



**HEALTH AND WELFARE PLAN
of the
PLUMBERS' WELFARE FUND, LOCAL
130, U. A.**

**PLAN DOCUMENT
&
SUMMARY PLAN DESCRIPTION
June 1, 2016**

Table of Contents

SCHEDULE OF BENEFITS 1

I. MAXIMIZING YOUR PLAN BENEFITS 6

II. ELIGIBILITY FOR PARTICIPATION 7

2.1 Eligibility-Present Participants 7

2.2 Initial Eligibility-New Employees 7

2.3 Effective Date of Coverage..... 8

2.4 Continued Eligibility..... 8

2.5 Hours Bank 8

2.6 Continuity of Employment Due to Disability..... 10

2.7 Military Service 10

2.8 Special Enrollment Opportunities..... 11

2.9 Family and Medical Leave Act (FMLA) 11

2.10 Reciprocal Agreements With Other Welfare Funds 12

2.11 Coverage of Employees of Affiliated Employers..... 12

2.12 Coverage of Non-Bargaining Unit Employees 12

**2.13 Participation of Newly Organized Plumbers of a Newly Organized
 Contributing Contractor 13**

2.14 Participation of Newly Organized Journeymen and Apprentices..... 14

2.15 Accelerated Eligibility for Individuals working as Union Salts 15

**2.16 Eligibility for Participation for Members Working Under the Plumbing
 Service and Maintenance Agreement 17**

2.17 Fraud Regarding Eligibility Rules 17

2.18 Your Duties And Responsibilities 18

III. TERMINATION OF ELIGIBILITY 18

3.1 Termination of Participant Eligibility 18

3.2 Self-Payment of Contributions 20

3.3 Reinstatement of Participants 21

3.4 Termination of Dependent Coverage..... 21

**IV. DEATH, ACCIDENTAL DISMEMBERMENT, WEEKLY ACCIDENT AND
MILITARY BENEFITS 21**

4.1 Death Benefit 21

4.2 Accidental Dismemberment Benefit..... 22

4.3 Weekly Accident or Sickness Benefit..... 22

4.4 Military Benefit..... 22

V. MEDICAL AND HOSPITAL BENEFITS..... 23

5.1 Deductible 23

5.2 Copayments..... 24

5.3 Out of Pocket Maximum..... 24

5.4 Coinsurance..... 24

5.5 Use Of Preferred Providers For Medical Benefits 25

5.6 Inpatient Hospital Benefit 26

5.7	Hospital Maternity Benefits	27
5.8	Residential Treatment Center Confinements	27
5.9	How To Maximize Your Hospital Benefits	27
5.10	Surgical Benefits	28
5.11	Coverage For Approved Clinical Trials.....	29
5.12	Organ Transplants and Pectus Excavatum Precertification Procedures	29
5.13	Outpatient Major Medical Benefits	30
5.14	Wellness Medical Benefits	30
5.15	Preventive Treatment & Immunizations	32
5.16	Infertility Treatment.....	36
5.17	Mental Health and Substance Abuse Benefits	37
5.18	Home Health Care.....	37
VI.	PRESCRIPTION DRUG BENEFIT	37
VII.	DENTAL BENEFITS	38
7.1	Dental Claims.....	38
7.2	Dental Benefit Definitions	38
7.3	Dental Benefits Descriptions	39
7.4	Limitations and Exclusions on Dental Benefits.....	41
VIII.	EYE CARE BENEFITS	42
IX.	HEARING CARE.....	42
X.	HOSPICE CARE	43
XI.	HEALTH REIMBURSEMENT ARRANGEMENT (“HRA”).....	43
11.1	Reimbursable Expenses Under the HRA	43
11.2	Accumulating HRA Credits	44
11.3	Using Your HRA Credits.....	45
11.4	Using Your HRA Debit Cards	45
11.5	Terminating or Forfeiting HRA Credits	46
XII.	COBRA CONTINUATION COVERAGE.....	46
12.1	What Is COBRA Coverage?	46
12.2	Who is a Qualified Beneficiary?.....	47
12.3	When is COBRA Coverage Available?.....	48
12.4	Notification Obligations.....	48
12.5	How Much Does COBRA Cost?	48
12.6	How is COBRA Coverage Provided?.....	48
12.7	When COBRA Ends	49
12.8	If You Have Questions.....	50
XIII.	YOUR RIGHTS UNDER HIPAA.....	50
13.1	HIPAA Privacy	51
13.2	The Plan’s Use and Disclosure of Your Protected Health Information.....	51
13.3	HIPAA Security	55
XIV.	PLAN LIMITATIONS AND EXCLUSIONS.....	56

14.1	General Limitations	56
14.2	Special Limitations	57
XV.	CLAIMS AND APPEAL PROCEDURE.....	58
15.1	No Assignment of Claims or Appeal Rights.....	58
15.2	Exhaustion of Remedies	59
15.3	Discretionary Decision Making Authority of the Trustees.....	59
15.4	Authorized Representative.....	59
15.5	Filing Your Initial Claim for Benefits	60
15.6	Types of Health Care Claims	62
15.7	Initial Health Care Claim Determination Timeframes.....	63
15.8	Denial of Initial Benefit Claims	65
15.9	Internal Review Appeal Procedure	66
15.10	External Review Appeal Procedure	69
XVI.	COORDINATION OF BENEFITS	72
XVII.	THE PLAN'S RIGHT OF SUBROGATION AND RIGHT OF REIMBURSEMENT ..	77
XVIII.	IMPORTANT INFORMATION ABOUT THE PLAN	79
18.1	Name and Type of Plan.....	79
18.2	Plan Sponsor and Administrator	79
18.3	Plan Vendor Contact Information.....	80
18.4	Identification Numbers	81
18.5	Agent for Service of Legal Process	81
18.6	Collective Bargaining Agreements	81
18.7	Plan Year.....	82
18.8	Source of Contributions and Benefits.....	82
18.9	Plan Investments	82
18.10	Workers' Compensation Not Affected	82
18.11	The Plan is Tax Exempt.....	82
18.12	Right of Trustees to Amend Trust and Plan.....	82
18.13	Application For Benefits.....	82
18.14	Payment of Benefits.....	83
18.15	Right of Trustees to Resolve Disputes and to Interpret Plan	84
18.16	Limitation on Legal Action Against the Plan	84
18.17	Incentive Program.....	84
18.18	Interests in the Trust Fund	85
18.19	Prohibition on Rescissions.....	85
18.20	No Employment Contract	85
18.21	Notification by Participants and Dependents.....	85
18.22	Qualified Medical Child Support Order	85
18.23	Important Notices of Specific Rights Under the Law.....	86
XIX.	STATEMENT OF ERISA RIGHTS.....	87
XX.	PROVISIONS RELATING TO THE PLAN'S RELATIONSHIP WITH BLUE CROSS/BLUE SHIELD	88
XXI.	DEFINITIONS.....	90

**PLUMBERS' WELFARE FUND,
LOCAL 130, U.A.**

June 1, 2016

**Administrative Offices
Third Floor
Stephen M. Bailey Auditorium
1340 West Washington Boulevard
Chicago, Illinois 60607
312-226-5000
FAX 312-226-7285
Website: plumberslu130ua.org**

Hours:

7:30 A.M. to 4:30 P.M. Monday, Tuesday, Wednesday, and Friday

7:30 A.M. to 8:00 P.M. Thursday

7:30 A.M. to 7:00 P.M. 2nd Tuesday of each Month

UNION TRUSTEES

James F. Coyne
Co-Chairman
Kenneth Turnquist
Scott Spangle
James Mansfield
William Matthies
Michael Shea,
Alternate Trustee

FUND ADMINISTRATOR

Joseph Ohm

MEDICAL ADVISOR

Dr. Nadim Khoury

LEGAL CONSULTANTS

Gregorio ♦ Marco
Laner Muchin, Ltd.
Faegre, Baker & Daniels, LLP

EMPLOYER TRUSTEES

David Ariano
Co-Chairman
Michael Chapel
David Kerrigan
James O'Sullivan
Brian Burns
S. J. Peters,
Alternate Trustee

FIELD REPRESENTATIVE

Anthony Rottman

ACCOUNTANT

Legacy Professionals LLP

ACTUARIAL CONSULTANT

Buck Consultants - Xerox

UTILIZATION REVIEW

Hines & Associates

INTRODUCTION

The Trustees of Plumbers' Welfare Fund, Local 130 U.A. are pleased to furnish you with this new combination Plan Document and Summary Plan Description (Plan/SPD) that explains the benefits available under the Welfare Fund, summarizes the eligibility rules for participation in the Fund, and presents your rights as a Participant. 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. Please note that coverage under the Plan is in no way a guarantee of continued employment with your Employer. This Plan/SPD describes the benefits available to Employees and their eligible Dependents and replaces the prior plan document summary plan description for the Plan. A separate plan document and summary plan description describe the benefits available to retirees.

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 eligible Dependents. 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.

The Trustees - one-half of whom represent Union plumbing contractors and one-half of whom represent the Chicago Journeyman Plumbers' Union, Local 130, U.A. - believe that your Plan provides you and your eligible family members with the best and most comprehensive health and welfare benefits in the construction industry. It is intended that this Plan/SPD be written so that you can understand how you and your family members become eligible for benefit coverage, how you remain eligible for benefit coverage, and what health and welfare benefits are available to you and your eligible family members. 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.

PLUMBERS' WELFARE FUND, LOCAL 130, U. A.

SCHEDULE OF BENEFITS

PARTICIPANT DEATH, ACCIDENT AND DISABILITY BENEFITS

Death Benefit	\$25,000.00 to designated beneficiary of eligible Participant. 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 off-set of \$2,000.00 to be applied to funeral expenses. Divorce revokes designation of spouse as beneficiary.
Accidental Dismemberment Benefit Payable for loss of (1) both hands or both feet, (2) loss of sight of both eyes, (3) loss of 1 hand and 1 foot, (4) loss of 1 hand and sight of 1 eye, and (5) loss of 1 foot and sight of 1 eye.	\$20,000.00 Principal Sum.
Payable for loss of (1) 1 hand or 1 foot, or (2) loss of sight of 1 eye.	\$10,000.00 Principal Sum.
Weekly Sickness or Accident Benefit Payable from first day of accident or eighth day of sickness	\$300.00 per week (reduced by applicable taxes); Maximum 52 weeks.
Military Service Benefit Payable if a Participant is required to leave covered employment to serve in the Armed Forces or Reserves for a period of 30 days or more	\$300 per week (reduced by applicable taxes); Maximum 52 weeks.

PARTICIPANT AND DEPENDENT MEDICAL COVERAGE COST SHARING

Deductible

\$200 for single coverage and \$600 for family coverage. **Benefits noted by an asterisk (*) are not subject to the annual deductible.** Dental benefits are subject to a separate deductible.

Copayments

\$150 copayment for each emergency room visit. This amount counts toward your out of pocket maximum but not your deductible.

Out of Pocket Maximum

\$1,500 for individual coverage and \$3,000 for coverage other than self-only coverage (e.g., family coverage). **Out-of-network benefits do not count toward the out of pocket maximum.**

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.

MEDICAL BENEFITS WHEN HOSPITALIZED

PLAN COVERAGE

BENEFIT AMOUNT

Room and Board

Room and board in an intensive care unit, semi-private or private room including Mental Health and Substance Abuse benefits).

The Plan covers 100% of the Reasonable and Customary Room and Board charges of a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered Room and Board 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, oncologist, hematologist, neonatologist, anesthesiologist, and pathologist incurred during the period of room and board.

The Plan covers 100% of the first \$2,000.00 plus 90% of all amounts exceeding \$2,000 in a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

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 such tests, and the tests are accepted by the Hospital instead of its own inpatient tests.

Attending Physician/Medical Consultants

The Plan covers 100% of the first \$2,000.00 plus 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. For Medical Consultants, a maximum of three (3) consultations per period of covered hospitalization.

Hospital Nursery Care*

The Plan will pay 90% for 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. Hospital nursery care benefits cover charges of the Hospital for nursery care and charges of a pediatrician for the child's initial inpatient examination. Certain benefits may be paid at 100% under the Well Baby benefit.

Residential Treatment Center Confinements

(including Mental Health and Substance Abuse benefits)

The Plan covers 100% of the first \$2,000.00 plus 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.

Blood Transfusions*

Paid in full, even if the transfusion is not received in a Hospital.

Anesthesia

*Anesthesia services administered for dental services shall be paid under the medical benefit according to the Schedule of Benefits.

The Plan covers 100% of first \$2,000.00, plus 90% of a PPO Facility or a PPO Provider exceeding \$2,000.00. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

SURGICAL BENEFITS

Primary Surgeon's Charges

The Plan covers 100% of the Reasonable and Customary Charge in the Chicago area established by the prevailing surgical fee schedule utilized by the Fund. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

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 is Medically Necessary.

Second or Third Surgical Opinion

The Plan covers 100% of the Reasonable and Customary Charge of a PPO Surgeon. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

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 within five (5) days before and twelve (12) months following the transplant surgery.

MATERNITY BENEFITS

Note: Payable only if mother is an Employee or spouse of an Employee

Hospital and Obstetrical

The Plan covers 100% of Room and Board and 100% of the first \$2,000.00 plus 90% of all other amounts exceeding \$2,000 in a PPO Hospital or Facility (excluding the Room and Board charges). The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

Pre-natal and Post-natal Care

Includes lab work and ultrasounds and related Doctor visits.

The Plan covers 100% of first \$1,000.00, plus 80% of the Reasonable and Customary Charges or Fees of an in-network provider exceeding \$1,000.00. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

Hospital Nursery Care*

The Plan pays 90% for 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. Hospital nursery care benefit covers charges of the Hospital for nursery care and charges of a pediatrician for the child's initial in-hospital exam.

Well Baby Care*

The Plan covers 100% of covered services from a PPO Hospital or Facility. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

OUTPATIENT BENEFITS

Outpatient Major Medical Care

(including Mental Health and Substance Abuse benefits) Includes office visits, imaging, and other diagnostic tests not otherwise covered elsewhere under the Plan.

Plan covers 100% of the first \$1,000 and 80% of the Reasonable and Customary Charges of a PPO provider exceeding the first \$1,000. The Plan pays 100% of any PPO Physician or Surgeon fee related to the outpatient surgery. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

Home Health Care

The Plan covers 100% of the first \$1,000.00, plus 80% of the Reasonable and Customary Charges or Fees of a PPO Provider exceeding \$1,000.00 for a maximum of 120 days less the number of days the patient was in a Hospital for the same sickness or disability. The Plan will pay 70% of the Reasonable and Customary Charges or Fees of a non-network provider.

Wellness Medical Benefit*

Up to 100% of the Reasonable and Customary Charges incurred by a Participant or Dependent for Wellness Medical Benefits from a PPO Provider (or 70% of the Reasonable and Customary Charges or Fees of a non-PPO provider) listed under the Plan.

Preventive Treatment*

100% of the Reasonable and Customary Charges or Fees of a PPO provider (or 70% of the Reasonable and Customary Charges or Fees of a non-PPO provider) for preventive health services and 100% of the cost for routine immunizations and vaccinations in accordance with the requirements of the Patient Protection and Affordable Care Act (“PPACA”) and its implementing guidance.

Infertility Treatment Benefits

*Medically Necessary services and procedures for assisted reproductive technologies rendered in connection with the treatment of Infertility.

The Plan will pay 80% of the Reasonable and Customary Charges or Fees of a PPO provider (or 70% of the Reasonable and Customary Charges or Fees of a non-PPO provider) for assisted reproductive technologies for no more than two attempts to achieve conception. However, if there has been a live birth, at the discretion of the Board, an additional two attempts may be permitted.

Durable Medical Equipment and Prosthetic Devices

The Plan covers 100% of the first \$1,500.00, plus 80% of the Reasonable and Customary Charges or Fees of a PPO provider exceeding \$1,500.00, but if the cost of any equipment or device exceeds \$1,500.00, the acquisition must be approved in advance by the Trustees. The Plan will pay 70% of the Reasonable and Customary Charges or Fees of a non-network provider.

PRESCRIPTION DRUGS*

100% of Reasonable and Customary cost for up to a **34 day supply** less the applicable co-payments 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 (3 month supply), less the applicable co-payments 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 co-payment but only if the drug is acquired from Accredo. Unless otherwise determined by the Trustees to be Medically Necessary, erectile dysfunction medication will be limited to six (6) pills per month.

DENTAL BENEFITS

Up to \$4,000.00 per calendar year for a Participant and each eligible Dependent with the exception of Pediatric Care and prophylaxis (teeth cleaning). The dental benefit is subject to a \$50.00 per person deductible (except for services provided under Coverage A), with a maximum deductible of \$150.00 per family unit. After the deductible is met, the Plan pays up to 100% of the reasonable cost of routine dental oral examinations and 80% of other covered dental services, up to the maximum benefit level of the Plan.

Dental sealants for Dependent children less than 19 years of age are covered up to 80% of the reasonable and customary charges. The Plan also pays a separate orthodontic benefit covering 80% of charges up to a maximum lifetime limit of \$4,500.00. This is in addition to the annual benefit amount.

The above annual and lifetime dollar limits do not apply to individuals under the age of 19.

EYE CARE*

Eye Examinations

Except for Pediatric Care, up to \$40.00 per examination for an examination by an ophthalmologist or licensed optometrist. Limit one examination in any 12 month period. The above dollar limits do not apply to individuals under the age of 19.

Eyeglasses/Contact Lenses

Except for Pediatric Care, up to \$350.00 for prescribed corrective eye glasses and frames and prescribed corrective contact lenses in any 12 month period. Up to \$40.00 for a contact fitting. The above dollar limits do not apply to individuals under the age of 19.

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 to locate a provider near you.

HEARING CARE*

Hearing Examinations

Up to \$125.00 with a limit of one examination in any 12 month period (except for a Dependent child under age 19 who suffers from degenerative hearing loss). The above limit does not apply to inpatient hearing tests performed on a newborn.

Hearing Aids

Up to \$1,500.00 with a limit of one hearing aid instrument in any 60 month period. (Unless Bilateral Hearing aids are determined to be Medically Necessary by the Fund's Medical Advisor, in which case the benefit is \$3,000.00.) The above limit does not apply to bone anchored hearing aids.

Hearing Aid Instruments for Dependents Under 19 Years of Age

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, or \$1,450.00 if Dependent received a new molded earpiece within 12 months. The above limits do not apply to bone anchored hearing aids.

HOSPICE CARE*

The Plan pays 80% of the Reasonable and Customary Charges for covered expenses provided by a PPO Provider up to 180 days per three year period. The Plan will pay 70% of the Reasonable and Customary Fees or Charges for covered expenses provided by a non-network provider.

EMPLOYEE ASSISTANCE BENEFITS

Employees who participate in the Plan are eligible to receive certain consultation and referral services provided through the Plan's Employee Assistance Program offered through ERS. For more information, contact the Fund Office or ERS directly at 1-800-292-2780.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Under the HRA you will be able to receive reimbursement for your out-of-pocket medical expenses that you were required to pay due to the deductibles, co-payments, and other dollar limits imposed by the Plan. Participants will accumulate one credit for each hour worked in Covered Employment. The current credit value is \$.50 cents. The Trustees may adjust the value of the credit from time to time. See Article XI of this Plan/SPD for additional details.

I. MAXIMIZING YOUR PLAN 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 any of your Dependents anticipate 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.
- 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.

II. ELIGIBILITY FOR PARTICIPATION

To be eligible for Plan benefits you must qualify as a Participant as described below. As a Participant you and your eligible Dependents are entitled to receive health and welfare benefits as described in this Plan/SPD.

2.1 Eligibility-Present Participants

If you are now a Participant, you will remain one until you fail to meet the minimum requirements described in the “Termination of Eligibility” section below.

2.2 Initial Eligibility-New Employees

If you are now a journeyman plumber, technical engineer, instrumentman, rodman, or apprentice working for a Contributing Contractor, you will become a Participant on the first day of a Benefit Quarter if you have been employed by a Contributing Contractor(s) and the Contributing Contractor(s) has made contributions to the Fund on your behalf for at least 250 hours worked in each of the two Contribution Quarters that immediately preceded the Benefit Quarter.

The following chart illustrates how your Initial Eligibility is determined under the Contribution Quarter/Benefit Quarter system:

Contribution Quarters	Benefit Quarters
<i>Work Performed During . . .</i>	<i>Determines Eligibility For . . .</i>
January, February March and April, May, June	July, August, September
April, May, June and July,	October, November, December

August, September

July, August, September and
October, November, December

October, November, December
and January, February, March

January, February, March

April, May, June

If you are a permanent full-time employee of an Affiliated Employer, you become a Participant on the first day of the month following the date you complete 30 days of employment, not including time worked as a temporary employee or a probationary employee (probation limited to 90 days).

2.3 Effective Date of Coverage

Your effective date of coverage will be the first day of the corresponding Benefit Quarter after you satisfy the eligibility requirements of this Plan. The effective date of coverage for a Dependent(s) will be the date you become eligible or the date your Dependent first meets the terms of eligibility for Dependent coverage under the Plan, whichever is later.

2.4 Continued Eligibility

After becoming initially eligible, you may continue to be eligible as long as you work for a Contributing Contractor(s) and the Contributing Contractors makes contributions on your behalf for at least 250 hours in the Contribution Quarter corresponding to the applicable Benefit Quarter.

The following chart illustrates how your Continued Eligibility is determined under the Contribution Quarter/Benefit Quarter system:

Contribution Quarters	Benefit Quarters
<i>Work Performed During . . .</i>	<i>Determines Eligibility For . . .</i>
January, February March	July, August, September
April, May, June	October, November, December
July, August, September	January, February, March
October, November, December	April, May, June

2.5 Hours Bank

Hours worked in excess of the number of hours required for initial and continued eligibility in the Plan will be credited toward an Hours Bank. Each Participant will have his own Hours Bank which may be used to continue eligibility in the Plan if a Participant does not have enough hours at a later date. Hours Bank hours credited for each Contribution Quarter are automatically used if necessary to continue eligibility. The maximum number of hours that may be credited to a

Participant's Hours Bank is 1,000 hours. All accumulated hours in a Participant's Hours Bank will be terminated immediately if the Participant begins employment with an employer who does not participate in the Fund or another UA welfare fund.

- A. Beginning January 1, 2014, the Hours Bank balance for Participants in the Local 130 Welfare Fund as of December 31, 2013 will be determined as follows:
1. A Participant who was currently employed as of January 1, 2014, and was not participating in the Plan pursuant to extended eligibility will be credited with up to 500 hours if he has worked less than twenty-four (24) continuous months.
 2. A Participant who is unemployed as of January 1, 2014, worked less than twenty-four (24) continuous months and was not participating in the Plan pursuant to extended eligibility will be credited with 500 hours less recent months unemployed.
 3. A Participant who is employed as of January 1, 2014, and was not participating in the Plan pursuant to extended eligibility will be credited with up to 1,000 hours if he has worked more than twenty-four (24) continuous months.
 4. A Participant who is unemployed as of January 1, 2014, worked more than twenty-four (24) continuous months and was not participating in the Plan pursuant to extended eligibility will be credited with 1,000 hours less recent months unemployed.
 5. If a Participant regained eligibility by working 150 hours in a three month period during the 2013 calendar year, he will be credited with 250 hours less the number of months used after regaining eligibility.
 6. If a Participant regained eligibility by working 150 hours in a three month period during the 2013 calendar year and worked an additional 150 hours in that initial three month period, he will be credited for an additional four months or 500 hours less the number of months already used after regaining eligibility.
- B. Beginning January 1, 2014, the Hours Bank balance for participants in the NIBF and Local 93 Welfare Fund as of December 31, 2013 will be determined as follows based upon a "look back" credit such participants had in the respective Local 93 Welfare Fund or NIBF as of December 31, 2013.
1. If a former Local 93 Participant or NIBF Participant could have continued coverage for the January 1, 2014 to March 31, 2014 Benefit Quarter, then such participants will be credited with 250 hours.

2. If a former Local 93 Participant or NIBF Participant could have continued coverage through June 30, 2014, such participants will be credited with 500 hours.
3. If a former Local 93 Participant or NIBF Participant could have continued coverage through September 30, 2014, such participants will be credited with 750 hours.
4. If a former Local 93 Participant or NIBF Participant could have continued coverage through December 31, 2014, such participants will be credited with 1,000 hours.

2.6 Continuity of Employment Due to Disability

For purposes of applying the eligibility rules, if you are a journeyman, technical engineer, instrument man, rodman or apprentice and must stop working for a Contributing Contractor because of a sickness or disability, you will still be considered in Covered Employment by a Contributing Contractor and will be credited 40 hours per week up to a maximum of six months for any one period of sickness or disability. This rule does not apply if you are receiving a pension from the Plumbers' Pension Fund, Local 130, U.A. or the Pension Fund- Technical Division, Local 130, U.A. This rule is intended to help establish or maintain eligibility while you are unable to work because of sickness or disability. It is important to note that this rule applies only if the sickness or disability caused you to stop working for a Contributing Contractor. In addition, if you are hospitalized on the date your eligibility terminates, Hospital coverage continues until the end of your period of hospitalization.

2.7 Military Service

The Plan also provides extended eligibility to Participants who are required to leave Covered Employment to serve in the Armed Forces or Reserves of the United States. Coverage continues during the period beginning on the day you leave Covered Employment to serve and ending 90 days from the date of your release from active duty or, in the case of a reservist, your return to inactive duty status. The maximum period of coverage is five (5) years from the date you left employment in Covered Employment, thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply. An employee of a Contributing Contractor immediately before his entry into active service in the Armed Forces or Reserves who returns to Covered Employment within 90 days after he is discharged, released or returned to inactive status is considered employed for 40 hours a week during the period of his military duty subject to the limitations set forth above. If you do not return to Covered Employment for a contributing contractor, this rule does not apply; however, if your failure to return within 90 days is the result of being hospitalized or convalescing from an illness or injury incurred or aggravated during your performance of military service, you will become immediately eligible upon returning to work in Covered Employment or work for an Affiliated Employer. Your eligibility for subsequent periods will be determined under the Plan's Eligibility Rules.

In order to exercise your continued coverage options above, you must notify the Fund Office when you are called to active service and provide copies of your discharge papers within the time periods provided under USERRA as described in the following chart.

Length of Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

2.8 Special Enrollment Opportunities

This Plan has no eligibility provision other than as shown in the previous sections. Employees and Dependents are automatically covered without a requirement that they enroll in the Plan. You should notify the Plan of any case in which you wish to add a Dependent through a birth, marriage, adoption or placement for adoption.

2.9 Family and Medical Leave Act (FMLA)

Under certain circumstances, you may be able to take up to 12 weeks of unpaid leave from your employment under FMLA during any 12-month period due to:

- A. The birth of a child or placement of a child with you for adoption or foster care;
- B. The care of a seriously ill spouse, parent or child;
- C. Your serious illness; or
- D. A qualifying exigency arising out of the fact that a family member is in the military on active duty.

FMLA also allows a qualifying person to take up to six months of unpaid leave to care for a service member who is recovering from a serious illness or injury sustained in the line of duty.

During your leave, you will maintain all the coverage offered through the Fund for up to a maximum of three months. You will remain eligible until the end of the leave, provided your Employer properly grants the leave under the federal law and you or your Employer makes the required notification and payment to the Fund. Contact your Employer for more information regarding such a leave and whether you are eligible. Your Employer will decide your eligibility for FMLA leave.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

If your coverage terminates, you will then be eligible to purchase COBRA continuation coverage as described in this Plan/SPD. Contact the Fund Office for additional information about your coverage during FMLA leave or continuing your coverage under COBRA.

2.10 Reciprocal Agreements With Other Welfare Funds

The Plumbers' Welfare Fund Local 130, U.A. has reciprocal agreements with other welfare funds throughout the country sponsored by local unions affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada. The reciprocal agreements require the transfer to this Fund of employer contributions made in another jurisdiction for Local 130 members working on travel cards. In this way, your eligibility can continue if you are working in Covered Employment under another local union jurisdiction. You must sign an agreement with the other welfare fund authorizing the transfer of contributions to this Fund. The Fund does not have reciprocal agreements with all local union jurisdictions. To learn about the jurisdictions covered by reciprocal agreements, please contact the Fund Office.

No Participant is entitled to benefits both under this Plan and a reciprocal plan at the same time and no Participant under a reciprocal plan is entitled to earn any eligibility or be considered in Covered Employment under the Plan during a period of time that contributions are transmitted from the Fund to the reciprocal plan. A Participant whose contributions are transmitted to the Fund by the trustees of a reciprocal plan is given credit for the hours of employment for which contributions were made, and the hours are regarded as hours in Covered Employment by a Contributing Contractor for purposes of receiving Accidental Death and Dismemberment Benefits under this Plan.

2.11 Coverage of Employees of Affiliated Employers

A full time permanent employee of an Affiliated Employer is eligible to participate (to the extent of the benefits provided to that class of Participants under this Plan) upon the first day of the month following the start of employment (his or her "Initial Eligibility Date"). For purposes of this section, a full-time employee is one who customarily works thirty (30) hours per week or more. The eligibility of a Participant under this paragraph terminates upon the earliest to occur of the following:

- The date his or her employment terminates; or
- The first day of the month following the month the employee ceases to be a full-time employee or ceases to be on authorized leave of absence because of sickness or disability.

2.12 Coverage of Non-Bargaining Unit Employees

A Contributing Contractor operating in the form of a corporation or limited liability company duly organized under the law of any state may request the Trustees to authorize the

eligibility of its Non-Bargaining Unit Employees for participation in this Fund. Eligibility of a Contractor's Non-Bargaining Unit employees may be permitted at the sole and exclusive discretion of the Trustees and any decision to deny coverage is final and binding upon the Contractor and its Non-Bargaining Unit Employees. If the Trustees approve a Contractor's request, the Contractor will execute a written participation agreement with the Fund as a precondition of the eligibility for participation of its Non-Bargaining Unit Employees.

The terms and conditions of the participation agreement are established by the Trustees and may be modified from time to time at the Trustees' sole discretion. The participation agreement is incorporated herein by reference. Non-Bargaining Unit Employees are not entitled to Death Benefits, Accidental Dismemberment Benefits, or Weekly Sickness or Accident Benefits. A Non-Bargaining Unit Employee of a corporate Contractor is eligible to participate hereunder no sooner than the first day of the month following the month the Non-Bargaining Unit Employee is enrolled for coverage with the Fund by his or her employer, or, if later, the first day of the month following the Trustees' approval of the Contractor's request to extend eligibility to its Non-Bargaining Unit Employees.

2.13 Participation of Newly Organized Plumbers of a Newly Organized Contributing Contractor

In the event a Contractor which employs licensed journeymen and/or apprentice plumbers (referred to for purposes of this section as Plumber(s)) is organized to become a Contributing Contractor (New Contributing Contractor), each Plumber employed by the New Contributing Contractor will be eligible for participation on the 1st day of the month immediately following the month in which the New Contributing Contractor signs a collective bargaining agreement with the Union to become a Contributing Contractor.

Eligibility will continue for subsequent months provided contributions are received for the Plumber for at least 100 or more hours of work in Covered Employment (from either the New Contributing Contractor or any other Contributing Contractor) in the immediately preceding month. For example, if a New Contributing Contractor signs a collective bargaining agreement on March 15, a Plumber is provided eligibility on April 1 for the month of April and his eligibility for the month of May will require that contributions are received for 100 or more hours of work in Covered Employment for the April work month. If contributions are not received for the Plumber for at least 100 or more hours of work in Covered Employment in a work month, his eligibility will terminate retroactively to the end of the work month for which 100 or more hours were not received (unless self-payment is received under the following paragraph).

In order to maintain eligibility if contributions for 100 or more hours of Work for Covered Employment are not received for a work month, the newly organized journeyman may make a self-payment at the Fund's self-payment rate for the difference between the hours contributed for the work month and 100 hours. Self-payment under these terms will be permitted for any subsequent work month in the Contribution Quarter in which the shortage initially occurred and for any work month in the next Contribution Quarter. For example, if a newly organized journeyman begins coverage as of April 1 and fails to work 100 hours in the July work month, he will be eligible to make self-payments for the months of July through September (the Contribution Quarter in which the hours shortage occurred) and the months of October through December (the

next Contribution Quarter). His coverage will terminate at the end of December if contributions for less than 100 hours of work in December are received. If the Plumber's eligibility terminates under this provision, he may only regain eligibility by satisfying the Initial Eligibility requirements of this Plan, he loses any balance accumulated in his Hours Bank and he is not eligible for any other form of self-pay toward any plan eligibility requirement.

Any contributions that are received for more than 100 hours in a month will be placed in the Plumber's Hours Bank. The Plumber will not be permitted to utilize the Hours Bank until he has accumulated 500 hours of contributions in his Hours Bank at the end of a Contribution Quarter. Upon accumulation of 500 hours in his Hours Bank at the end of a Contribution Quarter, the Plumber will obtain regular quarterly eligibility on the first day of the next Benefit Quarter. For example, if a Plumber has 500 hours in his Hours Bank on September 30, the end of the July, August, September Contribution Quarter, he will have regular quarterly eligibility beginning on October 1 for the October, November, December Benefit Quarter. Continuing Eligibility for subsequent Benefit Quarters will be determined under the Continuing Eligibility provisions of the Plan.

Prior to obtaining regular quarterly eligibility, the Plumber is entitled only to certain benefits. Coverage for a newly organized journeyman prior to obtaining regular quarterly eligibility does not include Death Benefits, Accidental Dismemberment Benefits, Weekly Sickness or Accident Benefits, Retiree Self-Pay Benefits, or the Military Service Benefit. These excluded benefits will be provided on the first day of the Benefit Quarter for which the Plumber is entitled to regular quarterly eligibility after satisfying the requirement of having 500 hours in his Hours Bank at the end of the immediately preceding Contribution Quarter.

A Plumber who is provided eligibility as a Newly Organized Plumber of a Newly Organized Contributing Contractor shall not be entitled to eligibility under the section entitled Participation of Newly Organized Journeymen and Apprentices.

2.14 Participation of Newly Organized Journeymen and Apprentices

Newly organized journeymen and apprentices (Newly Organized Journeymen) organized as part of the Union's organizational efforts will be eligible for participation on the first day of the month following their organization. Eligibility will continue for subsequent months provided contributions are received for the Newly Organized Journeymen for at least 100 or more hours of work in Covered Employment in the immediately preceding month. For example, if a journeyman is newly organized on March 15, he is provided eligibility on April 1 for the month of April, his eligibility for the month of May will require that contributions are received for 100 or more hours of work in Covered Employment for the April work month. If contributions are not received for the Newly Organized Journeymen for at least 100 or more hours of work in Covered Employment in a work month, his eligibility will terminate retroactively to the end of the work month for which 100 or more hours were not received. In order to maintain eligibility if contributions for 100 or more hours of Work for Covered Employment are not received for a work month, the Newly Organized Journeymen may make a self-payment at the Fund's self-payment rate for the difference between the hours contributed for the work month and 100 hours. Self-payment under these terms will be permitted for any subsequent work month in the Contribution Quarter in which the shortage initially occurred and for any work month in the next Contribution Quarter. For example, if a

Newly Organized Journeymen begins coverage as of April 1 and fails to work 100 hours in the July work month, he will be eligible to make self-payments for the months of July through September (the Contribution Quarter in which the hours shortage occurred) and the months of October through December (the next Contribution Quarter). His coverage will terminate at the end of December if contributions for less than 100 hours of work in December are received. If the Newly Organized Journeymen's eligibility terminates under this provision, he may only regain eligibility by satisfying the Initial Eligibility requirements of this Plan, he loses any balance accumulated in his Hours Bank and he is not eligible for any other form of self-pay toward any plan eligibility requirement.

Any contributions that are received for more than 100 hours in a month will be placed in the Newly Organized Journeymen's Hours Bank. The Newly Organized Journeymen will not be permitted to utilize the Hours Bank until he has accumulated 500 hours of contributions in his Hours Bank at the end of a Contribution Quarter. Upon accumulation of 500 hours in his Hours Bank at the end of a Contribution Quarter, the Newly Organized Journeymen will obtain regular quarterly eligibility on the first day of the next Benefit Quarter. For example, if a Newly Organized Journeymen has 500 hours in his Hours Bank on September 30, the end of the July, August, September Contribution Quarter, he will have regular quarterly eligibility beginning on October 1 for the October, November, December Benefit Quarter. Continuing Eligibility for subsequent Benefit Quarters will be determined under the Continuing Eligibility provisions of the Plan.

Prior to obtaining regular quarterly eligibility, the Newly Organized Journeymen is entitled only to certain benefits. Coverage for a Newly Organized Journeymen prior to obtaining regular quarterly eligibility does not include Death Benefits, Accidental Dismemberment Benefits, Weekly Sickness or Accident Benefits, Retiree Self-Pay benefits, or the Military Service Benefit. These excluded benefits will be provided on the first day of the Benefit Quarter for which the Newly Organized Journeymen is entitled to regular quarterly eligibility after satisfying the requirement of having 500 hours in his Hours Bank at the end of the immediately preceding Contribution Quarter.

2.15 Accelerated Eligibility for Individuals working as Union Salts

In the event an individual who worked pursuant to a written agreement with the Union to assist in efforts to organize a plumbing contractor that is not already a party to a collective bargaining agreement with the Union becomes employed by a Contributing Contractor (such individual shall be referred to for purposes of this Section as a "Union Salt"), such individual may be eligible to receive credit for work while working for the non-union contractor pursuant to this section, and such work shall be deemed to be Covered Employment as outlined below.

Hours of work performed as a plumber for a non-union contractor while acting as a Union Salt may be used toward the requirement of completing 500 hours of work in Covered Employment in two consecutive Contribution Quarters necessary to become eligible as a Participant under the Welfare Fund. A Union Salt must provide the Fund with sufficient documentation to prove the hours of work with the non-union contractor that were performed while a Union Salt. However, a Union Salt shall not become eligible as a Participant in the Fund before the Union Salt becomes employed by a Contributing Contractor.

Upon becoming employed by a Contributing Contractor, a Union Salt who has 500 hours of work in Covered Employment through work as a Union Salt will become eligible for coverage on the first day of the month after he is employed with a Contributing Contractor and will continue to be eligible throughout the quarter in which his initial eligibility begins. He will be eligible for coverage in the subsequent quarter if he worked at least 250 hours as a Union Salt in the quarter prior to becoming employed by a Contributing Contractor. In the event the Union Salt fails to qualify for continued quarterly eligibility for the subsequent quarter under the preceding sentence, the Union Salt will receive coverage for the first month of the subsequent quarter under the monthly eligibility terms of the next paragraph and will maintain continued eligibility under those provisions. In all other cases Continuing Eligibility for Union Salts obtaining regular quarterly eligibility will be determined under the Continuing Eligibility provisions of the Plan.

In the event a Union Salt does not have 500 hours of work in Covered Employment through work as a Union Salt at the end of the Contribution Quarter immediately preceding his commencement of Covered Employment, he will obtain eligibility on the first day of the month following his commencement of work in Covered Employment for a Contributing Contractor. Eligibility will continue for subsequent months provided contributions are received for the Union Salt for at least 100 or more hours of work in Covered Employment in the immediately preceding month. For example, if a Union Salt commences work in Covered Employment on March 15, he is provided eligibility on April 1 for the month of April, his eligibility for the month of May will require that contributions are received for 100 or more hours of work in Covered Employment for the April work month. If contributions are not received for the Union Salt for at least 100 or more hours of work in Covered Employment in a work month, his eligibility will terminate retroactively to the end of the work month for which 100 or more hours were not received.

In order to maintain eligibility if contributions for 100 or more hours of Work for Covered Employment are not received for a work month, the Union Salt may make a self-payment at the Fund's self-payment rate for the difference between the hours contributed for the work month and 100 hours. Self-payment under these terms will be permitted for any subsequent work month in the Contribution Quarter in which the shortage initially occurred and for any work month in the next Contribution Quarter. For example, if a Union Salt begins coverage as of April 1 and fails to work 100 hours in the July work month, he will be eligible to make self-payments for the months of July through September (the Contribution Quarter in which the hours shortage occurred) and the months of October through December (the next Contribution Quarter). His coverage will terminate at the end of December if contributions for less than 100 hours of work in December are received. If the Union Salt's eligibility terminates under this provision, he may only regain eligibility by satisfying the Initial Eligibility requirements of this Plan, he loses any balance accumulated in his Hours Bank and he is not eligible for any other form of self-pay toward any plan eligibility requirement.

Any hours of work performed as a plumber for a non-union contractor while acting as a Union Salt in excess of 500 hours and any contributions for work in Covered Employment received for more than 100 hours in a month will be placed in the Union Salt's Hours Bank. The Union Salt will not be permitted to utilize the Hours Bank until he has accumulated 500 hours in his Hours Bank at the end of a Contribution Quarter or obtained regular quarterly Initial Eligibility. Upon accumulation of 500 hours in his Hours Bank at the end of a Contribution Quarter, the Union Salt will obtain regular quarterly eligibility on the first day of the next Benefit Quarter. For

example, if the Union Salt has 500 hours in his Hours Bank on September 30, the end of the July, August, September Contribution Quarter, he will have regular quarterly eligibility beginning on October 1 for the October, November, December Benefit Quarter. Continuing Eligibility for subsequent Benefit Quarters will be determined under the Continuing Eligibility provisions of the Plan.

A Union Salt who is entitled to coverage pursuant to this section shall not be eligible pursuant to the terms applicable to a Newly Organized Plumber of a Newly Organized Contributing Contractor or a Newly Organized Journeyman.

Prior to obtaining regular quarterly eligibility, the Union Salt is entitled only to certain benefits. Coverage for a Union Salt prior to obtaining regular quarterly eligibility does not include Death Benefits, Accidental Dismemberment Benefits, Weekly Sickness or Accident Benefits, Retiree Self-Pay benefits, or the Military Service Benefit. These excluded benefits will be provided on the first day of the Benefit Quarter for which the Union Salt is entitled to regular quarterly eligibility after satisfying the requirement of having 500 hours in his Hours Bank at the end of the immediately preceding Contribution Quarter.

2.16 Eligibility for Participation for Members Working Under the Plumbing Service and Maintenance Agreement

An employee working solely as a Service Plumber or serviceman for a Contributing Contractor that is a party to the Plumbing Service and Maintenance Area Agreement is eligible to participate on the first day of the Benefit Quarter following the Service Plumber's employment if he has 250 Hours of Employment during the three months immediately preceding that Benefit Quarter. However, if the Service Plumber or serviceman is employed for fewer than three months during that three month period, the required number of Hours of Employment will be reduced to 167 hours and for fewer than two months 84 hours. Eligibility will continue for the following Benefit Quarter if the Service Plumber has 250 Hours of Employment during the three months immediately preceding that Benefit Quarter. For subsequent Benefit Quarters, the Plan's Continuing Eligibility rules shall apply.

For example, Tim is a Service Plumber hired by a Contributing Contractor on January 15. Tim will be first eligible for coverage under the Plan beginning April 1 so long as Tim works at least a total of 167 hours in February and March combined. Tim will maintain his eligibility from July-December so long as he works at least 250 hours in Covered Employment during April-June. Coverage in January-March of the following year will be based on Tim working at least 250 hours in Covered Employment between July-September (with the Plan's Continuing Eligibility rules continuing thereafter).

2.17 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 termination of eligibility for you and your entire family. The Fund Office also may notify the

Contributing Employer of the fraud, and it may be grounds for discipline up to and including termination of employment. You will be held responsible for any claims paid on behalf of an ineligible person.

2.18 Your Duties And Responsibilities

As a Participant in the Plan, you, or if you for any reason are unable to do so, one of your Dependents, 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 birth or death of a Dependent, and the Dependent's name and date of the event.
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 an eligible Dependent.
5. Detailed information if you or an eligible Dependent incurs a work related injury which may be comparable under any Workers' Compensation Act or similar Act.

Your failure to promptly notify the Fund Office within thirty (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 and your eligible family members with uninterrupted health and welfare benefits.

III. TERMINATION OF ELIGIBILITY

3.1 Termination of Participant Eligibility

Eligibility for health and welfare benefits terminates pursuant to the following rules:

If you are an eligible journeyman plumber, technical engineer, instrumentman, rodman, or apprentice, or a member of the Union working full-time for the Union or Affiliated Employer, your eligibility will terminate upon the first to occur of the following conditions set forth below:

1. You fail to meet the requirements for continuing eligibility as described above, including a failure to make any self-payments of contributions in a timely manner;
 - a. You or your Dependent commits an act of fraud or a material misrepresentation with respect to the Plan;
 - b. The Participant class under which you are eligible is terminated;
 - c. The Plan terminates, or

- d. The first day of the month following the month the Trustees determine that you have engaged in Prohibited Employment (see Definitions section).

IMPORTANT NOTE: If you apply for and are approved to receive a pension from the Plumbers' Pension Fund, Local 130, U.A., or the Pension Fund - Technical Engineering Division, Local 130, U.A., and any pension fund that has merged into the Plumbers' Pension Fund, Local 130, U.A., you will not thereafter receive credit for hours worked in Covered Employment even though the pension fund permits retirees to work in Covered Employment for a limited number of hours.

2. If you are a full-time employee of an Affiliated Employer (other than a member of the Union working full time for the Union which is deemed work in Covered Employment) you will lose eligibility under the following rules:
 - a. At the end of the month in which your employment terminates, or you cease to be a full time employee or cease to be on authorized leave because of sickness or disability; however, if upon your initial eligibility date with an Affiliated Employer you were then eligible for Plan benefits by reason of having worked in Covered Employment as a journeyman plumber, technical engineer, instrument man, rodman, or apprentice, your termination of eligibility will be subject to the rules noted above, and you will receive credit for the hours worked in Covered Employment in the 18 months before you started work with an Affiliated Employer as though those hours were worked in the 18 months immediately preceding the termination of your work with an Affiliated Employer.
 - b. The first day of the month following the month the Trustees determine that you have engaged in Prohibited Employment (see Definitions section).

EXAMPLE 1: Ms. Brown starts work with the Plumbers' Welfare Fund (an Affiliated Employer) as a probationary employee on January 15, 2007. On February 15, 2007, Ms. Brown is retained as a full-time employee. She will be eligible for Plan benefits on March 1, 2007, the first day of the month following her employment as a permanent full-time employee. Ms. Brown terminates her employment on November 30, 2007. She will not be eligible for benefits after that date.

EXAMPLE 2: Plumber Smith works full time in Covered Employment for XYZ Plumbing Company for 15 years. He then starts work with the Plumbers' Apprentice Fund, Local 130 as an instructor on January 28, 2006, and becomes eligible for benefits by reason of working for an Affiliated Employer. At that time Plumber Smith was also eligible for benefits by reason of his work in Covered Employment. When Plumber Smith retires as an Apprentice instructor he will receive credit for the hours he worked in Covered Employment with XYZ Plumbing Company in the 18 months prior to going to work for the Apprentice Fund. By reason of this rule, Plumber Smith will remain eligible for Plan benefits for 12 months following his retirement.

EXAMPLE 3: Assume that in Example 2 Plumber Smith had been working in the plumbing trade, but not in Covered Employment, prior to going to work for the Plumbers'

Apprentice Fund. Upon his retirement as an instructor he would not have any credit for hours worked in Covered Employment and his eligibility for Plan benefits would terminate upon his retirement.

Note: If a Covered Person is hospitalized on the date eligibility terminates under the Plan, coverage under the Plan's Hospital and Surgical benefits continues until the end of the period of hospitalization, subject to the Plan's limitations on the benefits payable.

3.2 Self-Payment of Contributions

If the combination of Contractor contributions for the Contribution Quarter and a Participant's Hours Bank balance is insufficient to continue coverage in the corresponding Benefit Quarter, you may be able to make a self-payment of contributions to continue coverage. To be eligible to make self-payments, you must be available for work in Covered Employment in the plumbing industry with a Contractor who participates in the Fund, or temporarily or permanently disabled.

Self-payments are equal to 250 times the hourly rate in effect for Contributing Contractors, reduced by contribution amounts determined to be attributable to the HRA and for the Retiree Plan, and further reduced by a 25% rate discount provided by the Fund.

Self-payments will be reduced by any hours worked in the corresponding Contribution Quarter and the available Hours Bank balance. Thereafter, all self-payments will be paid monthly based on the above calculation. Self-payments must be received at the Fund Office within ten days of receipt of a termination notice that is sent out by the Fund Office at least ten days prior to the termination of coverage.

You may continue eligibility by means of self-payments for up to four consecutive Benefit Quarters (i.e., 12 months). However, if a Contributing Contractor(s) made contributions to the Plan on your behalf for at least 250 hours for the Contribution Quarter which immediately precedes the termination of the 12-month self-payment period, you may continue your eligibility for a fifth consecutive Benefits Quarter. The fifth Benefit Quarter eligible for self-payment will begin immediately following the end of the original four consecutive Benefit Quarters self-payment period. This extension of the self-payment period is explained in the following example:

If your four consecutive Benefit Quarters self-payment period runs from October 1, 2015 through September 30, 2016, but the Fund received contributions on your behalf for at least 250 hours worked from July 1, 2016 – September 30, 2016 (i.e., the Contribution Quarter immediately preceding the end of the self-payment period), you will be eligible to continue your Active Plan eligibility through self-payments for the fifth Benefit Quarter of October 1, 2016 – December 31, 2016.

Participants eligible due to self-payments will be eligible for all benefits under the Plan. Continued eligibility under the HRA benefit is limited to the existing balance in the HRA account at the time you began making self-payments and no new amounts will be added to your HRA while making self-payments.

Participants who have exhausted their Plan eligibility through self-payments may be able to continue Plan coverage by electing COBRA continuation coverage.

3.3 Reinstatement of Participants

Once eligibility terminates, you regain eligibility on the first day of a Benefit Quarter if you have been employed by a Contributing Contractor(s) and the Contributing Contractor(s) has made contributions to the Fund on your behalf for at least 250 hours worked in each of the two Contribution Quarters that immediately preceded the Benefit Quarter.

3.4 Termination of Dependent Coverage

Coverage for your eligible Dependents terminates when any one of the following occurs:

1. Your coverage terminates;
2. Your Dependent fails to meet the eligibility requirements of the Plan for Dependent coverage;
3. Your Dependent commits an act of fraud or a material misrepresentation with respect to the Plan; or
4. The Plan terminates.

However, in the event of your death while an eligible Participant, your surviving spouse and eligible Dependents will remain eligible for Plan benefits for one year following the date of your death. Generally, the loss of eligibility will occur at the end of the month during which the event causing eligibility loss occurs. Notwithstanding the prior sentence, if a child ceases to meet the definition of “Dependent” of this Plan on any day during the one year period commencing on the Participant’s date of death, the Dependent child’s eligibility terminates on that date.

IV. DEATH, ACCIDENTAL DISMEMBERMENT, WEEKLY ACCIDENT AND MILITARY BENEFITS

4.1 Death Benefit

Death Benefit protection is provided to eligible Employees in the amount shown in the Schedule of 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 (your children and the children of your deceased child), 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 \$2,000 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 the deceased Participant's estate or the Participant's 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. If you decide at any time to change your beneficiary, you may request a new beneficiary form from the Fund Office.

4.2 Accidental Dismemberment Benefit

If a Participant suffers a loss listed in the Schedule of Benefits as the result of accidental bodily injury, the Plan will pay the benefit amount specified in the Schedule of Benefits.

No more than the principal sum requiring the largest payment will be paid for all losses suffered by a Participant due to any one accident. No accidental dismemberment benefit is paid unless the Participant survives the loss or dismemberment by 30 days. No benefit is paid for accidents occurring as a result of a worker's compensation or similar injury.

4.3 Weekly Accident or Sickness Benefit

The Weekly Accident or Sickness Benefit is paid at the rate stated in the Schedule of Benefits if you are unable to work in Covered Employment due to an accident or sickness requiring the regular care of a Physician or Surgeon, but only if immediately before the accident or the onset of the sickness you were working in Covered Employment or looking for such work during a period declared by the Trustees to be a period of high unemployment.

Your benefits begin with the first day of a disability caused by an accident or the 8th day of a disability caused by sickness, and may continue for a maximum of 52 weeks for any one disability. If benefits are paid for 26 weeks, additional benefits are paid only after a finding of continued disability by the Trustees' Medical Advisor. The Trustees must review your case and may approve continued payments. If you are an eligible Participant by reason of being an employee of an Affiliated Employer, you are entitled to Weekly Sickness or Accident Benefits under the same rules for a maximum of 52 weeks less the number of weeks of sick pay provided by your employer's sick pay policy.

Benefits are not payable for job related accidents covered under any Workers' Compensation Law, Occupational Disease Law, Employer Liability Law or other similar law. A Participant will not receive Weekly Sickness or Accident Benefits for any month after he has applied for and been approved to receive any pension benefit under the provisions of the Plumbers' Pension Fund, Local 130, U.A., and the Pension Fund - Technical Engineering Division, Local 130, U.A., AFL-CIO, the Plumbers the Plumbing Employees' Pension Trust for Employees of Affiliated Plans, or another applicable pension plan as a result of employment with an Affiliated Employer.

4.4 Military Benefit

A Military Benefit is paid at the rate stated in the Schedule of Benefits to a Participant who is called to serve for a period in excess of 30 days in the Armed Forces of the United States or a

Reserve component thereof and is therefore required to leave Covered Employment. Payments commence the week following the week the Participant is inducted or placed on active status but no benefit will be paid unless the Participant's period of military service exceeds thirty (30) consecutive days. Payments will end the week following the week the Participant is discharged, released, or returned to inactive status, but in no event will Military Benefits continue for more than 52 weeks. The Trustees, at their sole and complete discretion, may extend payments under this benefit for six-month intervals.

V. MEDICAL AND HOSPITAL BENEFITS

5.1 Deductible

A deductible is required for the following Hospital and outpatient benefits (referred to as "Covered Medical Expenses"):

- a. Outpatient major medical benefits;
- b. Inpatient Hospital benefits (excluding preadmission hospital tests); and
- c. Surgical benefits (excluding the cost of approved second or third surgical opinions).

To satisfy the deductible, you must pay the first \$200 of Covered Medical Expenses incurred during each calendar year for each eligible Covered Person before any benefits will be paid by the Plan. For families (you, your spouse and any of your eligible Dependents), the payment of the first \$600 of Covered Medical Expenses incurred during, each calendar year by all eligible family members satisfies the deductible. The deductible counts toward your Out-of-Pocket Maximum (discussed below).

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 Medical 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 Participant 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 Participant, his spouse and two children have **each** incurred and paid \$150 in expenses that would otherwise be payable under the Plan. Has the deductible been satisfied?

Yes. Once the \$600 family deductible is met by aggregating all of the family members' Covered Expenses, the individual deductible for each family member is considered satisfied even though no one member has met the \$200 individual deductible.

5.2 Copayments

Emergency Room Visits. You will also be charged a \$150.00 copayment for each emergency room visit. The \$150.00 emergency room copayment counts towards your Out-of-Pocket Maximum.

Copayments for prescription drug and dental benefits are described in the Schedule of Benefits.

5.3 Out of Pocket Maximum

The Plan limits the out-of-pocket expenses a Participant must pay for most (not all) conditions per individual and family, per calendar year. This is known as an Out-of-Pocket Maximum. When an individual or family 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 \$1,500 for individual coverage and \$3,000 for coverage other than self-only coverage (e.g., family coverage).

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 individual or non-individual Out-of-Pocket Maximums. Additionally, amounts you pay related to self-pay 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).

5.4 Coinsurance

Coinsurance is the percentage of covered expenses you must pay for after you meet your deductible. Generally, until you meet the Plan's Out-of-Pocket Maximum, the Plan does not pay covered expenses at 100%. 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.

5.5 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 over 225 hospitals.

Another benefit of the Blue Cross/Blue Shield network is the Physician network which includes over 24,500 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 on to its website at www.bcbsil.com. You can also check with 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 medical provider or facility when a PPO provider or facility is available, the Plan will cover only 70% of the Reasonable and Customary Charges of covered medical services 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 charges for Hospital special services, or \$4,200 and you would be responsible for the balance of \$1,800.00.

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 of 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 an eligible

Dependent 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.

5.6 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 disability 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 disability as the prior admission unless the facts clearly establish otherwise. Readmissions occurring after 30 days will be treated as a new sickness or disability.

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. The Plan does not cover surgical assistant charges.

4. Hospital Nursery Care

Hospital charges for the nursery care of a Participant's newborn child or children are provided as set forth in the Schedule of Benefits.

5.7 Hospital Maternity Benefits

Hospital Maternity Benefits are provided only for the pregnancy of an eligible Employee or the spouse of an eligible Employee carrying the Employee Participant's child. If an eligible Participant or the Participant's spouse is confined in a Hospital due to pregnancy, the maternity services are paid under the Plan's Hospital Benefits and the Plan's Surgical Benefit Schedule.

Under a federal law known as the Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act"), the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Newborns' Act generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under the Newborns' Act, the Plan may not require a provider to obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

No benefits are paid under this Plan for or by reason of an induced abortion, but if an abortion is required where the life of the mother would be endangered if the fetus were carried to term, or where medical complications have arisen from an abortion, a Participant is reimbursed for charges for required Hospital and medical services in accordance with the provisions of this Plan.

5.8 Residential Treatment Center Confinements

The Plan provides benefits for medical care, services, or supplies incurred during a Residential Treatment Center confinement. Charges for medical care, services and supplies incurred during a period of confinement in a Residential Treatment Center are paid as set forth in the Schedule of Benefits. See section 5.17 regarding covered Residential Treatment Center services for Mental Health Conditions and Substance Abuse.

5.9 How To Maximize Your Hospital Benefits

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 disability.

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

The Trustees need your cooperation to make this program a success. You are requested to call Hines and Associates' toll free number, 1-800-944-9401, before any non-emergency Hospital admission. If an emergency admission is required you, or your representative, should call 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 Hines and Associates to review medical necessity prior to or at the time of treatment and make appropriate recommendations.

5.10 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 assistant charges are not covered by the Plan.

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.

5.11 Coverage For Approved Clinical Trials

The Plan does not cover experimental or investigative treatment, procedures or medications. However, if you participate in an “approved clinical trial”, the Plan will cover routine patient costs for items and services furnished in connection with the trial, provided that such items otherwise would be covered under the Plan. “Routine patient costs” for this purpose include items and services typically provided under the Plan for a covered individual not enrolled in a clinical trial. In other words, the Plan will not deny coverage or impose additional conditions on coverage merely because you receive these items or services as part of a trial. Also, the Plan will not discriminate against you for participating in a clinical trial. This means, for example, that the Plan will not deny coverage for side effects that you develop as a result of participation in the trial. However, there is still no coverage for: (1) the experimental or investigational item or service itself, (2) items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis, or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

An “approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or another life-threatening disease or condition that is (i) federally funded or approved, (ii) conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a drug trial that is exempt from having such an investigational new drug application.

5.12 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 (5) days before or twelve (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 (5) days prior to the date the transplant surgery takes place and ending twelve (12) months after such date.

5.13 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 \$1,500.00, unless approved in advance by the Trustees, 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 120 days of Home Health Care Services minus the number of days of Inpatient Hospital Benefits for the same sickness or disability. The 120 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 \$2,000.00 during a calendar year for chiropractic care not deemed to be an Essential Health Benefit; or
- Binocular therapy after a maximum of 12 sessions.

5.14 Wellness Medical Benefits

For each Covered Person, the Plan pays the Reasonable and Customary Charges for covered Wellness Medical Benefits as shown in the Schedule of Benefits.

Covered Wellness Medical Benefits include the following examinations, tests, and procedures to the extent such examinations, tests, and procedures are not covered as Preventive Treatment (see the Definitions Section for the definition of the term “Preventive Treatment”).

1. Males over 18 Years of Age

- Routine Physical Examinations (including medical history and rectal exam)
- Complete Blood Count and Differential Count
- Urinalysis
- Complete Blood Chemistry (SMA-20)
- Stool Analysis for Blood Hemocult

Additional Covered Items for Males over 39 Years of Age

- Electrocardiogram
- PSA Test (payable once every 2 years, Annually if Age 50 or Older)
- Chest X-Ray

2. Females over 18 Years of Age

- Routine Physical Examination (including Medical History and rectal Exam.)
- Complete Blood Count and Differential Count
- Urinalysis
- Complete Blood Chemistry (SMA-20)
- Stool Analysis for Blood Hemocult
- Pelvic Exam and Pap Smear
- TSH (Thyroid Test), payable once every three years

Additional Covered Items for Females over 39 Years of Age

- Electrocardiogram
- Chest X-Ray
- Mammogram (payable once every 2 years, annually if age 50 or older)

3. Children under 18 Years of Age

- Routine Medical Exam (including Medical History)
- Complete Blood Count and Differential Count
- Urinalysis
- Complete Blood Chemistry
- In-Hospital Pediatrician Exams for Newborn Children

4. Covered Individuals Age 60 or Over (Or Within Risk Groups Determined by the Medical Advisor)

- Pneumovax vaccination

5.15 Preventive Treatment & Immunizations

The Plan will pay 100% of the Reasonable and Customary Charges or Fees of a PPO provider (or 70% of the Reasonable and Customary Charges or Fees of any other provider) for Preventive Treatment services required under PPACA such as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use
- Routine immunizations and vaccinations against diseases such as measles, polio or meningitis
- Flu and pneumonia shots
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits

Please contact the Fund Office or Express Scripts to determine which medications are eligible for the 100% cost share Preventive Treatment Benefit. The following Preventive Treatment services are also fully covered when provided by a PPO provider:

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men (ages 65-79) who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use for men (ages 45-79) and women (ages 55-79)
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening for adults
- Type 2 diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A

- Hepatitis B
 - Herpes zoster
 - Human papillomavirus
 - Influenza
 - Measles, mumps, rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, diphtheria, pertussis
 - Varicella
- Obesity screening and counseling for all adults
 - Sexually transmitted infection (STI) prevention counseling for pregnant women and adults at higher risk
 - Tobacco use screening for all adults and cessation interventions for tobacco users
 - Syphilis screening for pregnant women and all adults at higher risk

Additional covered preventive services for women, including pregnant women

- Anemia screening on a routine basis for pregnant women
- Bacteria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling for women at higher risk
- Breast feeding interventions to support and promote breast feeding
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women

- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Well-woman visits to obtain recommended preventive services

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Blood Pressure screening
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for children between 12 and 18
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source

- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children

- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

5.16 Infertility Treatment

The Plan provides coverage for Infertility treatments up to \$10,000 for Infertility treatments determined by the Trustees to be non-Essential Health Benefits. The Plan covers Medically Necessary services and procedures for assisted reproductive technologies rendered in connection with the treatment of Infertility. Such treatments include artificial insemination, gamete intrafallopian fertilization, zygote intrafallopian transfer, in vitro fertilization, intracytoplasmic sperm injection, low tubal ovum transfer, and uterine embryo lavage. Orally administered or injectable fertility medications are also covered.

The coverage of Medically Necessary services and procedures for assisted reproductive technologies as set forth in the Schedule of Benefits is for no more than two attempts to achieve conception during a lifetime. Coverage for treatments that include oocyte retrievals will be provided only when a successful pregnancy has not been attained or sustained through reasonable, less costly medically appropriate Infertility treatments; however, the requirement will be waived if the Participant or Participant's spouse has a medical condition that renders such treatment ineffective.

Coverage will not be provided for the following:

- Expenses for a reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, benefits will be provided if the diagnosis meets the definition of Infertility.
- Services or supplies rendered to a surrogate or in connection with the use of a surrogate.
- Medical and non-medical expenses of an oocyte or sperm donor; however, the medical expenses of the Participant or the Participant's spouse will be covered.
- Selected termination of an embryo in cases where the mother's life is not in danger.
- Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
- Infertility treatments which are determined to be experimental or investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.

- Infertility treatment rendered to a person other than the Participant or Participant's spouse.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

5.17 Mental Health and Substance Abuse Benefits

The Plan provides benefits for the diagnosis, treatment and cure of Mental Health Conditions and Substance Abuse. Eligible charges are those covered services deemed Medically Necessary by the Plan and shall be provided in parity with the Plan's medical and surgical benefits. The payment of covered services for Mental Health benefits and Substance Abuse 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 and Substance Abuse 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.

5.18 Home Health Care

The Plan covers Qualified 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 120 for any sickness or disability, less the number of days of hospitalization. The 120 day period resets if the Covered Person is readmitted to a Hospital following 30 days of Home Health Care Services.

VI. 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. Unless otherwise determined by the Trustees to be Medically Necessary, erectile dysfunction medication will be limited to six (6) pills per month.

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.

VII. DENTAL BENEFITS

The Plan pays the Dental Benefits stated in the Schedule of Benefits. The Dental Benefits under the Plan are subject to an individual Deductible with a maximum Deductible per family unit.

7.1 Dental Claims

The Fund's dental claims are processed by Delta Dental of Illinois. You will save money if you use a Dentist who is part of the Delta Dental network. If your dentist is part of the Delta Dental network advise your dentist that you are a Participant (or Dependent of a Participant) in the Plumbers' Welfare Fund, Local 130, U.A. You can also contact the Fund Office or go online at www.deltadental.com or call 1-630-718-4700 to learn if your dentist is a member of the Delta Dental network or to find a conveniently located network dentist. If you use a dentist who is out-of-network, you may be balance billed for any unpaid services you receive.

7.2 Dental Benefit Definitions

The following definitions are applicable for Dental benefits:

Allowable Charge. The usual, customary, and reasonable fee or charge for the Dental Services rendered and supplies furnished in the area where the Dental Services and supplies are provided.

Coverage Year. The twelve month calendar year -- January through December.

Deductible. The amount of Covered Dental Expenses that a Participant must pay before Dental Benefits are payable. See Schedule of Benefits for the amount of the individual Deductible and for the maximum Deductible for a Family Unit.

The Deductible applies only once in any calendar year. However, any expense applied against the Deductible in the last three months of a calendar year may also be applied against the Deductible for the next calendar year so that dental claims will not be subjected to a Deductible late in one calendar year and soon again in the next following year.

Dental Hygienist. A person licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene and who works under the supervision and direction of a Dentist.

Dentist. A person licensed by the State of Illinois or another State to practice dentistry and dental surgery.

Dental Service. The ordinary and usual professional services rendered by a Dentist.

Family Unit. A Participant and his eligible Dependents.

Maximum Amount Payable. The total amount payable for all covered dental services, excluding Pediatric Care, rendered during any one calendar year for any one member of Participant's Family Unit.

Treatment Plan. A written report, showing the recommended treatment of any dental disease, defect, or injury prepared by a Dentist as a result of any examination made by him or her.

7.3 Dental Benefits Descriptions

Coverage A - Routine Oral Examination

This benefit covers 100% of Allowable Charges for a Routine Oral Examination. No Deductible applies to Coverage A. This benefit covers two examinations a year, but at least six months must elapse between examinations.

Routine Oral Examination includes:

- Prophylaxis - may be done by a Dental Hygienist and is not subject to the Maximum Amount Payable;
- Oral examinations;

- X-rays - if professionally indicated (full mouth x-rays once in any 12 months);
- Diagnosis; and
- Topical fluoride applications for Dependent children (once in any 12 months).

Coverage B - Basic Dental Care

If a Participant or Dependent incurs expenses as a result of a dental disease, defect or injury, benefits are payable for Allowable Charges incurred for the services listed below. Also included is the expense incurred for examination, other than a Routine Oral Examination, if the examination is made in connection with dental disease, defect or injury, or suspected dental disease. This benefit is for the following services and is subject to the annual Deductible:

- Restorative services: amalgam, synthetic porcelain and plastic restorations;
- Periodontics: includes treatment for diseases of the gums;
- Endodontics: includes pulpal therapy and root canal filling;
- Oral surgery: provides for extractions and other oral surgery, including pre- and post-operative care;
- Emergency treatment for the relief of pain;
- Dental examinations required for a dental disease, defect, or injury; and
- Dental sealants for Dependent children under 16 years of age.

Coverage C - Gold Restorations, Crowns and Prosthetics

If, as a result of loss or removal of teeth due to dental disease, defect, or injury, a Participant or Dependent incurs expenses for dental prosthetics while coverage is in force, benefits are payable for the Allowable Charges incurred for those appliances listed below. This benefit is for the following Allowable Charges for dental procedures and is subject to the annual Deductible:

- Gold restorations when the teeth cannot be restored with another filling material;
- Crowns and jackets when the teeth cannot be restored with a filling material;
- Prosthetics: provides bridges, partial dentures, complete dentures and space maintainers;
- Denture replacement benefits: if the replacement of a denture is professionally indicated for a Participant or Dependent, benefits are payable for Allowable Charges incurred for a replacement that is not the result of the theft or loss of a previous denture supplied under this Plan. These benefits are payable only after a Participant has been covered for one year. If, however, the initial replacement of an opposing complete

denture requires the replacement of the existing complete denture, benefits are payable for the replacement of that denture. Any charge for denture replacement made less than five years after the prior denture replacement was made under the program are not payable; and

- Dental implants.

Coverage D - Orthodontic Care

This benefit covers 80% of Allowable Charges for necessary orthodontic treatment by a Dentist subject to the lifetime limit contained in the Schedule of Benefits. The Deductible does not apply to Coverage D. The lifetime orthodontic benefit is in addition to the annual maximum benefit applying to other dental benefits. Initial and subsequent installations of orthodontic appliances are covered. Orthodontic care charges are not allowable until orthodontic services are actually rendered. If eligibility terminates during the course of orthodontic treatment, the Plan will continue to pay for orthodontic treatment for the 30 days after loss of eligibility. However, the maximum amount for this extended eligibility period is the average of the previous quarterly payments, or if orthodontic treatments were received for less than three months on the date of termination, the maximum amount is \$100.00. The benefits payable after termination are subject to all other Plan provisions governing termination of eligibility.

The above dollar limits do not apply to dependents under the age of 19.

7.4 Limitations and Exclusions on Dental Benefits

Inlays, Crowns, and Jackets

If a tooth can be restored with amalgam, silicate or plastic, but a more expensive type of restoration is selected, the Plan pays only the benefit for the basic restoration. Any unpaid treatment cost is the responsibility of the Participant. The final determination of the appropriate level of service shall be made by the Plan's Dental Consultant.

Partial and Complete Dentures

If in the construction of a complete or partial denture "personalized" restorations or "specialized techniques" replace standard procedures, the Plan pays only the benefit for the standard denture. Any unpaid costs are the Participant's responsibility.

Mouth Rehabilitation

If you select a course of Mouth Rehabilitation, the Plan pays only the applicable percentage of the fees for procedures necessary to eliminate oral disease and replace missing teeth. The cost of any other treatment, including costs related to appliances or restorations intended to increase vertical dimension or restore the occlusion, are not covered.

Additional Exclusions

- Services performed for purely cosmetic purposes or to correct congenital conditions;

- Charges for courses of treatment, including prosthetics, undertaken before the person became an eligible Participant or Dependent; or
- Services of anesthetists or anesthesiologist.

VIII. EYE CARE BENEFITS

The Plan pays the cost of an eye exam by a licensed Physician or optometrist and the cost of prescribed glasses or contact lenses up to the maximum amounts shown in the Schedule of Benefits. With the exception of Pediatric Care, payments are not made for more than one pair of prescribed eye glasses or prescribed contact lenses during any 12 consecutive month period.

However, if a Participant or Dependent undergoes eye surgery or suffers a traumatic injury causing a change in his or her lens prescription, the Plan benefits are provided for each medically prescribed lens change during the six month period following the date of the surgery or the date of injury. The date of the last medically prescribed lens change before or during the six month period following eye surgery is the starting date for measuring the 12 month waiting period for additional eye care benefits.

The Plan, through an agreement with Eye Med, has made it possible for you to obtain eye exams, and a selection of eye glasses and contact lenses with no out-of-pocket cost if you use an eye care provider within the Eye Med Network. The Eye Med Network includes locations at most Sears, J.C. Penney, and participating Eye Med stores as well as other locations throughout the Chicago area. Please call Eye Med toll free at 1-866-723-0514 for the participating location near you.

At each Eye Med Provider, you may select from several eyeglass styles which are paid in full under the Fund's Vision Benefit. Upgrades and enhancements to the basic frames and lenses are available at an additional discounted charge. To obtain the Eye Med discount you are required only to go to an Eye Med location and identify yourself as a Participant in the Plumbers' Local 130 Welfare Fund. Please note that Lasik surgery is not covered under this vision benefit.

IX. HEARING CARE

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 twenty-four month period except for a Dependent child under 19 years of age who has degenerative hearing loss, in which case, one hearing exam every six month period is covered. 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; however, the Plan will pay for bilateral hearing aid instruments up to the amount shown in the Schedule of Benefits only if prescribed hearing aid instruments are determined by the Plan's medical advisor to be Medically Necessary. For Dependents under the age of 19 years, the Plan will pay for a new molded earpiece once in each 12 month period and for a new hearing aid instrument once in each 36 consecutive month period, up to the amount shown in the Schedule of Benefits, but the benefit

for the hearing aid instrument is reduced if the molded ear piece is acquired within 12 months of receiving the hearing aid instrument. The limits set forth in the Schedule of Benefits do not apply to bone anchored hearing aids.

X. HOSPICE CARE

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 diagnosis must be by a Physician approved by the Trustees or the Physician's diagnosis must be reviewed and concurred in by the Trustees' Medical Advisor. 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 co-pay, 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 and approved by the Trustees' Medical Advisor. Covered home hospice or outpatient hospice charges include part-time or intermittent nursing by a registered nurse or licensed practical nurse for up to 8 hours per day or services of a part-time or intermittent home health aide for up to 4 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 employee's home or is a member of the employee'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.

XI. HEALTH REIMBURSEMENT ARRANGEMENT ("HRA")

11.1 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 were 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 Retiree Plan;
- Payments required to continue Plan coverage under the self-payment program or COBRA;
- Any copayments, including copayments for Prescription Drugs;
- Out-of-pocket costs for benefits as permitted under Section 213 of the Internal Revenue Code (IRC §213), except for over-the-counter medications purchased without a Physician's written prescription;
- Amounts that exceed any limits for dental, eye care (including Lasik surgery), or hearing benefits; and
- Amounts charged by a Physician that exceed the Reasonable and Customary charge for the procedure or treatment.

11.2 Accumulating HRA Credits

Participants will accumulate one credit under the HRA for each hour worked in Covered Employment. On a monthly basis, portions of a full hour worked in Covered Employment shall be rounded up to the nearest hour. A Participant does not accumulate credits during any time that the Participant is not actively working in Covered Employment for a Contributing Contractor or an Affiliated Employer or is not eligible for benefits under this Plan. Each credit will be valued as described in the Schedule of Benefits. The Trustees may adjust the value of the credits from time to time. As of June 1, 2016, the value of the credit is \$.50 per hour. Credits will accumulate monthly based on the hours that a contractor or employer reports for a Participant. While a Participant may accumulate credits prior to becoming eligible for benefits under this Plan, a Participant will not be eligible to use or apply HRA credits to any claims or expenses until after becoming enrolled for benefits under this Plan. You may permanently opt out of and waive future reimbursements from the HRA each year. If at any time you believe that your hours were not properly reported, please contact the Fund Office.

Note: Generally, a Participant that is employed by an Affiliated Employer, is a Non-Bargaining Unit Employee, or is eligible for benefits under the Plan pursuant to a participation agreement will accumulate credits as if 174 hours per month of Covered Employment were reported for the Participant. Such a Participant does not accumulate credits during any time that the monthly payment for the Participant's coverage is not remitted to the Fund or the Participant is not eligible for benefits under the Plan.

You will receive credits to your HRA if either you or your spouse utilize a health club membership. If you or your spouse has 150 or more health club visits during a calendar year, you or your spouse will receive a \$300.00 credit to the HRA. If you or your spouse has 100 to 149 health club visits, you or your spouse will receive a \$200.00 credit to the HRA. If you or your spouse has 50 to 99 health club visits you or your spouse will receive a \$100.00 credit to the HRA. The number of visits required for the credit is for each individual. Visits by you and your spouse may not be combined to reach the required number to receive an HRA credit. However, both you and your spouse may receive a credit during the calendar year if you each meet one of the visit minimums. Credits to your HRA account will be made upon the Fund Office's receipt of your health club membership invoice and proof of visits.

11.3 Using Your HRA Credits

Participants may apply for reimbursement 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 Participant may be reimbursed up to the lesser of the amount of covered expenses or the amount of credits accumulated by the Participant. 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.

11.4 Using Your HRA Debit Cards

Participants 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.

11.5 Terminating or Forfeiting HRA Credits

When a Participant is terminated from Covered Employment or loses eligibility for coverage under the Plan, any remaining credits will be forfeited. No Participant or Dependent is vested in any credits under the HRA and cannot receive cash except in reimbursement of covered medical expenses. A Participant that loses eligibility under the Plan but has elected self-pay health coverage under the Retiree Medical Plan or COBRA continuation coverage will not forfeit accumulated credits and will be eligible to apply accumulated credits to covered medical expenses and payments for self-pay health coverage or COBRA.

If you lose active eligibility and elect COBRA, you will continue to accrue additional credits to your HRA account if you are still in Covered Employment and will have immediate access to those contributions. Your rights, if any, to COBRA under the HRA will be explained in the COBRA Election Notice that is provided following a loss of eligibility.

Upon the death of a Participant, the surviving spouse (or any Dependent if there is no surviving spouse) may apply any remaining accumulated credits of the Participant for covered medical expenses of the surviving spouse or other Dependents of the Participant provided that such surviving spouse or other Dependents are otherwise eligible for benefits under this Plan. Upon the death of a Participant, if no surviving spouse or Dependent is eligible for benefits under this Plan, then any remaining accumulated credits of such Participant shall be forfeited.

XII. 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 becomes available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their 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.

12.1 What Is 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 notice. 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." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. This is discussed in more detail in the separate paragraphs below). Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

The Plan provides one option for COBRA coverage which includes your group health coverage under the Plan. However, COBRA coverage does not include Death Benefits, Accidental Dismemberment Benefits, Military Benefits and Accident or Disability benefits. If you (as the

Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your Dependents who were covered by the Plan before the event that triggered COBRA coverage.

At your election, you may continue to accrue additional HRA credits while receiving COBRA continuation coverage at the rate established by the Trustees from time to time. However, the cost of the COBRA continuation coverage shall be appropriately adjusted for the HRA credits.

12.2 Who is a Qualified Beneficiary?

If you are a Participant or Service Plumber Participant, you will become a qualified beneficiary and eligible for COBRA if you lose your coverage under the Plan because either one of the following qualifying events happens:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

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

Your spouse dies;

Your spouse's hours of employment are reduced;

Your spouse's employment ends for any reason other than his or her gross misconduct;

Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

You become divorced or legally separated from your spouse.

Dependent children of a Participant will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

The parent-Participant dies;

The parent-Participant's hours of employment are reduced;

The parent-Participant's employment ends for any reason other than his or her gross misconduct;

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

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a “dependent child.”

12.3 When is COBRA Coverage Available?

The Fund Office will offer COBRA coverage to qualified beneficiaries when the qualifying event is the end of employment, reduction of hours of employment, death of the Participant, commencement of a proceeding in bankruptcy with respect to the Plan, or the Participant becoming entitled to Medicare benefits (under Part A, or Part B, or both).

If you elect self-pay health coverage under the Retiree Medical Plan of the Plumbers’ Welfare Fund, Local 130, U.A., you are not eligible for COBRA coverage. If your spouse elects self-pay health coverage, she/he is not eligible for COBRA coverage.

12.4 Notification Obligations

When the Fund Office or applicable claims administrator is notified of a qualifying event, you will be sent a COBRA Election Notice and COBRA Election Form for you and your Dependents 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.

In order to protect your Dependents’ rights, you should keep the Fund Office and claims administrator informed of any change in your address or in the addresses of Dependents.

For other qualifying events (divorce or legal separation of the Participant and spouse or a dependent child’s losing eligibility for coverage as a dependent child), the Participant must notify the Fund Office within 60 days after the qualifying event occurs.

12.5 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 percent (or, in the case of an extension of continuation coverage due to a disability, as discussed below, 150 percent) of the cost to the Plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

12.6 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. Covered Participants may elect COBRA coverage on behalf of their spouses and parents may elect COBRA coverage on behalf of their children. 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 the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA can be extended:

1. Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the Participant's termination of employment or reduction of hours.

2. Second qualifying event extension of 18-month period of continuation coverage

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

12.7 When COBRA Ends

COBRA coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group medical, dental or vision plan.

2. The required contribution is not timely paid.
3. The Fund terminates the Plan.
4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA coverage period.
5. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA coverage, their maximum coverage period is 36 months from the initial qualifying event, or
6. Your Dependents become entitled to Medicare.

12.8 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).

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. Additionally, you may qualify for a 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.

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

XIII. YOUR RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Because PPACA prohibits the use of preexisting condition limitations, certificates of creditable coverage are no longer needed. Therefore, the Fund Office will no longer issue certificates of creditable coverage.

13.1 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 Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information" or "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 protected health information 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 Welfare Fund Administrator 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.

13.2 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 beneficiary. 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 employee 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 participant (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, preauthorization, 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. 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 employee benefit 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 Summary Plan Description. 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.

4. Disclosure of Protected Health Information to Plan 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:

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

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.

13.3 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 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 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 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 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.

XIV. PLAN LIMITATIONS AND EXCLUSIONS

14.1 General Limitations

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

1. In connection with a general health examination except care, services or supplies that are Preventive Treatment or that are covered under the Plan's Wellness Medical Benefit;
2. Any expense that exceeds the applicable Plan limitation;
3. That are compensable under any Workers Compensation law, Workers' Occupational Disease law, Employer Liability law, or any other similar laws;
4. That are provided or paid for by any governmental agency or under any governmental law or program, except as specifically provided in the Plan;
5. That are rendered or supplied without charge, or for which there would be no charge except for the Plan;
6. That are not Medically Necessary;
7. That are related to surgical assistants;
8. That are related to vasectomy reversals (vasovasostomy) or reversal of a tubal ligation;
9. 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);
10. That are cosmetic in nature, unless the care, services or supplies are Medically Necessary. Mastectomy patients are covered for reconstructive surgery following the mastectomy as required by the Women's Health and Cancer Rights Act of 1998;
11. That are for personal hygiene, comfort or convenience items;
12. That are abortions, except as otherwise provided under the Plan;
13. 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;
14. That is extended Hospital care;

15. For organ transplants, unless the Trustees provide advance written approval or the procedure was performed on an emergency basis;
16. For treatment of pectus excavatum, unless the Trustees provide advance written approval;
17. For food or food supplements, 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.
18. 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;
19. That exceed the lesser of the Reasonable and Customary Charge or Fee, or the Plan's benefit for the covered care, service, or supply;
20. For Prescription Drugs filled through on-line or internet pharmacies;
21. 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;
22. For expenses for Infertility treatments, including diagnostic tests and Prescription Drugs, rendered to an individual other than the Participant or Participant's eligible spouse, except as otherwise provided under the Plan;
23. That is excluded under the terms of any group insurance contract which is a part of this Fund;
24. For retainer fees or similar fees by a Physician or other provider;
25. Medical care, services or supplies that are not provided or prescribed by or under the supervision of a Physician or Surgeon; and
26. 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.

14.2 Special Limitations

In addition to the limitations previously set forth in this Plan/SPD, the following limitations also apply:

Non-Bargaining Unit Employees

Non-Bargaining Unit Employees are not eligible for Death Benefits, Accidental Dismemberment Benefits, and Weekly Sickness or Accident Benefits.

Newly Organized Journeymen

Benefits for a newly organized journeyman do not include Death Benefits, Accidental Dismemberment, Weekly Sickness or Accident Benefits, Military Service Benefits, or the Retiree Plan until the newly organized journeyman satisfies the Continuing Eligibility requirements for the Benefit Quarter which corresponds to work performed in the Contribution Quarter during which immediate initial eligibility was extended.

Service Plumber Participants

Benefits for Service Plumber Participants do not include Death Benefits, Accidental Dismemberment, Weekly Sickness or Accident Benefits, Military Service Benefits, Eye and Hearing Care, Infertility, Dental Benefits, the Health Reimbursement Arrangement and Prescription Drug coverage. Also, Dependents of a Service Plumber Participant are not eligible to participate in the Fund and are not entitled to any benefits under the Plan.

Certain Schedule A Agreement Trainees

Benefits for Trainees with “Mc”, “Md”, or “Me” classifications who are subject to the Schedule A Agreement do not include Retiree Benefits, Death Benefits, Accidental Dismemberment, Weekly Sickness or Accident Benefits, Eye Care, Hearing Care, or Dental Benefit coverage.

XV. CLAIMS AND APPEAL PROCEDURE

15.1 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 Participants and Dependents 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 Participant, Dependent or beneficiary 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 a Participant, Dependent or beneficiary and the health care provider individual or institution shall have no independent right to payment.

Additionally, any benefit payable for claims incurred by an eligible Dependent named as an alternate recipient under the terms of a Qualified Medical Child Support Order (as defined by Section 609 of ERISA) may be paid directly to the individual or institution that provided the

covered services (except in cases where the Participant or the alternate recipient's custodial parent or legal guardian establishes that they are personally entitled to reimbursement of amounts personally advanced in payment of expenses covered by the Plan).

15.2 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 decision on appeal.

15.3 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.

15.4 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.

15.5 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, prescription drug, EAP, death and disability.

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 Fund, 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 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. Employee's name;
- b. Patient's name;
- c. Patient's date of birth;
- d. Social Security number of Employee or retiree;
- 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, 9th 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 Dependent 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 explanation of benefits (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, AD&D, and Military Benefit Claims

You should notify the Fund Office as soon as possible after you or a Dependent sustains an injury covered by the death, AD&D, or military benefit. The Fund Office provides the forms necessary to process your claim. You may be required to submit supporting information (e.g., a death certificate, discharge papers, etc.) to verify your eligibility for benefits.

Claims must be submitted no event later than 12 months following the date of accident, death, disability, or military discharge.

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, Military, Accident and Disability

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 if a claim has been paid in part or in full. If the claim is not paid, it also gives you the reason for the decision.

15.6 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 preauthorization. ***Organ transplant benefits are the only Plan benefits which require preauthorization. All other benefits do not require preauthorization 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 preauthorization; or
 - ii. The preauthorization 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 (such as recertification of the number of days of a Hospital stay) 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.

15.7 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 Participant, eligible Dependent, an authorized representative, or by a network provider. 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 15.1 and 15.4 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 (For Organ Transplants Only)

- 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 Participant filing a claim (Claimant) 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 initial 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.

4. Disability Claims

- a. Any claim involving a determination of disability must be decided no later than 45 days after receipt by the Fund. A Claimant must be notified within the 45-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 30 days due to circumstances beyond the Fund's control (e.g., inability of medical reviewer to meet deadline); provided notification is given to the Claimant before the expiration of the initial 45-day determination period. The period for making a decision may be delayed an additional 30 days, provided the Claimant is notified prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.
- c. If a claim cannot be processed due to insufficient information, the Fund must notify the Claimant about what information is needed before the expiration of the initial 45-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 30 days to make a decision and notify the Claimant.

15.8 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;
2. Any rescission of coverage; or
3. 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. 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. 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 internal or external 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).

15.9 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 an organ transplant) 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 it 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 notice of denial 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 Welfare Fund's Board of Trustees which meets no less than quarterly and is the Plan fiduciary to review claim appeals. Following the decision of the Board of Trustees, you may be eligible for external review. 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 right to present testimony and submit other evidence including but not limited to documents, written comments, or other information in support of an appeal.
4. 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.
5. 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.
6. 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.

7. 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 available external review process (described below) or 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 (For Organ Transplants Only).* 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 5 days following the next scheduled full Welfare Fund 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. Disability Claims

The decision will be made in the same manner as for health claims.

3. All Other Claims

The Fund will send you a notice of the decision on appeal within 60 days of a decision being reached 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. Provide an explanation of the Fund's external appeal procedure along with time limits;
7. 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;
8. 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
9. Provide the contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

15.10 External Review Appeal Procedure

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Fund, or if the Fund fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Fund's determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;

- the exclusions for experimental or investigational services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your authorized representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your authorized representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the Fund's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the covered person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Fund has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

1. Standard External Review

Within five business days after receipt of the request, the Fund will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- The Claimant is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- The Claimant has exhausted the applicable internal appeals process; and
- The Claimant has provided all the information and forms required to process the request.

After the Fund completes the preliminary review, the Fund will issue a notification in writing to you. If the request is eligible for external review, the Fund will assign an IRO to conduct such review. The Fund will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

The Fund will provide to the assigned IRO the documents and information considered in making the Fund's determination. The documents include:

- All relevant medical records;
- All other documents relied upon during the internal review; and
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and the Fund will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Fund. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Fund, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Fund's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

2. Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of

an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Fund will determine whether the individual meets both of the following:

- The Claimant is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- The Claimant has provided all the information and forms required so that the Fund may process the request.

After the Fund completes the review, the Fund will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Fund will assign an IRO in the same manner the Fund utilizes to assign standard external reviews to IROs. The Fund will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by review decision for an expedited external review as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Fund.

You may contact the Fund for more information regarding external review rights, or if making a verbal request for an expedited external review.

XVI. COORDINATION OF BENEFITS

This Article applies to benefits provided under all parts of the Plan except Weekly Sickness or Accident benefits, Death Benefits, Military Benefits and Accidental Dismemberment 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 trustees 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 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 “Local 130 Health and Welfare Plan” as used in this Article means that portion of the Local 130 Health and Welfare 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.

Effect on Benefits

1. This Article applies to determine the benefits as to a person covered under the Local 130 Health and Welfare Plan for any period of illness or injury compensable under the Local 130 Health and Welfare 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 Local 130 Health and Welfare 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 Local 130 Health and Welfare 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 Subparagraph (3) of this Paragraph (C), do not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

3. If (i) another Plan which is involved in Subparagraph (2) of this Paragraph (c) 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 Local 130 Health and Welfare Plan have been determined; and (ii) the rules set forth in Subparagraph (4) of this Paragraph (C) would require the Local 130 Health and Welfare 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 Local 130 the Health and Welfare Plan.
4. For the purpose of Subparagraph (3) of this Paragraph (C), 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 Local 130 Health and Welfare Plan, and the payment of benefits under the Local 130 Health and

Welfare 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 Local 130 Health and Welfare Plan during any period of illness or injury compensable under the Local 130 Health and Welfare 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 Local 130 Health and Welfare Plan determine, and the reduced amount is charged against any applicable benefit limit of the Local 130 Health and Welfare Plan.

For the purposes of determining the applicability of and implementing the terms of this Article of the Local 130 Health and Welfare 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 Local 130 Health and Welfare Plan must furnish to the Trustees necessary information to implement this provision.

Facility of Payment.

Whenever payments that should have been made under the Local 130 Health and Welfare 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 Local 130 Health and Welfare Plan and, to the extent of the payments, the Trustees are fully discharged from liability under the Local 130 Health and Welfare 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.

Special Rule Where Both Spouses are Participants.

Solely in situations where two Plan Participants are married, the Plan's Reasonable and Customary Charges or Fees for surgical, in-hospital doctor, dental, eye care, and hearing care charges are double the amount otherwise payable in situations where only one spouse is an eligible Participant. The Reasonable and Customary Charges or Fees for all other hospital and medical expenses are not adjusted.

XVII. 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 Participant, his estate, his Dependents, or his Dependent's estate, for illness, accident, sickness, work-related injury, or injury, regardless of how such injury occurred to the Participant or Dependents and the Participant or Dependents 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 Participant's or Dependents' 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 Participant or Dependent 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 Participant, his estate, his Dependents, or his Dependent's estate 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 Participant, his estate, his Dependents, or his Dependent's estate 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.

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 Participant or Dependents, as opposed to the general assets of the Participant or Dependents, 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 Participant or Dependents. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the Participant or Dependents be "made-whole" or that the entire debt be paid to the Participant or Dependents 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 Participant or Dependents 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 the event the Participant or Dependent 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 Participant or Dependent seeking monetary damages from the Participant or Dependent's general assets. The Fund shall also have the right to offset or withhold any future benefits that the Participant, Dependent, or estate may be entitled to receive until the Fund has been reimbursed.

The Participant or Dependents or the Participant acting on behalf of a minor Dependent 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 Participant or Dependents 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 Participant or Dependents do not attempt a recovery of 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 Participant or Dependents or paid on their 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 Participant or Dependents, 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 Participant or Dependents and their attorneys if applicable.

In the event of any failure or refusal by the Participant or Dependents 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 Participant or Dependents. After making claim for benefits from the Fund, the Participant or Dependents shall take no action which might or could prejudice the rights of the Trustees or the Fund.

In the event the Participant or Dependents recover 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 Participant and/or Dependents refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from Participants and/or Dependents by instituting legal action against the Participant and/or Dependents and/or by deducting such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The Participant or Dependents shall be required to pay their 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. In the event that an attorney is hired by or on behalf of the Participant or his Dependents 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.

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 Participant or Dependent, 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 Participant or Dependent, 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.)

XVIII. IMPORTANT INFORMATION ABOUT THE PLAN

18.1 Name and Type of Plan

This Plan is known as the Health and Welfare Plan of the Plumbers' Welfare Fund, Local 130, U.A. This Plan provides health and welfare benefits for expenses arising from hospitalization, surgery, medical treatment, prescription drug, vision or dental care. This Plan also provides benefits for disability, death, AD&D and health reimbursement account benefits. Details of the dental, vision and AD&D coverage are contained in separate certificates.

18.2 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor, Plan Administrator and the name 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:

**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, 2016, 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

Michael Chapel
Canyon Plumbing
14119 S. Harrison Avenue
Posen, IL 60469

David Kerrigan
Sherman Mechanical, Inc.
1075 Alexander Court
Cary, IL 60013-1891

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

18.3 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	www.express-scripts.com	1-800-451-6245
Accredo	www.accredo.com	1-877-222-7336
<i>Utilization Review</i>		
Hines & Associates	www.hinesassoc.com	1-800-944-9401
<i>Employee Assistance Program</i>		
ERS	www.ers-usa.org	1-800-292-2780

18.4 Identification Numbers

The number assigned to this Fund by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The Employer Identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-2141153.

18.5 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.

18.6 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 participating Contractors are required to contribute to the Fund.

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

18.7 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.

18.8 Source of Contributions and Benefits

All contributions to the Fund are made by Employers under their collective bargaining agreements with Local 130, U.A., or participation agreements with the Fund. 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 Participants and their Dependents and defraying reasonable administrative expenses.

18.9 Plan Investments

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

18.10 Workers' Compensation Not Affected

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

18.11 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 Trust 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 Trust since they are specifically set aside for the purpose of providing benefits to Participants.

18.12 Right of Trustees to Amend Trust 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 Participant, former Participant, retired Participant or Dependent 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.

18.13 Application For Benefits

If you become disabled 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 Participant is paid or reimbursed for medical expenses incurred by him and his eligible Dependents. For that reason all claim forms must be signed by the Participant.

18.14 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 Participant, 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 Participant 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 must be made by the Trustees, and is final and binding on all persons.

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.

18.15 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 Trust and Plan and to interpret and construe the provisions of the Trust 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 Trust Fund including benefit claims made by any Participant, Dependent, beneficiary, or any other person; questions concerning the construction, interpretation, or application of the language of the Plan, the Trust, 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 Trust 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 Trust, 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 and the Plan and any rules and regulations promulgated under the Trust and Plan. All decisions, determinations, and findings of the Trustees are binding upon all persons dealing with the Trust Fund or claiming any benefit thereunder.

18.16 Limitation on Legal Action Against the Plan

Any legal action by a Participant or Dependent (or their representatives, agents, heirs, or assigns) to enforce a right to benefits under this Trust or the Plan must be commenced within one year of the date the Participant or Dependent completes the administrative appeal of the benefit denial. For purposes of this Section, a Participant or Dependent 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 Participant or Dependent received notice of the initial denial or partial denial of his claim; or

The date the Participant or Dependent receives notice that his appeal of the initial denial or partial denial of his claim has been denied by the Fund or the Independent Review Organization.

For purposes of this Section, a Participant or Dependent 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.

18.17 Incentive Program

In the event you secure a refund of more than \$25.00 to the Trust Fund of an overcharge on a bill from a Hospital, doctor, or other provider for treatment provided to the Participant or Dependent, you shall receive twenty-five percent (25%) of the total amount of the refund but no more than \$500.00 per year.

18.18 Interests in the Trust Fund

No Participant, Service Plumber Participant, or any other person has any right, title, interest in or to the Trust Funds, or any part thereof; however, any Participant, or Service Plumber Participant 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 Participant, Service Plumber Participant, or any other person has any right, title, or interest in, or the option to receive, any part of the Contractors' contributions. No Participant, Service Plumber Participant, or any other person has the right to assign his benefits or receive a cash consideration in lieu of his benefits.

18.19 Prohibition on Rescissions

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

18.20 No Employment Contract

Nothing in this Plan or the Trust may be construed to constitute an employment contract between any Contractor and Employee.

18.21 Notification by Participants and Dependents

You and your Dependent(s), if applicable, are required to inform the Fund Office of any change in the employment status or family status (including but not limited to divorce, legal separation, or a child Dependent ceasing to meet the definition of a Dependent) that may affect your eligibility or your Dependent'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 employment, change of family status, 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 thirty (30) days from the date of the event affecting your or your Dependent's participation or the receipt of Plan benefits, or as otherwise permitted by law.

18.22 Qualified Medical Child Support Order

This Plan recognizes and will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. A QMCSO is an official court order that provides benefits for a Dependent child or children in the event of a divorce or other family law action.

Upon receipt of a medical support order, the Fund Office will promptly notify you and the person affected by the medical support order, of the receipt of such order and the Plan's procedures for determining whether the order is a QMCSO. The Fund Office will then determine whether the

order is a QMCSO pursuant to the Plan's procedures and notify you and each affected person of the determination.

18.23 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 of 2008

The Mental Health Parity Addiction and Equity Act of 2008 requires that the annual or lifetime dollar limits on mental health and substance abuse benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. Federal law also requires that plans providing both medical/surgical benefits and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on medical/surgical benefits.

HIPAA Privacy Notice

You have been furnished under separate cover a Notice of Privacy Practices describing the practices the Plan will follow with regard to your "protected health information." If you would like to receive another copy, please contact the Fund Administrator.

Patient Protection Notice

The Plan generally allows the designation of a primary care provider with respect to medical benefits. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Fund Office.

For children, you may designate a pediatrician as the primary care provider.

The Plan does not require you to obtain prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office.

XIX. STATEMENT OF ERISA RIGHTS

As a Participant, Trainee or Service Plumber Participant in 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 and work sites at which fifty or more participants are regularly employed, 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 participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents have to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.
- Receive, without charge, a copy of the Plan's procedures for determining the validity of Qualified Medical Child support orders.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may 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.

XX. PROVISIONS RELATING TO THE PLAN’S RELATIONSHIP WITH BLUE CROSS/BLUE SHIELD

This Section governs the relationship between the Plumbers’ Welfare Fund, Local 130, U.A. (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 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 network 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 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 Participants 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 Participant'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 Participant's responsibility to furnish to the Fund and/or the Network Administrator information regarding the Participant's 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 Participant may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Network Administrator is authorized by the Participant 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 Participant. 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 Participants.

Each Provider provides Covered Services only to Participants and does not deal with or provide any services to the Fund (other than as an individual Participant) 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 Participant 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 Participant'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 Participants 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.

XXI. DEFINITIONS

For purposes of the Plan, the following definitions apply:

Affiliated Employers

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. 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.

Board of Trustees or Trustees

The originally named Trustees, their successors who are duly appointed under this Plan's Trust Agreement, and the Alternate Trustees when authorized to act by a Trustee in the manner prescribed by the Trust. The Trustees will conduct the business of the Trust and execute all instruments in that name.

Contractor, Contributing Contractor or Contributing Employer

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 Contractor contributing to this Trust 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 Trust is a Contributing Contractor for the period of time for which contributions are being made.

A Contributing Contractor also includes any person or entity employing persons to perform work or is an Owner-Alumni that is party to a participation agreement with the Fund, and approved by the Board of Trustees, which provides, in writing, for the payment of contributions to the Fund for work performed by the employer's Employees, provided such agreement provides that employer will be bound by the terms of the Trust Agreement. The Trustees have the unqualified right to reject the application for participation of any Owner-Alumni or employer who is not a Contractor under the customs and usage of the trade, and their decision on any employer application is final and binding.

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 Employees. Likewise, the Fund may be an Employer with respect to its Employees 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 Employer 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 Contractor is required to make contributions to the Fund, either under a collective bargaining agreement or other written agreement. Covered Employment does not begin until your Employer is required to begin contributions (for example, after you have completed any required probationary period pursuant to the applicable agreement). Covered Employment also includes any hours worked for a union that sponsored a welfare fund that has merged with this Fund.

Covered Person

A Participant, Service Plumber Participant or Dependent who is eligible for a benefit or benefits under the Plan.

Dependent

The spouse of a Participant. For purposes of this Plan the term “spouse” means an individual who is a husband or wife of a Participant pursuant to a marriage legally conducted in the state or jurisdiction in which the marriage was performed that is legally recognized under federal U.S. law. The spouse of a Participant will lose Dependent status upon divorce or legal separation from the Participant. A spouse will be considered divorced or legally separated from the Participant on the date of entry of the court order granting the divorce or legal separation.

A child of a Participant who is under the age of 26 years. A child of a Participant commences Dependent status as of his or her date of birth. An employee’s child/children shall include:

- A natural child,
- A legally adopted child,
- A child placed for adoption with the employee,
- A child listed as an employee’s alternate recipient in a Qualified Medical Child Support Order (QMCSO),
- A foster child, or
- A step-child (i.e., the natural or legally adopted child of your current spouse).

An unmarried child of a Participant, 26 years of age or older, who is incapable of self-support due to a mental incapacity caused by a Mental Condition or physical handicap (which incapacity or handicap commenced while such child was an eligible Dependent) and is dependent upon the Participant for his or her principal support and maintenance.

The Fund reserves the right to request a marriage or birth certificate, or a copy of any applicable court order to verify Dependent status.

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 is generally considered Durable Medical Equipment.

Employee

Any person employed by a Contributing Contractor and on whose behalf contributions are made to the Plan pursuant to a collective bargaining agreement or to any other written participation agreement with the Fund accepted by the Trustees requiring Employer contributions on behalf of the person, in accordance with the terms of the Trust Agreement. The term Employee also refers to any regular, paid, full-time employee of the Union on whose behalf the Union contributes to the Plan and any regular, paid employee of the Fund on whose behalf the Fund contributes to the Plan.

An employee who works thirty (30) hours per week or more and is not a temporary or probationary employee is considered to be “full-time.” Unless otherwise set forth in this Plan, part-time employees, those hired for temporary tasks or finite periods of time, or those who work less than thirty (30) hours per week, are not full-time Employees and are not eligible for benefits.

ERISA

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

Essential Health Benefits

Items and services covered within the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (meaning services provided to individuals under age 19), including oral and vision care. The Board of Trustees has the sole discretion and responsibility to determine in good faith whether a benefit is deemed to be an “essential health benefit” pursuant to the guidance under PPACA.

Fund, Welfare Fund or Trust Fund

The Plumbers’ Welfare Fund, Local 130, U.A., including all property of the Trust including any group insurance contracts purchased by the Trustees for the benefit of Participants.

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 either the Participant or his spouse 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 which 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, care 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.

Non-Bargaining Unit Employee

Any full-time employee of a Contributing Contractor who is not an apprentice or journeyman plumber, Trainee, a Service Plumber or serviceman included within a bargaining unit represented by the Union or a member of any other labor organization providing pension and welfare benefits to its members.

Participant

An individual who is eligible to participate in the Plan.

Pediatric Care

Treatment and services provided to a Dependent who is under the age of 19.

Permanently Disabled

The inability to perform the normal duties of a journeyman plumber, technical engineer, instrumentman, rodman, or apprentice because of physical or mental disability or sickness if the disability or sickness is medically determined to be permanent and, in fact, continues at the time the Participant claims benefits under this Plan.

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, chiropracist, 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 Health and Welfare Plan of the Plumbers' Welfare Fund, Local 130, U.A. sponsored by the Fund's Board of Trustees.

Plumbers' Pension Plan and Pension

The Plumbers' Pension Fund, Local 130, U.A. and the monthly benefits provided thereunder.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended and any regulations promulgated thereunder.

PPO Hospital, Provider, or Facility

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.

Preventive Treatment

Preventive Treatment includes:

- Evidence-based items or services that have a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force (USPSTF) in effect on the first day of the Plan Year in which the preventive health service is provided to the Participant or eligible Dependent, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the Covered Person involved;

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Prohibited Employment

The following shall constitute Prohibited Employment:

- The conduct of a plumbing enterprise which is not, but could be, a party to a collective bargaining agreement with a local union affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada (“the United Association”);
- The conduct of an enterprise which performs work within the occupational jurisdiction of the Technical Engineering Division, Local 130, U.A., AFL-CIO, and is not a party to a collective bargaining agreement with the Technical Engineering Division, Local 130, U.A., AFL-CIO;
- Employment with a contractor which is not a party to a collective bargaining agreement with a local union affiliated with the United Association or the Technical Engineering Division, Local 130, U.A., AFL-CIO; or
- Continued employment with a contractor by a Participant who receives notice that an order has been issued by a local union affiliated with the United Association or the Technical Engineering Division, Local 130, U.A., AFL-CIO to withdraw its members from employment with the contractor because of the contractor’s noncompliance with the terms of the collective bargaining agreement with the Union or the Technical Engineering Division, Local 130, U.A., AFL-CIO.

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 or Fees

Charges 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, alcoholism and/or Substance Abuse, 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.

Schedule A Agreement

The current Residential & Light Commercial Construction “Schedule A” Agreement. Any Employee who is classified as a “Trainee” or other sub-classification of a Trainee under the Schedule A Agreement and working for a Contributing Contractor that is a party to the Schedule A Agreement will be eligible for the benefits applicable to Trainees as set forth in this Plan/SPD.

Service Plumber Participant

An individual who is employed by a contractor pursuant to the Plumbing Service & Maintenance Agreement and who is eligible to participate in the Plan pursuant to the terms of the Plan.

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.

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.

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.

4831-1336-7335, v. 7