

RETIREE MEDICAL PLAN
of the
PLUMBERS' WELFARE FUND, LOCAL 130, U. A.

PLAN DOCUMENT
&
SUMMARY PLAN DESCRIPTION
Effective June 1, 2017

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**RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND,
LOCAL 130, U.A.**

June 1, 2017

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7:30 A.M. to 7:00 P.M. (2nd Tuesday of each month)
7:30 A.M. to 8:00 P.M. (4th Thursday of each month)**

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Co-Chairman
Kenneth Turnquist
Scott Spangle
James Mansfield
William Matthies
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Alternate Trustee

EMPLOYER TRUSTEES

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FIELD REPRESENTATIVE

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LEGAL CONSULTANTS

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ACTUARIAL CONSULTANT

Segal Consulting

UTILIZATION REVIEW

Hines & Associates

INTRODUCTION

The Trustees of the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130 U.A. ("Fund") are pleased to furnish you with this new combination Plan Document and Summary Plan Description ("Plan/SPD") that explains the benefits available under the Retiree Medical Plan ("Plan"), summarizes the eligibility rules for participation in the Plan, and presents your rights as a Retiree and the rights of your eligible Spouses. You should take time to read this new Plan/SPD so that you are up to date on the benefits available to you under the Plan. This Plan/SPD describes the benefits available to Retirees and their Spouses and replaces the prior plan document and summary plan description for the Plan. A separate plan document and summary plan description describe the health and welfare benefits available to employees. This Plan is meant to be a "retiree-only" plan under the law.

Immediately following this brief introduction, this Plan/SPD sets out a Schedule of Benefits which will give you a quick reference to the health and welfare benefits provided to you and your Spouse. In most cases, terms that are capitalized are defined either in the Definitions Section of this Plan/SPD or in the applicable section where such terms are used.

It is intended that this Plan/SPD be written so that you can understand how you and your Spouse become eligible for benefit coverage, how you remain eligible for benefit coverage, and what health and welfare benefits are available to you and your Spouse. Do not hesitate to contact the Fund Office if you ever have any questions concerning your eligibility for coverage or the benefits to which you are entitled. The personnel in the Fund Office are there to help you.

Please note that under the Affordable Care Act of 2010 ("ACA"), "retiree-only" plans such as this Plan, are not subject to many of the mandates implemented under the ACA such as dollar limits on essential health benefits and providing 100% coverage for certain preventive care services.

**RETIREE MEDICAL PLAN OF THE
PLUMBERS' WELFARE FUND, LOCAL 130, U. A.**

SCHEDULE OF BENEFITS FOR PRE-MEDICARE RETIREES

RETIREE DEATH BENEFITS

\$7,500.00 to designated Beneficiary of eligible Retiree. If there is no designated Beneficiary, the death benefit will be paid to the surviving Spouse, descendants, or estate of decedent. Death benefit subject to possible offset of \$1,000.00 to be applied to funeral expenses. Divorce revokes designation of Spouse as Beneficiary. No death benefits are paid as a result of the death of a Spouse or surviving Spouse or if Pre-Medicare Retiree coverage is waived.

COVERED PERSONS MEDICAL COVERAGE COST SHARING

Deductible

\$200 per person for Major Medical. **Benefits noted by an asterisk (*) are subject to the annual deductible.** Any partial satisfaction of your deductible under the Health and Welfare Plan will also be carried over to this Retiree Medical Plan.

Copayments

\$150 copayment for each emergency room visit. This amount does not count toward your deductible but does count against your Out of Pocket Max.

Out of Pocket Max

There is a \$5,000 annual Out of Pocket maximum for each individual covered under this Plan.

Limitations on Benefits

The Plan only recognizes medical services and supplies that are Reasonable and Customary. It is important to note the limitations on benefits if the Provider is not a PPO Provider. In general, if you elect to use a non-PPO Provider or non-PPO Facility when a PPO Provider or PPO Facility is available, the Plan will cover only 70% of the Reasonable and Customary charges of Covered Expenses and charges by out-of-network doctors, Hospitals, and other providers, and you will be responsible for the balance of the total charges.

MEDICAL BENEFITS WHEN HOSPITALIZED

PLAN COVERAGE

BENEFIT AMOUNT

Hospital Room and Board*

Room and board in an intensive care unit, semi-private or private room).

There is no charge under the Plan for the first \$2,000.00. The Plan then covers 90% of all amounts exceeding \$2,000.00 in a PPO Hospital or PPO Facility. The Plan will pay 70% of the Reasonable and Customary fees or charges for Covered Expenses provided by a non-network provider.

Inpatient Hospitalization Services*

Necessary services and supplies not included in the Hospital Room and Board charge plus medical charges of a radiologist, blood transfusions, oncologist, hematologist, anesthesiologist, and pathologist incurred during the period of room and board.

There is no charge under the Plan for the first \$2,000.00. The Plan then covers 90% of all amounts exceeding \$2,000.00 in a PPO Hospital or PPO Facility. The Plan will pay 70% of the Reasonable and Customary fees or charges for Covered Expenses provided by a non-network provider. Payable only during the period room and board charges are covered.

Pre-admission Hospital testing

Pre-admission hospital testing consists of required tests performed prior to hospitalization.

Paid in full if the tests are included on the Plan’s Schedule of Benefits for such tests, and the tests are accepted by the Hospital instead of its own inpatient tests.

Attending Physician/Medical Consultants*

There is no charge under the Plan for the first \$2,000.00. The Plan then covers 90% of all amounts exceeding \$2,000 from a PPO Provider. The Plan will pay 70% of the Reasonable and Customary fees or charges for Covered Expenses provided by a non-network provider.

Residential Treatment Center Confinements*

There is no charge under the Plan for the first \$2,000.00. The Plan then covers 90% of all amounts exceeding \$2,000 in an in-network eligible Residential Treatment Center. The Plan will pay 70% of the Reasonable and Customary fees or charges for Covered Expenses provided by a non-network provider. Such benefits are only provided if the attending physician certifies in writing that the proper medical care would require continuous hospitalization in the absence of admission to a Residential Treatment Center. Maximum period of benefits is 365 days less the number of days the patient was hospitalized for the same sickness or illness. Substance Abuse is not covered under this Plan.

SURGICAL BENEFITS

Primary Surgeon’s Charges*

There is no charge under the Plan for the Reasonable and Customary charge in the Chicago area established by the prevailing surgical fee schedule adopted by the Trustees from time to time.

Assistant Surgeon’s Charges*

The Plan pays Assistant Surgeon charges up to 20% of the Reasonable and Customary charge of the PPO Surgeon’s charges. The Plan pays 70% of the 20% of the Reasonable and Customary charge of the non-network primary Surgeon’s charges. Paid only for procedures for which the use of an Assistant Surgeon in the determination of the Trustees, is Medically Necessary.

Second or Third Surgical Opinion*

There is no charge under the Plan for the first \$1,000. The Plan covers 80% of the Reasonable and Customary charges of a PPO Provider exceeding \$1,000. If non-PPO Provider, 70% of Reasonable and Customary for fees or charges for covered expenses paid.

Organ Transplants

The Plan does not cover organ transplants unless a Trustees’ certification of coverage is obtained before the surgery (except for non-experimental emergency procedures). See the explanation section on Organ Transplants. If pre-certification is obtained, applicable Plan benefits are provided for Hospital, medical, surgical, prescription drugs, rehabilitation, and other relevant medical services received.

Transplant Procedure	<u>Maximum Benefit Amount</u>
Kidney	\$143,300.00
Heart	\$391,800.00
Bone Marrow	
- Autologous	\$243,300.00
-Allogenic Related	\$362,100.00
-Allogenic Unrelated	\$447,300.00
Liver	\$313,600.00
Pancreas	\$148,900.00
Lung	\$343,000.00
Heart-Lung	\$504,400.00
Kidney-Pancreas	\$195,500.00
Intestine	\$814,500.00

Hospice Care

For charges incurred for Covered Hospice Care of a Terminally Ill Covered Person, the Plan will pay up to \$400.00 per day with a Maximum of \$74,000.00 for any one period of Hospice Care, plus up to \$500.00 for counseling by a Licensed Practitioner rendered during a period of Hospice Care.

OUTPATIENT BENEFITS

Outpatient Major Medical Care*

Includes office visits, imaging, and other diagnostic tests not otherwise covered elsewhere under the Plan.

There is no charge under the Plan for the first \$1,000 of the Reasonable and Customary charges with a PPO provider. The Plan also covers 80% of the Reasonable and Customary charges of a PPO Provider exceeding the first \$1,000. If Non-PPO Provider, 70% of Reasonable and Customary for fees or charges for covered expenses paid.

Home Health Care*

There is no charge for the first \$1,000.00 of the Reasonable and Customary charges of a PPO Provider. The Plan also covers 80% of the Reasonable and Customary charges or fees of a PPO Provider exceeding \$1,000.00 for a maximum of 365 days less the number of days the patient was in a Hospital for the same sickness or injury.

Durable Medical Equipment and Prosthetic Devices*

Cost covered as an outpatient major medical benefit, but if cost of any equipment or device exceeds \$500.00 (\$1,500 effective January 1, 2018), it must be pre-certified.

Vaccinations*

There is no charge under the Plan for the Reasonable and Customary Charges after the deductible based on fee schedule and Medical Necessity.

PRESCRIPTION DRUGS

100% of Reasonable and Customary cost for up to a **34-day supply** less the applicable copayments as follows:

- \$10.00 - for covered generic drugs,
- \$20.00 - for covered brand name drugs on Express Scripts' formulary, and
- \$40.00 - for covered brand name drugs not on Express Scripts' formulary.

100% for Express Scripts' Prescription Drug Mail Order Program (three-month supply), less the applicable copayments as follows:

- \$ 0.00 - for generic drug,
- \$10.00 - for brand name drug on Express Scripts' formulary, and
- \$20.00 - for covered brand name drugs not on Express Scripts' formulary.

For prescribed specialty and self-administered injectable drugs (except insulin), 100% of Reasonable and Customary cost less the applicable copayment but only if the drug is acquired from Accredo. Unless otherwise determined by the Trustees to be Medically Necessary, effective January 1, 2018, erectile dysfunction medication will be limited to six pills per month and the Plan will pay 50% of the cost of such approved medication. Note: Generic-equivalents will be prescribed unless otherwise determined to be Medically Necessary by the Plan in consultation with the prescribing Physician.

Specialty Drugs as follows:

100% of Reasonable and Customary cost less applicable \$20 copayment, but only if acquired from Accredo.

EYE CARE

Eye Examinations

Up to \$40 per examination in any 12-month period following a \$10 copayment for an examination by an ophthalmologist or licensed optometrist.

Eyeglasses/Contact Lenses

Up to \$150.00 for prescribed eye glasses and frames and prescribed corrective lenses in any 12 month period after a \$20 copayment.

Eye Examination and Eye Glasses or Lenses Following Eye Surgery or Traumatic Injury

The Plan's eye care benefits are provided for each medically prescribed lens change during the six months following eye surgery or a traumatic injury. The Plan's PPO Provider is Eye Med. Call 1-866-723-0514 for a participating location near you.

DENTAL BENEFITS

100% for preventive services. Other dental services will be paid at 50%, subject to a \$50.00 individual deductible. The annual maximum benefit payment for other dental services is \$1,000.00. Both the deductible and maximum are applied separately to each individual covered by the Plan. See Article III for additional information.

HEARING BENEFITS

(Effective January 1, 2018)

Up to \$125.00 with a limit of one examination in any 12 month period.

Up to \$1,500.00 with a limit of one hearing aid instrument in any 60 month period.

Up to \$50.00 for a new molded earpiece, once in each 12 month period, and up to \$1,500.00 for a newly prescribed hearing aid instrument once in each 36 month period.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

You will be able to use any remaining credits under your HRA while a member of the Health and Welfare Plan to receive reimbursement for your out-of-pocket expenses that you were required to pay due to deductibles, co-payments, and other limitations imposed by the Plan or Medicare.

**RETIREE MEDICAL PLAN OF THE
PLUMBERS' WELFARE FUND, LOCAL 130, U. A.**

SCHEDULE OF BENEFITS FOR MEDICARE-ELIGIBLE RETIREES

DEATH BENEFITS

\$7,500.00 to Beneficiary of Eligible Participants. If there is no designated Beneficiary, the death benefit will be paid to the surviving Spouse, descendants, or estate of decedent. Death benefit subject to possible offset of \$1,000.00 to be applied to funeral expenses. Divorce revokes designation of Spouse as Beneficiary. Death benefits are not paid as a result of the death of Spouses or surviving Spouses or if Medicare Retiree coverage is waived. Please see Section 15.15 for additional information.

**HOSPITAL AND PRESCRIPTION
DRUG BENEFITS**

BENEFIT AMOUNT

Hospital and Medical Benefit

As a supplement to Medicare covering hospital deductible and co-insurance amounts for Medicare approved charges. A Spouse or surviving Spouse must pay a monthly premium for these supplemental hospital and medical benefits. The Plan pays 50% of the monthly premium for a Spouse or surviving Spouse. The monthly premium is established by the Trustees.

Prescription Drug Coverage

A fully insured Medicare Part D prescription drug plan through Express Scripts Insurance Company. The Plan pays a portion of the premium for the Medicare Part D prescription drug plan. The amount is set by the Trustees.

EYE CARE

Eye Examinations

Up to \$40 per examination in any 12-month period following a \$10 copayment for an examination by an ophthalmologist or licensed optometrist.

Eyeglasses/Contact Lenses

Up to \$150.00 for prescribed eye glasses and frames and prescribed corrective lenses in any 12 month period after a \$20 copayment.

**Eye Examination and Eye Glasses or Lenses
Following Eye Surgery or Traumatic Injury**

Eye care benefits are provided for each medically prescribed lens change during the six months following eye surgery or a traumatic injury. The Plan's PPO Provider is Eye Med. Call 1-866-723-0514 for a participating location near you.

DENTAL BENEFITS

100% for preventive services. Other dental services will be paid at 50%, subject to a \$50.00 individual deductible. The annual maximum benefit payment for other dental services is \$1,000.00. Both the deductible and maximum are applied separately to each individual covered by the Plan. See Article III for additional information.

HEARING BENEFITS

(Effective January 1, 2018)

Up to \$125.00 with a limit of one examination in any 12 month period.

Up to \$1,500.00 with a limit of one hearing aid instrument in any 60 month period.

Up to \$50.00 for a new molded earpiece, once in each 12 month period, and up to \$1,500.00 for a newly prescribed hearing aid instrument once in each 36 month period.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

You will be able to use any remaining credits you earned under your HRA while a member of the Health and Welfare Plan to receive reimbursement for your out-of-pocket expenses that you were required to pay due to deductibles, copayments, and other limitations imposed by the Plan or Medicare.

I. MEDICAL COVERAGE FOR PRE-MEDICARE RETIREES

1.1 General Overview

The Plan offers Pre-Medicare retiree health coverage to eligible Covered Persons to provide uninterrupted basic health and welfare coverage between retirement and the time Medicare coverage begins. Dependent children of Retirees are not eligible for coverage under the Plan. If you elect Pre-Medicare retiree coverage under the Plan, coverage begins the month after your eligibility under the Health and Welfare Plan terminates. Although you must elect Pre-Medicare retiree health coverage within 60 days of your retirement date, the first premium is not due until the month before coverage starts. If the first premium is not paid by the end of the calendar month after the premium is due, coverage will not begin. Coverage begins once all banked hours under the Health and Welfare Plan are exhausted following retirement.

1.2 Type of Benefit Coverage

Pre-Medicare retiree health coverage includes inpatient Hospital, surgical, outpatient major medical, Prescription Drugs, and hospice. Pre-Medicare retiree benefits are subject to certain requirements, deductibles, and limitations. A Covered Person age 55 or older, or diagnosed with chronic heart or lung disease, hypertension, or chronic metabolic disease, is entitled to a pneumonia vaccination when Medically Necessary. An influenza vaccination is available once during each calendar year. Pre-Medicare retiree coverage does not include the following benefits:

- Maternity and obstetrical,
- Infertility,
- Weekly sickness, or
- Accidental dismemberment benefits.

If a Covered Person satisfies the deductible for a calendar year while eligible under the Health and Welfare Plan, no deductible is required for Pre-Medicare retiree health coverage for that calendar year. Any partial satisfaction of your deductible under the Health and Welfare Plan will also be carried over to this Retiree Medical Plan.

1.3 Eligibility For Pre-Medicare Retiree Health Coverage

Retiree. Pre-Medicare retiree health coverage is available to any retiree who meets the definition of Retiree as defined in Article XX of this Plan/SPD and who:

1. Is under age 65;
2. Is not eligible for Medicare;
3. Is receiving a monthly retirement or disability benefit from the Plumbers' Pension Fund, or the Pension Fund - Technical Engineering Division, Local 130, U.A.;

4. Was eligible for benefits under the Health and Welfare Plan during the month immediately before the month pension benefits from the Plumbers' Pension Fund, or the Pension Fund - Technical Engineering Division, Local 130, U.A., could have first been paid to the Retiree had he made proper application, provided that the eligibility for pension benefits continues until the Retiree makes proper application; and
5. Elects Pre-Medicare retiree health coverage within 60 days of his retirement date.

Notwithstanding the foregoing, an employee of an Affiliated Employer will be able to elect Pre-Medicare retiree health coverage if he or she:

1. Retires at or after attaining age 60 as an employee of an Affiliated Employer;
2. Is 100% vested for a pension under the Plumbing Employees' Pension Trust for Employees of Affiliated Plans (or would have been 100% vested had the Retiree's employer participated in the Plumbing Employees' Pension Trust throughout the Retiree's period of employment) or another applicable pension plan as a result of employment with an Affiliated Employer; and
3. Was eligible for benefits under the Health and Welfare Plan during the month immediately before the month for which pension benefits could have been paid had the Retiree made proper application, if eligibility for pension benefits continues until the Retiree makes proper application.

Spouse. If a Retiree is eligible to elect and does elect Pre-Medicare retiree health coverage, his/her Spouse as defined in Article XX of this Plan/SPD, if under age 65, may also elect health coverage. In certain situations, a Spouse of a Retiree may be entitled to health coverage even if the Retiree is not eligible for health coverage. This is only an option if the Spouse is under age 65 and is not entitled to Medicare and if the Retiree is vested in the Plumbers' Pension Fund or the Pension Fund - Technical Engineering Division, Local 130, U.A. , but cannot elect health coverage due to one of four situations identified below. For a pre-65 Spouse to qualify for coverage under this Section, the Retiree must be vested for a pension from the Plumbers' Pension Fund, the Pension Fund - Technical Engineering Division, Local 130, U.A., or the Plumbing Employees' Pension Trust for Employees of Affiliated Plans, or another applicable pension plan as a result of employment with an Affiliated Employer but is not eligible to elect health coverage or would not have been eligible under this Plan to elect health coverage because: :

1. The Retiree would have been eligible to elect Pre-Medicare retiree health coverage but he is 65 years of age or over in the month his first pension benefit is paid;
2. The Retiree dies after age 65 and before applying for a pension, but would have met the eligibility requirements for Pre-Medicare retiree coverage if he retired from the plumbing trade the day before his death and applied for his pension;
3. The Retiree dies between age 60 and 65 before applying for a pension, but would have met all the eligibility requirements for Pre-Medicare retiree health coverage if

he retired from the plumbing trade the day before his death and applied for his pension; or

4. The Retiree dies before age 60, but would have met all the eligibility requirements for Pre-Medicare retiree health coverage if he had retired from the plumbing trade the day before his death and would be eligible to receive a disability pension because of total and permanent disability.

In each of the above four situations, eligibility depends upon the Retiree's eligibility for benefits under the Health and Welfare Plan during the month before the month the pension started or would have started under the assumed conditions.

1.4 Proof of Insurability

No proof of insurability is necessary to initially elect Pre-Medicare retiree health coverage under the Plan. However, proof of creditable coverage will be required if either the Retiree or the Spouse enrolls in the Plan after initial eligibility.

1.5 Premium

Pre-Medicare retiree health coverage requires payment of a monthly premium. Call the Fund Office to learn the current monthly premium for coverage. You will receive a premium notice the first of the month before the month of coverage and payment is due by the 20th day of the month before the month of coverage. For example, for coverage in April, premium notices will be sent by March 1 and payment will be due by March 20. Timely payment of your premiums is a condition of continued Plan coverage.

1.6 Election Period

1. Initial Election Period for Retirees and Spouses

A Retiree must elect Pre-Medicare retiree benefit coverage within 60 days of his retirement date. The Spouse of a Retiree must also enroll within this same time period or within 60 days of the date she applies for a survivor's pension benefit from the Plumbers' Pension Fund or the Plumbing Employees' Pension Fund for Employees of Affiliated Plans. The first premium is not due until the month before coverage starts.

2. One-Time Deferred Election Period Following a Loss of Other Coverage

If a Retiree or Spouse declines coverage during the Initial Election Period at the time of the Retiree's retirement in order to be covered under a Spouses' plan or other available health coverage, the Retiree or Spouse may enroll in the Plan at a later date if the following conditions are met:

At the time of the deferral:

- You or your Spouse must be eligible for coverage under this Plan,

- You or your Spouse, must file a written election with the Fund Office,
- You or your Spouse must provide proof of other available insurance with the election, and
- If you or Spouse does not file an election, you and/or your Spouse will not be permitted to defer coverage.

At the time coverage is later elected:

- You or your Spouse must have made a valid election to defer coverage as stated above,
- You or your Spouse must have been continuously covered by the health plan of the Spouse's employer since the date that you or your Spouse opted out of this Plan, and provide proof of that coverage,
- You or your Spouse must apply to resume coverage with the Fund Office in writing, on or before the 60th day after termination of coverage under the health plan of your Spouse's employer. If your Spouse does not enroll within this period, you and your Spouse will not be allowed to enroll at a future date, and
- You or your Spouse must make the contributions and payment required by this Plan to maintain coverage.

Only one deferral opportunity is allowed under the Plan for Pre-Medicare retiree health coverage.

1.7 Term of Benefit Coverage

The maximum period of Pre-Medicare retiree health coverage under the Plan is ten years (120 months) for a Retiree and 20 years (240 months) for his or her Spouse. Several events may cause an earlier termination of coverage. Eligibility for Pre-Medicare retiree health coverage for a Retiree terminates upon the first of the month immediately following the first to occur of the following:

- The expiration of 120 months of coverage;
- The Retiree attains age 65 (becomes eligible for Medicare),
- The Retiree becomes enrolled in Medicare, or
- The Retiree fails to timely pay the monthly premium.

Eligibility for Pre-Medicare retiree health coverage for a Spouse terminates upon the first of the month immediately following the first to occur of the following:

- The expiration of 240 months of coverage;
- The Spouse becomes eligible or enrolled to Medicare;
- The Spouse fails to timely pay the monthly premium;
- The Spouse attains age 65 (becomes eligible for Medicare); or
- The Spouse remarries after divorce from or after the death of the Retiree.

Please see Section 15.13 for additional information regarding the obligation about notifying the Fund Office in the event of a change of address or other life change event.

Notwithstanding the above, coverage for both a Retiree and his/her Spouse terminates if the Retiree:

- Fails to make timely application for and receive a Social Security Disability benefit, (if applicable);
- Becomes employed or recovers from a disability causing a suspension of his pension benefits under the Plumbers' Pension Fund, the Pension Fund - Technical Engineering Division, Local 130, U.A. , or another applicable pension plan related to employment with an Affiliated Employer; or
- Fails to timely pay the monthly premium.

1.8 Electing Social Security Benefits

A Retiree who retires before age 55 because of total and permanent disability must apply for Social Security Disability coverage within 12 months and must qualify for such Social Security coverage within 30 months of electing Pre-Medicare retiree health coverage under the Plan. A person who receives a Social Security Disability benefit for 24 months qualifies for Medicare coverage after that period of time, regardless of age. Retirees who are eligible for coverage may be eligible for Medicare Supplement coverage as described in Article II.

1.9 Right to Modify, Amend, or Terminate

The Trustees reserve the sole right at any time and from time to time to modify, amend, or terminate the Retiree Medical Plan. No Covered Person has a vested right to future benefits under the Plan. The Trustees also have the sole authority to interpret the terms and provisions of this Plan.

1.10 Deductible

A deductible is required for the following Hospital and Outpatient Covered Expenses:

- a. Outpatient major medical benefits;

- b. Inpatient Hospital benefits (excluding preadmission Hospital tests); and
- c. Surgical benefits

To satisfy the deductible, you must pay the first \$200 of Covered Expenses incurred during each calendar year for each eligible Covered Person before any benefits will be paid by the Plan. This means that the Retiree and his/her covered Spouse have their own deductibles that need to be met separately.

The deductible amount is satisfied by payment of expenses otherwise covered and payable by the Plan. Your payment of medical charges or expenses not covered and payable under the Plan does not satisfy the deductible obligation. No amounts are paid by the Plan for Covered Expenses applied in satisfaction of the deductible.

If you are hospitalized during a period that includes portions of two calendar years and related expenses incurred during the hospitalization are applied to satisfy the deductible, the amounts applied in satisfaction of the deductible for the first calendar year will also be applied to satisfy the deductible requirement for the following calendar year.

The following examples explain how the deductible works.

EXAMPLE 1. A Retiree incurs expenses for cosmetic surgery, pays \$200 of the charges billed and submits the balance of the bill to Fund for payment. Has the deductible been satisfied?

No. The deductible must be satisfied out of expenses that are covered and payable under the Plan. Since the Plan does not cover cosmetic surgery, expenses incurred do not count towards satisfaction of the deductible.

EXAMPLE 2. A Retiree incurred and paid \$250, and his Spouse has incurred \$150 in expenses that would otherwise be payable under the Plan. Has the deductible been satisfied?

No. Although the Retiree and his Spouse have incurred and paid a combined \$400 in expenses that would be payable under the Plan, the Retiree and Spouse must pay the first \$200 of Covered Expenses each before the Plan will pay benefits on behalf of the individual. So, the deductible has been satisfied for the Retiree, but not for the Spouse.

1.11 Copayments

Emergency Room Visits. You will also be charged a \$150.00 copayment for each emergency room visit. This copayment will count toward the Out-of-Pocket Maximum but not the deductible.

1.12 Out-of-Pocket Maximum

The Plan limits the out-of-pocket expenses a Participant must pay for most (not all) conditions per individual, per calendar year. This is known as an Out-of-Pocket Maximum. When an individual reaches the Out-of-Pocket Maximum in a calendar year, the Plan will pay 100% of most of such person's or family's covered expenses incurred during the rest of the calendar year.

The amount for the Out-of-Pocket Maximum is \$5,000 per Covered Person. For example, a Retiree has a \$5,000 Out-of-Pocket Maximum while his/her covered Spouse has a separate Out-of-Pocket Maximum that must be met as well.

Expenses not eligible under the Plan or expenses in excess of any maximum of the Plan do not apply to, and are not affected by the Out-of-Pocket Maximums. Additionally, amounts you pay related to Pre-Medicare retiree contributions, balance billing amounts for non-network providers and other out-of-network cost-sharing expenses do not count toward the Out-of-Pocket Maximum (even if you have already met your Out-of-Pocket Maximum for the year).

1.13 Coinsurance

Coinsurance is the percentage of Covered Expenses you must pay for after you meet your deductible. Please refer to the Schedule of Benefits for the applicable Coinsurance rates. Also, it is important that you keep in mind that all out-of-network providers (those not in the PPO network) are subject to Reasonable and Customary charge limitations. This means that the maximum allowable amount for certain non-network services is based on the definition of a Reasonable and Customary charge in the Plan. Normally, the Plan's payment will be a percentage of the billed amount (see the Schedule of Benefits). However, in any case where the out-of-network provider's charge exceeds the Reasonable and Customary charge, the excess amount is not eligible under the Plan, and the provider is free to balance bill the patient.

On the other hand, if you see an in-network provider for covered services or treatment, the maximum allowable amount is based on a contracted fee schedule. Therefore, any amount of the in-network provider's bill over the Reasonable and Customary charge is not subject to balance billing. As a result, using an in-network provider saves money for the Plan and for you personally.

1.14 Use Of Preferred Providers For Medical Benefits

The Fund has an agreement with Blue Cross/Blue Shield of Illinois, a Preferred Provider Organization, for discounts in a network of Hospitals.

Another benefit of the Blue Cross/Blue Shield network is the Physician network which includes thousands of Physicians in Illinois and the border areas of the surrounding states. These doctors have agreed to charge the PPO scheduled allowance for services and will bill you only for copayments, deductibles, or non-Covered Expenses. In order to receive maximum benefits, check with your doctor to find out whether or not he or she is a Blue Cross/Blue Shield PPO Physician.

To locate a BC/BS network provider, call 1-800-810-BLUE (2583) or log onto www.bcbsil.com. You can also check with the Fund Office.

IMPORTANT NOTE

Because providers are added to and dropped from the Network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the Network, or contact the Network each time BEFORE you seek services.

For a list of In-Network providers, see www.bcbsil.com. For a paper copy of the provider directory, at no charge, contact the Fund Office.

All PPO doctors and all Hospitals will submit claims directly to Blue Cross/Blue Shield and should not expect from you payment in full up front. Often doctors and Hospitals that do not follow these procedures do so because a member has not shown their Blue Cross/Blue Shield ID card. Be sure to show your card in order to avoid a delay in claim processing. If any PPO doctors or Hospitals advise differently, please notify the Fund Office.

You are not required to use Physicians or Surgeons that are affiliated with the Blue Cross/Blue Shield PPO and you have complete freedom of choice in making your health care decisions. However, if you elect to use a non-PPO Provider or non-PPO Facility when a PPO Provider or PPO Facility is available, the Plan will cover only 70% of the Reasonable and Customary charges of Covered Expenses and charges by out-of-network doctors, Hospitals, and other providers, and you will be responsible for the balance of the total charges. An exception is made for emergency services approved by the Trustees. However, if you utilize Physicians or Surgeons within the PPO network, both you and the Fund will realize substantial savings. For example:

- The first dollar coverage by the Plan for Hospital special services in a PPO Hospital is \$2,000, and after that amount is paid the Plan covers 90% of the remaining charges for Hospital special services (assuming the \$200.00 deductible has been met). If Hospital special services totaled \$6,000.00, the Plan would pay \$5,600.00 (100% of \$2,000.00 and 90% of \$4,000.00) and you would be responsible to pay the balance of \$400.00.

If in the above example you chose a non-PPO Hospital when a PPO affiliated Hospital was available, the Plan would pay 70% of the Reasonable and Customary charges for Hospital special services. In order to receive the PPO discount, your Blue Cross/Blue Shield identification card must be presented to the PPO Provider. If you do not presently have an identification card one can be obtained from the Fund Office upon request. The card identifies you as a participant in this Plan and indicates your eligibility for reduced charges from Physicians, Hospitals and facilities affiliated with Blue Cross/Blue Shield. The card should be presented whenever you or your Spouse receives services from a preferred provider Physician, Hospital or ancillary medical service organization.

In determining the Reasonable and Customary charge or fee under any benefit offered under the Plan, the Trustees may rely upon the Medical Advisor retained by the Trustees; any recognized published schedule of prevailing surgical charges or fees, or any schedule utilized by Health Care Service Corporation a/k/a Blue Cross/Blue Shield of Illinois.

1.15 Maximizing Your Pre-Medicare Retiree Benefits

In order to minimize the costs of providing benefits under the Plan, the Plan encourages you to take the following steps to maximize your Plan benefits:

- Whenever possible, utilize Hospitals and Physicians who participate in the Blue Cross/Blue Shield Hospital and Physician PPO Network. The discounted charges available through Blue Cross/Blue Shield Affiliated Hospitals and Physicians reduce both your out-of-pocket obligations, if any, and the Fund's costs as well. *If you obtain medical services from a non-PPO medical provider or Hospital the Plan will recognize only 70% of the Reasonable and Customary charges or fees charged by that provider in circumstances where a PPO Provider is available, excepting emergency situations approved by the Trustees. You will be responsible for the remaining 30%, plus amounts over the Reasonable and Customary charges.*
- If you or your Spouse anticipates hospitalization, contact the Fund's Utilization Review Provider, Hines and Associates, at 1-800-944-9401 to receive assistance with your care and treatment plan.
- When Prescription Drug needs arise, fill your prescriptions at Express Scripts Affiliated Pharmacies. Using an Express Scripts Affiliated Pharmacy will reduce your out-of-pocket costs and result in additional savings to the Fund. Call Express Scripts' Mail Order Hotline at 1-800-451-6245 for additional assistance.

1.16 Inpatient Hospital Benefit

If you are confined in a Hospital and under the care of a Physician or Surgeon for a non-occupational injury or sickness, the Fund pays the Reasonable and Customary charges or fees for Hospital room and board and medical services (see Schedule of Benefits). This coverage is available only if you are hospitalized for at least 18 hours. The 18-hour requirement will not apply to Hospital charges for an operation or fracture, or for a blood transfusion.

1. Room and Board

The Plan will pay for Hospital charges covering room and board of a Covered Person for any sickness or injury as set forth in the Schedule of Benefits. This includes private, semi-private and intensive care unit rooms. If a Covered Person is readmitted to a Hospital within 30 or fewer days of his or her discharge, the readmission is presumed to treat the same sickness or injury as the prior admission unless the facts clearly establish otherwise. Readmissions occurring after 30 days will be treated as a new sickness or injury.

2. Pre-admission Hospital Testing

If you undergo any of the following tests in preparation for a Hospital admission, you will be paid or reimbursed the full, Reasonable and Customary charges for the tests, if

the tests are accepted by the Hospital in place of the same tests performed after Hospital admission:

- Blood Count
- Chest X-Ray
- Clotting Profile
- Electrocardiogram
- Blood Type Screening
- Blood Chemical Test
- Urinalysis
- Venereal Disease Test
- Sickle Cell Preparation

By having the tests performed before a Hospital admission, the cost is not charged against your deductible and will be charged as set forth in the Schedule of Benefits

3. Physician Services

Attending Physician. If you are hospitalized for a non-occupational injury or sickness, the Plan covers treatment by a licensed Physician as set forth in the Schedule of Benefits. This benefit excludes Inpatient Hospitalization Services set forth in the Schedule of Benefits.

Consulting Physician or Surgeon. If you are hospitalized and your attending Physician or Surgeon engages another Physician or Surgeon for a consultation on the diagnosis or treatment of your medical condition, the Plan pays for the services of the medical or surgical consultant as shown in the Schedule of Benefits. Surgical Assistants will be covered at 16% of the cost of the Surgeon's charge.

1.17 Residential Treatment Center Confinements

The Plan provides benefits for medical care, services, or supplies incurred during a Residential Treatment Center confinement. Substance Abuse is not covered under this Plan therefore any Substance Abuse treatments received at a Residential Treatment Center will not be covered. Charges for medical care, services and supplies, including treatment of Mental Health Conditions, incurred during a period of confinement in a Residential Treatment Center are paid under the Plan's Hospital benefits.

The maximum number of covered days of Residential Treatment Center care is 365 days.

1.18 Mental Health Condition Benefits

The Plan provides benefits for the diagnosis, treatment and cure of Mental Health Conditions. Eligible charges are those covered services deemed Medically Necessary by the Plan. The payment of covered services for Mental Health benefits will be paid in accordance with the provisions of the Plan and are subject to all limits and conditions applicable to medical benefits.

Covered Benefits Include:

- Inpatient Services: Inpatient Hospitalization for Mental Health services.

- **Outpatient Services:** Outpatient services that are not consistent with the treatment protocols for your condition will be subject to medical necessity review. All services must be provided by a licensed professional working within the scope of their license including, psychologists, psychiatrists, licensed clinical social worker (LCSW), registered nurse clinical specialists (RN CNS), and licensed clinical professional counselors (LCPC).
- **Combined Services:** Comprised of partial inpatient hospitalization combined with outpatient treatments.

1.19 Utilization Review

To monitor both the quality and necessity of Hospital care, Hines and Associates provides utilization review and case management services to any Covered Person anticipating a hospitalization. Under this program, Hines and Associates experts will consult with your Hospital or Physician on the necessity of Hospital admissions and surgical procedures (including outpatient surgery), the availability of alternate courses of treatment, and the appropriate length of Hospital stay. The utilization review program is designed to ensure that you receive the proper and necessary care required to treat your sickness or injury.

Please note that this program does not limit or eliminate any Plan benefits.

The Trustees need your cooperation to make this program a success. For PPO Providers, you are encouraged to call Hines and Associates' toll free number, 1-800-944-9401, before any non-emergency Hospital admission. If an emergency admission is necessary, you or your representative should call Hines and Associates within 48 hours of the Hospital admission.

When you contact Hines and Associates, the representative will ask you to respond to questions about your proposed hospitalization and the name of your attending Physician. All information provided will be held in strictest confidence and will be used only for purposes of administering the utilization review program.

In addition, you may voluntarily seek assistance from one of the Fund's case management specialists for guidance on issues arising during the course of extensive and long term medical treatment. For example, the case management specialist can provide advice on alternate types and sources of medical care including alternate sources of care in the event benefits under the Plan are exhausted.

The Trustees may authorize its Medical Advisor and/or Hines and Associates to review Medical Necessity prior to or at the time of treatment and make appropriate recommendations.

1.20 Surgical Benefits

If you have an operation performed by a licensed Physician or Surgeon, the Plan will pay the Reasonable and Customary charge for the surgery under the Fund's Schedule of Benefits by utilizing the published prevailing surgical charges or fees, or any schedule utilized by Blue Cross Blue Shield of Illinois at the discretion of the Board.

1. Assistant Surgeon Charges

For assistant Surgeon charges, the Plan pays up to 20% of the Plan's established Reasonable and Customary charge for the surgery. The assistant Surgical Benefit is paid only if the assistant Surgeon is Medically Necessary for the surgery. If you anticipate having surgery requiring an assistant Surgeon, contact the Fund Office to determine whether assistant surgical charges are payable for that procedure. Surgical Assistants will be covered at 16% of the cost of the Surgeon's charge.

2. Second Surgical Opinions

If you are scheduled for a non-emergency surgical operation and desire a second opinion from a licensed Physician or Surgeon confirming the Medical Necessity of the operation, the Plan will pay the Reasonable and Customary cost of the second surgical opinion as set forth in the Schedule of Benefits. If the second opinion does not confirm the Medical Necessity for the surgery recommended by your Physician or Surgeon, the Plan will pay the Reasonable and Customary cost of a third opinion from a Physician or Surgeon as set forth in the Schedule of Benefits.

1.21 Organ Transplants and Pectus Excavatum Precertification Procedures

The Plan will pay the Reasonable and Customary charges or fees, as determined from time to time by the Trustees, for organ donor transplants and pectus excavatum services incurred by a Covered Person that are not experimental. Many organ transplants and treatments for pectus excavatum are not covered under the Plan. To ensure you have coverage for these procedures, you must be pre-certified by the Trustees. If you have a non-emergency transplant procedure without being pre-certified, the Plan will not pay anything towards the cost incurred, directly or indirectly, for such procedure. Pre-certification is not necessary for an emergency transplant. Contact the Fund Office immediately if you are recommended or scheduled for any type of transplant surgery.

Donor expenses incurred in connection with an organ transplant procedure include the cost of securing an organ from a cadaver or tissue bank, the Surgeon's charges for removal of an organ, the charges for obtaining cells through bone marrow harvest or apheresis, the Hospital's charge for storage or transportation of the organ, and, in the case of a live organ donor, any hospitalization charges attributable to the donation of the organ.

Subject to Trustee approval, eligible transplant services must be received within five days before or 12 months following pre-certification. Approved transplant surgical procedures are paid as set forth in the Schedule of Benefits.

Additional Limitations on Organ Transplants

If the Trustees certify and approve payment for an organ transplant listed below, total benefits provided to a Covered Person under this Plan for all Hospital room and board, Hospital special services, surgical, inpatient and outpatient medical, rehabilitation, organ donor expenses and for any other covered services or supplies otherwise payable under the Plan that are:

1. Incurred as a result of a Covered Person undergoing an approved organ transplant; and
2. Incurred during a period beginning five days prior to the date the transplant surgery takes place and ending 12 months after such date.

1.22 Outpatient Major Medical Benefits

When you have a non-occupational sickness or injury not requiring hospitalization, the Plan pays the Reasonable and Customary charges for Medically Necessary medical care, services, or supplies as set forth in the Schedule of Benefits. However, the following limits and exclusions apply to outpatient medical services:

- Medical care, services, or supplies covered under another provision of the Plan;
- Dental care or services, except for dental care required as a result of a direct accidental blow to the mouth or dental care required due to non-dental medical treatment, for example, dental work required in connection with an organ transplant or cancer treatment;
- Purchase or rental of durable medical aids, appliances, or equipment in excess of \$500.00 (\$1,500 effective January 1, 2018), must be approved in advance by the Trustees (or the Plan's Medical Advisor), and the decision of the Trustees is final and binding, including the decision on whether to rent or purchase an item;
- Home Health Care charges after a Covered Person has received 365 days of Home Health Care Services minus the number of days of Inpatient Hospital Benefits for the same sickness or injury. The 365 day period resets if the Covered Person is readmitted to a Hospital following 30 days of Home Health Care Services;
- Medical care, services or supplies that are not provided or prescribed by or under the supervision of a Physician or Surgeon;
- Charges exceeding \$1,200.00 during a calendar year for chiropractic care; or
- For medical care, services, or supplies that are not provided or prescribed by, or under the supervision of, a Physician or Surgeon.
- For injectable prescription drugs that are self-administered by a Covered Person when such prescription drugs are not obtained from the specialty pharmacy designated by the Trustees, unless such prescription drug is not available from the designated specialty pharmacy.

1.23 Home Health Care

The Plan covers Home Health Care Services (see Definitions section) as an outpatient benefit, as prescribed by a Physician for continued care immediately following a Hospital (including a Skilled Nursing Facility) confinement. The maximum number of days of Home

Health Care Services is 365 for any sickness or injury, less the number of days of hospitalization. The 365-day period resets if the Covered Person is readmitted to a Hospital following 30 days of Home Health Care Services.

1.24 Prescription Drug Benefit

The Plan pays 100%, less the applicable copayment, of the Reasonable and Customary charge of Prescription Drugs, including injectable drugs which may be self-administered, prescribed by a Physician to cure or mitigate a sickness or illness. (See Schedule of Benefits.)

Your prescription needs may be met at a significant discount through the Fund's agreement with Express Scripts. Your use of Express Scripts' Affiliated Pharmacies allows you to make a smaller cash payment to receive necessary Prescription Drugs and also reduces the Fund's cost of providing and maintaining your Prescription Drug benefit at the current level of coverage.

The Express Scripts' nationwide network ensures that you will have a participating pharmacy near you, wherever you may be. In the Chicagoland Area, the Express Scripts' network includes most of the national pharmacy chains, as well as a broad network of independent pharmacies. Ask your pharmacist if he or she participates in the Express Scripts' network. If you would like the name of a participating pharmacy conveniently located in your area, contact the Fund Office, or utilize Express Scripts' toll-free information number, 1-800-467-2006.

Prescribed specialty drugs and self-administered injectable drugs (except insulin) must be purchased from Accredo to be eligible for coverage by the Plan. Contact the Fund Office if you need to fill a prescription for a self-administered injectable drug, or if Accredo is not able to fill the prescription. Unless determined to be Medically Necessary based on verification from your prescribing Physician, a generic alternative will be prescribed. If a non-generic drug is prescribed that is determined not to be Medically Necessary, you will be responsible for the cost difference between the non-generic drug and the generic equivalent. Unless otherwise determined by the Trustees to be Medically Necessary, effective January 1, 2018, erectile dysfunction medication will be limited to six (6) pills per month and the Plan will pay 50% of the cost of such approved medication.

For maintenance type drugs (e.g. heart medication, blood pressure medication, diabetic medication, etc.) you are encouraged to have your prescription filled through Express Scripts' Prescription Drug Mail Order Program. For birth control drugs, you are required to have your prescription filled through Express Scripts' Prescription Drug Mail Order Program. You can receive up to three months of prescribed maintenance drugs and medications. The Mail Order Program operates in the same manner as if the medication was purchased at a retail pharmacy with your Express Scripts' Identification Card, (use your BC/BS ID card), except for the amount of your copayment. Use of this Program will save you money.

1.25 Gender Dysphoria

Treatment of Gender Dysphoria will be considered a covered expense for Medically Necessary Services subject to any conditions and limitations set forth in this Plan. For purposes of this Section, Gender Dysphoria is defined as a disorder characterized by the diagnostic criteria

classified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

In order to be a covered expense, the Participant must undergo an evaluation by a Qualified Mental Health Professional (QMHP) experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with Gender Dysphoria and all relevant comorbid mental health conditions, including familiarity in the application of the Diagnostic Statistical Manual of Mental Disorders (DSM) or the then current version of the DSM. A practitioner will be considered a QMHP if they are a board certified psychiatrist, psychologist, or an in-network master's level provider with a degree in a clinical behavioral science field from a nationally accredited credentialing board and appropriately licensed in the jurisdiction in which they practice and are qualified to evaluate and treat Participants as noted above. For the treatment of Gender Dysphoria to be considered a Covered Expense, the Participant must satisfy all criteria in the current version of the DSM and have no confounding comorbid mental health conditions, which would be contraindications to treatment, and treatment must have been recommended by a qualified practitioner with appropriate training and credentials acceptable to the Trustees.

Covered expenses may include supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, or genital reconstructive surgery where those interventions and treatments comply with all other provisions of the Plan. Orchiectomy, oophorectomy/hysterectomy, penectomy, metoidioplasty, penile prosthesis, vaginectomy, and genital reconstructive surgery expenses are covered subject to the following conditions:

1. There is well-documented and persistent Gender Dysphoria;
2. The individual is age 18 or over;
3. Two referral letters from QMHPs as described above; one of which must be the Participant's treating mental health professional and second from an additional qualified mental health professional who has performed an appropriate evaluation of the Participant;
4. There must be documented control of any comorbid medical or mental health conditions that would render the Participant incapable of making a fully informed decision or interfere with the diagnosis of Gender Dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;
5. In the absence of a medical contraindication, complete 12 months of continuous hormone therapy appropriate to the member's gender goals and complete 12 months of living in a congruent gender role;
6. Obtain treatment from a practitioner and facility with appropriate experience in the provision of the requested services; and

Hormone therapy is covered under the Prescription Drug Benefit under the following conditions:

1. Completion of evaluations as outlined and have a diagnosis of Gender Dysphoria with no contraindications to treatment;
2. Treatment must be ordered and supervised by a practitioner experienced in the treatment of individuals with Gender Dysphoria; and
3. Age 18 or over.

Covered services for Gender Dysphoria will not include any service considered to be cosmetic or not Medically Necessary, including, but not limited to, hair replacement or removal, voice therapy or lessons, liposuction, rhinoplasty, breast augmentation, lip reduction, lip augmentation, laryngeal or thyroid cartilage shaving or contouring, abdominoplasty, chest wall contouring, body contouring, facial contouring, skin resurfacing, collagen injections and any other cosmetic procedure or service otherwise excluded under the Plan. Also not covered are the following:

1. Treatment outside the United States;
2. Transportation, meals and lodging;
3. Reversal of genital surgery; and
4. Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus.

II. MEDICAL COVERAGE FOR MEDICARE-ELIGIBLE RETIREES

2.1 Eligibility

Retirees, Spouses, and surviving Spouses who are at least 65, or Medicare eligible are eligible for a Medicare Supplemental health benefit. Coverage begins once all banked hours under the Health and Welfare Plan are exhausted following retirement.

2.2 Election Period and Premium

Retirees are automatically enrolled in the Medicare Supplement Benefit. The Spouse must elect coverage under the Medicare Supplement Benefit by the date he or she first becomes eligible for Medicare (usually his or her 65th birthday). Failing to timely elect coverage will constitute a waiver of the Medicare Supplement Benefit and no future opportunity for enrollment will be available. The only exception to this election deadline is if the Spouse was covered under the Health and Welfare Plan as a dependent and such coverage ended at or after the time that the Spouse first became eligible for Medicare. In such instances, the Spouse must elect coverage

under the Medicare Supplement Benefit within 60 days following the termination of his or her coverage under the Health and Welfare Plan.

The Plan automatically covers the Retiree's Medicare inpatient Hospital deductible and the inpatient co-insurance amount. A monthly premium will be charged for coverage under the Medicare Supplement Benefit for Spouses. The monthly premium for the Medicare Supplement Benefit may be deducted from the pension benefit payable to the Retiree. Alternatively, payment may be made directly to the Fund Office. The monthly premium may be adjusted by the Trustees from time to time.

2.3 Medicare Supplemental Hospital-Medical Benefits

Hospital-medical benefits up to the limits stated in the Schedule of Benefits are provided for certain Retirees, their Spouses. If a Retiree fails to enroll in Part A and/or B of Medicare, benefits under this provision are paid as though the Retiree did enroll.

Medicare supplemental hospital-medical benefits are not paid while a Covered Person is eligible for other benefits under the Plumbers' Welfare Fund, Local 130, U.A. due to active employment, COBRA continuation coverage, or Pre-Medicare retiree health coverage. A Covered Person is not entitled to benefits for any claims which have been covered or can be covered by another policy or plan providing coverage, including supplemental Medicare coverage.

2.4 Medicare Part D Prescription Drug Coverage

The Plan provides a fully insured Medicare Part D prescription drug plan through Express Scripts to Retirees and Spouses who are eligible for Medicare Part D. The terms and conditions of the prescription drug plan, including the formulary and the monthly premium, are determined by Express Scripts. The Plan pays a portion of the monthly premium for each Retiree and Spouse who elects, and is eligible for coverage under the Express' Scripts' Medicare Part D prescription drug plan. The monthly premium may be deducted from the pension benefit payable to the Retiree or surviving Spouse. Alternatively, payment may be made directly to the Fund Office. The monthly premium may be adjusted by the Trustees from time to time.

For more information regarding the Medicare Part D prescription drug plan sponsored by Express Scripts you can contact Express Scripts at 1-866-635-5306.

III. DENTAL BENEFITS (ALL RETIREES AND SPOUSES)

The Plan pays the Dental Benefits stated in the Schedule of Benefits. Retirees (including eligible spouses) who are eligible for Pre-Medicare or Medicare-eligible retiree benefits under this Plan will be eligible for Dental Benefits. The Dental Benefits under the Plan are subject to an individual deductible with a maximum deductible per family unit.

The election period rules set forth in Section 1.6 apply to retiree Dental Benefits. Effective January 1, 2018, Dental Benefits are automatically included in the applicable benefit packages of all new Retirees.

Retiree Dental Benefits pay up to \$1,000 per calendar year for covered dental services. Following payment of a \$50 deductible, covered dental services include 100% coverage for preventive and diagnostic services which include the following:

- Routine exams (up to two per calendar year)
- Cleanings (up to two per calendar year)
- X-rays (bitewings- one per calendar year, full mouth- every six months)
- Emergency exams & pain relief treatment

Following payment of a \$50 deductible, covered dental services also include 50% coverage for basic and major restorative services which include the following:

- Filings (silver (amalgam) and tooth colored (composite) on front teeth)
- Posterior composites
- Endodontics and periodontics
- Oral surgery and general anesthesia (associated with oral surgery)
- Dentures and bridges
- Implants
- Cast restorations- crowns, onlays, post and core
- Surgical periodontics

IV. VISION BENEFITS (ALL RETIREES AND SPOUSES)

Retirees or Spouses who elect Pre-Medicare or Medicare-eligible retiree benefits will be automatically enrolled in the Plan's vision benefit. For eye examinations, the Plan pays up to \$40 per examination in any 12 month period following a \$10 copayment. For eyeglasses and contact lenses, the Plan pays up to \$150 for prescribed eye glasses, frames and prescribed corrective lenses in any 12 month period after a \$20 copayment. Eye care benefits are provided as described in the Schedule of Benefits. Participants should use providers participating in the Eye Med Discount Eye Care Program (1-866-723-0514). This Program permits you to choose a wide variety of eyeglasses and frames that are paid in full under the Plan's vision benefit.

V. HOSPICE CARE (ALL RETIREES AND SPOUSES)

The Plan pays Hospice Care charges as shown in the Schedule of Benefits. Hospice care is specialized care for terminally ill patients designed to provide physical and psychological comfort for an individual suffering from a terminal illness and for members of the patient's family.

The covered Hospice Care benefit must be for a Covered Person who has been diagnosed as “terminally ill” which means being diagnosed with a life expectancy of six months or less. The Physician’s diagnosis must be reviewed and concurred in by the Trustees’ Medical Advisor or Peer Reviewer. The Hospice Care benefit is payable in addition to the Plan’s Hospital and outpatient benefits. The Plan’s Prescription Drug benefit, subject to the applicable copay, is paid throughout a period of hospice care. Hospice services may be provided as an inpatient at a licensed hospice care facility, Hospital or convalescent facility or as an outpatient at the patient’s home under a plan of hospice treatment prepared by a Physician. Covered home hospice or outpatient hospice charges include part-time or intermittent nursing by a registered nurse or licensed practical nurse for up to eight hours per day or services of a part-time or intermittent home health aide for up to four hours per day. This benefit is limited to 180 days per three-year period.

The following charges or services are not covered:

- Services and supplies which are not part of an approved hospice plan of treatment.
- Services of a care giver who lives in the Retiree’s home or is a member of the Retiree’s family.
- Domestic or housekeeping services unrelated to the patient’s care.
- Services providing a protective environment when no skilled service is required including companionship or sitter services.
- Services which are not directly related to a covered patient’s medical condition, for example: estate planning, pastoral counseling or funeral arrangement services, nutritional guidance or food services, or transportation services.
- Any charges or services not covered under the Plan or paid under another benefit of the Plan.

VI. DEATH BENEFITS (RETIREES ONLY)

Death Benefit protection is provided to Retirees in the amount shown in the Schedule of Benefits. Retirees who initially waive Pre-Medicare or Medicare-eligible retiree benefits under this Plan will **NOT** be eligible for Death Benefits. Upon your death, the Death Benefit is paid to your designated Beneficiary. If you die without a designated Beneficiary or if no designated Beneficiary survives you, the Death Benefit is paid to your surviving Spouse, otherwise, to your living descendants, per stirpes (divided between your children and the children of your deceased child as further explained), or to your estate if you have no living descendants. For example, if you fail to designate a Beneficiary and at your death you were survived by two children and two grandchildren (the children of your deceased child), your two children would each receive one-third of your Death Benefit and the remaining one-third of your Death Benefit would be divided between your two grandchildren (the children of your deceased child). Divorce revokes the designation of a Spouse as Beneficiary. The Trustees have authority to pay or reimburse your funeral or burial expenses up to \$1,000 from the Death Benefit amount payable. The Trustees, in

their sole discretion, may pay the funeral or burial expenses to a third party not otherwise reimbursed by your estate or your Beneficiary entitled to the death benefit.

It is important that you execute a Beneficiary designation when you become eligible for benefits. Beneficiary forms are available at the Fund Office. A valid designation of Beneficiary form should be signed and dated by you and filed with the Fund Office. You can change your Beneficiary designation at any time. Please request a new Beneficiary form from the Fund Office to do so.

VII. HEALTH REIMBURSEMENT ARRANGEMENT (RETIREES ONLY)

7.1 Reimbursable Expenses Under the HRA

The Plan will reimburse out-of-pocket expenses through a Health Reimbursement Arrangement (“HRA”). Under the HRA, you will be able to receive reimbursement for your out-of-pocket medical expenses that you are required to pay due to the deductibles, copayments, and other dollar limits imposed by the Plan. The HRA can also be used to reimburse you for amounts paid for medical expenses that exceed the Plan’s determination of the Reasonable and Customary charge for a procedure or treatment. Examples of expenses that can be reimbursed through the HRA include the following:

- Your deductible;
- Payments required under the Plan;
- Payments required to continue Plan coverage under COBRA;
- Any copayments, including copayments for Prescription Drugs;
- Out-of-pocket costs for benefits as permitted under Section 213 of the Internal Revenue Code, except for over-the-counter medications purchased without a Physician’s written prescription; and
- Amounts charged by a Physician that exceed the Reasonable and Customary charge for the procedure or treatment.

7.2 HRA Credits

Retirees who accumulated HRA credits while still a participant in the Health and Welfare Plan may continue to use accumulated HRA credits as set forth in this Section.

7.3 Using Your HRA Credits

Retirees may apply for reimbursement from the HRA at the end of each calendar quarter by contacting the Fund Administrator, submitting claims online at <https://employee.eflexgroup.com> or by using their HRA debit card as described below. A Retiree may be reimbursed up to the lesser of the amount of Covered Expenses or the amount of credits accumulated by the Retiree. In order to receive reimbursement for an expense, the charge must

have been incurred after the individual was covered by the HRA and while the individual was eligible for benefits under the Plan. Additionally, the claim must be properly substantiated with (1) a receipt or billing statement that includes the date of service or purchase, the name of the person and the amount paid, and (2) copies of the explanations of benefits from any health coverage regarding the expense. Additionally, reimbursement cannot be made for any amount that was paid from another source such as other health coverage. Claims that are not properly substantiated will be rejected by the Fund Office. You should keep copies of all materials submitted with your claim for reimbursement in case your tax records are audited. You will not be entitled to any earnings (such as interest) on the money credited to the HRA, nor will you be subject to losses.

7.4 Using Your HRA Debit Cards

Retirees with HRA accounts will be issued debit cards reflecting their HRA account balance. The debit cards will be administered through TASC DirectPay system. The amount available through your card will reflect the current unused credits to your HRA. You will not receive a card until you have earned initial eligibility under the Plan. Additionally, if you lose eligibility under the Plan, you generally will not be able to access allocations to the HRA made with respect to hours worked after your loss of eligibility until such time as you regain eligibility. Once you lose eligibility, you will not be able to use your debit card but you will be able to submit paper claims for dates of service prior to losing eligibility under the Plan, (however, you can continue to access HRA contributions allocated with respect to hours worked before you lost eligibility by submitting paper claims).

You may contact the Fund Office at 312-226-5000 or TASC at 800-350-3778 if you have questions about your HRA debit card.

7.5 Forfeiting HRA Credits

Upon the death of a Retiree, the surviving Spouse may apply any remaining accumulated credits of the Retiree for Covered Expenses or applicable payments of the surviving Spouse as long as the surviving Spouse is eligible for benefits under the Plan. If there is no surviving Spouse eligible for benefits under the Plan, then any remaining accumulated Credits will be forfeited. No Retiree or any other person is vested in any credits under the HRA and cannot receive cash except in reimbursement of Covered Expenses.

VIII. HEARING BENEFITS (RETIRES AND SPOUSES)

Effective January 1, 2018, Retirees or Spouses who elect Pre-Medicare or Medicare-eligible retiree benefits will be automatically enrolled in the Plan's hearing benefit. The Plan will pay the cost of a hearing examination by a qualified otologist, otolaryngologist, or audiologist, up to the maximum shown in the Schedule of Benefits. No more than one examination is covered during any twelve month period. If you obtain a prescribed hearing aid instrument, the Plan pays for the cost of the instrument or instruments up to the maximum amount shown in the Schedule of Benefits.

No more than one hearing aid instrument is covered during any 60-month period up to the amount shown in the Schedule of Benefits.

IX. COBRA CONTINUATION COVERAGE

The right to continue group health coverage under this Plan was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA coverage may become available to your Spouse if your Spouse is covered under the Plan, when your Spouse would otherwise lose his or her group health coverage under the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

9.1 What Is COBRA Coverage and Who is Eligible for COBRA Coverage?

COBRA coverage is a continuation of the Plan’s group health 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 occurs and any required notice of that event is properly provided to the Plan, COBRA coverage must be offered to each person losing coverage who is a “qualified beneficiary.” Your Spouse could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

If you are the Spouse of a Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because the Retiree dies, the Retiree becomes eligible for Medicare, or you become divorced or legally separated from the Retiree. Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plumbers’ Welfare Fund, Local 130, U.A., and that bankruptcy results in the loss of coverage of any Retiree, the Retiree will become a qualified beneficiary with respect to the bankruptcy so long as the Retiree is not already eligible for Medicare. A loss of coverage due to bankruptcy is the only qualifying event for a Retiree. The Retiree’s Spouse will also become a qualified beneficiary if bankruptcy results in the loss of their coverage under this Plan.

9.2 Who is a Qualified Beneficiary?

If you are the Spouse of a Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

The Retiree dies;

The Retiree becomes eligible or enrolled in Medicare Benefits (under Part A, Part B, or both); or

You become divorced or legally separated from the Retiree.

9.3 When is COBRA Coverage Available?

The Fund Office will offer COBRA coverage to qualified beneficiaries when the qualifying event is the death of the Retiree, divorce from the Retiree, commencement of a proceeding in bankruptcy with respect to the Plan, or the Retiree becoming entitled to Medicare Benefits (under Part A, or Part B, or both).

9.4 Notification Obligations

When the Fund Office is notified of a qualifying event, your Spouse will be sent a COBRA Election Notice and COBRA election form for your Spouse who would lose coverage due to the qualifying event within 45 days of the time it receives notice of a qualifying event. The election notice tells you about your right to elect COBRA continuation coverage, the due dates for returning the election form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

You and your Spouse, if applicable, are required to inform the Fund Office of any change in family status, such as death, divorce, or legal separation, that may affect your eligibility or your Spouse's eligibility, if applicable, to continue to participate in and receive benefits under the Plan. An individual receiving benefits as a result of electing COBRA continuation coverage is required to inform the Fund Office of any change of family status (i.e., such as death, divorce, or legal separation), or Medicare eligibility that may affect the eligibility of such individual to continue to receive benefits under this Plan. Such notification must be made within 60 days from the date of the event affecting your Spouse's COBRA benefits, or as otherwise permitted by law.

9.5 How Much Does COBRA Cost?

The standard COBRA premium is determined by the Trustees and adjusted from time to time as permitted by federal law. Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, as discussed below, 150%) of the cost to the Plan for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage.

9.6 How is COBRA Coverage Provided?

Once the Fund Office has notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA coverage. Retirees may elect COBRA coverage on behalf of their Spouses. The person electing COBRA coverage has 60 days after the COBRA election notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed election form. An election of continuation coverage is considered to be made on the date the COBRA election form is postmarked. Your initial COBRA payment will be due within 45 days following your timely election of COBRA.

COBRA coverage is a temporary continuation of coverage. When the qualifying event is divorce or legal separation, COBRA coverage lasts for up to a total of 36 months for the Spouse.

9.7 When COBRA Ends

COBRA coverage may end for any of the following reasons:

1. Your Spouse becomes covered under another group medical, dental or vision plan.
2. The required premium is not timely paid.
3. The Plan is terminated.
4. Your Spouse reaches the end of the 36-month COBRA coverage period.
5. Your Spouse becomes entitled to (enrolled in) Medicare.

9.8 Other Options to COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace created pursuant to the Affordable Care Act. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Generally, the Marketplace enrollment period is 60-days. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, even if that plan generally does not accept late (or mid-year) enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or call 800-318-2596 for more information.

9.9 If You Have Questions

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

In order to protect your and your Spouse's rights, you should keep the Fund Office informed of any changes in the addresses. You should also keep a copy, for your records, of any notices you sent to the Fund Office.

X. YOUR RIGHTS UNDER HIPAA

10.1 HIPAA Privacy

HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Fund office.

This Plan and the Board of Trustees, will not use or further disclose information that is protected by HIPAA known as "protected health information" ("PHI"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

You will have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office at Fund Administrator of the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A., 1340 West Washington Boulevard, 3rd Floor, Chicago, IL 60607, (312) 226-5000 if:

- You need a copy of the privacy notice;
- You have questions about the privacy of your health information; or
- You wish to file a complaint under HIPAA.

10.2 The Plan's Use and Disclosure of Your Protected Health Information

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations. The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your authorized representative. With an authorization, the Plan will disclose PHI to the applicable Pension Fund, reciprocal benefit plans and Workers' Compensation insurers for purposes related to administration of those plans.

1. Definition of Payment

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- a. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- b. Coordination of benefits;
- c. Adjudication of health benefit claims (including appeals and other payment disputes);
- d. Subrogation of health benefit claims;
- e. Establishing retiree contributions;
- f. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- g. Billing, collection activities, and related health care data processing;
- h. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Covered Person (and their authorized representatives') inquiries about payments;
- i. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- j. Medical Necessity reviews, or reviews of appropriateness of care or justification of charges;
- k. Utilization review, including, pre-certification, concurrent review, and retrospective review;
- l. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan); and
- m. Reimbursement to the Plan.

2. Definition of Health Care Operations

Health Care Operations include, but are not limited to, the following activities:

- a. Quality assessment;
- b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
- c. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- d. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- e. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- f. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- g. Business management and general administrative activities of the entity, including, but not limited to:
 - i. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
 - ii. customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
 - iii. resolution of internal grievances; and
 - iv. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

3. The Plan's Disclosure of Protected Health Information to the Board of Trustees

The Plan is a multiemployer plan under which the Board of Trustees is both the Plan Sponsor and Plan Administrator. When the Board of Trustees is engaged in settlor functions it is acting as Plan Sponsor and will not have access to PHI. The Plan Sponsor certifies that the Plan has incorporated the appropriate safeguards and provisions to comply with HIPAA's privacy rules. When the Board of Trustees is engaged in administrative functions it is acting as Plan Administrator and will have access to PHI to the extent necessary to administer the Plan. The Board of Trustees will maintain adequate separation between its Plan Administrator and Plan Sponsor functions.

With respect to PHI, the Plan Sponsor agrees to:

- a. Not use or further disclose the information other than as permitted or required by this Plan/SPD or as required by law;
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor 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 unless authorized by the individual;
- d. Not use or disclose the information in connection with any other benefit or plan of the Plan sponsor unless authorized by the individual;
- e. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this Plan/SPD. Specifically, the Plan sponsor will report to the Plan any Breach as defined by 45 CFR § 164.402;
- f. Make PHI available to the individual in accordance with the access requirements of HIPAA;
- g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- h. Make the information available that is required to provide an accounting of disclosures;
- i. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA;
- j. Cooperate with the Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.

- k. If feasible, return or destroy all PHI received from the Plan that the Plan 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. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- l. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

4. Disclosure of Protected Health Information to Fund Office Employees

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI, in addition to the Trustees and business associates of the Fund:

- The Fund Administrator,
- The Field Representative, and
- All other staff members of the Plan Sponsor to whom the Fund Administrator has delegated responsibility for Plan administration,

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan in accordance with HIPAA's minimum necessary rules. If these persons do not comply with this Plan and its related HIPAA policies, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

10.3 HIPAA Security

The Plan will also comply with the security regulations issued pursuant to the HIPAA, 45 CFR Parts 160, 162 and 164 (the "Security Regulations"). The Board of Trustees 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 electronic PHI 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 Board of Trustees will use electronic PHI 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 Fund who uses or discloses electronic PHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's sanction policy.

3. Ensure that any agent or subcontractor to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Take appropriate action related to any Security Incident of which it becomes aware.

Unless defined otherwise in this document, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

XI. PLAN LIMITATIONS AND EXCLUSIONS

11.1 General Limitations

The Plan does not cover any medical care, services, or supplies rendered or supplied to a Covered Person:

1. That exceeds the applicable Plan limitation;
2. That are compensable under any workers' compensation law, workers' occupational disease law, employer liability law, or any other similar laws;
3. That are provided or paid for by any governmental agency or under any governmental law or program, except as specifically provided in the Plan;
4. That are rendered or supplied without charge, or for which there would be no charge except for the Plan;
5. That are not Medically Necessary;
6. That are related to vasectomy reversals (vasovasostomy) or reversal of a tubal ligation;
7. That are considered experimental or investigational (for purposes of the Plan, experimental or investigational care, services, or supplies include but are not limited to those treatments, procedures, or items determined to be experimental or investigational under federal law and regulations or the laws and regulations of the state of Illinois);
8. That are cosmetic in nature, unless the care, services or supplies are Medically Necessary;
9. That are for personal hygiene, comfort or convenience items;
10. For primarily custodial care provided to take care of a Covered Person who cannot take care of himself and is not primarily rendered or applied to cure any illness or injury;
11. That is extended Hospital care in excess of the limits set forth in the Plan;

12. For organ transplants, unless the Trustees provide advance written approval or the procedure was performed on an emergency basis;
13. For treatment of pectus excavatum, unless the Trustees provide advance written approval;
14. For food or food supplements, holistic medicine, vitamins, minerals, appetite suppressants or dietary supplements or formulas, whether or not prescribed by a Physician, but this exclusion does not apply to the following: (a) total parenteral nutrition or enteral nutrition when it is used in circumstances where normal ingestion of food is not possible and the total parenteral nutrition or enteral nutrition is Medically Necessary as the only means to permit the Covered Person to obtain nutrients necessary to sustain physical health; and (b) infant formulas for the treatment of phenylketonuria (PKU) or other heritable diseases.
15. That are incurred while outside of the geographical boundaries of the United States of America except where the Covered Person requires medical care while traveling temporarily outside of the United States;
16. That exceed the lesser of the Reasonable and Customary charge or fee, or the Plan's benefit for the covered care, service, or supply;
17. For Prescription Drugs filled through on-line or internet pharmacies;
18. For procedures and treatments provided by nurse practitioners in an "in store clinic" or similar facility that does not have a medical doctor or Physician (M.D. or D.O.) on the premises on a full-time basis;
19. For expenses for Infertility treatments, including diagnostic tests and Prescription Drugs, rendered to an individual other than the Covered Person, except as otherwise provided under the Plan;
20. That is excluded under the terms of any group insurance contract which is a part of this Fund;
21. For retainer fees or similar fees by a Physician or other provider;
22. For claims connected with the treatment of Substance Abuse;
23. Medical care, services or supplies that are not provided or prescribed by or under the supervision of a Physician or Surgeon; and
24. Hospital expenses not covered under the Plan's basic coverage such as the cost of newspapers, personal comfort items, telephone charges, and similar items provided during hospitalization.

XII. CLAIMS AND APPEAL PROCEDURE

12.1 No Assignment of Claims or Appeal Rights

Rights to make claims or appeals may not be assigned to any other party, including a health care provider, and any purported assignment will not make that entity a Claimant or Beneficiary under this Plan. All benefit payments are paid to Covered Persons or Beneficiaries (“Claimants”) and are not grantable, transferable, or otherwise assignable in anticipation of payment in whole or in part, by the voluntary or involuntary acts of any Claimant or by operation of law.

Any benefit payable under the Plan, at the sole discretion of the Trustees, may be paid directly to the individual or institution that provided the covered services. If payments are made to the health care provider individual or institution that provided the covered services, the payment will be considered the same as payment to Claimant and the health care provider individual or institution shall have no independent right to payment.

12.2 Exhaustion of Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action. **If your appeal is denied, no legal action can be brought with respect to a claim under the Plan after one year from the date of the decision on appeal.**

12.3 Discretionary Decision Making Authority of the Trustees

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions and the terms used in this Plan/SPD. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties hereto and beneficiaries of this Plan. No such determinations involved in or arising under the Trust Agreement or this Plan/SPD will be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the applicable association and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such collective bargaining agreements.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

12.4 Authorized Representative

An authorized representative is the person who can act on the Claimant's behalf to file a claim under the Plan. The Fund requires a written statement from the individual that he/she has designated the named individual(s) as the authorized representative along with the representative's name, address and phone number. Where the individual is unable to provide a written statement, the Fund requires written proof (e.g. power of attorney for health care purposes, court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf. Acting as an authorized representative does not provide the person or entity any independent rights, including the rights of a beneficiary, the right to receive information from the plan or the right to receive information or documents from the plan based upon any alleged failure to timely provide such information or documents.

Once the individual names an authorized representative, the Fund must route all future correspondence related to claims and appeals to the authorized representative and not the individual. However, the Fund will make every effort to copy the original Claimant where possible. The Fund must honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization, unless the original Claimant has limited the authorized representation to one claim or a series of claims related to the same illness or accident. The individual may revoke a designated authorized representative by submitting a signed statement.

The Fund reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

12.5 Filing Your Initial Claim for Benefits

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures. Health claims can be filed for the following benefits: medical, HRA, dental, vision care, hearing, prescription drug, and death.

If you make a simple inquiry about the Plan's provisions without a claim form, or an inquiry as to eligibility, which does not request benefits, the Fund will not treat your inquiry as a claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, that will not be treated as a claim for benefits. When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan/SPD, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

How to File a Claim

You may obtain a claim form by calling the Fund Office. However, if you use the services of a PPO or other network provider, the provider will generally file your claims for you.

Medical, Dental, Hearing and Vision Claims

The following information must be provided by you and/or the provider in order for your request for medical benefits to be considered a claim, and for the Fund to be able to decide your claim:

- a. Retiree's or Spouse's name;
- b. Patient's name;
- c. Patient's date of birth;
- d. Social Security number of Retiree or Spouse;
- e. Date of service;
- f. CPT-4 (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association), if applicable;
- g. ICD-10 (the diagnosis code found in the *International Classification of Diseases, 10th Edition, Clinical Modification*, as maintained and distributed by the U.S. Department of Health and Human Services), if applicable;
- h. Billed charge;
- i. Number of units (for anesthesia and certain other claims);
- j. National Provider Identifier (NPI) of the provider;
- k. Billing name and address; and
- l. When another fund is the primary payer, include a copy of the other fund's Explanation of Benefits ("EOB") statement along with the submitted claim.

To file a claim for medical benefits received from a non-PPO-provider, you need to complete a claim form and send it along with the itemized bill to the Fund Office for processing. Claims must be submitted within one year of incurring the expense. If you or your Spouse has primary coverage under Medicare or another group medical plan, please submit claims to both plans. If this Plan is secondary, be sure to send an EOB from the other insurance company or plan. See the section on Coordination of Benefits for information about primary coverage.

Prescription Drug Claims

In general, you do not have to file claims for prescription drug benefits. Generally, participating pharmacies will submit claims for you. You will pay the pharmacy the copayment and then the claim payment is made directly to the pharmacy.

Death Claims

Your Spouse should notify the Fund Office as soon as possible after your death. The Fund Office provides the forms necessary to process your claim. Your Spouse may be required to submit supporting information (e.g., a death certificate) to verify your Spouse's eligibility for benefits.

Claims must be submitted within 12 months following the date of death.

Where to File all Claims

<u>Contact Information</u>	<u>Type of Claim</u>
Fund Office 1340 West Washington Boulevard, 3 rd Floor Chicago, Illinois 60607 P- 312-226-5000 F- 312-226-7285	Medical, Dental, Vision, Prescription Drug, Death

Explanation of Benefits (EOB) Form

When you file a medical, dental, or vision claim, an explanation of benefits (EOB) form is sent to you. This form tells you the extent to which a claim has been paid. If the claim is not paid, it also gives you the reason for the decision.

12.6 Types of Health Care Claims

- a. Urgent Care. An urgent care claim is a pre-service claim for medical care or treatment that would:
 - i. Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
 - ii. Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- b. Pre-service. A pre-service claim is a claim for treatment where the Plan requires that you obtain pre-certification. ***Organ transplant benefits and certain durable medical equipment require pre-certification. All other benefits do not require pre-certification and therefore are not considered pre-service claims.*** The Plan will not deny benefits for these procedures or services if:
 - i. It is not possible for you to obtain pre-certification; or
 - ii. The pre-certification process would jeopardize your life or health.
- c. Post-service. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services for which you are seeking benefits.

- d. Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:
 - i. Reduced benefits; or
 - ii. A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

Generally, when network providers submit the claims, payment is made directly to the provider. Network providers handle the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the provider.

12.7 Initial Health Care Claim Determination Timeframes

Claim Filing Deadline

Claims should be filed within 90 days following the date charges were incurred. Failure to submit the claim within the time frame will not invalidate or reduce any claim if it was not reasonably possible to meet this time frame. In such case, the claim must be submitted as soon as reasonably possible, but in no event later than 12 months following the date charges were incurred.

Decision Timeframes

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Fund's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim. A claim may be filed by a Claimant, an authorized representative, or by a network provider (each a "Claimant"). In the event a claim is filed by a provider, such provider shall not automatically be considered a Claimant's authorized representative. In addition, any claim filed by an authorized representative or health care provider is subject to the limits set forth in Sections 12.1 and 12.4 above.

- 1. Urgent Health Care Claims
 - a. An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice.
 - b. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. The notice will state the special circumstances and the date the Plan expects to make a decision. You

will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received if sooner.

2. Pre-Service Health Care Claims

- a. An initial determination will be made within 15 days from receipt of your claim. If additional time is necessary due to matters beyond the control of the Plan, you will be informed of the need for an additional 15 days within the original 15-day period.
- b. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then will have up to 45 days to provide the requested information. The notice will state the special circumstances and the date the Plan expects to make a decision. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

3. Post-Service Health Care Claims

- a. Claims for Post-Service treatments or services must be decided no later than 30 days after receipt by the Fund. A Claimant filing a claim must be notified within the 30-day initial determination period if the claim is denied (in whole or in part).
- b. The time for deciding the claim may be extended by 15 days due to circumstances beyond the Fund's control (e.g., inability of the medical reviewer to meet a deadline); provided notification is given to the Claimant before the expiration of the initial 30-day determination period.
- c. If a claim cannot be processed due to insufficient information, the Fund Office or applicable claims administrator must notify the Claimant about what information is needed before the expiration of the 30-day initial determination period. Thereafter, the Claimant will have 45 days after his/her receipt of the notice to supply the additional information. If the Claimant does not provide the information during the 45-day period, the claim will be denied. During the period in which the Claimant is permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Fund receives the Claimant's response to the request for information. The Fund then has 15 days to make a decision and notify the Claimant.

12.8 Denial of Initial Benefit Claims

a. Adverse Benefit Determination

For the purpose of the initial claims and appeal processes, an "Adverse Benefit Determination" is defined as:

1. A denial, reduction, or termination of a benefit or a failure to provide or make payment in whole or in part for a benefit or a denial or termination of a beneficiary's eligibility to participate in this Fund; or
2. A benefit denial resulting from the application of any utilization review requirement or 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.

b. Notice of Adverse Benefit Determination

If the claim is wholly or partially denied, a notice of this initial denial (the Adverse Benefit Determination) must be provided to the Claimant in writing (or electronically, as applicable) within the timeframe required to make a decision on that claim. This notice of initial denial must:

1. Give the specific reason(s) for the denial;
2. Reference the specific provision(s) of the Plan/SPD on which the denial is based;
3. Include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes);
4. Include a statement of the specific reason(s) for the Adverse Benefit Determination; as well as a description of the Plan's standard, if any, that was used in denying the claim;
5. Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
6. Provide an explanation of the Fund's appeal procedure along with time limits;
7. Contain a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following an appeal;
8. If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
9. If the denial was based on a medical judgment (Medical Necessity, experimental or investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and

10. The contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

12.9 Internal Review Appeal Procedure

a. Filing an Appeal

Claimants have the right to a full and fair review if a claim for benefits is denied by the applicable claims administrator. If the claim is denied and the Claimant disagrees with that Adverse Benefit Determination decision, the Claimant or the Claimant's authorized representative may ask for an appeal review. However, you must provide notification to the Fund Office authorizing this representative. A healthcare professional that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

NOTE: If you made an inquiry to the Fund Office or to Hines & Associates prior to receiving a service as to whether that service (other than a service requiring precertification) is covered by the Plan and your inquiry was denied, THIS INQUIRY WILL NOT BE TREATED AS A CLAIM AND WILL NOT BE AFFORDED APPEAL RIGHTS UNDER THE PLAN. In their sole discretion, the Trustees may review inquiries at the next regularly scheduled quarterly Board meeting. Inquiries reviewed by the Trustees will not change the status of the inquiry to a claim.

Appeal requests must be in writing and must include the specific reasons the Claimant believes the denial was improper. Additionally, all relevant documentation should be submitted for consideration on review.

The Claimant has 180 calendar days following receipt of an initial Adverse Benefit Determination to request an appeal review. **The Fund will not accept appeals filed after this 180-day period for any benefits.**

If you file your appeal on time and follow required procedures, a new, full and independent review of your claim will be made and initial benefit decision will not be deferred to. Claim appeals are reviewed by the Fund's Board of Trustees which meets no less than quarterly and is the Plan fiduciary to review claim appeals. The decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal. However, oral notice of a determination on your urgent care claims may be provided to you sooner.

b. Appeal Process

Once a Claimant files a written request for appeal, he/she will be provided with the following:

1. The opportunity, upon request and without charge, for reasonable access to and copies of all relevant documents. A document, record, or information is "relevant" if:

- a. It was relied upon by the Fund in making the initial claim determination,
 - b. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon),
 - c. It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making, or
 - d. It constitutes a statement of Fund policy regarding the denied treatment or service.
2. The opportunity to submit written comments, documents, records and other information relating to the claim for benefits to the Fund.
 3. A full and fair review by the Board of Trustees that takes into account all comments, documents, records and other information submitted, without regard to whether such information was submitted or considered in the initial benefit determination.
 4. A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary (or fiduciaries, i.e., the Board of Trustees) of the Fund who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
 5. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary or fiduciaries must consult with a health care professional who: (1) has appropriate experience in the field of medicine involved in the medical judgment; and (2) is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual. The Fund must provide upon request the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
 6. If the Plan should fail to strictly adhere to these internal claims appeal procedures, a Claimant will be deemed to have exhausted the Plan's internal claims appeal process and may initiate any other available legal remedies under ERISA or state law. Coverage under the Plan will continue for the Claimant pending the outcome of the appeal.

Information requested by the Claimant and relied upon by the Plan for the underlying denial will be provided free of charge.

- c. Timing of Notice of Denial on Appeal

1. Health Claims

- *Urgent Care Claims.* A determination will be made within 72 hours from receipt of your appeal.
- *Pre-Service Claims.* A determination will be made within 30 calendar days from receipt of your appeal.
- *Post-Service Claims.* Decisions involving health claims on appeal will be provided within five days following the next scheduled full Board of Trustees meeting which immediately follows the Plan's receipt of a request for review, unless the request for review is received within 30 days preceding the date of the next scheduled Board of Trustees meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. Special circumstances may arise which may require a further extension of time to the third meeting of the Board of Trustees. In such instances, the Fund Administrator will notify you of the extension.
- *Concurrent Care Claims.* A determination will be made before the reduction or termination of your benefit.

2. All Other Claims

The Fund will send you a notice of the decision on appeal within 60 days of a decision by the Board of Trustees.

d. Notice of Denial on Appeal

If the claim is wholly or partially denied on appeal, a notice of this denial on appeal (final Adverse Benefit Determination) must be provided to the Claimant in writing (or electronically, as applicable) within the timeframe required to make a decision on that claim. This notice of denial on appeal must:

1. Give the specific reason(s) for the denial;
2. Reference the specific provision(s) of the Plan/SPD on which the denial is based;
3. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes);
4. Contain a statement of the specific reason(s) for the Adverse Benefit Determination; as well as a description of the Plan's standard, if any, that was used in denying the claim;

5. Contain a statement that the Claimant has the right to bring civil action under ERISA Section 502(a) following receipt of the appeal denial;
6. If the appeal denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request; and
7. If the denial was based on a medical judgment (Medical Necessity, experimental or investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request.

XIII. COORDINATION OF BENEFITS

This Article applies to benefits provided under all parts of the Plan except Death Benefits.

Definitions

The term “Plan” as used in this Article means any plan providing benefits or services for or by reason of medical, dental, or vision care or treatment, which benefits or services are provided by:

1. Group blanket insurance coverage, group Blue Cross or Blue Shield, or other group prepayment coverage, coverage under a labor-management trustee plan, union welfare plan, employer organization plan, and coverage sponsored by or provided through a school or other educational institution, and
2. Coverage under any plan solely or largely tax-supported or otherwise provided for, by, or through action of any governmental program (for example, Medicaid, TRICARE, Medicare, and Veterans’ Coverage) or required or provided by any statute or law.

In no event shall the term “Plan” include individual policies issued on a franchise basis nor group remittance subscriber contracts. The term “Plan” is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term “Retiree Medical Plan” as used in this Article means that portion of the Plan that provides the benefits that are subject to this Article.

The term “Allowable Expense” as used in this Article means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person with respect to whom a claim is made. When a plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid.

The term “Dependent” as used in this Article means, with respect to the Retiree Medical Plan, any person included within the definition of “Spouse” of the Retiree Medical Plan, and with respect to any other Plan, any person who qualifies as a dependent under that Plan.

Effect on Benefits

1. This Article applies to determine the benefits as to a person covered under the Retiree Medical Plan for any period of illness or injury compensable under the Retiree Medical Plan if, for the Allowable Expenses incurred as to such person during such period, the sum of:
 - a. The benefits that would be payable under the Retiree Medical Plan in the absence of this Article, and
 - b. The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to those contained in this Article would exceed such Allowable Expenses.
2. For any period in which this Article applies, the benefits that would be payable under the Retiree Medical Plan in the absence of this Article for the Allowable Expenses incurred as to such person during such period is reduced to the extent necessary so that the sum of the reduced benefits and all the benefits payable for such Allowable Expense under all other plans, except as provided in paragraph 3. below, do not exceed the total of the Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had the claim been duly made therefor.
3. If (i) another plan which is involved in paragraph 2. above and which contains a provision coordinating its benefits with those of the Health and Welfare plan would, according to its rules, determine its benefits after the benefits of the Retiree Medical Plan have been determined; and (ii) the rules set forth in Subparagraph (4) of this Paragraph (C) would require the Retiree Medical Plan to determine its benefits before the other plan, then the benefits of the other plan will be ignored for the purposes of determining the benefits under the Retiree Medical Plan.
4. For the purpose of paragraph 3. above, the rules establishing the order of benefit determination are:
 - a. The benefits of a plan with no provision for coordination of benefits are determined before the benefits of a plan which contains such provision.
 - b. The benefits provided under Part A and Part B of Title XVIII of the Social Security Act, as amended, (Medicare) are determined before the benefits provided under any other plan, to the extent the Social Security Act or other applicable law does not require that Medicare Benefits be determined after the benefits provided under any other plan.

- c. The benefits of a plan covering a person as an employee who is neither laid off nor retired are determined before the benefits of a plan covering a person as a laid off or retired person if both plans utilize this rule in establishing the order of benefit determination.
- d. The benefits of a plan that covers the person on whose expense the claim is based other than as a dependent are determined before the benefits of a plan which covers the person as a dependent;
- e. The benefits of a plan that covers the person on whose expenses claim is based as a dependent of a person whose day and month of birth is earliest in the calendar year are determined before the benefits of a plan which covers the person as a dependent of a person whose day and month of birth is later in the calendar year. However, if the other plans do not have this day and month rule, then the benefits of a plan that covers the person on whose expenses claim is based as a dependent of a male person are determined before the benefits of a plan that covers the person as a dependent of a female person; except that in the case of a person for whom claim is made as a dependent child of divorced or separated parents.
 - i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of the parent with custody of the child are determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
 - ii) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan that covers the child as a dependent of the parent with custody are determined before the benefits of a plan that covers that child as a dependent of the step-parent, and the benefits of a plan that covers that child as a dependent of the stepparent are determined before the benefits of a plan that covers that child as a dependent of the parent without custody.

Notwithstanding (i) and (ii) above, if there is a court decree that otherwise establishes financial responsibility for the medical and dental or other health care expenses with respect to the child, the benefits of a plan that covers the child as a dependent of the parent with financial responsibility are determined before the benefits of any other Plan that covers the child as a dependent child.
- f. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:

- i) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
- ii) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- g. As to plans as to which rules (a), (b), (c), (d), (e) and (f) do not establish an order of benefit determination, the benefits of a plan that has covered the person on whose expenses claim is based for the longer period of time are determined before the benefits of a plan that has covered such person the shorter period of time.
5. The Trustees are not required to determine the existence of any plan, or the amount of benefits payable under any plan except the Retiree Medical plan, and the payment of benefits under the Retiree Medical Plan are affected by the benefits that would be payable under any and all other Plans only to the extent that the Trustees have or are furnished with information relative to the other plans.
6. When this Article operates to reduce the total amount of benefits otherwise payable to a person covered under the Retiree Medical Plan during any period of illness or injury compensable under the Retiree Medical Plan, each benefit that would be payable in the absence of this Article is reduced either proportionately or in any other equitable manner as the Trustees of the Retiree Medical Plan determine, and the reduced amount is charged against any applicable benefit limit of the Retiree Medical Plan.

For the purposes of determining the applicability of and implementing the terms of this Article of the Retiree Medical Plan or any provision of similar purpose of any other plan, the Trustees may, without the consent of or notice to any person, release to or obtain, from any insurance company or other organization or person, any information concerning any person, that the Trustees deem necessary for this purpose. Any person claiming benefits under the Retiree Medical Plan must furnish to the Trustees necessary information to implement this provision.

Facility of Payment

Whenever payments that should have been made under the Retiree Medical Plan in accordance with this Article are made under any other plan, the Trustees have the right, exercisable alone and in their sole discretion, to pay over to organizations making the other payments any amounts determined to be warranted in order to satisfy the intent of this Article, and the amounts paid are deemed to be benefits paid under the Retiree Medical Plan and, to the extent of the payments, the Trustees are fully discharged from liability under the Retiree Medical Plan.

Right of Recovery

Whenever payments have been made by the Trustees for Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Trustees have the right to recover the payments, to the extent of the excess, from among one or more of the following, as the Trustees determine: any persons to or for or with respect to whom such payments were made, any insurance company, or any other organization.

XIV. THE PLAN'S RIGHT OF SUBROGATION AND RIGHT OF REIMBURSEMENT

In the event the Fund pays or is obligated to pay benefits on behalf of a Retiree, his estate, his Spouse, or his Spouse's estate ("Claimant"), for illness, accident, sickness, work-related injury, or injury, regardless of how such injury occurred, the Fund shall have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance cover-age, or any other first-party contract or claim, the Trustees of the Funds and the Fund shall be subrogated to all of the Claimants' right of recovery against such person, corporation, insurance, carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim and shall have a right of reimbursement from the Claimant to the full extent of payments made by the Fund and for the cost of collection of these amounts, including attorney's fees. The Fund has a right to be reimbursed from any settlement, judgment, insurance proceeds, no-fault automobile insurance payments, or other recovery for any and all benefits paid in connection with such injury, illness, accident, or sickness up to the amount of recovery. The full amount of benefits paid shall include any PPO Charge or other payment to a medical discount provider paid with respect to the involved benefits which shall be considered part of the amount of benefits paid.

A Claimant must immediately inform the Fund in writing of any legal action or any recovery that arises subsequent to the payment of benefits by the Fund. A Claimant must cooperate fully with the Fund in connection with the exercise of its rights under this provision and must do nothing to prejudice such rights of reimbursement and repayment. Your failure to promptly notify the Fund Office of any legal action or recovery may result in a delay or denial of Plan benefits. Please see section 15.13 for additional Notice requirements.

The Trustees and the Fund shall have a first equitable lien and constructive trust upon any recovery by agreement in the amount of all benefits paid up to the amount of recovery, regardless of how the recovery is allocated or structured and this equitable lien by agreement shall be enforceable as part of an action to enforce plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Claimant, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the Claimant. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the Claimant be "made-whole" or that the entire debt be paid to the Claimant prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred

by the Claimant in recovering the amounts or by any state law doctrine, such as the “Common Fund” doctrine, which would purport to impose such a reduction.

- In addition, the Fund’s right of recovery applies:
- Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical expenses;
- Regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the “collateral source” rule); and
- Even if the recovery was reduced due to the negligence of the Claimant or any other common law defense.

In the event the Claimant dissipates the recovery received related to the injury, accident, or sickness prior to reimbursing the Fund, the Fund shall have the right to file an action in law against the Claimant seeking monetary damages from the Claimant’s general assets. The Fund shall also have the right to offset or withhold any future benefits that the Claimant may be entitled to receive until the Fund has been reimbursed.

The Claimant or the authorized representative of the Claimant shall execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The Fund may withhold benefits until such Subrogation or Reimbursement Agreement is signed. The Claimant shall do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joinder of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the Claimant does not attempt to recover the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund shall, if in the Fund’s best interest and at the Trustees’ sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the Claimant or paid on the Claimant’s behalf, together with the costs of collection, including attorney’s fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by an uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery shall take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund’s attorney’s fees, shall be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the Claimant, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be distributed to the Fund.

The remainder or balance of any recovery shall then be paid to the Claimant and his or her attorneys if applicable.

In the event of any failure or refusal by the Claimant to execute any document requested by the Trustees or the Fund or to take other action requested by the Trustees or the Fund to protect the interests of the Trustees or the Fund, the Trustees may withhold payment of benefits from the Fund or deduct the amount of any payments from amounts otherwise payable by the Fund for future claims of the Claimant. After making claim for benefits from the Fund, the Claimant shall take no action that could prejudice the rights of the Trustees or the Fund.

In the event the Claimant recovers any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim the Fund will request repayment of the amount of its equitable lien for the full amount of benefits paid by the Fund. If the Claimant refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from Claimants by instituting legal action against the Claimant and/or by deducting such amounts as may be due on future claims submitted by the Retiree or Spouse. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The Claimant shall be required to pay his own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Trustees shall pay no legal costs or fees from the Fund without receiving a recovery and then only, in their sole discretion, within the terms of this provision. Claimants will indemnify the Plan for any attorney fees paid by the Plan as a result of the attorney filing an action to enforce the common fund doctrine or other equitable lien provision. In the event that an attorney is hired by or on behalf of the Claimant and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire such attorney. If the attorney representing the eligible individual nevertheless wishes to proceed, and creates a common fund from which the Trustees can recover pursuant to their equitable lien by agreement for subrogation and reimbursement, the Trustees, on behalf of the Fund and at their sole discretion, may agree to reduce its recovery to include the attorney's legal fees. This reduction shall also include any prorated portion of the cost of recovery. If the attorney agrees to proceed, he will be considered to have waived the common fund doctrine.

Should any money subject to the terms of this subrogation and reimbursement section or a subrogation and reimbursement agreement be recovered by or on behalf of any Claimant, and such money is transferred to the Claimant, Claimant agrees that such money is a Plan asset and that Claimant is a fiduciary to the Plan with respect to that money, pursuant to ERISA § 3(21)(A)(i). As a fiduciary, Claimant is required to hold the money in trust on behalf of the Plan and not otherwise spend or distribute the money until the Plan has released its subrogation lien in writing. If the Claimant is a fiduciary pursuant to the foregoing, a failure to comply with the reimbursement and subrogation agreement or this Article XIV shall be considered a breach of fiduciary duty, and the Trustees may enforce the terms of the reimbursement and subrogation agreement and this Article XIV through legal action, reduction of benefits, or any other available legal or equitable means.

These provisions shall apply to any case in which the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a Claimant, together with cost of collection,

as of the date of this provision, and any subrogation and reimbursement claim or lien presented by the Fund or Trustees, where the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a Claimant, together with cost of collection, as of the date of these provisions, shall be construed to involve an equitable lien by agreement under these provisions.

(If you want more information about Subrogation, contact the Fund Office.)

XV. IMPORTANT INFORMATION ABOUT THE PLAN

15.1 Name and Type of Plan

This Plan is known as the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. This Plan is considered a "retiree only" plan and provides health and welfare benefits for expenses arising from hospitalization, surgery, medical treatment, prescription drug, vision or dental care to Covered Persons. This Plan also provides Medicare supplemental benefits and benefits for death and health reimbursement account benefits. Details of the dental and vision coverage are contained in separate certificates.

15.2 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor, Plan Administrator and the named fiduciary of the Plan. The Board of Trustees is responsible for the Plan's operation. The Board of Trustees consists of five employer and five Local Union 130 U.A. representatives. If you wish to contact the Board of Trustees, you may use the address and phone number below:

Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U. A.

Administrative Offices

Third Floor

Stephen M. Bailey Auditorium

1340 West Washington Boulevard

Chicago, Illinois 60607

Phone: (312) 226-5000

As of June 1, 2017, the Trustees of this Fund are:

UNION TRUSTEES

James F. Coyne, Co-Chairman
1340 W. Washington Boulevard
Chicago, IL 60607

Kenneth A. Turnquist
1340 W. Washington Boulevard
Chicago, IL 60607

Scott C. Spangle
1340 W. Washington Boulevard
Chicago, IL 60607

James A. Mansfield
1340 W. Washington Boulevard
Chicago, IL 60607

William E. Matthies
1340 W. Washington Boulevard
Chicago, IL 60607

Michael Shea, Alternate Trustee
1340 W. Washington Boulevard
Chicago, IL 60607

EMPLOYER TRUSTEES

David Ariano, Co-Chairman
Ravinia Plumbing
1580 Old Skokie Rd.
Highland Park, IL 60035

Todd DeFranco
DeFranco Plumbing
20330 N Rand Rd.
Kildeer, IL 60074

James Bruckner
Chas F. Bruckner & Son, Inc.
503 W. 26th Street
Chicago, IL 60637

James O'Sullivan
O'Sullivan Plumbing, Inc.
9726 194th Place
Mokena, IL 60448

Brian Burns
C. W. Burns Co., Inc.
1536 Brook Dr. # E
Downers Grove, IL 60515

S.J. Peters, Alternate Trustee
Plumbing Contractors Association
603 Rogers Street, Suite 2
Downers Grove, IL 60515

15.3 Plan Vendor Contact Information

See the following contact information about the Plan's various vendors:

<i>Medical Benefits</i> Blue Cross Blue Shield of Illinois	www.bcbsil.com	1-800-571-1043
<i>Dental Benefits</i> Delta Dental of Illinois	www.deltadentalil.com	1-800-323-1743
<i>Vision Benefits</i> EyeMed	www.eyemedvisioncare.com	1-866-723-0514
<i>Prescription Drug Benefits</i> Express Scripts Accredo	www.express-scripts.com www.accredo.com	1-800-451-6245 1-877-222-7336
<i>Utilization Review</i> Hines & Associates	www.hinesassoc.com	1-800-944-9401
<i>Wellness</i> Healthways (Silver Sneakers)	www.healthways.com	1-800-327-3822
<i>EAP</i> ERS	www.ers-eap.com	1-800-292-2780

15.4 Identification Numbers

The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 503 The Employer Identification number assigned to the Board of Trustees by the Internal Revenue Service is 46-5193231.

15.5 Agent for Service of Legal Process

The Fund Administrator is the Fund's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Fund Administrator at the address shown in "Plan Sponsor and Plan Administrator" above. However, documents may also be served upon the Trustees individually at their respective addresses.

15.6 Collective Bargaining Agreements

The Fund is established and maintained under the terms of collective bargaining agreements between the Union and the Kankakee & Iroquois Counties Plumbing & Piping Contractors Association, the West Suburban Association of Plumbing Contractors, and the Plumbing Contractors Association of Chicago, respectively. These agreements set forth the conditions under which Contributing Contractors are required to contribute to the Fund. Copies of the agreements are available upon request.

Upon written request to the Fund Office, Retirees and beneficiaries may obtain information as to the address of a particular Contributing Contractor and whether that Contributing Contractor is required to pay contributions to the Fund.

15.7 Plan Year

The Plan Year begins on June 1 and ends on May 31. The fiscal year of this Plan for purposes of its financial records is also based on the Plan Year.

15.8 Source of Contributions and Benefits

Contributions to the Fund are made by Employers under their collective bargaining agreements with Local 130, U.A. and participant self-payments. Such agreements require contributions to the Plan at a fixed rate per hour worked. Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a trust fund for the purpose of providing group health and welfare benefits to Covered Persons and defraying reasonable administrative expenses.

15.9 Plan Investments

The Fund's assets and reserves are held in custody at the AmalgaTrust Company, Inc., Chicago, Illinois.

15.10 Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirement for coverage of Workers' Compensation insurance.

15.11 The Plan is Tax Exempt

The Plan is classified by the Internal Revenue Service as a 501(c)(9) trust. This means that the Employers' contributions to the Fund are tax deductible and are not included as part of your income. Also, in most cases, the benefit paid on your behalf is not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of the Fund since they are specifically set aside for the purpose of providing benefits to Covered Persons.

15.12 Right of Trustees to Amend Fund and Plan

The Trustees expressly reserve the right to amend this Plan/SPD at any time and from time to time in order to add to or modify the Plan or to eliminate benefits. No Covered Person or Beneficiary is vested in health and welfare benefits under this Plan. If the Trustees amend or terminate the Plan, they will notify you in writing of any material changes that are made to your coverage.

15.13 Your Duties And Responsibilities

As a Covered Person, or the representative of a Covered Person (if they are unable to do so for any reason), you have the following duties and responsibilities to keep the Trustees, through the Plan Administrator, informed without undue delay of the following:

1. Any change in your address or telephone number.
2. The death of you or your Spouse.
3. Your divorce or legal separation from your Spouse.
4. Detailed information about any accident or event caused by the act of a third party which results in a claim for benefits by you or your Spouse.
5. Any other material matter relating to health and welfare benefits for you and your Spouse.

Your failure to promptly notify the Fund Office within 30 days of any of the above events may result in a delay or denial of Plan benefits. Through your cooperation the Plan will continue to provide you with uninterrupted health and welfare benefits.

15.14 Application For Benefits

If you become injured or sick, contact the Fund Office as soon as possible for a benefit application form. If possible, contact the Fund Office before you enter the Hospital or receive treatment by a Physician. You must make application for benefits within one year from the date

medical services are rendered. Generally, except for amounts paid directly to Providers, only the Covered Person is paid or reimbursed for medical expenses incurred by a Retiree or his Spouse. For that reason all claim forms must be signed by the Covered Person.

15.15 Payment of Benefits

Death Benefits are paid to your surviving designated Beneficiary or as otherwise provided in the Plan. All other benefits in the Plan are payable to the Covered Person, to the Hospital, or other eligible providers of covered services. No benefits are payable from the Plan to or for the benefit of any individual who intentionally and unjustifiably causes the death of a Retiree as determined by the Trustees. The Trustees may, without the consent of any Beneficiary, pay any benefit accrued under this Plan for medical benefits to the provider of the medical or Hospital service or to reimburse the person or persons who paid the provider of the Hospital or medical service but the reimbursement will not exceed the benefit accrued for the medical or Hospital services. Any determination under this paragraph will be made solely by the Trustees, and is final and binding on all persons. No Death Benefits will be paid if the Retiree was not enrolled in either the Pre-Medicare or Medicare eligible retiree benefits at the time of the Retiree's death.

Benefits accrued on your behalf will be paid upon your death, at the Fund's option, to the first surviving class of the following:

1. Your surviving designated Beneficiary;
2. Your Spouse;
3. Your dependent children, including legally adopted children;
4. Your parents;
5. Your brothers and sisters; or
6. Any person the Trustees determine is entitled to payment.

The Fund may rely upon an affidavit or other written statement to determine benefit payments, unless it receives written notice of a valid claim before payment is made. The affidavit will release the Fund from further liability. Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

If benefit payments are payable to an infant, or to a person under legal disability, or to a person not adjudicated incompetent but, by reason of mental or physical disability, in the opinion of the Trustees, is unable to properly administer the benefit payments, then the payments may be paid out by the Trustees for the benefit of the infant or person, in any of the following ways as they think best; and the Trustees have no duty or obligation to see that the funds paid are used or applied for their intended purpose or purposes:

1. Directly to the infant or disabled person;
2. To the legally appointed guardian or conservator of the infant or disabled person;

3. To any spouse, parent, descendant, brother or sister of the infant or disabled person for welfare, support and maintenance;
4. By the Trustees using the payments directly for the support, maintenance, and welfare of any the infant or disabled person.

15.16 Right of Trustees to Resolve Disputes and to Interpret Plan

The Trustees have the power to adopt rules and regulations for the administration of the Fund and Plan and to interpret and construe the provisions of the Fund and Plan and any rules and regulations adopted by the Trustees. All questions or controversies of any character arising between any parties or persons in connection with administration or operation of the Fund including benefit claims made by any Retiree, Spouse, Beneficiary, or any other person; questions concerning the construction, interpretation, or application of the language of the Plan, the Fund, rules and regulations adopted by the Trustees, or any other writing, decision, or instrument; or any other act involving the operation or administration of the Fund will be submitted to the Trustees for decision. The Trustees have the power and authority to take any and all actions required to resolve all questions and controversies; including the power to make factual findings; to fix omissions in the Fund, the Plan, any rules and regulations promulgated by the Trustees or any benefit communications; to resolve Plan ambiguities; and to construe the terms of the Trust Agreement and the Plan and any rules and regulations promulgated under the Fund and Plan. All decisions, determinations, and findings of the Trustees are binding upon all persons dealing with the Fund or claiming any benefit thereunder.

15.17 Limitation on Legal Action Against the Plan

Any legal action by a Covered Person (or their representatives, agents, heirs, or assigns) to enforce a right to benefits under this Fund or the Plan must be commenced within one year of the date the Covered Person completes the administrative appeal of the benefit denial. For purposes of this Section, a Covered Person is considered to complete his administrative appeal of a benefit denial when one of the two occurs below, whichever one occurs first:

- The expiration of 180 days after the date a Covered Person received notice of the initial denial or partial denial of his claim; or
- The date the Covered Person receives notice that his appeal of the initial denial or partial denial of his claim has been denied by the Fund.

For purposes of this Section, a Covered Person is considered to receive notice on the date the notice is mailed, postage prepaid, to the person at the address shown on the Fund's records.

15.18 Interests in the Fund

No Covered Person or any other person has any right, title, interest in or to the assets of the Fund, or any part thereof; however, any Retiree who is covered by a group insurance contract, or his Beneficiary, is entitled to benefits in the amount and subject to the terms and conditions of the group insurance contract. No Covered Person or any other person has any right, title, or interest in, or the option to receive, any part of the Contributing Contractors' contributions. No Covered

Person or any other person has the right to assign his benefits or receive a cash consideration in lieu of his benefits.

15.19 Fraud Regarding Eligibility Rules

It is a fraudulent act to provide false documentation to establish eligibility of a person who is not eligible for Plan benefits. In the event that a claim is filed on behalf of a formerly eligible person and you receive an explanation of benefits indicating that that person was covered, you must notify the Fund Office that the individual is no longer eligible. Acts of fraud will be grounds for retroactive termination of eligibility for you and your Spouse. You will be held responsible for any claims paid on behalf of an ineligible person.

15.20 Important Notices of Specific Rights Under the Law

Women's Health and Cancer Rights Act of 1998 Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan chooses to cover mastectomies, then the plan is generally subject to WHCRA requirements. To the extent WHCRA applies to a particular Welfare Benefit Program, coverage will be provided for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance and (3) prostheses and treatment of physical complications of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. Please consult the Schedule of Benefits for specific deductible and coinsurance information related to mastectomy benefits. For further information, contact the Fund Administrator.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 protects Americans against discrimination based on their genetic information when it comes to health insurance and employment.

Mental Health Parity Addiction and Equity Act

Because this Plan is a "retiree-only" health plan which does not cover employees, this Plan is exempt from the rules of the Mental Health Parity Addiction and Equity Act and its implementing regulations.

HIPAA Portability Rules

Because this Plan is a "retiree-only" health plan which does not cover employees, this Plan is exempt from the rules relating to HIPAA Portability which include special enrollment rights and nondiscrimination restrictions.

15.21 Prohibition Against Discrimination

Pursuant to Section 1557 of the Patient Protection and Affordable Care Act, the Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Joseph Ohm, Fund Administrator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Retiree Medical Plan of the Plumbers’ Welfare Fund, Local 130, U. A., c/o Joseph Ohm, Fund Administrator, 1340 West Washington Boulevard, 3rd Floor, Chicago, Illinois 60607, Phone: (312) 226-5000, johm@ualocal130funds.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Ohm, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language	Message About Language Assistance
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Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-226-5000.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-226-5000.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-312-226-5000。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-226-5000. 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-312-226-5000.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-226-5000.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-312-226-5000.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-312-226-5000.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-312-226-5000.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-312-226-5000.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wikanang walang bayad. Tumawag sa 1-312-226-5000.
Arabic	مقر (1-312-226-5000). مقرب لصنا. ناجملا ب كل رفاوتت قيو غلا ةدعاسملا تامدخ نإف ةغلا ركذا ثدحتت تنك اذا: ةظوحلم،
Urdu	لاک - نیہ بائیسد نیم تقم تامدخ یک ددم یک نابز وک پا وت، نیہ ےتلوب ودرا پا رگا: رادریخ نیرک 1-312-226-5000.

Hindi	ध्यान दः यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह 1-312-226-5000.
Gujarati	યુના: જો તમે જરાતી બોલતા હો, તો િનઃકુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-312-226-5000.

XVI. STATEMENT OF ERISA RIGHTS

As a Covered Person under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Plan administrator’s office and at other specified locations, such as the union hall, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the plan administrator (the administrator may make a reasonable charge for the copies).
- Receive a summary of the Plan’s annual financial report: The Plan administrator is required by law to furnish each Covered Person with a copy of this summary annual report.
- Continue health care coverage for yourself or your Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse has to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

In addition to creating rights for Covered Person, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Covered Person and Beneficiaries. No one, including your employer, your union, or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial.

You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the

control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order you may file suit in Federal Court. If it should happen that Plan fiduciaries misused the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should call the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington D.C. 20210.

XVII. PROVISIONS RELATING TO THE PLAN'S RELATIONSHIP WITH BLUE CROSS/BLUE SHIELD

This Section only applies to the Pre-Medicare retiree health benefits and governs the relationship between the Fund and Health Care Service Corporation, a/k/a Blue Cross/Blue Shield of Illinois ("Network Administrator") and does not in any way limit or override any other provision of the Trust Agreement or Plan to the contrary. However, to the extent there is a conflict between the terms of these provisions and the applicable Network Agreement ("Agreement") between the Fund and the Network Administrator, the Agreement shall rule. Nothing in the Plan or the Agreement shall be construed to constitute the Fund as an agent of the Network Administrator.

1. Network Administrator's Separate Financial Arrangements with Providers

The Fund acknowledges that the Network Administrator has contracts with certain Providers ("Network Administrator Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates agreements and contracts to which the Network Administrator is a party, including the Covered Persons under this Plan, and that pursuant to the Network Administrator's contracts with Network Administrator Providers, under certain circumstances described in those contracts, the Network Administrator may receive substantial payments from Network Administrator Providers with respect to services rendered to all such persons for which the Network Administrator was obligated to pay the Network Administrator Provider, or the Network Administrator may pay Network Administrator Providers substantially less than their claim charges for services, by discount or otherwise, or may receive from Network Administrator Providers other substantial allowances under the Network Administrator's contracts with them. Neither the Fund nor Covered Person are entitled to receive any portion of any such payments, discounts and/or other allowances as part of any claim settlement or otherwise except as otherwise set forth in the Agreement.

2. Information and Records

It is the Covered Person's responsibility to ensure that any Provider, other Blue Cross and Blue Shield plan, insurance company, employee benefit association, governmental body or program, or any other person or entity, having knowledge of or records relating to (1) any illness or injury for which a claim or claims for benefits are made under this Plan, (2) any medical history which might be pertinent to such illness, injury, claim or claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such claim or claims, furnish to the Network Administrator, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, claim or claims. It is also the Covered Person's responsibility to furnish to the Fund and/or the Network Administrator information regarding a Covered Person becoming eligible for Medicare, termination of Medicare eligibility, or any change in Medicare eligibility status in order that the Network Administrator be able to make claim payments in accordance with Medicare Secondary Payer laws.

3. Payment of Claims and Assignment of Benefits

All payments by the Network Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing covered services for which such payment is due, and the Network Administrator is authorized by the Covered Person to make such payments directly to such Providers.

Once covered services are rendered by a Provider, the Participant has no right to request the Network Administrator not to pay the Claim submitted by such Provider and no such request by a Participant or his agent will be given effect.

Benefits under the Plan will be paid either directly from the general assets of the Fund or by the Network Administrator on behalf of the Fund pursuant to the terms of the Agreement. No assets of the Network Administrator or amounts which have been paid to the Network Administrator by the Fund under the Agreement are assets of or under the Plan.

Neither this Plan nor a Participant's claims for payment of benefits under this Plan are assignable in whole or in part to any person or entity at any time. Coverage under this Plan is expressly non-assignable or non-transferrable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under this Plan. However, if the Network Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Network Administrator will have no obligation to pursue recovery of such payment.

4. Participant/Provider Relationship

The choice of a Hospital and Physician is solely the choice of the Covered Person. It is expressly understood that the Network Administrator does not itself undertake to furnish Hospital or medical service, but solely to make payment to a Hospital or Physician for the covered services received by Covered Persons.

Each Provider provides covered services only to Covered Persons and does not deal with or provide any services to the Fund (other than as an individual Covered Person) or the Plan.

5. Host Plan's Separate Financial Arrangements with Host Plan Providers

Other Blue Cross and Blue Shield Plans outside of Illinois (Host Plans) may have contracts similar to the agreements described in this Section with certain Providers (Host Plan Providers) in their service area.

When a Covered Person receives health care services outside of Illinois and from a Provider which does not have a contract with the Network Administrator, the Host Plan, if any, will process the claim in accordance with the Host Plan's applicable contract, if any, with the Host Plan Provider. Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount realized or expected by the Host Plan based on separate financial arrangements or other non-claims transactions with Host Plan Providers. In other instances, laws in a small number of states may dictate the basis upon which the Covered Person's liability is calculated.

6. BlueCard Access Fees

Host Plans may charge the Network Administrator an access fee for making their negotiated payment rates and the resulting savings available on claims incurred by Covered Persons outside of Illinois. When the Network Administrator is charged an access fee by a Host Plan for such services, the fee will be treated as a claim payment.

XVIII. DEFINITIONS

For purposes of the Plan, the following definitions apply:

Affiliated Employer

The Chicago Journeyman Plumbers' Union, Local 130, U.A., the Plumbers' Pension Fund, Local 130, U.A., the Plumbers' Welfare Fund, Local 130, U.A., the Apprentice and Journeymen Education and Training Trust Fund, Local 130, U.A., the Kankakee & Iroquois Counties Plumbing & Piping Contractors Association, the West Suburban Association of Plumbing Contractors, and the Plumbing Contractors' Association Midwest. An entity will not be an Affiliated Employer unless it executes a participation agreement with the Fund and that agreement is approved by the Trustees.

Beneficiary

The person, estate, trust, or organization properly designated by a Retiree to receive any amounts payable under the Plan following the death of such Retiree.

Board of Trustees or Trustees

The originally named Trustees or their successors who are duly appointed under the Fund's Trust Agreement, and the Alternate Trustees when authorized to act by a Trustee in the manner

prescribed by the Trust Agreement. The Trustees will conduct the business of the Fund and execute all instruments in that name.

Contributing Contractor

Any contractor contributing to this Fund under the terms of an agreement with the Union providing for contributions is a Contributing Contractor for the period of time for which contributions are being made. Any Contributing Contractor contributing to this Fund pursuant to the terms of an agreement with the Technical Engineering Division, Local 130, U.A., AFL-CIO, providing for contributions to the Welfare Fund - Technical Engineering Division, Local 130, U.A., AFL-CIO, or to this Fund is a Contributing Contractor for the period of time for which contributions are being made.

The Union is a Contributing Contractor during the period of time it contributes to this Fund in the same manner as other Contributing Contractors on behalf of its retirees. Likewise, the Fund may be a Contributing Contractor with respect to its retirees not covered by collective bargaining agreements, provided that the Fund has in effect a valid participation agreement, and further provided that the Fund will not have a voice in the selection of any Trustee.

Covered Employment

The employment of an employee within a bargaining unit represented by the Union, or within a bargaining unit represented by the Technical Engineering Division, Local 130, U.A., AFL-CIO, and on account of such employment the Contributing Contractor is required to make contributions to the trust pursuant to the terms of the Trust Agreement. The term Covered Employment includes full-time employment of a member of the Union as an employee of the Union.

Covered Expense

Any Medically Necessary, Reasonable and Customary charge, cost, or expense, at least part of which is covered under the Plan, for which a benefit payment is made.

Covered Person

A Retiree, Spouse or surviving Spouse who is enrolled in the Plan.

Durable Medical Equipment

Equipment which is Medically Necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, is intended for general use, is appropriate for use in the home, and which is not generally useful to a person in the absence of an illness or injury. Durable Medical Equipment does not include equipment used primarily and customarily for a non-medical purpose, equipment that basically serves the comfort or convenience of a patient, or deluxe equipment when standard equipment is available and medically adequate. Oxygen and transcutaneous electrical nerve stimulation (TENS) is generally considered Durable Medical Equipment.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, and any regulations promulgated thereunder.

Fund

The trust fund of the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A., including all property of the Fund including any group insurance contracts purchased by the Trustees for the benefit of Covered Persons.

Health and Welfare Plan

The Health and Welfare Plan of the Plumbers' Welfare Fund, Local 130, U.A.

Home Health Care

The Reasonable and Customary charges made by a Home Health Care Agency for the following Medically Necessary services or supplies furnished to a Covered Person in the person's home under a Home Health Care Plan providing for care in lieu of hospitalization for the same or related condition:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health care aide services which consist primarily of caring for the Covered Person;
- Physical therapy, occupational therapy, speech therapy, and medical social services provided by the Home Health Care Agency; and
- Laboratory services by or on behalf of a certified Home Health Care Agency.
- Home health care expenses do not include charges for the following:
 - Services or supplies not included in the Home Health Care Plan;
 - Services of a person who is a member of the family of a Covered Person or a person who ordinarily resides in the Covered Person's home;
 - Custodial care;
 - Transportation; or
 - Any period in which the Covered Person is not under the continuing care of a Physician.

A “Home Health Care Plan” is a program for care and treatment established and approved in writing by the covered person’s attending Physician within seven days after termination of the covered person’s Hospital confinement, together with a certificate by the Physician that the proper treatment of the injury, sickness, or infirmity requires continuing confinement as a bed patient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided in the home health care plan.

A “Home Health Care Agency” is an organization which (1) is primarily engaged in providing skilled nursing and other therapeutic services, (2) is duly licensed by appropriate governmental authority, if legally required in the jurisdiction of the agency, (3) provides for full-time supervision of the services by a Physician or registered nurse, and (4) maintains a complete medical record of each patient.

Hospital

An institution fully accredited as a hospital by the Joint Commission on the Accreditation of Hospitals and state licensed that (1) is equipped with facilities for diagnosis and surgery, except that surgical facilities are not required if the medical care or services rendered are for a Mental Health Condition, (2) maintains, on a 24-hour basis, registered nurses who are in attendance, on duty or on call, and (3) is not operated by the U.S. Government or any agency thereof or by any state (or political subdivision thereof) or any agency thereof. For the purposes of this Plan, the term “Hospital” includes an ambulatory surgical treatment center licensed by the state of Illinois or a similar facility licensed by another state; Skilled Nursing Facilities; and facilities for treatment of Mental Health Conditions and Substance Abuse that are licensed and operated according to law.

Hospital also includes Residential Treatment Centers that are structured, rehabilitative treatment programs designed by licensed practitioners acting within the scope of their licenses, but does not include programs or services consisting primarily of counselling by individuals not licensed or any court ordered evaluations, programs which are primarily diagnostic evaluations, or screening of mental health or learning disabilities, care in lieu of incarceration, family retreats, half-way houses, boarding houses or other facilities that are primarily a supportive environment, even if counselling is provided in that setting.

Notwithstanding the foregoing, Hospital does not include an institution that is a convalescent home, a custodial home, a rest home, or a health resort.

Infertility

The inability to conceive a child after one-year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if a Physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.

Unprotected sexual intercourse means sexual union between a male and a female without the use of any process, device or method that prevents conception, including but not limited to,

oral contraceptives; chemical, physical or barrier contraceptives; natural abstinence; or voluntary permanent surgical procedures.

Medically Necessary or Medical Necessity

Any treatment, care, service, or supply which is broadly accepted by the medical profession as effective, appropriate, and essential in the diagnosis and/or treatment of an illness, sickness, or injury, is based upon generally recognized and accepted standards of health care, and could not have been omitted without adversely affecting the patient's condition. Excluded is (1) any drug or medicine which is not approved by the U.S. Food and Drug Administration (FDA) or is experimental or limited in use whether or not approved by the FDA; (2) any experimental medical or surgical treatment or (3) any care, service or supply not furnished in connection with diagnosing or treating any illness, sickness or injury. The fact that a Physician or Surgeon may prescribe, order, recommend or approve a treatment, service or supply does not make it Medically Necessary.

Medicare or Medicare Benefits

The Hospital and medical benefits provided under Part A of Title XVIII of the Social Security Act, as amended.

Mental Health Condition

A Mental Health Condition is a condition or illness that affects an individual's emotional or psychological well-being. Mental Health Conditions include, but are not limited to, dementia, delirium, anxiety disorder, schizophrenia, depression, bipolar disorder, delusions, obsessive-compulsive behavior, Anorexia, Bulimia, attention deficit disorder, mental retardation, and autism. Mental Health Condition shall be further defined to include any condition or disorder specified in the International Classification of Diseases, 10th Revision (ICD-10) or the most current revision of the International Classification of Diseases (ICD) commonly used in the medical community.

Physician or Surgeon

A doctor of medicine duly licensed by a state to practice medicine in all of its branches. For purposes of this Plan, the term Physician or Surgeon also includes a practitioner licensed to practice as a podiatrist, chiropodist, optometrist, chiropractor, psychologist, mental health or substance abuse professional, or licensed to treat human ailments without the use of drugs or medicine or without operative surgery, if the practitioner is duly licensed under an appropriate state licensing authority, the benefit claimed is for services within the scope of the practitioner's license, and the services would be reimbursed under this Plan if performed by a doctor of medicine.

Plan

Means this Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A. sponsored by the Fund's Board of Trustees.

Plumbers' Pension Fund

The Plumbers' Pension Fund, Local 130, U.A. (including any pension fund previously merged into the Plumbers' Pension Fund, Local 130, U.A.) and the monthly benefits provided thereunder.

PPO Facility, PPO Hospital, or PPO Provider

Any Physician or Surgeon, Hospital, Provider or Facility, having a written agreement with Health Care Service Corporation, a/k/a Blue Cross/Blue Shield of Illinois governing participation in the Blue Cross/Blue Shield of Illinois Hospital, Accountable Care Organization or Physician Preferred Provider Organization.

Prescription Drug

A drug or medicine, which may be self-administered, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease; which is:

- Classified as a drug by Federal law;
- Dispensed only upon the prescription of a practitioner licensed by law to administer the drug; and
- Bears the legend: "Caution: Federal law prohibits dispensing without prescription."

For purposes of the Plan, the term "Prescription Drug" includes insulin if prescribed by a Physician; but does not include devices or their components, parts or accessories. The term "Prescription Drug" includes needles and accessories needed to take insulin or any other injectable Prescription Drug that may, from time to time, be covered as a Prescription Drug. An over-the-counter medicine is not a Prescription Drug even if prescribed by a Physician.

Prosthetic Device

An artificial part which aids or replaces a body part or function and which is designed, manufactured, or adjusted to fit a particular individual. A one-size-fits-all device that can be adjusted by the individual for a better fit would not qualify as a Prosthetic Device. A Prosthetic Device does not include a deluxe device when a standard device is available and medically adequate.

Reasonable and Customary

Charges, costs, or fees for medical or dental care, services or supplies of the level usually furnished for cases of the nature and severity of the case being treated and that are, as determined by the Trustees, within the range of usual and customary representative fees or charges in the same geographic area for the same services, under similar or comparable circumstances.

Residential Treatment Center

A facility providing physical or mental rehabilitation, including treatment for Mental Health Conditions, on an inpatient basis. The facility must be licensed to provide the treatments by the state where it is located. A Residential Treatment Center does not include programs consisting primarily of counselling by individuals not licensed or any court ordered evaluations, programs which are primarily diagnostic evaluations, or screening of mental health or learning disabilities, care in lieu of incarceration, family retreats, half-way houses, boarding houses or other facilities that are primarily a supportive environment, even if counselling is provided in that setting.

Retiree

A Retiree is an individual who leaves Covered Employment with a Contractor or Affiliated Employer at the age of 55 or older and who:

- Became permanently disabled while eligible for benefits under the Health and Welfare Plan of the Plumbers' Welfare Fund, Local 130, U.A., or
- Is receiving retirement benefits under the provisions of the Plumbers' Pension Fund, the Pension Fund – Technical Engineering Division, Local 130, U.A., AFL-CIO, or the Plumbing Employees Pension Trust for Employees' of Affiliated Plans, if he was eligible for benefits under the Health and Welfare Plan when his pension benefits commenced.

Skilled Nursing Facility

An institution or a distinct part of an institution that:

1. Has a transfer agreement with one or more Hospitals,
2. Is primarily engaged in providing comprehensive post-acute Hospital and rehabilitative Inpatient care, and
3. Is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Facility does not mean institutions that provide only minimum care, custodial care services, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Mental Conditions, pulmonary tuberculosis or Substance Abuse.

Spouse

An individual to whom the Retiree lawfully is married under the laws of the jurisdiction in which the marriage was entered into, consistent with U.S. federal law. This term also includes surviving Spouses (i.e., the legal Spouse of the Retiree at the time of the Retiree's death).

Substance Abuse

Substance Abuse is the uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency which develops with continued use, requiring medical care as determined by a qualified Physician. Addictive substances include, but are not limited to, alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, tranquilizers, amphetamines, hallucinogens, and tobacco. Substance Abuse shall be further defined to include any condition or disorder specified in categories 291 and 292 and categories 303 through 305 of the International Classification of Diseases, 10th Revision (ICD-10) or the most current revision of the International Classification of Diseases (ICD) commonly used in the medical community.

Trust Agreement

The Trust Agreement of the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A.

Union

The Chicago Journeymen Plumbers' Association, Local Union No. 130, of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, or in the case of a dissolution or disaffiliation of the Union, any successor to the Union.