce, any prior designation of the ex-spouse as Beneficiary shall be null and void unless a designation in favor of the ex-spouse is made subsequent to the divorce.

If a beneficiary is not designated, or if the designated beneficiary predeceases the Participant, then beneficiary shall mean, in the following order: (1) Spouse; (2) Children; (3) parents; (4) your estate.

In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

(d) Claims and Appeals

All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 11, below.

(e) Pensioner Benefits

Benefits provided under this Section 3.2 to Pensioners are available to Pensioners who have opted out of the Medicare Policy under Section 21.2.

3.3 Health Reimbursement Account

Health Reimbursement Accounts are available for reimbursement of expenses incurred for medical care for Participants and their Dependents ("medical expenses"). "Medical care" includes the diagnosis, cure, mitigation, treatment, or prevention of disease. Expenses paid for medical care includes those paid for the purpose of affecting any structure or function of the body or for transportation primarily for and essential to medical care.

The Health Reimbursement Accounts are available to Participants only as set forth below.

(a) Eligible Expenses in General

Medical expenses are eligible for reimbursement from a Participant's Health Reimbursement Account if they:

(1) Were incurred on or after the date on which the Participant, or Dependent, for who the expense was incurred, was enrolled in any non-HRA group health plan that satisfies the annual limit and preventive services requirements, (expenses are incurred when a Participant (or dependent) is provided with medical care that gives rise to the expenses, not when he is billed for or pays for the medical care);

(2) Were incurred on or after the date on which the Participant or Dependent was eligible for the HRA under the terms of this Plan;

(3) Qualify as a medical expense under §213 of the Internal Revenue Code; and

(4) Have not been or will not otherwise be paid by the Fund, or have not been reimbursed by or are not reimbursable under any other health plan coverage.

(b) Examples of Eligible Expenses

Eligible reimbursable medical expenses under this Plan include, but are not limited to, expenses for:

(1) Deductibles and co-payments for hospital, physician, prescription drugs, dental and vision care.

(2) Health services such as hearing aids, vision care, routine physicals, well baby care, counseling therapy, long-term rehabilitation services (alcoholism and drug abuse), and weight reduction programs if they are physician recommended or ordered due to a specific diagnosed medical condition, such as obesity, hypertension, etc. (reduced calorie or diet-related food is not a reimbursable expense).

(3) Fees in excess of the Fund's benefit limits, including those for orthodontia and psychiatric services.

(4) Premiums for certain other health insurance excluding premiums for individual market coverage.

(c) Manner of Reimbursement

Covered expenses up to the limits set forth in paragraph (e), below, will be reimbursed provided: (1) they are submitted within 12 months from the date an Explanation of Benefits (EOB) was provided for the covered expense, or if no EOB is issued for such expense then within 12 months of the date incurred; (2) the Participant was eligible at the time the claim was incurred; and (3) the Participant is eligible at the time the claims is submitted. Notwithstanding:

- A Participant who has had coverage under the Medical/Rx Plan whose coverage has been terminated may submit claims for medical expenses incurred while he was eligible for coverage, provided that from the time eligibility terminated through the time of submission of such claims he/she has been continually available for work for contributing employers and has not worked for non- contributing employers in the plumbing and pipefitting industry, or returned to work under the Collective Bargaining Agreement.

- A terminated Opt-Out Participant may submit claims for medical expenses incurred in the Calendar Year in which his/her eligibility terminated, provided that from the time eligibility terminated through the time of submission of such claims he/she has been continually available for work for contributing employers and has not worked for non-contributing employers in the plumbing and pipefitting industry or returned to work under the Collective Bargaining Agreement. Notwithstanding, a terminated Opt-Out Participant is allowed to make a one-time election to opt-out of and waive future reimbursements from the HRA.

All payments for claims will be made directly to the Participant, and not to a provider of service. Checks will generally be drawn bi-weekly.

If a Participant submits a claim for more than the current balance of his Health Reimbursement Account, the claim will be paid up to the limits set forth in paragraph (e), below, for the Calendar Year minus any prior payments for that

year.

(d) Submission of Claims

In order to receive reimbursement for an eligible claim, a Participant must complete a claim form and submit it to the Fund. Claim forms are available at the Fund Office.

> Note that all claims must include: (1) a written statement from an independent third party verifying that a medical expense in a specified amount has been incurred (e.g. an Explanation of Benefits covering a medical or dental claim, itemized vision claim or prescription co-payment), and (2) a written statement from the Participant that the expense has not been reimbursed by or is not reimbursable under any other health plan coverage.

If payment is made from a Participant's HRA in excess of the correct amount of the claim, the Plan has the right to recover the excess amount of money from the Participant. The Plan also has the right to withhold or deduct from all future payments until the overpayment is returned.

(e) Annual Benefit Amount

The following benefit amount is available during each Calendar Year:

Participant Classification	Annual HRA Benefit
Active Employee on Medical/Rx Plan	No benefit, unless Unrestricted Journeyman, Light Rate Journeyman, or Apprentice who receives amount specified in Collective Bargaining Agreement.
Active Employee on Opt-Out Plan	Effective 6/1/19, $3.00 per hour of Contributions received, plus amount received as designated in Collective Bargaining Agreement for Unrestricted Journeyman, Light Rate Journeyman, or Apprentice.
Non-Medicare Pensioner on Medical/Rx Plan	No benefit
Non-Medicare Pensioner on Opt-Out Plan or Medicare Pensioner on Opt-Out Plan who opted out of coverage under Article 21	$600.00
Non-Medicare Surviving Spouse on Medical/Rx Plan	No benefit
Non-Medicare Surviving Spouse on Opt-Out Plan or Medicare Surviving Spouse on Opt-Out Plan who opted out of coverage under Article 21.	$600.00

The amount to which a Participant is eligible for a Calendar Year is determined

by the Participant's classification as of January 1 of that year. Notwithstanding the foregoing, a Participant who enrolls in Opt-Out coverage during the Calendar Year will be allocated an additional $600 to his/her Health Reimbursement Account as of the date of enrollment in the Opt-Out Plan.

(f) Exclusions from Coverage

(1) The HRA benefit is not available to Surviving Spouses otherwise eligible if the Pensioner to whom he/she was married was not a member in good standing at the time of his/her death.

(2) The HRA benefit is not available to Irrigation Plumbers or Metal Trade Helpers.

(3) The HRA benefit may not be used to purchase, or pay premiums for, individual health insurance coverage.

(4) The HRA benefit may not be used to reimburse medical expenses incurred by individuals not covered by an eligible non-HRA group health insurance plan that satisfies the annual limit and preventive services requirements. In other words, if a Participant's Dependent is not enrolled in the Plan, or another eligible non-HRA group health insurance plan, then no medical expenses incurred by the Dependent may be reimbursed by the HRA benefit.

(g) Balance in HRA

The balance accumulated in an Active Employee's HRA account will remain available to that individual when he/she becomes a Pensioner.

The balance in a Pensioner's or Active Employee's account may be used by his/her Surviving Spouse. Upon the death of an Active Employee, an amount equal to the balance of his/her Bank, per Section 2.1, shall be deposited in his/her HRA for use by the Surviving Spouse.

(h) Account Balances Upon Termination of Eligibility

Upon termination of eligibility, a participant's HRA will be suspended, to be reinstated if the participant reestablishes eligibility within 12 months of such termination. If Contributions are not received on behalf of the Participant within 12 months, the balance in the HRA will remit to the Fund.

Notwithstanding, if eligibility terminated under Section 2.3, the balance in the HRA will be remitted to the Fund and will not be reinstated if the Participant reestablishes eligibility.

3.4 Outstanding Payments

If any benefit payment made by the Trustees out of the Fund is unclaimed for a period of two years, it shall revert to and again become part of the Fund, free and discharged from any claim therefore, provided that any unclaimed benefit or a benefit which has been forfeited due to the inability of the Plan to find a Participant or beneficiary shall be reinstated in the event a claim is made for the unclaimed or forfeited benefit by a Participant or a Beneficiary.

In the event any other payment issued by the Fund, for any reason, has not been redeemed by the payee for a period of 24 months, or such lesser time as set forth on the payment issued by the Fund, such payment is void and reverts to the Plan as a plan asset.

3.5 VSP Vision and NationsHearing

Participants may participate in the VSP Vision and NationsHearing Program. All terms and conditions are governed by the brochures and summaries provided by VSP and NationsHearing, respectfully.

3.6 Medtipster

The Medtipster Program is available to Active Participants and non-Medicare eligible Pensioners and non-Medicare eligible Surviving Spouses. This is a prescription "overlay" program which can assist individuals in finding the lowest-cost generic prescription drugs in their geographic area, with a reduced co-payment in many cases. Medicare-eligible individuals can also use the program to find the lowest-cost drugs in their geographic area, but their copayment will not be reduced or waived. All terms and conditions are governed by brochures and summaries provided by Medtipster.

3.7 Hearing Benefit

Hearing Benefits are provided as follows: $3,000 per every three years to be used for medically necessary hearing services and products, such as hearing exams and tests, hearing aids, batteries, and repairs.

ARTICLE 4 – ENROLLMENT IN MEDICAL/RX OR OPT-OUT PLANS

4.1 Enrollment

In addition to the benefits set forth in Article 3, above, non-Medicare eligible Participants may choose between the following coverage Options: Medical/Rx coverage, Opt-Out coverage A or B. A Participant is automatically enrolled in Medical/Rx coverage for the Calendar Year unless at the time of initial enrollment or during the open enrollment month of November (during which changes may be made for the next Calendar Year), he executes an Opt-Out Enrollment Form. This Enrollment Form is available at the Fund Office. A Participant can only decline Medical/Rx coverage if:

(1) The Participant is actually enrolled in a group health plan that does not consist solely of excepted benefits (e.g. can be a spouse's plan) (Other Coverage); and

(2) The Other Coverage meets the Affordable Care Act minimum value standard.

Medicare is not "Other Coverage" for purposes of this provision.

There are 3 plans available under Medical/Rx coverage – Full, Standard, and Basic. If a Participant does not elect one of the coverage plans for which he/she is eligible, coverage will be provided under the Standard Plan.

Notwithstanding, Apprentice Applicants, Apprentices 1 and 2, Metal Trades Helpers, and Irrigation Workers only have coverage under the Basic Plan.

Except as provided below, a Participant may not switch between Options during a Calendar Year. The Participant's Dependents are enrolled in the same Option as the Participant.

See Article 5 for Medical/Rx Coverage and Articles 6 and 7 for Opt-Out Coverage.

4.2 Permitted Election Changes

A Participant may switch coverage Options during a Calendar Year only as follows:

(a) A Participant's acquisition of a new Dependent as a result of marriage, birth, adoption, or placement for adoption, if a request to change an election is made within 30 days of such event. An election change for marriage shall be effective the first day of the first month following the requested change. An election change for birth, adoption, or placement for adoption shall be effective the date of birth, adoption, or placement for adoption. Notwithstanding, August 4, 2023, if a Child is not enrolled within this 60-day period, coverage shall be effective the date such person became a Child as defined in Article 1 upon receipt of completed enrollment materials (this exception does not apply to an individual who is a Child due to status as a stepchild or legal guardianship).

(b) An Opt-Out Participant (i.e. Opt-Out Coverage) may switch to Medical/Rx coverage during the Calendar Year if each of the following conditions are met:

(1) The Participant was covered under a group health plan or had health insurance coverage at the time he made his election for Opt-Out coverage ("Other Coverage");

(2) The Participant executed an Acknowledgment at the time of his election for Opt-Out coverage verifying he/she had Other Coverage;

(3) The Participant's Other Coverage:

(A) was COBRA coverage and which has been exhausted; or

(B) was non-COBRA coverage which has been terminated as a result of:

i. loss of eligibility due to judgment or order of separate maintenance, legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, relocation from HMO service area, or cessation of Dependent status; or

ii. employer contributions toward such coverage were terminated; and

(4) The Participant requests enrollment in Medical/Rx coverage within 30 days of the termination of the Other Coverage.

An election change for the reasons set forth above shall be effective the first day of the first month following the requested change.

(c) A Participant taking leave under the Family Medical Leave Act may change his election for the period of time he/she is on such leave.

(d) An Opt-Out Participant may switch to Medical/Rx coverage during the Calendar Year if:

(1) The Participant loses eligibility for Medicaid or State Children's Health Insurance Program ("CHIP") coverage; or

(2) The Participant becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

In both instances, the employee must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

(e) Once per year, a Participant with Medical/Rx coverage can elect to switch from the Full Plan to the Standard or Basic Plan or from the Standard Plan to the Basic Plan. Once such election is made, no further changes can be made until the next Open Enrollment.

4.3 Participant on Disability

A Participant entitled to coverage under Section 2.2 (Disability), above, may elect to change coverage Options during such period of time he is disabled and entitled to benefits under Section 2.2, pursuant to the rules set forth in Section 4.2, above.

ARTICLE 5 – SCHEDULE OF BENEFITS FOR NON-MEDICARE MEDICAL/RX COVERAGE

5.1 Networks

The Fund has contracted with a preferred provider network. A list of the physicians participating in this network (the Provider Network) is available at the Fund Office, free of charge. If a Plan Participant receives covered services from a provider who is not a Participating Provider because he or she reasonably relied on incorrect information from the Provider Directory, then the Plan Participant will only be responsible for the Participating Providers' copayment, deductible, or coinsurance. Participants and their Dependents may choose to receive treatment from an out-of-network provider, but will incur greater out of pocket expenses if they do so.

Services Provided by Nonparticipating Provider at Participating Facility: Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating providers at participating facilities, in the absence of Consent to Out of Network Services, the Plan will:

(a) not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;

(b) calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount or such services; and

(c) apply any cost-sharing payments with respect to such items and services toward any in- network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

Continuing Care Patient: If a covered person is a Continuing Care Patient of a provider or facility that terminates its participating provider status with the Plan as a result of: (a) termination of its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or (b) termination of benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network, the Plan will:

(a) notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c), below;

(b) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and

(c) allow such individual to elect to continue to benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a

Continuing Care Patient had such termination not occurred, during the period beginning on the date on which the notice under (a), above, is provided and ending on the earlier of 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

5.2 Medical Benefits

(a) Chart of Benefits

As set forth in Section 4.1, Participants may elect between three plans: Full Plan, Standard Plan, and Basic Plan. Subject to the exclusions set forth in Section 5.3, below, the following benefits are provided by each plan option:

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductibles - In/Out Satisfies each other	$500/person $1,000/family	$1,000/person $2,000/family	$1,000/person $2,000/family	$2,000/person $4,000/family	$1,500/person $3,000/family	$5,000/person $10,000/family
Annual Out of Pocket Co-Insurance and Co-Payment Maximums - In/Out Satisfies each other	$1,000/person $2,000/family	$2,000/person $4,000/family	$2,500/person $5,000/family	$5,000/person $10,000/family	$5,350/person $10,700/family	$10,000/person $20,000/family
In-network Out-of-Pocket Maximums Medical and Prescription Drugs Essential Health Benefits	The combined in-network annual out of pocket maximums for medical (deductible, co-payments, and co-insurance) and prescription drugs (co-payments and co-insurance) for in-network essential health benefits cannot exceed annual limits imposed by the Affordable Care Act. For 2024, these amounts are $8,550 per individual and $18,900 per family. Once this amount has been met during the calendar year, all in-network essential health benefits will thereafter be paid at 100% of the approved amount. The Plan annual out of pocket maximums for in-network essential health benefits will be automatically adjusted each year to the limits set by the US Department of Health and Human Services (HHS).					

The below percentages represent the percentage paid by the Plan. If marked with an "*" the Plan pays after satisfaction of the In-Network Deductible set forth above. If marked with an "", the Plan pays after satisfaction of the Out-of-Network Deductible set forth above.**

The co-insurance that must be paid by the Covered Person is based on the lesser of the billed charge or Diagnosis Related Group (DRG) charge.

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Outpatient Care						
Acute Kidney Dialysis	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Emergency Services for an Emergency Medical Condition	For out of network expenses for Emergency Services for an Emergency Medical Condition, the in-network out-of-pocket maximums apply and the out of network co-insurance and copayment count towards in-network out of pocket maximums.					

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Facility/Physician Co-pay is waived if emergency care is for accidental injury or if admitted.	100% after $250 copay*	100% of the Recognized amount after $250 copay*	100% after $350 copay*	100% of the Recognized amount after $350 copay*	100% after $450 copay*	100% of the Recognized amount after $450 copay*
Lab/X/Ray/Diagnostic Testing	90%*	90% of the Recognized amount*	80%*	80% of the Recognized amount*	70%*	70% of the Recognized amount*
Habilitation Services	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Hemodialysis	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Pre-Admission testing	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Radiation and Chemotherapy	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Rehabilitation: Occupational/Physical/ Speech/Respiratory Therapy	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Second surgical opinion	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Surgery (All Related Expenses)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Inpatient Hospital						
Facility - Inpatient Hospital (Semi-private room)	90%*	80% UCR**	80%*	70% UCR **	70%*	60% UCR **
Birthing Center/Ambulatory Surgery Center	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Surgery	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Anesthesia	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Assistant Surgeon	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
In-Hospital Consultations	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Imaging (ex. MRI)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Respiratory Therapy	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Acute Kidney Dialysis	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Organ Transplant Benefits	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Mental Health						
Inpatient Care/ Outpatient Treatment	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Program						
Outpatient Psychotherapy	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Alcohol/Substance Abuse						
Inpatient Care/ Outpatient Treatment Program	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Outpatient Psychotherapy	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Physician's Office/Urgent Care						
Charge for Visit for Illness/Injury	100% after $20 co-pay	80% UCR**	100% after $25 co-pay	70% UCR**	100% after $25 co-pay	60% UCR**
Specialists & Consultations	100% after $20 co-pay	80% UCR**	100% after $25 co-pay	70% UCR**	100% after $50 co-pay	60% UCR**
Pre and Post Natal Care	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Allergy Testing/Treatment	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Diagnostic Lab/X-Ray	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Surgery	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**

Preventive Services Required to be Covered by Law

Preventive service benefits are covered without cost-sharing in-network to the extent required under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits **if provided in-network**.

The following is a representative list of items covered by law as preventive services as of May 1, 2023, but is not a complete list of all such items, and this list changes from time to time. For a list of items and services covered as preventive care under federal law at any given time, please visit the following websites:

- U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- Health Resources & Services Administration Adopted-Guidelines for Women, Children, and Youth: https://mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

Items and services covered by the Plan for preventive services will be updated and amended automatically as required by law, which may include additions to and subtractions from the representative list of covered items set forth below.

Be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status, and impose treatment limitations such as once per lifetime, once per year, etc. Providing all such limitations in this Plan document is not possible. Some of the representative items or services set forth below may indicate coverage once per year, etc., but that does not mean other representative preventive services do not have limitations as to timing, amounts, who is covered, etc. Contact the Fund Office if you have any questions regarding the scope of coverage for any preventive service or item.

For Adults: • Screenings, most	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
commonly covered annually, including the following: o Abdominal Aortic Aneurysm o Cholesterol o Colorectal Cancer (and follow-up, if required by law) o Depression o Hepatitis C o HIV o Hypertension o Latent Tuberculosis o Lung Cancer o Prediabetes and Type 2 Diabetes o Syphilis o Unhealthy Alcohol and Drug Use • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and population may vary. • Tobacco Smoking Cessation Interventions • Unhealthy Alcohol Use Behavioral Counseling • Weight Loss to Prevent Obesity-Related Morbidity and Mortality Behavioral Interventions						
For Women: • Screenings,	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
including for the following: o Anxiety o Breast Cancer (Mammography) o Cervical Cancer o Diabetes After Gestational Diabetes o Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults o Osteoporosis o Urinary Incontinence o STIs (including Chlamydia and Gonorrhea) • BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic Testing • Obesity Prevention Counseling • Sexually Transmitted Infections Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits						
For Pregnant Women or Women Who May	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Become Pregnant: • Screenings, including for the following: o Anxiety o Bacteriuria o Contraception o Gestational Diabetes o Rh(D) Incompatibility o STIs (including Chlamydia, Gonorrhea, Hepatitis B, HIV, and Syphilis) o Preeclampsia o Urinary Tract or other Infection • Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies) • Contraception Education, Counseling, Provision of Contraceptives and Follow-Up Care (including sterilization surgery) • Healthy Weight and Weight Gain Behavioral Counseling • Perinatal Depression Preventive Interventions • Preeclampsia Prevention • Substance Use Assessment • Tobacco						

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
Intervention and Counseling • Well-Women Visits, which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits						
For Infants, Children, Adolescents, & Young Adults (Newborn—21 years old): • Screenings, including for the following: o Anemia o Autism Spectrum Disorder o Behavioral / Social . Emotional o Blood Pressure o Cervical Dysplasia o Depression and Suicide Risk o Developmental o Dyslipidemia o Hearing o Lead Level o Newborn Blood, Bilirubin, and Critical Congenital Heart Disease o Obesity o Scoliosis o STIs (including but not limited to Chlamydia, Gonorrhea, HIV, and Syphilis) o Tobacco, Alcohol, and Drug Use o Tuberculosis o Vision • Fluoride Varnish	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**

Medical Benefits	Full Plan		Standard Plan		Basic Plan	
	In-Network	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
and Oral Fluoride Supplementation • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary • Oral Health Risk Assessment and Referral • Sudden Cardiac Arrest / Death Risk Assessment • Tobacco, Alcohol, and Drug Use Interventions • Well-Baby/Child Examinations						
Preventative Services Not Required to be Covered by Law						
Prostate/Immunization (limited to 1 per calendar year)	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**
Routine Physical	100%	80% UCR**	100%	70% UCR**	100%	60% UCR**
Affiliates						
Chiropractors - $1,000 Annual Limit	90%	80% UCR	80%	70% UCR	70%	60% UCR
Podiatrists	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Other Services						
Skilled Nursing Facility (Pre-Approval Required)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Private Duty Nursing (Pre-Approval Required)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Home Health Care (Pre-Approval Required)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Hospice Care (Pre-Approval Required)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Durable Medical Equipment	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Ground Ambulance (up	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of Network**
to 2 trips per confinement)						
Air Ambulance (when Medically Necessary)	90%*	90% of lesser of billed charges of the Qualified Payment Amount, after deductible* (in-network deductible and in-network out-of-pocket maximums apply and this co-insurance and deductible for air ambulance are to be counted towards in-network out of pocket maximums).	80%*	80% of lesser of billed charges of the Qualified Payment Amount, after deductible* (in-network out-of-pocket maximums apply and this co-insurance and deductible for air ambulance are to be counted towards in-network out of pocket maximums).	70%*	70% of lesser of billed charges of the Qualified Payment Amount, after deductible* (in-network deductible and in-network out-of-pocket maximums apply and this co-insurance and deductible for air ambulance are to be counted towards in-network out of pocket maximums).
Diabetic Education Classes: Cost of Class, up to maximum of $400.00. Covers one class only per Participant per lifetime.						

(b) Pre-Certification/Medical Case Management & Utilization Review: Must Contact Hines & Associates, Inc.,

The following is a list of services to be Pre-Certified by Hines (this list may change from time to time, so please contact Hines if you have any questions as to whether a service requires Pre-Certification):

- Acute Inpatient Admissions (medical, surgical, behavioral health)
- Skilled Nursing Facility
- Behavioral Health Residential Stays
- Select outpatient Surgeries:
  - Nasal Surgeries
  - Blepharoplasty
  - Ventral hernia repair
  - Varicose vein surgery
  - Bioengineered skin and soft tissue replacement
  - Partial or Full Joint Replacements
  - Osteochondral Autografts

- Sclerotherapy
- Panniculectomy
- Abdominoplasty
- Breast Reduction
- Hysterectomies
- UP3/UPPP – uvulopalatopharyngoplasty
- Excess skin removal of arms, chests, and legs
- AV Fistula or graft access for dialysis
- Bariatric (weight loss) Surgery
- Shock wave lithotripsy for plantar fasciitis
- AICD and Biventricular device insertions
- Oncology related surgeries including Port Insertions
- Spinal surgeries (Including spinal injections for pain management)
- Maxillo-facial surgery
- Biopsies as primary procedures
- Back or neck procedures including:
  - IDET (intradiscal Electrothermal Annuloplasty)
  - Percutaneous Radiofrequency Neurotomy
  - Artificial Intervertebral Disk Implantation
  - Automated Percutaneous Lumbar Diskectomy (APLD)

- Select Outpatient Diagnostic Testing Review:
  - CT Angiogram
  - CT Calcium screening
  - MRI of the heart
  - Capsule Camera Endoscopy
  - Virtual Colonoscopy
  - Oncology related PET, CT, or MRI
- Select Outpatient infusion and injection therapies. A Covered Person should call Hines to confirm whether an infusion or injection requires precertification. See also the exclusion for Outpatient infusion and injection therapies administered in facility settings in Section 5.3, below.

Any Pre-Certified service is subject to all other Plan terms, conditions, and exclusions.

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

5.3 Exclusions

In addition to and not in lieu of other restrictions to coverage set forth in this Plan, the following services and benefits are not covered by the Plan:

(1) Services provided before the effective date of coverage.

(2) Services provided after the effective date of termination of coverage.

(3) Charges that are not Reasonable and Customary.

(4) Services or supplies not Medically Necessary.

(5) Services or supplies provided mainly as a rest cure, maintenance or custodial care.

(6) Charges related to donating an organ or tissue to an individual other than a Participant or Dependent.

(7) Services for educational or vocational testing or training.

(8) Exercise programs for treatment of any condition, except for physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(9) Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera sheet intended for use as corneal bandages.

(10) Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except for open cutting operations), and treatment or corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(11) Charges for travel outside the United States without Plan approval if sole purpose is to obtain medical services, supplies or drugs.

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

(13) Care and treatment of hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician.

(14) Services or supplies in connection with hearing aids or exams for their

fitting, in excess of $3,000 per every three years for medically necessary hearing services and products.

(15) Expenses for cosmetic surgery; unless: (1) treatment is rendered by a physician for injuries sustained in an accident and such treatment is begun within ninety days after such accident; (2) treatment is for a congenital anomaly; (3) treatment is rendered for reconstruction of the breast, surgery and reconstruction of the other breast for symmetrical appearance, or prostheses and physical complications in all stages of mastectomy; or (4) such surgery is incidental to any other covered illness.

(16) Charges for use of any treatment, supply, device or facility which (a) does not have required governmental approval, or (b) is experimental, investigative or not a generally accepted medical practice.

(17) Services that are not health care services (e.g. personal and convenience, completion of forms, cost of transportation except covered ambulance services).

(18) Services, care, supplies or devices not prescribed by a physician and not directly related to the diagnosis or treatment of illness or injury.

(19) Services not rendered by a licensed physician. In the case of treatment of psychiatric conditions, services must be rendered by a licensed physician, licensed clinical psychologist, or licensed social worker.

(20) Expenses in connection with dental work, except: (1) for treatment made necessary by an accident and rendered by a physician or a legally licensed dentist within 90 days of such accident, or (2) in the event dental procedures are required to prevent complications arising from the treatment of a life-threatening medical condition, as supported by documentation acceptable to the Trustees, dental procedures will be covered to the extent not covered by an dental benefits (insured or self-insured) for which the Covered Person is eligible.

(21) Charges for services rendered by Participant's or Dependent's immediate family (i.e., spouse, brother, sister, parent, or child) or regular member of the Participant's or Dependent's immediate household.

(22) Services for which a charge would not have been made had no coverage existed; services that the Participant or Dependent is not legally obligated to pay.

(23) Services provided by Employer facilities.

(24) An injury or illness for which the Participant or Dependent is eligible for benefits under any workers' compensation plan.

(25) Any injury or illness arising from a motor vehicle accident in the State of Michigan.

(26) Any injury or illness arising from a motor vehicle accident in a State other than Michigan for which there is in effect, or is required to be in effect, any policy of No- Fault insurance. This exclusion is not applicable to expenses not paid by any policy of No-Fault insurance as a result of state required policy deductibles or maximums.

(27) Charges for in-vitro fertilization, GIFT or similar or more extensive procedures.

(28) Charges for food supplements and vitamins.

(29) Custodial care, which means care furnished to aid the Covered Participant in the activities of a normal daily life, such as help to walk, bathe, eat or dress.

(30) Expenses incurred for treatment of injuries, sickness, or disability incurred while the Participant or Dependent was engaged in illegal activity.

(31) Expenses incurred as a result of being under the influence of any illegal drug (or illegal or improper use of a legally prescribed drug) or as a result of an injury incurred while engaged in an illegal activity.

(32) Any injury or illness resulting from war, whether or not a declared war.

(33) Expenses in connection with care rendered within a facility of, or provided by, the United States Veterans' Administration for service-connected disabilities, Illnesses, or Injuries.

(34) Expenses incurred for treatment of self-inflicted injuries, unless they were the result of a physical or mental condition.

(35) Charges for care, items, services or treatment for gender dysphoria (e.g., sex transformations, gender reassignment surgery and related treatment). This exclusion includes all medication, implants, surgery, medical or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.

(36) Charges related to bariatric surgery. Notwithstanding, the Plan will cover, on a one-time basis only (no repeat or corrective procedures), the procedures set forth in (A) or (B), below, only if the Covered Person meets the indicated criteria, subject to a 25% co-insurance (to which out of pocket maximums do not apply), with a maximum benefit of $10,000:

(A) Roux-en-Y Gastric Bypass (RYGB):

To be eligible, Covered Person must satisfy all selection criteria set forth in (i)- (vi), below:

(i) Presence of severe obesity that has persisted for at least five years, defined as any of the following:

(a) Body mass index (BMI) exceeding 40; or
(b) BMI greater than 35 in conjunction with any of the following severe co-morbidities:

(I) Coronary heart disease; or
(II) Type 2 diabetes mellitus; or
(III) Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea); or
(IV) Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); and

(ii) completed growth (18 years of age or documentation of completion of bone growth); and

(iii) non-smoking for at least four months prior to surgery; and

(iv) attempted weight loss in the past without successful long-term weight reduction; and

(v) must meet either criterion (a) or (b), below:

(a) Physician-supervised nutrition and exercise program: Covered Person must have participated in physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet all of the following criteria:

(I) Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and

(II) Nutrition and exercise program(s) must be for a cumulative total of six months or longer in duration and occur within two years prior to surgery, with participation in one program of at least three

consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program(s) will be completed prior to the date of surgery.); and

(III) Covered Person's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the Covered Person's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program. For Covered Persons who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the Covered Person's participation and progress may substitute for physician medical records; or

(b) Multidisciplinary surgical preparatory regimen: Proximate to the time of surgery, Covered Person must participate in an organized multidisciplinary surgical preparatory regimen of at least three months duration meeting all of the following criteria:

(I) Consultation with a dietician or nutritionist; and

(II) Reduced-calorie diet program supervised by dietician or nutritionist; and

(III) Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional; and

(IV) Behavior modification program supervised by qualified professional; and

(V) Documentation in the medical record of the Covered Person's participation in the multidisciplinary surgical preparatory regimen. Note: A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation (documentation should include medical records of the physician's initial assessment of the Covered Person, and the physician's assessment of the Covered Person's progress at the completion of the multidisciplinary surgical preparatory regimen); and

(vi) For Covered Persons who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression), who are currently under the care of a psychologist/psychiatrist, or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary.

(B) Open or Laparoscopic Vertical Banded Gastroplasty (VBG) and Laparoscopic Adjustable Silicone Gastric Banding (LASGB, Lap-Band):

To be eligible, Covered Person must:

(i) meet the Selection Criteria for RYGB, set forth above in paragraph (36)(a)(i)-(vi), above; and

(ii) be at increased risk of adverse consequences of a RYGB due to the presence of any of the following co-morbid medical conditions:

(a) Hepatic cirrhosis with elevated liver function tests; or
(b) Inflammatory bowel disease (Crohn's disease or ulcerative colitis); or
(c) Radiation enteritis; or
(d) Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or
(e) Poorly controlled systemic disease.

(C) The above procedures are the only procedures covered by the Plan, which means, among others, the following are not covered procedures under any circumstance:

- Loop gastric bypass;
- Gastroplasty, more commonly known as "stomach stapling" (see below for clarification from vertical band gastroplasty);

- Duodenal switch operation;
- Biliopancreatic bypass (Scopinaro procedure);
- Mini gastric bypass;
- Silastic ring vertical gastric bypass (Fobi pouch)
- Intragastric balloon;
- LASGB, except in limited circumstances noted above in paragraph 36(b); and
- VBG, except in limited circumstances noted above in paragraph 36(b).

(D) Routine cholecystectomy will be covered when performed in concert with covered bariatric procedures.

(37) Charges related to weight loss programs, unless the Covered Person:

(a) has a body mass index $\geq$ 30 kg/m^2; or

(b) has a body mass index $\geq$ 27 and <3 0 kg/m^2 and one or more of the following comorbid conditions:

- Coronary artery disease
- Diabetes mellitus type 2
- Sleep apnea
- Obesity-hypoventilation syndrome (Pickwickian syndrome)
- Hypertension (systolic blood pressure $\geq$ 140 mm HG or diastolic blood pressure $\geq$ 90 mm Hg on more than one occasion)
- Dyslipidemia:
  - LDL cholesterol $\geq$60 mg/dL; or
  - HDL cholesterol < 35 mg/dL; or
  - Serum triglyceride levels $\geq$ 400 mg/dl;

and the program is approved as appropriate and monitored by Hines and Associates

(38) Charges related to the Pregnancy of a Dependent Child, other than preventive prenatal care.

(39) Notwithstanding any other provision of this plan to the contrary, no medical claims will be paid in excess of the stop loss attachment point until funding for such claims is received by the Fund from the stop loss carrier.

(40) Any injury or illness arising from a motorcycle accident in the State of Michigan for which coverage for medical benefits is required by law.

(41) Notwithstanding any term of this Plan to the contrary, coverage for Clinical Trials is excluded, except for Routine Patient Costs incurred in an Approved Clinical Trial as set forth below. For purposes of this provision:

(a) An Approved Clinical Trial is a clinical trial for which coverage is required under federal law, PHSA Sec. 2709, which is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (i.e. any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is a federally funded trial or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (or is exempt from investigational new drug application requirements); and

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

(1) the investigational item, device, or service, itself;
(2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
(3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

(42) Gene Therapy

(43) Charges for acupressure, acupuncture, therapeutic massage, biofeedback, and homeopathy therapy.

(44) Charges for ground ambulance transportation in excess of charges that would have been approved if the person were taken to a local facility equipped to provide treatment, taking into consideration Medical Necessity.

(45) Charges for air ambulance transportation:

(a) where there is a facility equipped to provide treatment that could have been timely reached by ground ambulance, taking into consideration Medical Necessity (in which case the Plan will cover charges that would have been approved if the person were taken by ground ambulance to such facility); or

(b) in excess of charges that would have been approved if the person were taken to a local facility equipped to provide treatment, taking into consideration Medical Necessity

(46) Elective Abortions

(47) Outpatient infusion and injection therapies must be administered in a home, office, or free-standing infusion center setting to be covered, unless (1) it is Medically Necessary that the treatment be provided in a facility setting; (2) the medication is subject to limited distribution and is available only at certain facilities; or (3) the Covered Person would have to travel more than 50 miles from his or her home to receive services in an office or free-standing infusion center setting. Therapy commenced prior to September 1, 2023, will be subject to a 60-day grace period to allow for any transition to the most appropriate site where services can be safely administered.

5.4 Reimbursement of Expenses

Eligible expenses will be reimbursed for the Calendar Year in which they were incurred, even if submission of a claim occurs in the following year. Claims must be submitted within 12 months of the date incurred. However, when a Participant's or Dependent's coverage terminates for any reason, written proof of claim must be submitted within 90 days of the date of termination of coverage.

In order to receive reimbursement for an eligible expense, a Participant must complete a claim form and submit it to the Fund. Claim forms are available at the Fund Office. All claims must include (1) a written statement from an independent third party verifying that a medical expense in a specified amount has been incurred, and (2) a written statement from the Participant that the expense has not been reimbursed by or is not reimbursable under any other health plan coverage.

5.5 Drug Coverage

(a) Administration

Self-funded prescription drug coverage is administered by a Pharmacy Benefits Manager. Participants are issued a prescription drug card and must present this

card at participating pharmacies for benefits. Wal-Mart and Sam Club's retail pharmacies are excluded from the pharmacy network. Participants are not able to fill prescriptions through these pharmacies.

(b) Covered Drugs

The following drugs are covered under this program:

- Federal Legend Drugs
- Compounded Medication
- Insulin/Insulin Syringes
- Prescription Vitamins (Vitamin D, generic only, for covered persons over age 65 will be covered under preventive services coverage)
- Retin-A (age 25 and under)
- Injectable Bee Sting Kits
- Injectable Imitrex
- Injectable Immunomodulators
- Injectable Allergens
- Injectable and Oral Fertility Drugs
- Miscellaneous Injectable Drugs
- Nicotral
- Sexual Dysfunction Agents (generic only, at 12 pills per month, with prior authorization; however, such limit may be changed at any time in the discretion of the Pharmacy Benefits Manager)
- Immunizations for children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP). If such immunizations are not available under this prescription drug coverage, they shall be covered as provided in Section 5.2 (Medical Benefits).

The Fund covers preventive health drugs without cost-sharing, as required by federal law. Preventive health drugs must be: (1) prescribed by a healthcare provider (even for over-the-counter products); and (2) obtained from an in-network pharmacy. Preventive health drugs include the following:

- Antiretrovirals (PrEP)
- Aspirin
- Bowel Preparation Products
- Breast Cancer Prevention Drugs
- Female contraceptives, including but not limited to the full range of FDA-approved contraceptives and emergency contraceptives;
- Fluoride
- Folic Acid
- Low to Moderate Dose Statins
- Tobacco Cessation Drugs

Please be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status. Please contact the Fund Office to obtain a list of covered preventive health drugs and the specific coverage criteria applicable to each drug. You may also find a list of a number of such drugs at U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

(c) Exclusions

The following drugs are excluded under this program:

- Injectable Vitamins
- Oral Sexual Dysfunction Drugs (other than those specifically covered)
- Cosmetic Drugs
- Smoking Cessation Drugs (other than those specifically covered)
- Injectable Vaccines and Immunizations
- Injectable Growth Hormones
- Singulair, unless the Covered Person presents a letter from his or her physician stating that the Singulair is prescribed for the treatment of asthma.
- Norvir
- Proton Pump Inhibitors
- All of the exclusions listed above in Section 5.3 apply to Drug Coverage.
- Hepatitis C treatment will be limited to one treatment per lifetime if the Covered Person is/was not compliant with the treatment program.
- Bulk Powders
- Weight Loss Drugs
- New to market medications are excluded until a clinical review and tier placement decision has been performed by the Pharmacy Benefits Manager (PBM)
- Coverage will only be provided for drugs determined by the PBM to be the most clinically and economically valuable brand drugs in the following categories (a list of covered and excluded brand drugs is available from the Fund Office or PBM)
    - Acne (Prior authorization required age 25 or older)
    - Androgen
    - Diabetes/Glucose Testing Supplies
    - Insulin
    - Injectable Anti-Diabetic
    - Overactive Bladder

(d) Co-payments

Co-payments may vary depending upon whether coverage is provided under the Full, Standard, or Basic Plan.

(1) Drugs for which a manufacturer assistance program is available

Full, Standard, or Basic Plan: For any drug which costs over $400 per month and for which a manufacturer assistance program is available, the Covered Person shall pay either:

- a 50% copayment if the Covered Person does not obtain and use an available manufacturer assistance program; or
- a 0% copayment if the Covered Person does obtain and use an available manufacturer assistance program (however, the Covered Person must pay any copayment required at point of sale to use the assistance program and the Fund will reimburse the Covered Person for such copayment).

The Health Plan Advocate has been retained by the Fund to assist Covered Persons obtain and use available manufacturer assistance program.

(2) Drugs for which a manufacturer assistance program is not available

The following copayments apply:

	Full Plan	**Standard Plan**	**Basic Plan**
	Prescription Benefits		
Retail	**Retail (34-day supply, except Generic which can be filled 90-day supply)**	**Retail (34-day supply, except Generic which can be filled 90-day supply)**	**Retail (34-day supply, except Generic which can be filled 90-day supply)**
Tier 1	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay
Tier 2	Preferred Brand: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Preferred Brand: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Preferred Brand: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay
Tier 3	Non-Preferred Brand: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Non-Preferred Brand: $25 coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Non-Preferred Brand: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay
Mail Order	**Mail Order (90-day supply, except Specialty)**	**Mail Order (90-day supply, except Specialty)**	**Mail Order (90-day supply, except Specialty)**
	Preferred Brand: 25% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay	Preferred Brand: 25% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay	Preferred Brand: 25% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay
	Non-Preferred Brand: 25% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay	Non-Preferred Brand: 25% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay	Non-Preferred Brand: 35% coinsurance, Minimum $35 co-pay, Maximum $175 co-pay

	Specialty: 30-day supply only. Must be filled at Costco Specialty Pharmacy. 25% coinsurance, Minimum $100 co-pay, Maximum $200 co-pay	Specialty: 30-day supply only. Must be filled at Costco Specialty Pharmacy. 25% coinsurance, Minimum $100 co-pay, Maximum $200 co-pay	Specialty: 30-day supply only. Must be filled at Costco Specialty Pharmacy. 25% coinsurance, Minimum $100 co-pay, Maximum $200 co-pay
	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay	Generic: 25% coinsurance, Minimum $15 co-pay, Maximum $75 co-pay

Retail and Mail Order Prescription Drug Coverage is subject to the following:

- Difference between cost of brand name drug and generic: If a Covered Person chooses a brand name drug where there is a generic alternative available, in addition to the above co-payments, the Covered Person must pay the difference between the cost of a brand name and generic drug.

- Quantity Limits: Covered drugs may be filled for a maximum of a 34-day supply at a retail pharmacy. A mail order prescription drug program is available for maintenance drugs, which allows a Participant or Dependent to obtain a 90-day supply of a covered drug subject to a single co-payment as set forth above. 34-day and 90-day quantity limits are determined by the Pharmacy Benefits Manager. A list of such limits is available at the Fund Office upon request.

- Generic Substitution: Unless otherwise prescribed by a physician, if there is a generic alternative, available prescriptions will be filled with generic drugs even if the physician prescribes a brand drug. As noted above, in addition to the co-insurance or co-payment amount, the Covered Person must pay the difference between the cost of any brand name and generic drug.

- Reimbursement: If a Participant or Dependent pays cash for a covered drug, the Fund will reimburse the Participant, excluding any applicable co-payment. Requests for reimbursement must be submitted to the prescription drug service provider within 90 days of payment.

(e) Prior Authorization and Step Therapy

Certain drugs require prior authorization to be covered. A list of such drugs is available from the Fund Office or PBM.

Compound drugs which cost the Fund over $200 require an acceptable letter of medical necessity to be covered.

Certain drugs are subject to a step therapy program. A list of such drugs is available from the Fund Office or PBM.

(f) Prescription Drug and Medical In-Network Combined Out of Pocket Maximum

The combined in-network annual out of pocket maximums for medical (deductible, co-payments. and co-insurance) and prescription drugs (co-payments, and co-insurance) for in-network essential health benefits cannot exceed annual limits imposed by the Affordable Care Act, for 2024 these amounts are $9,450 per individual and $18,900 per family. Once this amount has been met during the calendar year, all in-network essential health benefits thereafter will be paid at 100% of the approved amount. The Plan annual out of pocket maximums for in-network essential health benefits will be automatically adjusted each year to the limits set by the IJS Department of Health and Human Services (HHS).

5.6 Managed Second Opinion Program

In order to prevent unnecessary or potentially harmful surgical treatments, the second opinion program fulfills the dual purpose of protecting the health of the patient and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the medical necessity of an elective surgical procedure or to explore alternatives. An elective surgical procedure is one that can be scheduled in advance; that is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending physician and who is similarly board certified in the appropriate specialty. Charges for a second surgical opinion will be paid at 100% of reasonable and customary charges even if the deductible has not been satisfied.

5.7 Benchmark

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

ARTICLE 6 – SCHEDULE OF BENEFITS – OPT-OUT A COVERAGE

Opt-Out coverage is available to: (1) Active Participants, non-Medicare eligible Pensioners, and non- Medicare eligible Surviving Spouses who opt-out of Medical/Rx coverage under Article 5, and (2) Medicare eligible Participants and Medicare eligible Surviving Spouses who have opted out of coverage under Section 21.2.

Opt-Out A coverage provides the following:

6.1 Dental Coverage

Dental benefits under the Opt-Out Plan are self-funded. A Participant may opt-out of receiving Dental benefits under this Opt-Out coverage.

(a) Definitions Applicable to Dental Coverage

As used in this section, the following words have the following meanings:

- Covered Dental Charges means the Reasonable and Customary charges of a Dentist that an individual is required to pay for services and supplies that are necessary for treatment of a dental condition rendered in accordance with accepted standards of dental practice.

- Dentist means a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.
- Diagnostic Services means procedures employed by the Dentist in evaluating the existing condition to determine the required dental treatment.

- Endodontic Services means procedures for the treatment of non-vital teeth.

- Treatment Date means the date that the service is rendered except for the following:

  A. For crowns, bridges, inlays, onlays, and dentures the Treatment Date shall be the date the final impression is taken.
  B. For Endodontic Services the Treatment Date shall be the date the pulp chamber is opened and drained.
  C. For Orthodontic Services the Treatment Date shall be the date the initial appliance is installed.

- Orthodontic Services means necessary treatment and procedures required for the correction of malposed teeth.

- Posterior Tooth or Teeth means all teeth located distal to the bicuspids.

- Preventive Services means dental procedures or techniques employed by a Dentist to prevent the occurrence of dental abnormalities or disease.

- Prosthodontic Services means procedures for construction of fixed bridgework, partial and complete dentures.

- Restorative Services means those techniques employed to rebuild, reform, or repair the substance of the teeth lost by cavities.

(b) Benefits and Exclusions

Benefits are payable for Covered Dental Charges if the Treatment Date is within the period of time that the Participant is eligible for coverage. Any such benefits are subject to Annual and Lifetime Maximums, Copayments, Exclusions, and

other applicable limitations.

Covered Dental Services

(1) Type 1 Services Preventive and Diagnostic Dental Procedures

- Prophylaxis treatment, including scaling and polishing, not to exceed two such procedures per insured individual in a calendar year.
- Four bite wing x-rays per individual per calendar year.
- One full mouth x-ray per individual every three calendar years.
- One full mouth fluoride treatment, not to exceed one per calendar year for each dependent child to age 26 if medically and dentally necessary.
- Space maintainers for covered dependent children under age 26 to replace primary teeth if medically and dentally necessary.
- Two dental examinations per individual per calendar year.
- Emergency palliative treatment for pain.
- Other x-rays when needed to diagnose and treat a specified covered condition.

(2) Type 2 Services – Basic Dental Procedures

- Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.
- Bite splint appliances once every 5 years
- Periodontics (gum treatments).
- Endodontics (root canals).
- Extractions. This service includes local anesthesia and routine post-operative care.
- Recementing bridges, crowns, inlays, onlays, or dentures.
- Fillings, other than gold.
- General anesthetics, upon demonstration of Medical Necessity.
- Antibiotic drugs.
- Relining or rebasing of dentures, but not more than one of either in a 36 month period.
- Sealants; occlusal guards.

(3) Type 3 Services – Major Dental Procedures

- Gold restorations, including inlays, onlays and foil fillings.
- Installation of crowns.
- Installing precision attachments for removable dentures.
- Installing partial, full or removable dentures to replace one or more natural teeth, except third molars.

- Initial installation of fixed bridgework to replace one or more natural teeth.
- Repair of crowns, bridgework, and removable dentures.

(4) Type 4 Services – Orthodontic Procedures

Orthodontic Services including all necessary examinations, interceptive therapy and comprehensive therapy. This benefit is only available for persons younger than 26 years of age.

(c) Schedule of Benefits

Deductible per Covered Person for Type 1-4 Services: $ -0-

Percentage of Covered Dental Charges Paid by Fund for Services:

	Plan Pays
Type 1 Services	100%
Type 2 Services	100%
Type 3 Services	80%
Type 4 Services	50%

(d) Dental Benefit Maximums

Benefits for each Participant and Dependent shall not exceed the benefit maximum as follows:

Type 1, 2 and 3 combined – Annual.....$1,500.00

Type 4 – Lifetime..... $1,500.00

(e) Predetermination of Dental Coverage

A Predetermination of Dental Coverage from the Dentist may be filed with the Fund Office prior to treatment. In response, the Fund Office will inform the Participant or Dependent receiving treatment and the attending Dentist of the amount payable under the Plan for such treatment. Treatment must begin within ninety days of the receipt of the Fund Office's response or the Predetermination of Dental Coverage shall be rendered invalid.

If a Predetermination of Dental Coverage is not submitted prior to services being performed, payment will be paid based on the information submitted and the terms and provisions of this Plan. If the Dentist submits a Predetermination of Dental Coverage and then alters the course of treatment, payments will be adjusted accordingly.

(f) Exclusions

All of the exclusions listed above in Section 5.3 apply to the provision of dental benefits. In addition, dental benefits payable under this Plan shall not include any of the following:

(1) charges for services furnished without the recommendation and approval of a Dentist acting within the scope of his license; or

(2) charges for services not dentally necessary, unless such service is specifically listed as eligible under Covered Dental Expenses; or

(3) charges for services performed primarily for cosmetic reasons, unless such service is specifically listed as eligible under Covered Dental Charges; or

(4) charges for the replacement of lost, missing, stolen or duplicate prosthetic devices or other dental appliances; or

(5) charges for facings on pontics or crowns posterior to the second bicuspid; or

(6) charges for any care, services, or supplies or devices provided for or in connection with the treatment of the temporomandibular joint or for Temporomandibular Joint Dysfunction or Syndrome (TMJ); or

(7) charges for prophylaxis, or oral examinations more often than two times in a calendar year; or

(8) charges for fluoride treatment more often than once in a calendar year; or

(9) charges for a complete series, full mouth x-rays, or panorex more often than once in a 36-month period; or

(10) charges for adjustments of prosthodontic appliances within six months of their initial placement; or

(11) charges for dental treatment or visits which consist only of a telephone communication; or

(12) charges for relines of full or partial dentures more often than once in a 36 month period and within 12 months after the initial placement; or

(13) charges for a bite splint appliance more often than once in a five year period; or

(14) charges for bio-feedback training; or

(15) charges for a partial or full removable denture, fixed bridgework, a crown or gold restoration, if the replacement of such denture, bridgework, crown or gold restoration is required within five years after the previous installation unless made necessary by the loss of additional teeth; or

(16) charges for procedures, appliances or restorations necessary to alter vertical dimensions or restore occlusion; or

(17) Expenses incurred for or relating to dental implants.

(g) Reimbursement of Expenses

Eligible expenses will be reimbursed in accordance with Section 5.5, above.

6.2 Vision Discount Card

Opt-Out Participants and their Dependents are issued a Vision Discount Card from SVS Vision.

The following chart outlines the available coverages depending on whether a Participant goes to an SVS affiliated provider or resides more than 25 miles from an SVS affiliated provider and therefore obtains services from a non-affiliated provider:

SVS AFFILIATED PROVIDER	
Vision Testing Examination (includes Contact Exam)	Full Coverage
Frames	
Fashion Frames	Full Coverage
Designer Frames	$24 Allowance
Regular Lenses (Glass or Plastic)	
Single Vision	Full Coverage
Bifocal	Full Coverage
Trifocal	Full Coverage
Special	Full Coverage
Contact Lenses (in lieu of glasses)	
Cosmetic	$50.00
Medically Necessary	Full Coverage
Note: Contact Exam and Professional Fees included.	
RESIDING OUTSIDE 25 MILES OF SVS	
Vision Testing Exam (Refraction)	$45.00
Frame Only	$45.00
Regular Lenses (Glass or Plastic)	
* Single Vision	$38.00
* Bifocal	$50.00

* Trifocal	$59.00
* Special	$67.00
Contact Lenses (in lieu of glasses)	
Cosmetic	$61.00
Medically Necessary	$169.00
Note: Contact Exam and Professional Fees Additional	

In addition to the above:

(1) Participants shall receive a 20% discount on all out-of-pocket expenses;

(2) SVS warrants all frames and lenses for one year;

(3) There is no extra charge for oversized lenses or extra strong prescriptions; and

(4) The following vision care coverage will not be offered to Participants: Medical and Surgical Treatment, Visual Training, Orthoptics, Photo-sensitive Lenses, Tints other than Solid No. 1 or No. 2, or Low Vision Aids, unless otherwise indicated above.

6.3 Health Reimbursement Account (HRA)

Pensioners and Surviving Spouses who have elected Opt-Out A coverage receive a $600.00 annual credit to their Health Reimbursement Account. Active Participants who have elected Opt-Out A receive an additional $3.00 per hour of Contributions received. Use of the HRA is governed by Section 3.3. Annually, a Participant is permitted to permanently opt-out of and waive HRA benefits provided under this Opt-Out coverage.

6.4 Other Coverage

Opt-Out Participants are eligible for benefits set forth in Article 3 subject to the terms and conditions set forth therein.

ARTICLE 7 – SCHEDULE OF BENEFITS – OPT-OUT B COVERAGE

Opt-Out B coverage provides the following:

7.1 Health Reimbursement Account (HRA)

Pensioners and Surviving Spouses who have elected Opt-Out B coverage receive a $600.00 annual credit to their Health Reimbursement Account. Active Participants who have elected Opt-Out A receive an additional $3.00 per hour of Contributions received. Use of the HRA is governed by Section 3.3. Annually, a Participant is permitted to permanently opt-out of and waive HRA benefits provided under this Opt-Out coverage.

7.2 Other Coverage

Opt-Out B Participants are eligible for benefits set forth in Article 3 subject to the terms and conditions set forth therein.

ARTICLE 8 – COORDINATION OF BENEFITS

8.1 Application

This provision shall apply in determining the benefits for an allowable expense, if the sum of:

(a) the benefits that would be payable under the Plan in the absence of this provision; and

(b) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision, would exceed such allowable expense payable under this Plan.

8.2 Coordination

Plan rules regarding coordination:

(a) Another plan without a coordinating provision shall always be deemed to be the primary Plan.

(b) If another plan has a provision that makes this Plan primary, then:

(1) The plan covering the patient directly rather than as a dependent is primary and the other is secondary.

(2) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

(3) If neither (1) nor (2) applies, the plan covering the patient longest is primary.

(c) With respect to dependents of divorced parents, the following rule applies:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;

(2) if (1) does not apply:

(A) the plan covering the parent with custody of the dependent shall be

considered the primary plan;

(B) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable; then

(C) the plan covering the parent without custody shall be considered last.

(3) if neither (1) nor (2) apply, coordination of benefits shall be determined in accordance with the Michigan Coordination of Benefits Act (MCL 550.251, et seq.), or any successor law.

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

The following addresses specific situations where MSP Rules are applicable:

(1) Coordination with Coverage by Virtue of Current Employment Status

In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Pensioner under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is

(A) Secondary to the plan covering the Covered Person as a dependent, and

(B) Primary to the plan covering the Covered Person other than as a dependent,

then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Pensioner is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse's plan are primary to the benefits provided by this Plan (and in no event will this Plan pay more than the complementary Medicare coverage set forth in Section 5.4).

(2) End Stage Renal Disease

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility

and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by Medicare's Secondary Payer rules.

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

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

As to any Calendar Year to which this provision is applicable, the benefits that would be payable under the Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced benefits and the benefits payable for such allowable expenses under another plan(s) shall not exceed the total allowable expenses under this Plan. Benefits payable under another plan include the benefits that would have been payable had the claim been duly filed under that plan.

Notwithstanding anything in this section to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan.

For the purpose of coordination of benefits with other plans, as allowed by applicable law, the Plan Administrator shall retain the right, without the consent of or notice to any person, to release or to obtain from any insurance company or other organization or person, any information, with respect to any Participant or Dependent, which the Plan Administrator deems to be necessary for the purpose of implementing this provision. Any person claiming benefits under the Plan shall furnish to the Plan Administrator such information as may be necessary to administer this provision and as allowed by applicable law.

Whenever payments have been made by the Plan with respect to allowable expenses in a total amount which is at any time in excess of the maximum amount of payment necessary at that time to satisfy the requirements of this provision, the Fund has the right to recover such excess payments from among one or more of the following: any persons to or for, or with respect to whom, such payments were made; any insurance companies; or any other organizations.

ARTICLE 9 – THIRD PARTY LIABILITY

9.1 Subrogation

(a) Application

Subrogation means the Plan has the right to recover from a Participant or

Dependent those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are paid by the Plan to a Participant or Dependent for medical, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Participant or Dependent may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

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

The Plan's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Plan's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Plan has first priority to any funds recovered by the injured Participant or Dependent from the third party or insurer.

Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, i.e., the common fund doctrine will not be applied.

The Plan also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Plan is repaid in full for benefits paid because of the injury.

(b) Conditions to Payment of Benefits

If a Participant or Dependent sustains an injury caused by a third party, the Plan will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(1) As soon as reasonably possible, the Participant or Dependent must notify the Claims Administrator that he or she has an injury caused by a third party.

(2) Prior to the receipt of benefits for such injury, the injured Participant or Dependent must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third

party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Participant or Dependent or other person as required by law.)

(3) The Participant or Dependent does not take any action that would prejudice the Plan's subrogation rights.

(4) The Participant or Dependent cooperates in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim

The Plan's subrogation rights allows the Plan to directly pursue any claims the Participant or Dependent has against any third party, or insurer, whether or not the Participant or Dependent chooses to pursue that claim.

(d) Enforcement

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Participant or Dependent, the Participant or Dependent agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other equitable remedy.

At the Plan's option, it may enforce this provision by deducting amounts owed from future benefits.

9.2 Workers' Compensation

The Plan does not pay any claims covered by Workers' Compensation. The Plan will only cover those claims which:

(a) Workers' Compensation denies because they are not work related; and

(b) Are covered under the terms of the Plan.

If a Participant or Dependent receives any benefits under this Plan that are properly payable by workers' compensation, then this Plan must be indemnified by the Participant or Dependent for the amount paid by the Plan for such benefits. The Plan shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section.

ARTICLE 10 – RECIPROCITY

Upon receipt of a Reciprocity Authorization and subject to the rules and regulations adopted by the Trustees, the Fund may enter into reciprocity agreements pursuant to which (1) Contributions received on behalf of individuals who are working on a temporary basis in the jurisdiction of the Union will be forwarded to such individuals' home locals, and (2) contributions received from other health and welfare funds on behalf of Participants will be credited by the Fund.

ARTICLE 11 – INTERNAL CLAIMS AND APPEALS PROCESS

For benefits provided under the fully insured policies, including life insurance, and the Medicare Policy set forth in Article 21, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of this Article 11 and 12.

11.1 Types of Claims Reviewed Under this Article 11

Urgent Health Claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;

Pre-service Health Claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;

Post-service Health Claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician;

Concurrent Claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination;

Claims Contesting Rescission of Coverage: claims based on a retroactive cancellation of coverage; and

Disability Claims: initial claims for disability benefits or any claims contesting the rescission of coverage of a disability benefit.

11.2 Initial Submission of Claims

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

11.3 Notice That Additional Information is Needed to Process Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

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

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

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

11.4 Avoiding Conflicts of Interest

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

11.5 Initial Decision on a Claim

(a) Additional Evidence

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

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

(b) The Fund Deadline for Making an Initial Decision on a Claim is:

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.

- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

- For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

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

11.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

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

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

- An explanation of the basis for disagreeing with any of the following:

- The health care professionals that treated the Claimant;
- The advice of the health professional obtained by the Plan; or
- A disability determination from the Social Security Administration.

- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

- The adverse benefit determination must be in a culturally and linguistically appropriate manner as required by law.

11.7 Internal Appeals

(a) Adverse Benefit Determinations

A Claimant may appeal any Adverse Benefit Determination received Section 11.6. An Adverse Benefit Determination means any of the following:

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

(b) Submission of Internal Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment

pending the outcome of an internal appeal.

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted to the Fund Office.

(c) Time for Submitting Internal Appeals

A Claimant must appeal a benefit denial within the following time limits:

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

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

(d) Notice of Decision on Internal Appeal

The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable),
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA §502(a); and
- a statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar

date on which such contractual limitation expires.

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

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

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

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

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

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims – 30 days after receiving the appeal if one level appeal is applicable.
- For Post-Service Health Claims: The Trustees shall decide the appeal at a Board Meeting.*
- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be

made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.

11.8 Deemed Exhaustion of Internal Claims and Appeals Processes

If the Plan fails to adhere to all the requirements in this Article 11 with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 12. The Claimant is also entitled to pursue any available remedies under Section 502(a) of ERISA, or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue available remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

11.9 Discretion of Trustees

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

conclusive.

11.10 Limitations of Actions

For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in Section 12.2. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

ARTICLE 12 – EXTERNAL REVIEW PROCESS

12.1 Eligibility for External Review

The external review process applies to any final internal adverse benefit determination that involves (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment); (2) whether the Plan is complying with the nonquantitative treatment limitation provisions which, in general require parity in the application of medical management techniques; (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717; or (4) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review.

A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan, or based on a Plan exclusion is not eligible for the external review process.

12.2 Request for External Review

A Claimant must file a request for an external review with the Fund within four months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law.

The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

12.3 Preliminary Review

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

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;

(ii) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the Plan's internal appeal process; and

(iv) The Claimant has provided all the information and forms required to process an external review.

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

12.4 Referral to Independent Review Organization

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

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

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

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

Claimant and Fund within one business day.

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

1. The Claimant's medical records;

2. The attending health care professional's recommendation;

3. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;

4. The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

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

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

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

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

2. the date the IRO received the assignment and the date of the IRO decision;

3. references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

6. A statement that judicial review may be available to the Claimant; and

7. Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

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

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

12.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives:

(i) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal

adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as outlined in Section 12.3, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

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

12.6 Discretion of Trustees

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

12.7 Limitations of Actions

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

ARTICLE 13 – COBRA

13.1 Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated

Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

For avoidance of doubt, all references to legal separation includes a Judgment or Order of Separate Maintenance under Michigan law or other similar orders or judgment under other applicable state law

13.2 Nature of COBRA Continuation Coverage

(a) COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his Spouse, and dependent Children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(b) A Participant will become a qualified beneficiary if coverage is lost under the Fund because either one of the following qualifying events happens:

(1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or

(2) Employment ends for any reason other than gross misconduct.

(c) The Spouse of a participant will become a qualified beneficiary if coverage is lost under the Fund because any of the following qualifying events happens:

(1) Death of spouse;

(2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;

(3) Spouse's employment ends for any reason other than his or her gross misconduct;

(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) Divorce or legal separation from the participant.

(d) Dependent Children become qualified beneficiaries if coverage is lost under the Fund because any of the following qualifying events happens:

(1) The parent-participant dies;

(2) The parent-participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;

(3) The parent-participant's employment ends for any reason other than his or her gross misconduct;

(4) The parent-participant becomes entitled to Medicare benefits (under Part A, Part B, or both);

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

(6) The child stops being eligible for coverage under the Fund as a "Dependent Child."

13.3 When COBRA Coverage Is Available

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

13.4 Participant/Spouse Obligation to Give Notice to the Fund of Some Qualifying Events

In the event of legal separation or divorce or a dependent child loses eligibility for coverage as a dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the participant and his spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce or legal separation), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Fund of a legal separation, divorce or a child losing eligibility gives the Fund the right to hold the participant and his/her spouse separately and fully liable for any benefits paid by the Fund which would not have been paid had the Fund received timely notification of such event. At its sole election, the Fund may suspend the payment of future benefits until such amount has been recovered.

13.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Fund for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Fund.

Coverage under the Fund will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium.

13.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(a) When the qualifying event is the death of the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(b) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

> For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

(c) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(1) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Fund is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18- month period of continuation coverage.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(2) Second Qualifying Event Extension

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

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

13.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

13.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA

premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. Coverage will be terminated on the first day of the month of coverage for which payment has not yet been received, and retroactively reinstated if such payment is received within the grace period. If payments are not made by the end of the grace period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

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

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

Qualified Beneficiaries who have COBRA coverage under the Opt-Out plan will not be required to pay a monthly premium for such coverage. All other terms and conditions of COBRA coverage will continue to apply. If upon a duly made motion to review this provision there is not unanimous consent for this waiver of premium to remain part of this Plan, it shall automatically terminate.

13.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Fund.

If a Qualifying Event occurs, the Fund Office will offer each Qualified Beneficiary an opportunity to elect to continue the health care coverage as provided below:

(a) If on the day before the Qualifying Event, the Qualified Beneficiary was covered under the Medical/Rx plan, COBRA Continuation Coverage will be offered for the following benefits:

(1) Medical/Rx Coverage the Qualified Beneficiary had on day before the Qualifying Event); and

(2) Health Reimbursement Account for the year in which the Qualifying Event occurred only or, at the Qualified Beneficiary's option, for the duration of the Continuation Coverage.

The Qualified Beneficiary may choose to continue Medical Coverage only.

(b) If on the day before the Qualifying Event, the Qualified Beneficiary was covered under Opt-Out coverage, COBRA Continuation Coverage will be offered for the following benefits:

(1) Self-funded dental;

(2) Vision Discount Card; and

(3) Health Reimbursement Account for the year in which the Qualifying Event occurred only or, at the Qualified Beneficiary's option, for the duration of the Continuation Coverage.

The Qualified Beneficiary may choose to continue the self-funded dental and vision benefits only.

Note also that coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the Fund. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

13.10 Enrollment of Dependents During Period of COBRA Coverage/Coverage Options

A child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a child to COBRA coverage, he must notify the Fund Office within 30 days of the adoption, placement for adoption, or birth.

During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, he must notify the Fund Office within 30 days of the loss of coverage.

13.11 Qualified Medical Child Support Orders

If a Child is enrolled in the Fund pursuant to a qualified medical child support order while the Participant was an active employee under the Fund, he is entitled to the same rights under COBRA as any dependent Child.

13.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits

and such entitlement would have caused the qualified beneficiary to lose coverage under the Fund had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

13.13 Keep the Fund Office Informed of Address Changes

A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

13.14 Exclusions from COBRA Coverage

COBRA coverage will not be offered to:

(a) Anyone who is:

(1) a self-employed plumber (e.g., a Working Principal),

(2) a shareholder, owner, partner, proprietor, officer, director, or salaried employee of an Employer, or

(3) the spouse, child, parent, or sibling of any person defined under subparagraph (1) or (2),

if the reason for loss of coverage is failure of the Employer to remit required contributions; or

(b) Any Participant, or Spouse or Child of such Participant, not included in (a), above, if the Participant fails to obey a strike notice issued as a result of failure of an Employer to pay contributions.

ARTICLE 14 – QUALIFIED MEDICAL SUPPORT ORDER

As set forth below, and in accordance with §609 of ERISA, this Plan shall provide benefits as required by a Qualified Medical Support Order.

14.1 Qualified Medical Child Support Order ("QMCSO") means a medical child support order-

(a) which creates or recognizes the existence of an Alternate Recipient's right to, or

assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and

(b) clearly specifies

(1) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient (i.e. child/ren) covered by the order (except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any alternate recipient);

(2) a reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined;

(3) the period to which such order applies; and

(4) the plan to which the order applies.

14.2 A medical child support order will fail to be a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 U.S.C. §1396g-1.

14.3 Procedures for Determining Qualified Status of Medical Support Orders.

Upon receipt of a medical child support order, the following procedures will be used when determining whether it is a Qualified Medical Child Support Order pursuant to the terms of ERISA:

(a) The Participant and any potential Alternate Recipients and/or their designated representatives will be immediately notified in writing that the Order has been received by the Fund and has been referred to legal counsel for determination of its status within 45 days, such notice to include a provision permitting an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order and a copy of the plan's procedures for determining the qualified status of the order.

(b) The Order will be simultaneously referred to the Fund Attorneys for review and a determination of its status. This determination will be made within 45 days after receipt of the Order or within any time period that may be established by federal regulations in the future.

(c) After determining the status of an Order, the Participant and Alternate Recipients and/or their designated representatives will be notified in writing. If the QMCSO

is acceptable, the Alternate Recipients and/or their designated representative will be informed of the Alternative Recipient's health benefits and of the Plan's procedures to provide benefits.

(d) If the Funds' legal counsel determines that an Order is not a QMCSO, legal counsel will suggest necessary modifications. During this interim period, the Fund may either provide coverage or wait and provide retroactive coverage once the QMCSO is approved.

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

14.4 National Medical Support Notice Deemed to be a QMCSO

(a) If the Plan receives an appropriately completed National Medical Support Notice and the Notice meets the requirements of Section 14.1, the Notice shall be deemed to be a QMCSO.

(b) In any case in which an appropriately completed National Medical Support Notice is issued regarding a child of a plan participant who is a noncustodial parent, and the Notice is deemed under Section 14.4(a) to be a qualified medical child support order, the Fund Office, within 40 business days after the date of the Notice, shall –

(1) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to paragraph A.2.(a)) to effectuate the coverage; and

(2) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this subparagraph shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.

14.5 Any payment for benefits made by the Fund pursuant to a QMCSO in reimbursement for

expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

14.6 The Plan will comply with any other requirements of §609 of ERISA regarding QMCSO.

ARTICLE 15 – FAMILY AND MEDICAL LEAVE ACT

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

If the Employer continues a Participant's coverage during an FMLA leave and the Participant fails to return to work, he may be required to repay the Employer for all contributions paid to the Plan for such coverage during the leave. The Fund will not return any contributions to the Employer. Failure to return to work at the end of a FMLA Leave may constitute a Qualifying Event under COBRA.

ARTICLE 16 – INTERPRETATION OF PLAN DOCUMENTS

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

ARTICLE 17 – ABSENCE DUE TO MILITARY DUTY

If coverage under the Plan is terminating due to military service, a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. Military service means that service covered under the Uniformed Services Employment and Reemployment Act, 38 USC §4303. The Participant must notify the Fund Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.

Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period of service must be less than five years and a Participant must return to work as a Plumber under the Collective Bargaining Agreement within the following time frames:

- For uniformed service of less than 31 days, by the next workday after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of the Participant.

- For service of more than 30 days but less than 181 days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant.

- For service of more than 180 days, within 90 days after completion of the service.

ARTICLE 18 – CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages under this Plan, for any or all classes of Participants or Dependents, at any time.

ARTICLE 19 – HIPAA PLAN SPONSOR PROVISIONS

Protected Health Information ("PHI"), as defined in HIPAA, shall only be disclosed to the Plan Sponsors in accordance with the following procedures:

19.1 PHI will only be disclosed to Plan Sponsors (i.e. the Union or the Association) when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations.

19.2 The Plan Sponsors agree to:

(a) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Provide individuals access to PHI as required by the privacy rules;

(f) Provide individuals the right to amend PHI maintained in a designated record set as required by the privacy rules;

(g) Make available the information required to provide an accounting of disclosures or PHI as required by the privacy rules;

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Director of the Secretary of Health and Human Services, or its designee, for purposes of determining compliance by the group health plan with this subpart;

(i) If feasible, return or destroy all PHI received from the plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Provide for adequate separation between the group health plan and the plan sponsor. To do so:

(1) Only those employees of the Plan Sponsor who are also Trustees of this Fund shall be given access to the PHI;

(2) Access to PHI for such individuals shall be limited to the plan administration functions that the Plan Sponsor performs for the group health plan; and

(3) Any issue of noncompliance by such persons with these provisions shall be referred to the Trustees for resolution and appropriate action.

19.3 The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor shall, in accordance with the Security Regulations:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.

(3) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(4) Report to the Plan any Security Incident of which it becomes aware.

ARTICLE 20 – RESCISSION OF COVERAGE

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce or legal separation, (2) lapsed Union membership, which is required to maintain Retiree coverage, (3) that a Participant or Dependent is covered under another health plan, or (4) any other event which makes a Participant a Dependent ineligible for coverage.

A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

In the event coverage is rescinded as a result of fraud or intentional misrepresentation, in addition to any legal and equitable means of recovery available, the Plan has the right to demand and receive repayment from the Participant or Dependent, jointly and severally, for all costs incurred by the Fund after the Date of Rescission, and the Fund is also entitled to demand and receive repayment from the Participant or Dependent, on a joint and several basis, all costs and attorneys' fees expended in collecting such amounts owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

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

administrative recordkeeping.

ARTICLE 21 – MEDICARE ELIGIBLE PARTICIPANTS AND DEPENDENTS

21.1 Coverage

Medicare eligible Participants and Dependents are provided coverage via a fully insured Medicare coordinated policy (Medicare Policy). The terms and conditions of such coverage are set forth in the Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and drug plan set forth in Article 5.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare or the Medicare Policy.

This Fund does not cover any expenses for Medicare eligible Participants or Dependents. All such expenses are covered by Medicare or the Medicare Policy.

21.2 Opt-Out

A Medicare eligible Participant may opt-out of coverage under the Fund and re-enroll at a later date under the following conditions:

(a) A Participant and his/her Medicare eligible dependents can re-enroll at a later date only if: (1) they have maintained Medicare Parts A (hospitalization), B (medical), and Part D (prescription drugs) from the date of opt-out to the date of re-enrollment, and (2) the Participant otherwise qualifies for coverage as a Pensioner. Medicare Part D prescription drug coverage will be considered maintained during this period only if obtained at the earliest date available after the date of opt-out.

(b) For any eligible dependent who is not Medicare eligible, only if: (1) he/she has maintained comprehensive health care coverage, similar to the coverage provided by the self-insured medical and prescription drug coverage provided by the Fund (Other Coverage) from the date of opt-out to the date of re-enrollment, and (2) the Participant re-enrolls under (a), above. The Trustees shall determine in their sole discretion whether the Other Coverage was similar to coverage provided by the Fund.

(c) For purposes of the foregoing provisions, "date of re-enrollment" is the date coverage is re-established under this Fund, as follows:

(1) For the Participant and his/her Medicare eligible Dependents, the date

allowed by the Medicare plan in effect at the time of re-enrollment; and

(2) For the Participant's non-Medicare eligible Dependents, coverage under the self-insured medical and prescription drug coverage provided by the Fund will become effective on the same date coverage under (1) becomes effective for the Participant.

(d) Provided the Participant would have been eligible to reinstate his own coverage under the Fund as of the date of his death, upon the Participant's death, his/her Surviving Spouse can re-enroll in the Fund if he or she provides proof of coverage as set forth in (a) or (b) above, as applicable, and makes a request to re-enroll within 30 days of the Participant's death. If Medicare eligible, the Surviving Spouse's coverage will take effect no earlier than the date allowed by the Medicare plan in effect at that time. If not Medicare eligible, his/her coverage will take effect the first of the month following the date of the request.

(e) Any request for re-enrollment will be subject to all the terms of the Plan document in effect at the time of any such request.

ARTICLE 22 – DIALYSIS BENEFIT PRESERVATION PROGRAM

Dialysis Benefit Preservation Program

The Fund has contracted with a dialysis cost management company to provide managed outpatient dialysis. This service is optional and is provided at no cost to Covered Persons. If the Covered Person elects to have their outpatient dialysis benefits processed under this program, this program is provided in lieu of other outpatient dialysis benefits provided under the Plan. Once identified as a potential candidate, a Covered Person will be contacted by a representative to offer enrollment in the Dialysis Benefit Preservation Program (the "Dialysis Program").

22.1 Care Support

Through the Dialysis Program, an expert Dialysis Treatment Coordinator contacts the Covered Person to offer cost savings techniques to help extend Plan benefits. Cost savings techniques include purchasing Medicare supplement during the dialysis waiting period prior to Medicare becoming your primary payer; self-injecting epogen at home; and exploring home hemodialysis as an option. Pre-certification of dialysis is required. Please see more details in Section 22.2.

22.2 Outpatient Dialysis Management Program

(a) Outpatient Dialysis Treatment – Coverage

Outpatient Dialysis Treatment will be covered at 100% of the Usual and Reasonable Charge for out-of-network services. When a provider, including a PPO provider, accepts the payment from the Plan for services provided under this Article 22, the provider will be deemed to consent and agree that: (i) such

payment shall be for the full amount due for the provision of services and supplies to a covered person, and (ii) it shall not "balance bill" a covered person for any amount billed but not paid by the Plan. However, in no event will the Plan be responsible for any amount in excess of the applicable PPO negotiated charge for an in-network provider or Usual and Reasonable for an out of network provider.

(b) Outpatient Dialysis Treatment – Description

This Section describes the Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to covered persons and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis, under the Dialysis program.

(1) Reasons for the Dialysis Program. The Dialysis Program has been established to provide cost effective services, taking into consideration:

(A) the concentration of dialysis providers in the market in which covered persons reside may allow such providers to exercise control over prices for dialysis-related products and services,

(B) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to covered persons,

(C) evidence of (i) significant inflation of the prices charged to covered persons by dialysis providers, (ii) the use of revenues from claims paid on behalf of covered persons to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(D) the fiduciary obligation to preserve Plan assets against charges which exceed reasonable value due to factors not beneficial to covered persons, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the covered persons interests, such as subsidies for other plans and discriminatory profit-taking.

(2) Dialysis Program Components. The components of the Dialysis Program are as follows:

(A) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, covered persons for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-

related claims").

(B) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after the effective date of a covered person's enrollment in the Dialysis Program, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the covered person.

(C) Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies received on an out of network basis and the PPO fee for covered services and/or supplies received on an in-network basis, after deduction for all amounts payable by coinsurance or deductibles. The Plan provisions related to coordination of coverage at Sections 8.2 and 21.1 (regarding Medicare coordination) are applicable to coverage under the Dialysis Program.

(i) Usual and Reasonable Charge. With respect to dialysis related claims, the Usual and Reasonable Charge is based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation, taking into consideration the nature and severity of the condition being treated. Usual and Reasonable Charges shall not include any increase in charges determined to be the result of the effects of market concentration or discrimination in charges.

(a) Market Concentration: Whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

(b) Discrimination in Charges: Whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against

reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or for the same or materially comparable goods and services.

(ii) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the covered person, billed charges also will be reviewed to determine if market concentration and/or discrimination in charges, as described above, have been material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review. If so, the amount payable for such claims by the Fund shall not include any such increase in charges.

(iii) Where appropriate and reasonable, in the Fund's complete discretion it may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with a provider which may differ from the terms of set forth herein for payment.

(iv) All charges must be billed by a provider in accordance with generally accepted industry standards.

(D) Secondary Coverage

As noted above, all payments under this Article 22 are subject to the Plan provisions related to coordination of coverage in Articles 8 and 21.

In the event that a covered person is not required to obtain secondary coverage or Medicare coverage under Article 21 (or any other provision of this Plan), in the event that the Plan Administrator determines that it would reduce Plan expenses if the covered person obtained such coverage, the Plan Administrator may, in its sole and complete discretion, require the covered person to enroll in the other coverage when eligible to do so and reimburse the covered person for the cost of such other coverage for the duration of treatment covered under this Article 22.

22.3 Discretion

Consistent with Article 16 of the Plan, the Trustees have full discretionary authority to interpret the terms of this Article 22, including determining eligibility for benefits and the amount of benefits due.

The Board of Trustees has reviewed, approved, and adopted this restated Plan of Plumbers Local 98 Insurance Trust Fund on this 16th day of October, 2023.

UNION TRUSTEES

EMPLOYER TRUSTEES

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