U. A. PLUMBERS LOCAL UNION NO. 68

GROUP PROTECTION PLAN

AND

MECHANICAL CONTRACTORS ASSOCIATION OF HOUSTON, INC.

SUMMARY PLAN DESCRIPTION

AND

AMENDED AND RESTATED RULES AND REGULATIONS OF THE PLAN

EFFECTIVE: JANUARY 1, 2019

TABLE OF CONTENTS

TO ALL PARTICIPANTS 1
DISCLOSURE OF STATUS AS A GRANDFATHERED HEALTH PLAN 2
WHEN TO NOTIFY THE FUND OFFICE 3
NINE WAYS TO CONTROL YOUR HEALTH CARE BILLS 4
HOW TO FILE A CLAIM 6
SCHEDULE OF BENEFITS – REGULAR PLAN 7
- Benefits For Employees Only 7
- Benefits For Employees And Dependents 7

SCHEDULE OF BENEFITS – MEDICARE SUPPLEMENT PLAN 20
ARTICLE I – ELIGIBILITY, EFFECTIVE DATE OF COVERAGE AND TERMINATION DATE 22
- Section 1.01. Eligibility for Employees 22
- Section 1.02. Initial Eligibility 23
- Section 1.03. Continuation of Eligibility 23
- Section 1.04. Hour Bank Account 24
- Section 1.05. Reinstatement 24
- Section 1.06. Eligibility Rules For Employees Of Newly Contributing Employers 25
- Section 1.07. Special Eligibility Rules/NON-Bargained 27
- Section 1.08. Disability Credits 27
- Section 1.09. Reciprocity 28
- Section 1.10. Termination of Employee's Coverage 28
- Section 1.11. Eligibility for Dependent's Coverage 29
- Section 1.12. Effective Date of Dependent's Coverage 30
- Section 1.13. Termination of Dependent Coverage 31
- Section 1.14. Special Enrollment 32
- Section 1.15. Retirees 32
- Section 1.16. No Retroactive Cancellation of Coverage 33

ARTICLE II – LEAVES OF ABSENCE FOR MILITARY SERVICE 34
ARTICLE III – FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993 36
ARTICLE IV – DISABILITY BENEFITS FOR EMPLOYEES 38
- Section 4.01. Benefits 38
- Section 4.02. Successive Disabilities 38

Section 4.03. Limitations 38
Section 4.04. Extension of Benefits Due to a Disabling Condition 39
ARTICLE V – MEDICAL DEDUCTIBLE AMOUNTS, PLAN MAXIMUMS AND OUT-OF-POCKET LIMITS 40
Section 5.01. Deductible Amounts 40
Section 5.02. Common Accident 40
Section 5.03. Annual Maximums 40
Section 5.04. Lifetime Maximums 41
Section 5.05. Out-of-Pocket Limits 41
ARTICLE VI – PRE-ADMISSION CERTIFICATION 42
ARTICLE VII – MEDICAL EXPENSE BENEFITS 43
Section 7.01. Eligible Expenses 43
Section 7.02. Non-Eligible Expenses 43
Section 7.03. Covered Medical Expenses 43
ARTICLE VIII – DENTAL BENEFITS 56
Section 8.01. Dental Benefits 56
Section 8.02. Deductible Amount 56
Section 8.03. CoInsurance Percentage 56
Section 8.04. Eligible Dental Expenses 56
Section 8.05. Maximum Dental Benefits 56
Section 8.06. General Information 57
ARTICLE IX – VISION BENEFITS 58
ARTICLE X – LIMITATIONS AND EXCLUSIONS 59
ARTICLE XI – HEALTH REIMBURSEMENT ARRANGEMENT (HRA) 64
Section 11.01. Establishment Of HRA 64
Section 11.02. Eligibility to Participate 64
Section 11.03. Integration Requirement 65
Section 11.04. Termination of Eligibility 65
Section 11.05. Source of Contributions 66
Section 11.06. Eligible HRA Expenses 66
Section 11.07. Carryover/Forfeiture of HRA Account Balances 67
Section 11.08. Submitting a Claim for Reimbursement 68
Section 11.09. Reimbursement by the Plan 68
Section 11.10. Reimbursements After Termination of Eligibility 69

Section 11.11. Coordination of Benefits 69
Section 11.12. Effect Of Mistake 69
Section 11.13. Amendment and Termination 69
Section 11.14. Tax Consequences 69
Section 11.15. Non-Assignability Of Rights 70
Section 11.16. Nondiscrimination 70
Section 11.17. Suspension of HRA Account 70
Section 11.18. Permanent Opt-Out 70
ARTICLE XII – MEDICARE SUPPLEMENT BENEFIT PLAN FOR RETIREES AND SPOUSES OVER THE AGE OF 65 72
Section 12.01. Eligibility 72
Section 12.02. Benefits 72
ARTICLE XIII - COORDINATION OF BENEFITS 73
Section 13.01. Application 73
Section 13.02. Order of Benefit Determination 74
Section 13.03. Coordination With Medicare 75
Section 13.04. Coordination With Medicaid 76
Section 13.05. Military Insurance Coverage 76
Section 13.06. Veterans Affairs Facility Services 76
Section 13.07. Motor Vehicle No-Fault Coverage Required By Law 76
Section 13.08. Coverage by a Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or a Dental Maintenance Organization (DMO) 77
Section 13.09. Copayment and Non-Scheduled Prescription Drug Providers 77
Section 13.10. Release of Information 77
Section 13.11. Payment to Insurance Carriers 78
Section 13.12. Recovery 78
ARTICLE XIV – SUBROGATION 79
ARTICLE XV – COBRA CONTINUATION COVERAGE 81
Section 15.01. Your Right To COBRA Continuation Coverage 81
Section 15.02. You Must Provide Notice To The Plan Of Certain COBRA Qualifying Events 82
Section 15.03. Notification Procedures 83
Section 15.04. How Is COBRA Coverage Provided? 85
Section 15.05. Benefits 86
Section 15.06. Payment For Continuation Coverage 86

Section 15.07. Self-Payment Cost 86
Section 15.08. Interaction Of COBRA And The Affordable Care Act – Other Options 87
Section 15.09. When COBRA Continuation Coverage Ends 87
Section 15.10. Name, Address And Telephone Number Of The Party Responsible For COBRA Administration 88
Section 15.11. Unavailability Of Coverage 88
Section 15.12. Notice Of Termination Of COBRA 88
Section 15.13. Keep The Fund Informed Of Address Changes 88
Section 15.14. If You Have Questions 88
ARTICLE XVI – CLAIMS AND APPEALS PROCEDURES 89
Section 16.01. Definitions 89
Section 16.02. Assignment 90
Section 16.03. Claims Procedures 90
Section 16.04. Claims Appeal Procedures 99
Section 16.05. Timeframes for Notices of Appeal Determinations 100
Section 16.06. Content of Appeal Determination Notices 102
Section 16.07. Decision of the Board of Trustees Is Final and Binding 102
Section 16.08. When a Lawsuit May Be Filed 103
ARTICLE XVII – DEFINITIONS 104
ARTICLE XVIII – INTERPRETATION, AMENDMENT, TERMINATION AND MAXIMUM LIABILITY 115
Section 18.01. Interpretation 115
Section 18.02. Amendment and Termination 115
Section 18.03. Maximum Liability of the Plan 115
ARTICLE XIX – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 116
Section 19.01. Use and Disclosure of Protected Health Information (PHI) for Health Care Treatment, Payment for Health Care, and Health Care Operations 116
Section 19.02. Use and Disclosure by Authorization 118
Section 19.03. Use of PHI by the Plan Sponsor 118
Section 19.04. Separation between the Plan and the Plan Sponsor 119
Section 19.05. Compliance with HITECH Act 119
ARTICLE XX – PRIVACY NOTICE 120
ARTICLE XXI – INFORMATION REQUIRED UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 129
NOTICE 135

TO ALL PARTICIPANTS

We are pleased to present you with this new Summary Plan Description ("SPD") and Amended and Restated Rules and Regulations of the Plan, which describes the benefits provided by the Fund. The SPD and the Amended and Restated Rules and Regulations of the Plan have been updated to include Plan changes through January 1, 2019.

Medical, Dental and Disability benefits are paid for directly from the assets of the Fund. Vision benefits are insured by VSP Vision Care and Life Insurance and Accidental Death and Dismemberment Insurance benefits are insured by ULLICO.

We urge you to read this new SPD and Amended and Restated Rules and Regulations of the Plan carefully so you will better understand the benefits that you and your family may be entitled to receive. While it is hoped that everyone will enjoy good health at all times, we believe you will feel, as we do, that the Fund benefits provide financial security in times of need.

In order to have your claims paid on a timely basis, be sure to read and comply with the "How to File a Claim" requirements outlined on page 6.

If you have any questions regarding your eligibility, benefits under the terms of the Plan, or how to file a claim, please contact the Fund Office at (713) 869-2592 or (800) 833-2980.

Please remember that, in order to be official, any information concerning your rights under the Plan must be communicated to you in writing by the Fund Office.

This document and other important information can be found at the Plumbers Local Union No. 68 Benefits Website: www.PLU68benefitfunds.com

Sincerely,

BOARD OF TRUSTEES

DISCLOSURE OF STATUS AS A GRANDFATHERED HEALTH PLAN

The Trustees of the U. A. Plumbers Local Union No. 68 Welfare Fund (Group Protection Plan)(Plan)(Fund) believe this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at:

468 Link Road
Post Office Box 8726
Houston, Texas 77249-8726
(713) 869-2592 or (800) 833-2980.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WHEN TO NOTIFY THE FUND OFFICE

ALL EMPLOYEES ARE REMINDED THAT THEY MUST NOTIFY THE FUND OFFICE AS FOLLOWS:

1. Upon initial coverage, Employees are required to furnish the Fund Office with a certified copy of their marriage certificates, divorce decrees and birth certificates and/or legal documentation for each Eligible Dependent.

2. If there is a change of address.

3. If new Dependents are to be covered. (You must provide birth certificates and/or legal documentation.)

4. If there is a divorce/legal separation. (You must provide court certified divorce or legal separation papers.)

5. If there is a marriage. (You must provide certified copy of marriage certificate or Declaration and Registration of informal marriage.)

6. If there is a death. (You must provide a certified copy of death certificate.)

7. If a dependent ceases to be an Eligible Dependent, as set forth under the eligibility requirements of the Plan.

NINE WAYS TO CONTROL YOUR HEALTH CARE BILLS

You can play a major part in controlling your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing the approaches set forth below in your efforts to control your health care expenses, you will positively affect your out-of-pocket health care costs and your health.

1. **Treat yourself right.** Many Illnesses and Injuries can be prevented. Major Illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing Illness, both major and minor and reducing the occurrence of heart disease. In addition, remember to wear your seatbelt when driving and take the time to be careful around your home to avoid unnecessary household accidents.

2. **Ask "dumb" questions.** Actually, the only dumb questions are the ones you don't ask. Ask about charges on your Hospital bill if you don't understand them. All your health care providers have people who can help answer your billing questions.

   For example, patients who are informed about what to expect during their Hospital confinement usually recover faster and have fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!

   Inquire about the costs of medications. Generic drugs often cost less than name brands and your Physician will prescribe them if you ask.

   Ask your health care provider questions during your visits. It may be best to write down your questions before the visit and take the list with you to avoid forgetting something important. If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, do not be hesitant to get a second opinion from another Physician or health care professional.

3. **Don't be in when you can be out.** Ask your Physician about the use of outpatient services in your Hospital or Physician's office for tests, treatments and many types of minor surgery. Outpatient care is always less expensive than a Hospital confinement and can often accomplish the same objective. Remember, you will more likely recover better from such minor surgical procedures in your home than being in a Hospital.

4. **Use the emergency room for "emergencies."** Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible,

contact your Physician before deciding to use the emergency room or use your judgment to use the emergency room only for true emergencies. Another alternative to control healthcare cost is the use of Urgent Care if necessary.

5. **Understand your coverage before you have to use it.** Make sure you understand your health coverage. Read this SPD and Amended and Restated Rules and Regulations of the Plan and all other important information you receive explaining your benefits. The SPD and Amended and Restated Rules and Regulations describe how the benefits will work and what is and what is not covered. Ask questions if something in the SPD and Amended and Restated Rules and Regulations of the Plan or health care materials is not clear.

6. **The shorter your Hospital confinement, the less you pay.** When it's practical, have tests performed before you enter the Hospital during your pre-admission screening process. Except in a true emergency, avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary time waiting for surgery, services or required specialized treatment. Also, it is important to leave the Hospital at the first opportunity your Physician informs you that you are ready to be discharged.

   Remember – your charges related to your hospitalization may be reduced if it is determined your Hospital confinement was unnecessary, began on a weekend or holiday for an admission that was not medically necessary at that time, or you remained in the Hospital for more days than have been certified as necessary for your condition.

7. **Don't expect a "free" lunch.** Be a cost-conscious consumer. Even though our Fund or the government may pay for most of your health care needs, the services and treatment you receive are never free. The cost is passed on either in the form or increased premiums, higher deductibles, or greater percentage of coinsurance. If you make an effort to control how you use health care services, everyone, especially you, will benefit.

8. **Watch for early warnings!** Keep in touch with your body and any changes, even those that may seem minor. Learn the early warning signs of specific illnesses such as heart disease and cancer. Early detection of illnesses could save your life and may save you money.

9. **Use PPO providers whenever possible.** The health plan uses a Preferred Network of health care Providers. Use these health care providers whenever possible. When you and your eligible dependents use PPO providers, you and the Fund save money.

These recommended approaches may lead you to live a healthier life, enjoy better health, and result in lower out-of-pocket medical costs!

HOW TO FILE A CLAIM

If you or your Dependents become sick or injured and you believe you may be entitled to benefits under the Plan:

1. You should immediately telephone the Fund Office at (713) 869-2592 or (800) 833-2980. If after hours please leave a message.

2. The Fund Office will tell you if you are eligible for benefits under the Plan.

3. The Fund Office will furnish you with a claim form for any claims you may be required to submit to the Plan. No claims forms are required to be filed by you when you use PPO Providers.

4. An Annual claim form per family must be completed and submitted to the Fund Office each year. In some situations, the Fund Office may require an additional claim form.

5. Complete your portion ("Claimant's Statement") of the form.

6. If your claim is related to a disability, be certain to submit the form to your Physician for completion of his or her part of the form ("Attending Physician's Statement").

7. Mail the completed form with any invoices applicable to the claim to the Fund Office at:

   Plumbers Local Union No. 68 Group Protection Plan
   P. O. Box 8726
   Houston, Texas 77249-8726

SCHEDULE OF BENEFITS – REGULAR PLAN

BENEFITS FOR EMPLOYEES ONLY

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Benefits

The life insurance and accidental death and dismemberment (AD&D) insurance benefits are insured through Union Labor Life Insurance Company (ULLICO). Retirees are not eligible for the life insurance or the AD&D insurance benefit.

LIFE INSURANCE AND AD&D INSURANCE BENEFITS	
Life Insurance Benefit	$10,000*
AD&D Insurance Benefit	$10,000*

* Reduced to $6,500 upon attainment of age 70. Reduced further to $5,000 upon attainment of age 75.

Disability Benefits

Disability benefit claims are paid directly from the assets of the Fund. Participant must have worked 80 hours in the previous month to qualify.

DISABILITY BENEFITS	
Income Benefit	50% of the current Journeyman's hourly cash wage per week, based on a 40-hour week
Additional Hospital Confinement Benefit	$30 per day
Benefits Begin (Non-Job Related Accident or Illness)	8th day after the onset of the disability
Maximum Benefit Period Annually	12 paid weeks or up to age 70, whichever occurs first

BENEFITS FOR EMPLOYEES AND DEPENDENTS

Claims for medical and dental benefits are paid directly from the assets of the Fund. Vision benefits are insured through VSP and claims are paid by VSP.

Benefits provided by the Plan will be determined in accordance with the following Schedule of Benefits.

***NOTE*: Procedures not specifically stated as covered are excluded.**

Medical Deductibles and Out-of-Pocket Limits

DEDUCTIBLES AND OUT-OF-POCKET LIMITS	
Calendar Year Deductible	$685 per person per Calendar Year; maximum $1,370 per family. Most preventive care benefits and hearing aids are covered before the deductible is met.
Emergency Room Deductible	$100 Non-Emergency; no family maximum. Emergency Room Deductible waived if Hospital admission occurs in conjunction with Emergency Room visit. There is an additional Non-PPO penalty deductible of $100 per occurrence.
Out-of-Pocket Limits	PPO (In-Network): $7,350 after the Calendar Year Deductible. Non-PPO (Out-of-Network): $27,400 after the Calendar Year Deductible. Penalties for failure to obtain pre-certification, health care the Plan doesn't cover and deductibles do not count toward the out-of-pocket limits.

Medical Benefits

MEDICAL BENEFITS	PPO	NON-PPO *
Physician Services	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expense after the Calendar Year Deductible
Preventive Services		
Routine Physical Examinations (Including Lab Expenses)	Plan pays 100% of the charge up to a maximum payment of $400 per exam; Calendar Year Deductible waived	
	Annually for ages 3 to 18, then limited to once every 5 Calendar Years for individuals between the ages of 19 and 39; limited to once every Calendar Year for individuals 40 years of age or older	
Sigmoidoscopies (Routine)	Plan pays 100% of the charge up to a maximum payment of $250 per examination; Calendar Year Deductible waived	

*Reasonable and Customary is 100% of Medicare UCR

MEDICAL BENEFITS	PPO	NON-PPO *
Sigmoidoscopies (Routine)(Cont.)	Limited to once every 3 Calendar Years for individuals at least age 45	
Mammograms	Plan pays 100% of the PPO Eligible Expense for the Physician's exam fee and radiology expenses; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses for the Physician's exam fee and radiology expenses; Calendar Year Deductible waived
	Limited to once per Calendar Year	
Pap Smears	Plan pays 100% of the PPO Eligible Expense for the Physician's exam fee and lab expenses; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses for the Physician's exam fee and lab expenses; Calendar Year Deductible waived
	Limited to once per Calendar Year	
Prostate Exams	Plan pays 100% of the PPO Eligible Expense for the Physician's exam fee and lab expenses; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses for the Physician's exam fee and lab expenses; Calendar Year Deductible waived
	Limited to once per Calendar Year	
Immunizations		
Tetanus or Tdap (Tetanus, diphtheria, and pertussis) Shots	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
	Limited to once every 10 Calendar Years	
Pneumococcal Shots	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
	Limited to once every 6 Calendar Years	

*Reasonable and Customary is 100% of Medicare UCR

MEDICAL BENEFITS	PPO	NON-PPO *
Influenza (Flu) Shots	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
	Limited to once per Calendar Year	
Hepatitis A Immunizations for Children under Age 18	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
Hepatitis B Immunizations	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
Meningitis Immunizations	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
Shingles Vaccines	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
	Limited to $400 per person per lifetime. Must be 50 years of age or older (or any age if the vaccine is recommended by a physician in connection with diabetic neuropathy)	
PKU Infant Tests	Plan pays 80% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
HPV Vaccines	Plan pays 100% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived
	Limited to $400 per person per lifetime	

MEDICAL BENEFITS	PPO	NON-PPO *
Diagnostic Tests (X-Rays, Lab Tests)	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
Diagnostic Imaging (CT/PET Scans, MRIs)	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
Prescription Drugs (Including Diabetic Supplies)		
Generic Drugs	***Retail***: You pay up to the first $5.00, then the Plan pays 85% coinsurance for up to a 90-day supply; ***Mail Order:*** You pay up to the first $5.00, then the Plan pays 90% coinsurance for a 90-day supply	
Preferred Brand Name Drugs	***Retail***: You pay up to the first $5.00, then the Plan pays 80% coinsurance for up to a 30-day supply, 85% coinsurance for a 90-day supply; ***Mail Order:*** You pay up to the first $5.00, then the Plan pays 90% coinsurance for a 90-day supply	
Non-Preferred Brand Name Drugs	***Retail:*** You pay up to the first $5.00, then the Plan pays 80% coinsurance for up to a 90-day supply; ***Mail Order:*** You pay up to the first $5.00, then the Plan pays 80% coinsurance for a 90-day supply	
If you choose a preferred brand or non-preferred brand drug instead of its generic equivalent, you will pay the applicable brand coinsurance plus a penalty. The penalty is the difference in cost between the brand and generic medications. ***Note:*** This penalty applies even if your doctor writes “dispense as written” (DAW) on the prescription.		
Outpatient Surgery	Plan pays 80% of the PPO Eligible Expense; Calendar Year Deductible waived	Not covered

MEDICAL BENEFITS	PPO	NON-PPO *
Outpatient Surgery (Cont.)	No benefits will be paid for services rendered by a Surgical Assistant who is not licensed in the state where the surgery is performed. Charges attributable to a Surgical Assistant who is a Physician will be paid up to a maximum of 20% of the primary Surgeon's charges. Charges attributable to a Surgical Assistant who is not a Physician will be paid up to a maximum of 17% of the primary Surgeon's charges. For Assistant Surgeons who are Non-PPO Physicians: 100% of the Medicare allowable amount	
Emergency Room Care	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible and the separate $100 Non-Emergency Deductible. Emergency Room Deductible waived if Hospital confinement occurs in conjunction with Emergency Room visit	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible, the separate $100 Non-Emergency Room Deductible plus an additional $100 Penalty Deductible. Emergency Room Deductible waived if Hospital confinement occurs in conjunction with Emergency Room visit
Ambulance Services	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
Urgent Care Services	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible

MEDICAL BENEFITS	PPO	NON-PPO *
Inpatient Hospital Services	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Generally not covered. If patient is admitted to a non-PPO Hospital directly through the Hospital's emergency room, Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	Maximum daily room and board limit is the average semi-private room rate.	
	You must pre-certify all non-emergency Hospital confinements and certify all emergency Hospital confinements within 72 hours of the commencement of the confinement (or the next working day if the admission occurs over a weekend or on a holiday). If you do not pre-certify/certify a Hospital confinement, benefits for covered Hospital services will be reduced, based upon current BCBS sanctions for PPO and reduced to 50%, up to a maximum of $1,000 for the entire confinement for Non-PPO.	
	For properly certified Hospital confinements, if you or your Eligible Dependent remains in the Hospital beyond the number of days certified as Medically Necessary, it will result in NO benefit payment for the additional days.	
	No benefits will be paid for services rendered by a Surgical Assistant who is not licensed in the state where the surgery is performed. Charges attributable to a Surgical Assistant who is a Physician will be paid up to a maximum of 20% of the primary Surgeon's charges. Charges attributable to a Surgical Assistant who is not a Physician will be paid up to a maximum of 17% of the primary Surgeon's charges. For Assistant Surgeons who are Non-PPO Physicians: 100% of the Medicare allowable amount.	

MEDICAL BENEFITS	PPO	NON-PPO *
Mental Health Services – Inpatient	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Generally not covered. If patient is admitted to a non-PPO Hospital directly through the Hospital's emergency room, Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	You must pre-certify all non-emergency Hospital confinements and certify all emergency Hospital confinements within 72 hours of the commencement of the confinement (or the next working day if the admission occurs over a weekend or on a holiday). If you do not pre-certify/certify a Hospital confinement, benefits for covered Hospital services will be reduced, based upon current BCBS sanctions for PPO and reduced to 50%, up to a maximum of $1,000 for the entire confinement for Non-PPO.	
	For properly certified Hospital confinements, if you or your Eligible Dependent remains in the Hospital beyond the number of days certified as Medically Necessary, it will result in NO benefit payment for the additional days.	
Mental Health Residential Treatment Center Services	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
Mental Health Services – Outpatient (includes Partial Hospitalization and Intensive Outpatient Treatment)	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
Substance Abuse Services	Not covered	Not covered

MEDICAL BENEFITS	PPO	NON-PPO *
Maternity Services – Inpatient	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Generally not covered. If patient is admitted to a non-PPO Hospital directly through the Hospital's emergency room, Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	Inpatient Maternity Services are **not** covered for Eligible Dependent children	
Maternity Services – Outpatient	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	Outpatient Maternity Services are **not** covered for Eligible Dependent children	
Private Duty Nursing/Home Health Agency Services	Plan pays 80% of the PPO Eligible Expenses after the Calendar Year Deductible	Plan pays 60% of Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	Limited to a maximum: $15,000 per Calendar Year	
Physical Therapy – Outpatient Visits Following Surgery	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	Services must be provided within 12 months following surgery and by a Licensed Physical Therapist Services provided more than 12 months following surgery will be paid as "Visits Not Following Surgery" under Outpatient Physical Therapy, as set forth below.	
Physical Therapy – Outpatient Visits Not Following Surgery	Plan pays 80% of the PPO Eligible Expense per visit after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible

MEDICAL BENEFITS	PPO	NON-PPO *
	Limit: combined total of 24 visits under both PPO and Non-PPO plan options. Services must be rendered by a Licensed Physical Therapist	
Extended Care Facility	Plan pays 80% of the PPO Eligible Expense after the Calendar Year Deductible	Generally not covered. If the patient is admitted to a non-PPO Hospital directly through the Hospital's emergency room, Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible
	You must pre-certify all non-emergency Extended Care Facility confinements and certify all emergency Extended Care Facility confinements within 72 hours of the commencement of the confinement (or the next working day if the admission occurs over a weekend or on a holiday). If you do not pre-certify/certify an Extended Care Facility confinement, benefits for covered Extended Care Facility services will be reduced, based upon current BCBS sanctions for PPO and reduced to 50%, up to maximum of $1,000 for the entire confinement.	
	For properly certified Extended Care Facility confinements, if you or your Eligible Dependent remains in the Extended Care Facility beyond the number of days certified as Medically Necessary, services provided during this period will **not** be covered.	
	The stay must begin after a Hospital stay of three or more consecutive days and within 14 consecutive days of termination of that Hospital confinement; and The attending Physician must certify that 24-hour nursing care is necessary for recuperation from the Illness or Injury that required the initial confinement (payment will continue only if the attending Physician certifies such confinement remains necessary for recuperation).	
Durable Medical Equipment (DME over $200 must have a predetermination)	Plan pays 80% of PPO Eligible Expense after the Calendar Year Deductible	Plan pays 60% of the Reasonable and Customary Eligible Expenses after the Calendar Year Deductible

MEDICAL BENEFITS	PPO	NON-PPO *
Chiropractic Services	Plan pays ***lesser of*** 80% of the $50 or the PPO Eligible Expense per visit	Plan pays ***lesser of*** 60% or $50 per visit after the Calendar Year Deductible
	Limited to a combined PPO and Non-PPO maximum of 24 visits per Calendar Year.	
	Chiropractic Benefits include examinations, consultations, manipulations or modalities such as diathermy, ultra-sound, traction, etc. Services must be provided by a Licensed Chiropractor.	
Acupuncture Services	Plan pays ***lesser of*** 80% of the $50 or the PPO Eligible Expense per visit	Plan pays ***lesser of*** 60% or $50 per visit after the Calendar Year Deductible
	Limited to a combined PPO and Non-PPO maximum of 24 visits per Calendar Year.	
	Must be rendered by a Licensed Acupuncturist (L.Ac.), M.D. or D.O.	
Voluntary Second Surgical Opinion	Plan pays 80% of the PPO Eligible Expense; Calendar Year Deductible waived	Plan pays 60% of the Reasonable and Customary Eligible Expenses; Calendar Year Deductible waived

Hearing Aid Benefits

HEARING AID BENEFITS	
Benefit Period	3 calendar years
Deductible	Calendar Year Deductible Waived
Coinsurance	Plan pays 80%
Maximum Benefit Payment Per Person Per Benefit Period	$1,500
Hearing aid benefits include charges for the purchase, fitting, servicing, and repair of the hearing aids. Does not include charges for batteries or the installation/replacement of batteries.	
Charges for the replacement of a hearing aid within the three-year Benefit Period are payable at 80% coinsurance and will be subject to the same $1,500 annual maximum payment per person. The Plan will not cover costs for replacement of hearing aids that are lost or stolen.	

Dental Benefits

DENTAL BENEFITS	
Dental Calendar Year Deductible	$100 per person per calendar year
Preventive Dental Services	Plan pays 100% of Reasonable and Customary Eligible Expenses. Preventive services include prophylaxis, x-rays, exams and fluoride treatments. Benefits for each of these services is limited to once per Calendar Year.
	Prophylaxis (cleanings) for children under age 18 are limited to twice per Calendar Year
Other Dental Services	Plan pays 80% of Reasonable and Customary Eligible Expenses
Maximum Dental Benefit	$2,500 per person per calendar year
	Prophylaxis (cleanings) for children under age 18 are not subject to the $2,500 calendar year maximum benefit
In the event there are various methods for performing the Dental procedures otherwise covered by this Plan, the eligible Dental benefit will be limited to the least expensive method that will produce a professionally adequate result, as determined by the Plan.	

Vision Benefits

VISION BENEFITS	
In-Network Exam and Materials (Lenses and Frames or Contact Lenses)	You pay a $25 copay
In-Network Contact Lens Fitting and Evaluation	Covered in Full
In-Network Allowance for Retail Frames	Plan pays up to $230 (You pay 100% of amounts in excess of $230)
In-Network Allowance for Elective Contact Lenses	Plan pays up to $230 (You pay 100% of amounts in excess of $230)
Out-of-Network Allowances	
Examination	Plan pays up to $45
Single Vision Lenses	Plan pays up to $30
Bifocal and Progressive Lenses	Plan pays up to $50
Trifocal Lenses	Plan pays up to $65
Lenticular Lenses	Plan pays up to $100

VISION BENEFITS	
Frame	Plan pays up to $70
Elective Contact Lenses	Plan pays up to $105

For information about the vision expense benefits provided under the Plan, please refer to the separate booklet from VSP Vision Care which by this reference is incorporated with, and forms a part of, this Summary Plan Description and Amended and Restated Rules and Regulations of the Plan.

If there is a discrepancy between the provisions of this Summary Plan Description and Amended and Restated Rules and Regulations of the Plan, and the provisions of the group vision policy or certificates of insurance produced by the insurer, the actual provisions of the insurer's documents will prevail.

SCHEDULE OF BENEFITS – MEDICARE SUPPLEMENT PLAN

(FOR RETIREES/SPOUSES OVER 65 INCLUDING DISABLED INDIVIDUALS UNDER 65)

Part A	Medicare Benefits	Plan Supplement Benefits
Hospital:	***Medicare Pays***	***The Plan Pays***
Days 1-60	All but the Part A deductible	Part A deductible
Days 61-90	All but 25% of Part A deductible	25% of Part A deductible
Days 91-150	All but 50% of Part A deductible	50% of Part A deductible
Days 151–365	No benefits	80% of the expenses which would normally be considered Medicare Part A Eligible Expenses
Skilled Nursing Facility:	***Medicare Pays***	***The Plan Pays***
Days 1–20	100% of the cost	No benefits
Days 21–100	All but 12½% of Part A deductible	12½% of the Part A deductible

Part B	Medicare Benefits	Plan Supplement Benefits
Medicare Part B Calendar Year Deductible	No benefits	No benefits
Professional Fees	80% of approved Medicare charges	100% of the remainder of approved charges after Medicare pays
Blood	80% of approved amount after the first 3 pints	20% of the first 3 pints; 100% of the remainder of approved charges after Medicare pays

Part B	Medicare Benefits	Plan Supplement Benefits
Private Duty Nursing/Home Health Agency Services	No benefits	80% of the Reasonable and Customary eligible expenses. Limit: $15,000 annual maximum
Outpatient Prescription Drugs *	No benefits	80% of the Reasonable and Customary eligible expenses; $5,000 calendar year maximum; deductible waived
Foreign Hospital, Physician and Medical Care Not Covered by Medicare	No benefits	80% of the Reasonable and Customary eligible expenses for emergency care only (non-emergency care expenses are not covered)
Excess Physician charges (the Difference Between Medicare Part B and Reasonable and Customary)	No benefits **	No benefits **

*** IF YOU PARTICIPATE IN THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM, YOUR PRESCRIPTION DRUG COVERAGE UNDER THIS PLAN WILL TERMINATE.**

**** THIS MAKES IT VERY IMPORTANT THAT BENEFITS BE ASSIGNED AND THAT THE PHYSICIAN AND HOSPITAL ACCEPT THE ASSIGNMENT PRIOR TO SERVICES BEING RENDERED. "BALANCE BILLINGS" ABOVE THE MEDICARE-APPROVED CHARGES ARE NOT COVERED BY THE PLAN AND MUST BE PAID BY THE PARTICIPANT.**

Medicare benefits are subject to change from time to time. Please contact Medicare or visit www.medicare.gov for the most up to date information on your Medicare benefits and coverage. In the event benefits provided under Title XVIII of the Social Security Amendments of 1965 are amended, your Medicare Supplement benefits will be revised accordingly.

ARTICLE I – ELIGIBILITY, EFFECTIVE DATE OF COVERAGE AND TERMINATION DATE

SECTION 1.01. ELIGIBILITY FOR EMPLOYEES

Individuals employed under the jurisdiction of a Collective Bargaining Agreement of U. A. Plumbers Local No. 68 and Non-Bargaining Unit Employees, as allowed by the Trust Agreement, may be eligible for employee coverage. A Participation Agreement must be signed for Non-Bargaining Unit Employees.

Initial Eligibility and Continuation of Eligibility for Provisional Trainees, as defined in the Collective Bargaining Agreement, will be the same as provided for other individuals employed under the Collective Bargaining Agreement. However, the eligible benefits will NOT INCLUDE Dependent Coverage, Life Insurance, Accidental Death and Dismemberment, or Disability Benefits Coverage. Further, on the first of the month after attainment of First Period Apprenticeship, eligibility will be for all benefits, the same as provided other individuals employed under the Collective Bargaining Agreement, including those benefits previously excluded such as Dependent Coverage, and as described in this Article I.

Self-employed persons are not eligible for the benefits provided by the Fund. Contributions will not be accepted from self-employed persons, sole proprietors or partners, neither will they be eligible for benefits under the Plan. Any inadvertent acceptance of contributions from such persons will not give rise to any rights to benefits under the Plan.

Notwithstanding any provision to the contrary, if a covered Non-Bargaining Unit Employee becomes covered through the Collective Bargaining Agreement of U. A. Plumbers Local No. 68, such Employee will be given credit toward satisfying the initial enrollment requirement (a period of 3 non-consecutive months of work in Covered Employment during which time the Employee must have worked a minimum of 240 hours), and will be given credit toward satisfying the requirement for establishing an Hour Bank Account (a period of 3 non-consecutive months in any 15-month period during which an Employee has contributions made to the Fund, on his or her behalf, by Contributing Employers for hours exceeding 120 hours). Such credit will be based on the number of consecutive months the Employee was covered as a Non-Bargaining Unit Employee immediately before becoming covered through the Collective Bargaining Agreement.

For example, a Non-Bargaining Unit Employee with six (6) months of continuous coverage under the Plan becomes covered through the Collective Bargaining Agreement. Such Employee would be considered to have met the initial enrollment requirement under the Plan and will be credited with six (6) months of coverage toward satisfying the requirement for obtaining an Hour Bank Account.

SECTION 1.02. INITIAL ELIGIBILITY

Employees working under the terms of a Collective Bargaining Agreement become eligible on the first day of the month following a period of three non-consecutive months of work in Covered Employment during which time the Employee must have worked a minimum of 240 hours. Such hours also include hours worked in another geographic jurisdiction that have been reciprocated by an employer on behalf of the Employee. Hours worked at contribution rates that differ from the Plumbers Local Union No. 68 construction contribution rate will be credited on a pro-rata basis.

Exception: Non-Bargaining Unit Employees. Coverage for Non-Bargaining Unit Employees begins the month following the month the first employer-contribution is paid in accordance with the Non-Bargaining Agreement, and terminates at the end of the month employment is terminated.

SECTION 1.03. CONTINUATION OF ELIGIBILITY

The eligibility of an Employee will continue on a month-to-month basis provided he or she meets the minimum hours requirement. The minimum hours requirement is 120 hours of work in Covered Employment per month. Employees may meet this requirement on the basis of hours available to him or her from any of the following sources, listed in the order in which they may be utilized:

A. From hours for which contributions have been made by Contributing Employers to the Plan on behalf of the Employee during the immediately preceding month;

B. From hours of Disability Credits which may be applicable to the Employee in accordance with the Disability Credit provisions; and

C. From the Hour Bank Account of the Employee as established in accordance with the Hour Bank Account provisions.

NOTE: For the Disability Benefits Coverage only, an Employee must have been actively-at-work and otherwise eligible for Plan benefits for at least 80 hours during the month prior to the start of the disability.

If an Employee works fewer than 120 hours in a month, the Employee will be permitted to continue coverage by paying the difference between the number of hours worked in the month and 120 hours. This provision applies only during an Employee's first year of coverage under the Plan, and only if such Employee has never had any hours credited to his or her "Hour Bank Account" (Hour Bank Account is described in Section 1.04, below). The required payment will be determined by the Fund Office, and will be a minimum of $100.

SECTION 1.04. HOUR BANK ACCOUNT

Following a period of 3 non-consecutive months in any 15 month period during which an Employee has contributions made on his or her behalf by Contributing Employers to the Plan for hours exceeding 120 hours, the excess hours will be credited to the Employee's individual Hour Bank Account, provided such Employee has not incurred a break in Covered Employment or interruption of eligibility. However, the maximum number of hours that an Employee may accumulate in his or her Hour Bank Account, after deduction for the current month's coverage, is 720 hours.

Hours from the Hour Bank Account that are applied to the Employee's continuing eligibility, in accordance with the continuing eligibility provision, will be considered withdrawn and the Employee's Hour Bank Account will be reduced by the number of hours withdrawn.

Unless the Employee makes continuous timely self-payments to maintain coverage, any hours otherwise remaining to the Employee's credit in his or her Hour Bank Account on the date his or her eligibility terminates under these rules will be considered forfeited and of no future value to the Employee. Such hours may not be re-credited to the Employee's Hour Bank Account in the event he or she again becomes eligible in accordance with either the Initial Eligibility provision or the Reinstatement provision of these Amended and Restated Rules and Regulations, nor may such hours be used for purposes of reinstating eligibility under those provisions. In no event will the Employee's Hour Bank Account balance be subject to forfeiture during a continuous self-payment period and reinstatement of such Employee will be in accordance with the provisions of Section 1.05 of this Article.

Notwithstanding these provisions, the Hour Bank Account of an Employee will be forfeited if he or she engages in employment or self-employment, in the same trade and industry as the Employees covered by the Plan, with an employer who does not contribute to the Plan. Furthermore, an Apprentice who is dropped from the Apprenticeship Program after exhausting all internal appeals, forfeits his/her hour bank.

The Hour Bank Account provisions are subject to change by the Board of Trustees at any time and in their sole discretion.

SECTION 1.05. REINSTATEMENT

In the event an Employee's eligibility for the benefits provided under the Plan terminates as a result of insufficient hours in his or her Hour Bank Account, he or she will be required to continue month-to-month eligibility by making self-payments on a timely basis. Such self-payments must be made commencing with the first month that coverage would otherwise terminate and continue until he or she has worked sufficient hours in Covered Employment to meet the requirements for coverage.

An Employee who has not yet established an "Hour Bank" and is unable to work the required 120 hours per month will be allowed to "Short Pay." Short Pay would allow the Employee to pay the current contribution hourly rate for the difference between hours worked and 120 hours required, with a minimum payment of $100.

Employees who have previously been covered under the Plan and had earned a prior "Hour Bank" will be required to work a total of 240 hours in two consecutive months to gain coverage for the third month at which time the "Hour Bank" will be established.

In the event his or her coverage terminates as a result of the Employee failing to make timely self-payments, the eligibility of the Employee will terminate and he or she will be required to meet the eligibility requirements set forth under Section 1.02 of this Article.

SECTION 1.06. ELIGIBILITY RULES FOR EMPLOYEES OF NEWLY CONTRIBUTING EMPLOYERS

Employees of newly Contributing Employers that enter into a Collective Bargaining Agreement with the Union will be eligible under the following terms and conditions:

A. Initial Eligibility

Employees of a newly Contributing Employer will initially become eligible for one month of coverage under the Plan beginning on the first day of the month following the execution of a Collective Bargaining Agreement, provided such employees were covered under the newly Contributing Employer's health plan on the day prior to the execution of the Collective Bargaining Agreement.

In addition, the following items must be received by the Fund Office prior to the proposed effective date of coverage:

1. A copy of the executed Collective Bargaining Agreement;

2. Proof of coverage under the Contributing Employer's health plan; and

3. A list of all Bargaining Unit Employees of the newly Contributing Employer, including their names, addresses, telephone numbers, and social security numbers.

In order to effect immediate eligibility under the Plan, the Fund will establish a "negative" Hour Bank Account for each Employee. Each Employee will be credited with 240 "negative" hours.

Once an Employee becomes covered for the initial one-month period, his or her continuing eligibility for subsequent months will be determined in accordance with the following subsection.

B. Continuation of Eligibility

To maintain eligibility, Employees are required to work a minimum of 120 hours per month in Covered Employment and Employer contributions must be received by the Fund from the newly Contributing Employer. There is a one-month lag between the time an Employee works and the time the corresponding hours are credited for purpose of his or her continuing eligibility requirements. Thus, hours worked in Covered Employment during an Employee's initial eligibility month will be used to satisfy the eligibility requirements for his or her third month of coverage. Any hours of Covered Employment in excess of 120 hours in a given month will be applied to an Employee's negative Hour Bank Account, in order to credit the original hours advanced to the Employee's Hour Bank Account, until the negative Hour Bank Account reaches zero.

During the period of time that the negative Hour Bank Account is not at zero, if an Employee work less than the required 120 hours in any given month, he or she will be considered to have a COBRA qualifying event, as described in Article XV. In addition, an Employee may only receive Disability Credits and/or disability benefits once his or her negative Hour Bank Account reaches zero.

C. Reinstatement of Eligibility

An Employee who:

1. Fails to work at least the required 120 hours in any given month;

2. Fails to elect continuation coverage under COBRA; and

3. Has not reached zero in his or her negative Hour Bank;

will regain coverage under the Plan only through the initial eligibility rules outlined in this Article I.

D. Newly Hired Employees

Employees hired by a newly Contributing Employer subsequent to the effective date of the Collective Bargaining Agreement with the newly Contributing Employer will be subject to the normal initial eligibility rules of this Plan as outlined in this Article I.

E. Except as stated above, all eligibility rules for Employees of newly Contributing Employers will be the same rules that apply to collectively bargained Employees, including, but not limited to, the rules applicable to the Hour Bank, Termination of Eligibility, and Eligibility Rules for Dependents.

SECTION 1.07. SPECIAL ELIGIBILITY RULES/NON-BARGAINED

Non-Bargained Employees

Non-Bargaining Unit Employees of Contributing Employers may participate in the Plan if their Employer executes a Participation Agreement that provides for their coverage, and the Agreement is approved by the Trustees. Coverage is available only for regular full-time Employees of Contributing Employers who reside in the geographical and work jurisdiction of the Union, and who are not otherwise covered under any Collective Bargaining Agreement that requires contributions for health benefits. Employees hired after the effective date of the Participation Agreement must be added within 60 days.

1. Coverage for Employees not covered by a Collective Bargaining Agreement with Local 68 will begin the month following the month in which the first employer contribution is received by the Fund from the Contributing Employer. The coverage will terminate at the end of the month that employment is terminated. These Employees will not accrue an Hour Bank Account. In order for Non-Bargaining Unit Employees to be eligible for coverage under the Plan, the employer must be signatory to a Collective Bargaining Agreement with Local Union No. 68 and employ the Employees under the Collective Bargaining Agreement unless otherwise allowed by the Trust Agreement and Non-Bargaining Participation Agreement.

2. Employer contributions are due on or before the first day of the month for which coverage is intended. The contributions are considered delinquent if not received by the 10th of the applicable month. A Non-Bargained Employee's coverage will terminate on the last day of the month the Non-Bargained Employee worked for the Contributing Employer.

3. Non-Bargained Employees whose coverage has terminated may be eligible to continue the Hospital, Medical, Dental and Vision benefits provided by the Fund in accordance with the COBRA provisions as set forth in Article XV.

4. All other provisions of the Plan not inconsistent with the foregoing will be applicable for the Non-Bargaining Unit Employees.

SECTION 1.08. DISABILITY CREDITS

An Employee will receive the minimum hours needed to continue coverage under the Plan, not to exceed 12 weeks while receiving short term disability under the Plan, or not to exceed 12 months while receiving Workers Compensation.

SECTION 1.09. RECIPROCITY

After the Employee becomes eligible in accordance with the Initial Eligibility provisions, in the event he or she has contributions made on his or her behalf by an employer bound by a Collective Bargaining Agreement to make such contributions to another trust fund similar to the trust for this Plan, he or she may, upon making written request in accordance with a reciprocal agreement, if any, between the trustees of such other trust and the Trustees of this Plan, will have such contributions transferred from such other trust fund to the trust for this Plan. The transferred contributions will be converted to hours and credited to his or her Hour Bank Account. The number of hours to be credited under this method will be computed by dividing the total dollar amount of all transferred contributions received in connection with periods of employment falling within a working month, by the hourly contribution rate in effect for that month under the terms and provisions of the agreements between Contributing Employers and the Union underlying the trust for this Plan. In the event that the transferred hourly contribution rate is less than the hourly contribution rate in effect for the applicable month under the terms and provisions of the agreements executed between Contributing Employers and the Union that underlies the trust for this Plan, the Employee may contribute an amount equal to such deficiency plus any applicable processing fees assessed by the reciprocating fund. The payment must be made within 10 days of receipt of the deficiency notice. Hours in his or her Hour Bank Account cannot be used to satisfy the aforementioned deficiency.

For purposes of administering the credited hours attributable to an Employee under these provisions, there will be no distinction made between hours credited to the Employee on the basis of contributions made by the Contributing Employer, directly to this Plan, on the Employee's behalf, and hours credited on the basis of contributions transferred on the Employee's behalf from other trust funds, in accordance with these Reciprocity provisions.

SECTION 1.10. TERMINATION OF EMPLOYEE'S COVERAGE

Except as otherwise provided in the Section containing the Disability extension of benefits provisions, an Employee's coverage will terminate on the ***earliest of*** the following dates:

A. The first day of the month during which the Employee fails to meet the minimum hours of work in Covered Employment requirement for continuing eligibility, as specified in this SPD and Amended and Restated Rules and Regulations of the Plan;

B. When the Employee fails to remit required self-payment premium for coverage when due, his or her coverage will terminate at the end of the last period for which the premium payment has been made;

C. The last day of the month in which the Employee leave Covered Employment for qualified military service for a period of more than 30 days, and that is protected

under the federal law known as "USERRA". This rule of termination will not apply if the Employee elect to continue coverage as described in the Section that covers Leaves of Absence for Military Service Article;

D. The day on which the Trustees become aware that an Employee is working in the same trade and industry as the Employees covered by this Plan except that such employment is for a non-Contributing Employer (Competitive Employment);

E. When the Employee ceases to be in a class eligible for coverage;

F. The date on which there are insufficient assets left in the Trust Fund to pay benefits; or

G. The date the Plan terminates.

H. End of the month when an Apprentice is dropped from the Apprenticeship Program after exhausting all internal appeals.

SECTION 1.11. ELIGIBILITY FOR DEPENDENT'S COVERAGE

A. Your Eligible Dependents include your lawful spouse and your eligible child(ren) until the end of the month in which the child(ren) turn 26 years of age. The word "child" or "children" includes natural born children, legally adopted children, children placed in the Employee's home for the purpose of adoption prior to the child's adoption, and stepchildren, provided proper enrollment documentation has been submitted to, and received by, the Fund Office.

B. Dependents become eligible for the benefits provided by the Plan on the earliest of the following dates:

1. Date the Employee becomes eligible for coverage under the Plan, provided that on that date he or she has Eligible Dependents; or

2. Date the Employee acquires an Eligible Dependent through birth, adoption or placement for adoption, provided that on that date the Employee is covered, or is eligible for coverage, by the Plan; or

3. With respect to dependents acquired as a result of the Employee's marriage, the first day of the first calendar month after the date of marriage.

C. In the event a husband and a wife are both eligible to be covered by the Plan as Employees, both will be eligible to cover any Eligible Dependents they might have. Allowable benefits will be subject to the Coordination of Benefits provision.

D. The Fund will comply with the terms and provisions of a Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain a copy of the

procedures that governs qualified medical child support order (QMCSO) determinations from the Fund Office, without charge.

E. In the event a dependent child who is covered under the Plan chiefly depends upon you for support and maintenance and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to be considered an Eligible Dependent after he or she reaches age 26. The child's eligibility will terminate at the ***earlier of*** the following dates:

1. The date the child recovers from the handicap; or

2. The date the child no longer chiefly depends upon you for support and maintenance.

You must submit proof of the dependent child's incapacity to the Fund within 31 days after the date he or she reaches the eligibility age as set forth under the terms of the Plan. The Plan will not request such proof more than once a year after the end of the 2-year period that follows the date the child reaches the eligibility age as set forth under the terms of the Plan.

SECTION 1.12. EFFECTIVE DATE OF DEPENDENT'S COVERAGE

The effective date of coverage for each Eligible Dependent will be the ***later of*** the:

A. Date on which the Employee becomes eligible for Dependent coverage;

B. For a new spouse, the first day of the month following the month in which the Employee and spouse are married, provided that proper enrollment documentation is submitted to, and received by, the Fund Office within 30 days of the marriage. Proper enrollment documentation for a new spouse consists of: a new Enrollment Card with the spouse added; a certified copy of the marriage certificate; or a Declaration and Registration of informal marriage and a completed claim form. If the Fund Office does not receive proper enrollment documentation within 30 days of the marriage, coverage for the new spouse will become effective on the first day of the month following the month in which proper enrollment documentation is received;

C. For a newborn child, the child's date of birth, provided that proper enrollment documentation is submitted to, and received by, the Fund Office within 90 days of the child's date of birth. Proper enrollment documentation for a newborn child consists of: a new Enrollment Card with the child added; a copy of the birth certificate; a copy of the child's Social Security card; and a completed claim form. If the Fund Office does not receive proper enrollment documentation within 90 days of the child's date of birth, coverage for the newborn child will become

effective on the first day of the month following the month in which proper enrollment documentation is received;

D. For a legally adopted child or a child placed in the Employee's home for the purpose of adoption prior to the child's adoption, the child's date of adoption, or date of placement for adoption, respectively, provided that proper enrollment documentation is submitted to, and received by, the Fund Office within 30 days of the child's date of adoption, or date of placement for adoption. Proper enrollment documentation for a newly adopted child, or a child newly placed for adoption, consists of: a new Enrollment Card with the child added; a copy of the birth certificate; a copy of the child's Social Security card; and a completed claim form. If the Fund Office does not receive proper enrollment documentation within 30 days of the child's date of adoption, or date of placement for adoption, coverage will become effective on the first day of the month following the month in which proper enrollment documentation is received;

E. For a new stepchild, the date the child was acquired as a result of marriage, provided that proper enrollment documentation is submitted to, and received by, the Fund Office within 30 days of the marriage. Proper enrollment documentation for a new stepchild consists of: a new Enrollment Card with the child added; a copy of the birth certificate; a copy of the child's Social Security card; and a completed claim form. If the Fund Office does not receive proper enrollment documentation within 30 days of the marriage, coverage will become effective on the first day of the month following the month in which proper enrollment documentation is received; or

F. For a Provisional Trainee's Dependents, the first day of the month following attainment of First Period Apprenticeship and satisfaction of applicable eligibility requirements as set forth in Section 1.11.

SECTION 1.13. TERMINATION OF DEPENDENT COVERAGE

Dependent coverage under the Plan will terminate on whichever of the ***earliest of*** the following events:

A. When the Employee's coverage under the Fund is terminated;

B. When the Employee cease to make any required self-payment premium and or COBRA payment for Dependent coverage;

C. When the Employee ceases to be in a class of Employees eligible for dependent coverage;

D. When the Eligible Dependents cease to meet the definition of a Dependent (when an Eligible Dependent child ceases to meet the definition of a Dependent as a result of turning age 26, coverage for such Eligible Dependent child will continue through the end of the month in which such child turns age 26);

E. When the Eligible Dependents enter the military, naval, or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;

F. When Dependent coverage has been discontinued under the provisions of the Plan; or

G. On the date the Plan terminates.

In the event, prior to, or within, 31 days after reaching the specified age whereby coverage under the Plan would otherwise terminate for an eligible dependent child, and the Employee has opted to continue coverage of the Adult child as an eligible dependent, the Plan must receive proof that substantiate the adult child has been deemed disabled and thereby incapable of earning his or her own living and is dependent upon the Employee for his or her support. In such a case, coverage for the adult child will continue in force provided that the incapacity continues and the Plan remains in full force and effect. The Plan may periodically require the Employee to provide proof of the adult child's continued disability. Such supporting documentation will be submitted to the Trustees for a determination regarding coverage of the adult child. The determination will be made in the sole discretion of the Trustees of the Plan in their sole discretion.

SECTION 1.14. SPECIAL ENROLLMENT

This Plan complies with the federal law regarding Special Enrollment by virtue of the fact that all Employees and their Eligible Dependents are automatically enrolled in the Plan as soon as the eligibility requirements of the Plan are met. There is no option to decline coverage. For more information about Special Enrollment under this Plan, contact the Fund Office.

If you and/or your dependents decline coverage under this Plan because you and/or your dependents are covered under either the State Children's Health Insurance Program ("CHIP") or under Medicaid and you lose eligibility for this coverage or you become eligible for financial assistance under either of these programs, you and your dependents may be able to enroll in the Plan provided that you and your dependents otherwise satisfy all the eligibility requirements described in this Summary Plan Description and Rules and Regulations of the Plan. If you request enrollment in the Plan within 60 days of losing coverage under CHIP, Medicaid, or becoming eligible for financial assistance, coverage will be effective retroactive to the date CHIP or Medicaid coverage terminated, or the date financial assistance was granted.

SECTION 1.15. RETIREES

An Employee who retires under the Plumbers Local Union No. 68 Pension Plan and whose coverage is currently in force upon retirement, may continue coverage by making monthly self-payments until he or she is eligible to be covered by Medicare. In the event the Retiree's Eligible Dependents (who were covered under the Plan at the time of the

Employee's retirement) are not eligible for Medicare, the Retiree may also continue to make self-payments for them until they are either no longer Eligible Dependents or become eligible for Medicare.

Once a Retiree, or Retiree's Eligible Dependent, is eligible for Medicare, the self-payment may continue provided he or she is eligible for, and enrolled in, Medicare Parts A and B. Then, the allowable medical expenses will be based on the primary/secondary position determined by the applicable Medicare rules. The prescription drug coverage for Medicare-eligible Retirees and their Medicare-eligible Eligible Dependents will be through an Employer Group Waiver Plan ("EGWP") contract with the Centers for Medicare and Medicaid Services ("CMS") effective July 1, 2016.

If a Retiree, or a Retiree's Eligible Dependent, chooses to enroll in an individual Medicare Part D prescription drug program, coverage under the Plan for such individual(s) will terminate.

If a Retiree terminates participation in the extended Retiree coverage, there is no “open enrollment” allowed, except as may be specifically designated by the Board of Trustees.

If a Retiree under the Plumbers Local Union No. 68 Pension Plan is eligible to enroll in Retiree coverage and chooses not to enroll at the time of retirement, he or she may elect to enroll (along with his or her Eligible Dependent spouse, provided such spouse was an Eligible Dependent at the time of the Retiree's retirement) and provided this “late” enrollment occurs within 30 days of becoming eligible for and enrolled in Medicare Parts A and B.

If a Retiree chooses not to enroll his Eligible Dependent spouse at the time of retirement, the Retiree may have the opportunity to enroll his or her Eligible Dependent spouse (provided such spouse was an Eligible Dependent at the time of retirement), provided he or she does so within 30 days of the spouse becoming eligible for and enrolled in Medicare Parts A and B.

Retiree coverage is offered as an alternative to COBRA coverage. Once you elect retiree coverage as an alternative to COBRA coverage, you and your Eligible Dependents will not be eligible to elect COBRA coverage upon termination of the retiree coverage. If you would prefer to elect COBRA coverage instead of retiree coverage, please refer to Article XV, “COBRA Continuation Coverage.”

SECTION 1.16. NO RETROACTIVE CANCELLATION OF COVERAGE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

ARTICLE II – LEAVES OF ABSENCE FOR MILITARY SERVICE

If an Employee takes a leave of absence for qualified military service (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard), the Employee's coverage, and coverage for his or her Dependents, under the Plan will continue for the first 30 days of the leave. Thereafter, coverage for the Employee and his or her Eligible Dependents will terminate unless the Employee elects to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To ensure the protection of rights under USERRA, the Employee is obligated to notify the Plan as soon as he or she is called up for military service.

Under USERRA, medical, dental, and vision coverage may be continued for the Employee and his or her Eligible Dependents for the period of the Employee's leave, up to a maximum of 24 months. The Plan will require the Employee to pay for continued coverage. This right to continue coverage will generally be subject to the Plan's payment, notification, and cancellation terms, as well as other administrative procedures, time frames and rules for COBRA coverage.

The Employee will receive eight (8) Military Service Credits for each day served in the armed forces up to a maximum of five years. In no event, however, will he or she be credited with more than 40 such credits in any one week, 120 during any one calendar month, 1,440 during any one Calendar Year or a total of 7,200 credits.

Each of these credits will count as an hour in the same manner as if contributions had been made on the Employee's behalf by a Contributing Employer during successive appropriate periods of time immediately prior to his or her return to active service. Appropriate periods of time for purposes of applying hours to the Employee's credit immediately prior to his or her return to work in covered employment, regardless that the dates on which credits are earned and on which they are applied may not be the same, will correspond to the periods set forth within which the Employee is credited for them.

The eligibility of the Employee will be fully restored as provided by the application of his or her credits to the hours of work requirements in accordance with these provisions.. However, the eligibility of the Employee will not be fully restored prior to the date he or she returns to work in covered employment for the Contributing Employer. Also, in the event the qualified military service of the Employee continues for 12 months or more, for purposes of reinstatement, his or her credits will be deemed as earned within the 12-month period immediately following the date the Employee's eligibility terminated under these provisions due to such qualified military service.

In the event the Employee does not apply to return to work in covered employment with a Contributing Employer within the 90 days required for entitlement of Active Duty Credits, he or she will be considered as not previously eligible under these provisions. In that event, the Employee will be required to meet the Initial Eligibility provisions set forth in Section 1.02 of Article I.

Any hours the Employee has earned and any contributions credited toward his or her eligibility will be protected under USERRA if, when you are discharged (not less than honorably) from military service, you return to work or seek re-employment within the following time periods:

A. If the period of service was less than 31 days, your eligibility will be reinstated on the date you return to work, provided that you return to work at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours); or

B. If the period of service was 31 days or more but less than 180 days, the Employee's eligibility will be reinstated on the day he or she makes application to return to work with an Employer, provided that the Employee make the application 14 days from the date of discharge; or

C. If the period of service was more than 180 days, the Employee's eligibility will be reinstated on the day he or she makes an application to return to work with an Employer, provided that the Employee makes an application within 90 days from the date of discharge.

If you are hospitalized or recovering from an injury caused by military service, these time limits are extended up to two years.

If the Employee does not return to work in Covered Employment or does not seek re-employment in Covered Employment within these time periods, he or she will forfeit his or her credited hours of Covered Employment and contributions.

The above provision notwithstanding, this Plan will comply with all requirements of USERRA and all future amendments to that law. In the event the SPD and Amended and Restated Rules and Regulations of the Plan, by its wording, conflicts with USERRA, then the provisions of USERRA will govern.

ARTICLE III – FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993

In the event the Employee is eligible for the benefits provided by this Plan and eligible for Family and/or Medical Leave, you are entitled to continue the Fund's health care coverage during that period of leave. As explained in the Fund's FMLA Policies and Procedures, your Employer must notify the Fund of the type, and duration, of the Family or Medical Leave that you have requested.

Your Employer must also continue to make contributions to the Fund at the hourly rate specified by the Board of Trustees.

In the event the Employee and his or her Employer meet the requirements explained above, the Employee and his or her Dependents will be eligible for the same benefits they had (or were eligible to receive) immediately before the leave began provided the Employee and his or her Dependents make timely self-payments.

To qualify for a Family or Medical Leave, the Employee must have been employed by the same Contributing Employer during the 12-month period immediately before the beginning of the applicable Family or Medical Leave. In the event the Employee qualifies, he or she may take up to a total of 12 weeks of Family Medical Leave during any 12-month period. The Employee's coverage will continue during the period of leave as though you are still working in Covered Employment.

You may take Family or Medical Leave for any of the following reasons:

A. The birth or care of a newborn child;

B. For the placement of a newly adopted or foster child;

C. For the care of your spouse, son, daughter or parent who has a "serious health condition"; or

D. For a "serious health condition" that causes the Employee to be unable to perform his or her job.

If the Employee takes leave in certain circumstances, such as serious illness, birth of a child, or caring for a seriously ill parent or spouse, the Employee may qualify for leave under the Family Medical Leave Act for up to 12 weeks. The Employee also may be entitled to up to 12 weeks of leave for a qualifying exigency that arises in connection with the military service of a child, spouse, or parent.

If the Employee takes leave to care for a child, spouse, parent or next of kin (i.e., nearest blood relative) who is a member of the Armed Forces and is either undergoing medical treatment or is on a temporary disability retired list as a result of a serious injury

or illness, the Employee may qualify for leave under FMLA for up to 26 weeks during a single year. To qualify, the injury or illness must have been sustained in the line of military duty and rendered the service member medically unfit to perform his or her duties.

In the event the Employee is considering taking a Family or Medical Leave, the Employee must first advise his or her employer of your intentions. For more information regarding Family or Medical Leave, the Employee and/or his or her Employer should contact the Fund Office.

ARTICLE IV – DISABILITY BENEFITS FOR EMPLOYEES

SECTION 4.01. BENEFITS

In the event an Employee works at least 80 hours during the month immediately preceding the onset of a disabling condition, the Plan, upon receipt of due proof that an Employee, while covered for this benefit, became totally disabled due to a non-occupational Illness or Injury, will pay the Employee a disability benefit and, if applicable, an additional hospital confinement benefit.

A. Disability Benefit

The maximum amount of the income benefit payable is 50% of the current Journeyman's hourly cash wage per week, based on a 40-hour week. The maximum benefit period annually for disability is the ***earlier of*** 12 weeks or age 70. The daily benefit for periods less than one week are 1/7th of the weekly benefit.

Benefits begin on the 8th day after the onset of a non-job related Illness or the occurrence of a non-job related accidental Injury.

B. Additional Hospital Confinement Benefit

The maximum amount of the benefit payable is $30 per day of the Hospital stay, and the maximum benefit period for each hospitalization is 12 weeks. Benefits begin on the 8th day of the Hospital stay.

SECTION 4.02. SUCCESSIVE DISABILITIES

Successive disabilities due to the same Illness or Injury, which are related to the cause of a previous disability, will be considered the same disability.

SECTION 4.03. LIMITATIONS

This Plan will **not** pay any disability benefits:

A. During which the Employee is not under the direct care and treatment of a Physician;

B. Due to a self-caused Illness/Injury or an Injury during the commission of, or the attempt to commit, a felony.

SECTION 4.04. EXTENSION OF BENEFITS DUE TO A DISABLING CONDITION

In the event the coverage of an Employee under the Plan terminates while he or she is Totally Disabled, the Plan will pay a Disability Benefit as though coverage under the Plan had not terminated, as long as the Total Disability remains continuous and uninterrupted, but not beyond the **earlier of** expiration of the maximum benefit period of 12 weeks or age 70.

ARTICLE V – MEDICAL DEDUCTIBLE AMOUNTS, PLAN MAXIMUMS AND OUT-OF-POCKET LIMITS

SECTION 5.01. DEDUCTIBLE AMOUNTS

A. Calendar Year Deductible

For each Calendar Year, the Deductible Amount applies to the total of the PPO Allowed Amounts and/or Reasonable and Customary Non-PPO Eligible Expenses for covered Medical expenses during such Year.

The Deductible Amount is shown in the Schedule of Benefits beginning on page 8. When a family has satisfied the Family Deductible Amount, shown in the Schedule of Benefits, each other family member will be considered as having satisfied his or her Deductible for that Calendar Year. However, any Deductible Amounts previously applied towards the other family members' Calendar Year Deductibles will not be eligible for retroactive benefit consideration by the Plan.

B. Outpatient Emergency Room Deductible

In the event an Employee and/or Eligible Dependent receives treatment in a Hospital's Emergency Room, an additional $100 Non-Emergency Deductible amount will be applied to the PPO that the Employee must meet before the Plan pays on any of the covered benefits..

In the event a Hospital stay occurs in conjunction with such Emergency Room visit, the additional Deductible amount will be waived.

SECTION 5.02. COMMON ACCIDENT

In the event two or more covered members of a family incur PPO Allowed Amounts and/or Reasonable and Customary Non-PPO Eligible Expenses due to an accidental injury received in the same accident, the Deductible Amount will apply only once for all such PPO Allowed Amounts and/or Non-PPO Reasonable and Customary Eligible Expenses in that plan year.

SECTION 5.03. ANNUAL MAXIMUMS

PPO Eligible Expenses and Non-PPO Reasonable and Customary Eligible Expenses are subject to the following annual maximums:

A. Up to a maximum of 24 chiropractic visits;

B. Up to a maximum of 24 visits for acupuncture treatment; and

C. $15,000 per person for private duty nursing and/or Home Health Agency services.

SECTION 5.04. LIFETIME MAXIMUMS

PPO Allowed Amounts and Reasonable and Customary Non-PPO Eligible Expenses are subject to the following lifetime maximums:

A. $2,000 per person for charges attributable to the inpatient Hospital surgical treatment of the temporo-mandibular joint;

B. $400 per person for charges attributable to vaccinations to prevent infection due to human papillomavirus (HPV); and

C. $400 per person for charges attributable to vaccinations against herpes zoster or "shingles."

SECTION 5.05. OUT-OF-POCKET LIMITS

When an Employee or Eligible Dependent incurs and pays $7,350 in PPO Eligible Expenses, after the Deductible Amount, in any one plan year, the percentage payable for PPO Eligible Expenses changes to 100% for the remainder of the applicable year. When an Employee or Eligible Dependent incurs and pays $27,400 in non-PPO Eligible Expenses, after the Deductible amount, in any one plan ear, the percentage payable for non-PPO Eligible Expenses changes to 100% for the remainder of the year.

For purposes of calculating out-of-pocket maximum amounts, there are separate in-network (PPO) and out-of-network (non-PPO) out-of-pocket limits. The in-network and out-of-network out-of-pocket limits are NOT interchangeable. Amounts applied to the in-network out-of-pocket limit may NOT be applied to the out-of-network out-of-pocket limit and vice versa.

ARTICLE VI – PRE-ADMISSION CERTIFICATION

Before an Employee or an Eligible Dependent is admitted to a Hospital for any reason other than emergency, he or she must be sure to have the Employee or Physician telephone for pre-admission certification **PRIOR TO** the commencement of an inpatient Hospital confinement. In the case of hospitalization resulting from an emergency visit, admission certification should be obtained within 72 hours of the start of such hospital stay, or by the next working day if the admission occurred over a weekend or on a holiday.

The Employee or Physician must pre-certify all non-emergency Hospital stays and certify all emergency Hospital admissions within 72 hours of the first day of the stay (or the next working day if the admission occurs over a weekend or on a holiday). If the Employee or Physician does not pre-certify/certify a Hospital stay, benefits payable by the Plan for covered Hospital services will be subject to BCBS sanctions for PPO and reduced 50% to a maximum of $1,000 for NON-PPO, for the entire stay.

In the event that an Employee or Eligible Dependent continues a certified Hospital stay beyond the number of days certified as Medically Necessary, no benefits will be paid for the additional days.

Any function performed by the Plan for medical review, as described herein, may be performed by an agency or organization specifically designated by the Plan for this purpose. Any functions performed by such agency or organization will be considered functions performed by the Plan.

The Medical Review Organization ("MRO")will notify, in writing, the patient's attending Physician, the patient or his or her family, and the Hospital that a "Medical Review Request" has been made. In addition, the MRO will advise these individuals and entities, in writing, of the number of days of the Hospital inpatient stay considered necessary for treatment of the patient's diagnosed Illness or Injury.

The attending Physician of the patient may at any time request that the MRO re-evaluate or extend the number of days of the Hospital inpatient Hospital stay that has been determined to be Medically Necessary for treatment of the patient's diagnosed Illness or Injury.

In the event an Employee or Eligible Dependent, subsequent to obtaining the required pre- or post-admission Hospital certification; continues an inpatient stay beyond the number of days certified as medically necessary, no benefits will be paid by the Plan for the additional days.

ARTICLE VII – MEDICAL EXPENSE BENEFITS

Medical Expense benefits are payable for Employees and Eligible Dependents covered under the Plan.

SECTION 7.01. ELIGIBLE EXPENSES

The Plan will pay the claim for Eligible Expenses in accordance with the provisions described in this Article and in the Schedule of Benefits, subject to all Plan provisions. All payments will be subject to applicable limitations and exclusions as provided under the terms of the Plan.

The expenses billed to the Plan for the covered benefits are called "Eligible Expenses." Eligible Expenses are determined by the Plan or its designee, and are limited to those that are:

A. "Medically Necessary" (as defined in the "Definitions" Article of this document);

B. Not services or supplies that are excluded from coverage (as provided in the "Limitations and Exclusions" Article of this document);

C. Not services or supplies in excess of any applicable limit and/or annual maximum benefit as set forth in the Schedule of Benefits;

D. Not services or supplies provided in connection with a job-related Illness or Injury; and

E. For the diagnosis or treatment of an Injury or Illness (except where wellness/preventive services are payable by the Plan).

Generally, the Plan will not reimburse the Employee or Eligible Dependent for all Eligible Expenses. Usually, he or she will have to satisfy any applicable Deductibles and Coinsurance toward the Eligible Expense amount incurred.

SECTION 7.02. NON-ELIGIBLE EXPENSES

The Employee, or Eligible Dependent, is responsible for paying the full cost of any expenses that are determined to be: (a) not Medically Necessary; (b) in excess of the PPO Allowed Charge or Reasonable and Customary Eligible Expense; (c) not covered by the Plan; (d) in excess of any applicable limit; or (e) payable on account of a penalty because of failure to comply with the Plan's Utilization Management requirements.

SECTION 7.03. COVERED MEDICAL EXPENSES

The following are covered medical expenses under the terms of the Plan:

A. Physician Services

1. Professional services provided by a health care provider in an office, Hospital, Emergency Room, urgent care facility, or other covered health care facility.

2. Assistant surgeon fees for Medically Necessary services, but only up to a maximum of 20% of the Eligible Expenses payable to the primary surgeon (17% if the surgical assistant is not a Physician). No benefits will be paid for services rendered by a surgical assistant who is not licensed in the state where the surgery was performed.

3. Office visit with a health care provider for a voluntary second surgical opinion obtained prior to elective surgery.

4. Multiple Surgical Procedures.

   When more than one surgical procedure is performed through the same incision or operative field, or at the same operative session, the Plan will determine which surgical procedures will be considered separate procedures and which will be considered included as a single procedure for the purpose of determining benefits. When the procedures are considered separate procedures, the following percentages of the Allowed Charge will be paid as a Covered Benefit: 100% of the Allowed Charge for the most costly procedure, plus 50% of the Allowed Charge per procedure for the secondary and additional procedures.

B. Preventive Services

1. Routine physical examination, including laboratory expenses, annually for Employees and Eligible Dependents between the ages of 3 to 18, once every five (5) Years for Employees and Eligible Dependents between the ages of 19 and 39, and once every year for Employees and Eligible Dependents who are 40 years of age or older up to a maximum benefit payment of $400.

2. Physician's examination fee and radiology charges for an annual mammogram.

3. Physician's examination fee and laboratory charges for an annual pap smear that is performed as a preventive measure.

4. Physician's fee for an annual prostate examination or the charges made by a laboratory for a prostate-specific antigen (PSA) blood test.

5. Routine Sigmoidoscopy once every three (3)years for individuals who are at least 45 years of age, up to a maximum benefit payment of $250.

C. Vaccinations / Immunizations

1. Vaccinations to prevent infection due to human papillomavirus (HPV) for Employees and Eligible Dependents. Eligible Expenses include the vaccines and the physician office visits during which the vaccines are administered. Limit: $400 per person per lifetime.

2. Vaccination against herpes zoster or "shingles" for Employees and Eligible Dependents ages 50 and older, as well as Employees and Eligible Dependents of any age for whom the vaccination is recommended, by a physician, in connection with diabetic neuropathy. Eligible Expenses include the vaccine and the physician office visit during which the vaccine is administered. Limit: $400 per person per lifetime.

3. Tetanus or Tdap (Tetanus, diphtheria, and pertussis) shot once every 10 years.

4. Pneumococcal shot once every six (6) years.

5. Influenza shot once each year.

6. Hepatitis B immunization.

7. Meningitis immunization.

8. Immunizations and associated Physician's office visits for Eligible Dependent children up to age 14 for the listed immunizations that are based upon, but not restricted to, the time frames specified below:

   a. Birth - Hepatitis B vaccine (HBV);

   b. 1 to 4 months - second dose of Hepatitis B vaccine;

   c. 2 months - Diphtheria, tetanus and pertussis vaccine (DTaP) and Haemophilus influenza type B vaccine (Hib), Inactivated poliovirus vaccine (IPV) and Pneumococcal conjugate vaccine (PCV);

   d. 4 months - DTaP, Hib, IPV and PCV;

   e. 6 months - DTaP, Hib and PCV;

   f. 6 to 18 months - HBV and IPV;

g. 12 to 15 months - Hib, MMR (measles, mumps and rubella) and PCV;

h. 12 to 18 months - Varicella (chicken pox);

i. 15 to 18 months - DTaP;

j. 4 to 6 years - DTaP, MMR and IPV;

k. 11 to 12 years - Tetanus booster (Td); and

l. 12 to 14 years - such other immunizations as may be required by law but have not otherwise been received prior to the Dependent child's 14th year.

D. Laboratory Services (Outpatient)

Technical and professional fees for laboratory services ordered by a health care provider.

E. X-Rays (Outpatient)

X-ray treatments and X-ray examinations when recommended by the attending Physician;

F. Diagnostic Imaging (Outpatient)

1. Computed tomography (CT), also known as a computerized axial tomography (CAT) scan, including CT angiography;

2. Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

3. Positron emission tomography, also called PET imaging, PET scan, or PET-CT when it is combined with CT.

G. Prescription Drugs (Including Diabetic Supplies)

1. Generic drugs, preferred brand name drugs and non-preferred brand name drugs.

2. If the Employee or Eligible Dependent chooses a preferred brand or non-preferred brand drug instead of its generic equivalent, he or she must pay the applicable brand coinsurance plus a penalty. The penalty is the difference in cost between the brand and generic medications. This

penalty applies even if your doctor writes “dispense as written” (DAW) on the prescription.

H. Ambulatory (Outpatient) Surgical Facility Services

1. Outpatient surgery and/or testing.

2. Anesthesia and its administration.

3. Treatment received at a free-standing surgical facility for services performed and charges submitted by a Hospital for the use of the surgical room, provided the service performed would have been covered if performed as a Hospital inpatient service. Services must be rendered within 24 hours from, and in connection with, a surgical procedure, or in the case of diagnostic procedures within seven (7) consecutive days before the procedure, but not including services of a Physician or private nurse.

I. Emergency Room (ER) Services

1. Hospital ER facility services for a Medical Emergency.

2. Ancillary services (such as laboratory or x-ray) performed during the ER visit.

Expenses for ER services are covered only when those services are for a “Medical Emergency,” as that term is defined in the “Definitions” Article.

J. Ambulance Services

1. Local ground transportation to the nearest appropriate facility for treatment of a Medical Emergency or acute Illness, or for an inter-health care facility transfer;

2. Local ground transportation for a Covered individual who is Inpatient and needs to be transported to another Hospital or facility to obtain necessary specialized diagnostic and/or therapeutic services, provided each of the following criteria are met:

a. The patient’s condition is such that use of any other method of transportation is contraindicated;

b. The services are not available where the Covered Individual is an Inpatient; and

c. The Hospital furnishing the services is the nearest one with such facilities.

3. Local ground transportation for a patient from a Hospital or other facility to home or another facility (such as a Skilled Nursing Facility) when the patient cannot be safely transported in another way without endangering the Participant's health.

   Expenses for ambulance services are covered only when those services are for a Medical Emergency as that term is defined in the "Definitions" Article. In addition, the ambulance service must be licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

K. Urgent Care Services

1. Urgent care facility services for an urgent medical condition;

2. Ancillary services (such as laboratory or x-ray) performed during the urgent care visit.

L. Preadmission Testing (Outpatient)

Laboratory tests, x-rays, and other tests performed on an outpatient basis prior to a scheduled Hospital admission or outpatient surgery.

M Hospital Services (Inpatient)

1. Room and board facility fees in a semi-private room with general nursing services.

2. Private room charges in excess of the semi-private room rate only if a private room is Medically Necessary or if the facility does not provide semi-private rooms (reimbursement based on the Hospital's lowest rate for private accommodations).

3. Specialty care units (e.g., intensive care unit, cardiac care unit).

4. Laboratory, x-ray, and diagnostic services.

5. Related Medically Necessary ancillary services (e.g., prescription drugs and supplies administered while hospitalized).

6. Newborn care.

The Employee and/or Physician must pre-certify all non-emergency Hospital stays and certify all emergency Hospital stays within 72 hours of the beginning of

the stay (or the next working day if the admission occurs over a weekend or on a holiday). If you do not pre-certify/certify a Hospital stay, benefits for covered Hospital services will be subject to a 50% co-insurance payment by the Employee. In addition, benefits for covered Hospital services will be limited to a maximum of $1,000 for the entire stay.

N. Mental Health Services

1. Inpatient Hospital services as described above under “Hospital Services (Inpatient).”

2. Residential Treatment Center services.

3. Partial Hospitalization services.

4. Intensive Outpatient treatment.

5. Outpatient office visits.

Benefits for mental health services will be provided in “parity” with medical/surgical services, in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

O. Maternity Services

1. Hospital and health care provider fees for maternity services.

2. Charges made by a Birthing Center provided the Employee or Eligible Dependent spouse:

   a. Utilizes a Birthing Center that offers their services on the basis of a total cost price package;

   b. Submits acceptable documentation to the Plan that the stay was pre-arranged; and

   c. Barring complications that result in the transfer to inpatient stay in a Hospital, the eligible individual remains in the Birthing Center no more than 24 hours.

3. Charges made by a Nurse Mid-Wife, provided he or she is qualified as a certified Nurse Mid-Wife, as described in the “Definitions” Article, but only for services rendered in a Birthing Center.

Pregnancy-related care is covered for a female Employee or Eligible Dependent Spouse only. ***No coverage is provided for maternity or delivery expenses of Eligible Dependent children.***

Hospital Length of Stay for Childbirth: This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section, or requiring a Health Care Provider to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

P. Private Duty Nursing / Home Health Agency Services

1. Private duty nursing and/or Home Health Agency care, prescribed by the attending Physician, and performed by a Registered Nurse (RN). If an RN is not available, as certified by the attending Physician, benefits will be provided for the services of a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN), but only for nursing duties and excluding all domestic activities.

2. Any services of a qualified Home Health Agency with the exception of meals, personal and comfort items and housekeeping services.

Q. Outpatient Physical Therapy Services

Short-term, active, progressive rehabilitation performed by licensed or duly qualified therapists, as ordered by a Physician.

There must be reasonable expectation that the therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable period of time. Maintenance Therapy is not covered by the Plan;

R. Extended Care Facility Services

Services and supplies ordered by a health care provider and provided by an extended care facility (also called Skilled Nursing Facility, subacute care facility or long term acute care facility).

Extended Care Facility Services must meet the following criteria:

1. The stay must begin after a Hospital stay of three or more consecutive days and within 14 consecutive days of termination of that Hospital confinement; and

2. The attending Physician must certify that 24-hour nursing care is necessary for recuperation from the Illness or Injury that required the initial confinement (payment will continue only if the attending Physician certifies such confinement remains necessary for recuperation).

3. You must pre-certify all non-emergency Extended Care Facility confinements and certify all emergency Extended Care Facility confinements within 72 hours of the commencement of the confinement (or the next working day if the admission occurs over a weekend or on a holiday). If you do not pre-certify/certify an Extended Care Facility confinement, benefits for covered Extended Care Facility services will be reduced to 50% co-insurance. In addition, benefits for covered Extended Care Facility services will be limited to a maximum of $1,000 for the entire confinement.

4. For properly certified Extended Care Facility confinements, if you or your Eligible Dependent remains in the Extended Care Facility beyond the number of days certified as Medically Necessary, services provided during this period will **not** be covered

S. Durable Medical Equipment (DME)

1. Rental of DME, but only up to the allowed purchase price of the DME.

2. Purchase of the standard model of DME.

3. Repair, adjustment, servicing or Medically Necessary replacement of the DME only if needed due to a change in the patient's physical condition, or if replacement is likely to cost less than repair.

4. Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.

5. DME over $200 must have a predetermination

T. Spinal Manipulation (Chiropractic) Services

Spinal manipulation services including related ancillary services (e.g., office visits, x-rays, physical therapy, diagnostic tests)(maximum 24 visits per calendar year).

U. Acupuncture Services

1. Acupuncture services when used in pain management, or as otherwise prescribed by a Physician(maximum 24 visits per calendar year).

2. To be covered, acupuncture must be performed by:

   a. A Physician (MD or DO) with proper credentials to perform acupuncture in the state in which he or she is licensed; or

   b. An acupuncturist who is properly licensed by the state in which he or she is practicing, provided the services are within the scope of that license, or where licensing of an acupuncturist is not required. The acupuncturist must be certified by the National Certification Commission for Acupuncturists (NCCA).

V. Reconstructive Surgery

Reconstructive surgery, but only if it is solely intended to improve bodily function or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.

W. Breast Reconstruction after Mastectomy

If the Employee or his or her Eligible Dependent is receiving benefits in connection with a mastectomy and elect breast reconstruction in connection with the treatment, coverage is provided for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

X. Blood Products/Transfusions

1. Blood transfusions where blood is un-replaced.

2. Blood plasma.

Y. Corrective Appliances (Prosthetic & Orthotic Devices)

1. Rental of Prosthetic and Orthotic Devices, but only up to the allowed purchase price of the device.

2. Purchase of the standard model of a Prosthetic or Orthotic Device.

3. Repair, adjustment, or servicing of a Prosthetic or Orthotic Device, or replacement of the device due to a change in the Participant's physical condition or if the device cannot be satisfactorily repaired.

Z. Hospice Care Services

Hospice care services, including Inpatient Hospice care and Outpatient home Hospice care, for terminally ill persons assessed to have a life expectancy of six (6) months or less.

AA. Transplants (Organ and Tissue)

1. Services directly related to the following non-experimental transplants of human organs or tissue, including facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies:

   a. Bone Marrow/Peripheral Blood Stem Cell;

   b. Heart;

   c. Heart/Lung;

   d. Kidney;

   e. Kidney/Pancreas;

   f. Liver;

   g. Lung;

   h. Pancreas.

2. Charges related to the transplantation of tissue and/or an organ includes:

   a. patient screening;

   b. tissue and/or organ procurement;

   c. transportation of the tissue and/or organ, patient and/or donor;

   d. surgery for the patient and donor;

   e. follow-up care in the home or a Hospital;

   f. immuno-suppressant drugs.

The recipient and/or donor must be admitted to a transplant center program in a major medical center approved by either the Federal government or the appropriate state agency of the state in which the center is located.

BB. Temporo-Mandibular Joint (TMJ) Dysfunction Services

Temporo-mandibular joint (TMJ) dysfunction services are covered only in connection with an inpatient surgical hospitalization.

CC. Clinical Trials

1. If the covered individual is eligible to participate in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition, the Plan will not:

   a. deny you participation in the trial;

   b. deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items and services otherwise covered by the Plan that are furnished in connection with participation in the trial; and

   c. discriminate against the covered individual because of his or her participation in the trial.

2. The Plan will deem you eligible to participate in the trial if:

   a. The covered individual's health care provider is a contracted preferred network provider participating in this Plan, and that provider has concluded that your participation in the trial would be medically appropriate; or

   b. You provide medical and scientific information establishing that your participation would be medically appropriate.

3. Routine patient costs do not include the following:

   a. The investigational item, device, or service, itself;

   b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

   c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. If one or more of the Plan's contracted preferred network providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a contracted preferred network provider, if the provider will accept you as a participant in the trial.

5. An "Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is funded or approved by the federal government, conducted under an investigational new drug application reviewed by the federal Food and Drug Administration, or a drug trial exempt from having such an investigational new drug application.

6. A "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

ARTICLE VIII – DENTAL BENEFITS

Dental Expense Benefits are payable for Employees and Eligible Dependents.

SECTION 8.01. DENTAL BENEFITS

The Plan will pay Eligible Dental Expenses incurred by the Employee and/or Eligible Dependent that exceed the expenses applied toward satisfying the Deductible Amount, if any. Eligible Dental expenses will be limited to the least expensive method of performing a procedure provided such method achieves a professionally adequate result as determined by the Plan.

SECTION 8.02. DEDUCTIBLE AMOUNT

An additional $100 per person Deductible will be applied once each year to eligible Dental expenses that have been incurred by Employees and/or Eligible Dependents.

SECTION 8.03. COINSURANCE PERCENTAGE

After satisfying the Deductible Amount, the Plan will pay 100% of the following Dental expenses: Work must all be completed on the date of service.

A. Oral examination;

B. X-rays;

C. Prophylaxis (Cleaning); and

D. Fluoride treatment.

SECTION 8.04. ELIGIBLE DENTAL EXPENSES

Eligible Dental expenses are subject to the following provisions:

A. The expenses will not be excluded or otherwise limited by other provisions applicable to this coverage.

B. The expenses will be a Reasonable and Customary charge within the area for the services rendered, procedures performed and/or supplies furnished.

SECTION 8.05. MAXIMUM DENTAL BENEFITS

The maximum amount of benefits payable for all services, procedures and/or supplies for any benefit period for an Employee or Eligible Dependent will be $2,500 per person per year. However, prophylaxis (cleanings) for children under age 18 are not limited to

the once-per-year requirement neither are those expenses subject to the annual $2,500 maximum.

SECTION 8.06. GENERAL INFORMATION

A. Method of Payment

Generally, payment will be made directly to the Dentist of the Employee and/or Eligible Dependent. Only one payment will be made for a course of treatment and will be made upon completion of the treatment by the Dentist.

B. Exclusions

No claim will be paid on charges for which an Employee or Eligible Dependent is not otherwise required to pay, charges that would not have been made in the event this Plan did not exist, or charges for expenses incurred for any of the following

1. On account of or in connection with:

    a. Charges made by other than a Dentist or charges for treatment by other than a Dentist, except for prophylaxis, provided such treatment is otherwise covered by this Plan and which may also be performed by a licensed dental hygienist working under the supervision of a Dentist;

    b. Prosthetic devices (including bridges and crowns) and the fitting of such devices ordered for an individual prior to his or her becoming covered under this Plan; or

    c. Illness or accidental Injury for which the Employee or Eligible Dependent is otherwise entitled to benefits under any Workers' Compensation Law or Act.

2. For services, procedures and/or supplies to the extent that, in the absence of this benefit, would be Eligible Expenses reimbursable in full, or in part, under other coverage provided by this or any other benefit otherwise provided by this Plan or pursuant to a contract of insurance issued by an insurance company. Payment for these expenses will be made under this benefit first, and any excess, exclusive of amounts not reimbursable due to applicable co-insurance requirements, would be eligible Dental expenses if the expenses otherwise qualify.

ARTICLE IX – VISION BENEFITS

Vision Benefits are payable for Employees and Eligible Dependents

For information about the vision benefits provided under the Plan, please refer to the separate booklet from VSP® Vision Care, which by this reference is incorporated with, and forms a part of, this Summary Plan Description and Amended and Restated Rules and Regulations of the Plan.

If there is a discrepancy between the provisions of this Summary Plan Description and Amended and Restated Rules and Regulations of the Plan and the provisions of the group vision policy or certificates of insurance produced by the insurer, the actual provisions of the insurer's documents will prevail.

ARTICLE X – LIMITATIONS AND EXCLUSIONS

No payment will be made under this Plan for expenses incurred in connection with any of the following:

A. Hospital stays, treatments, services, procedures and/or supplies if not recommended and approved by a Physician.

B. Hospital stays, treatments, services, procedures and/or supplies while an Employee or Eligible Dependent is not under the regular care and treatment of a Physician.

C. Expenses arising out of, or in the course of, employment (including self-employment) if the Injury or Illness is subject to coverage, in whole or in part, under workers' compensation or Occupational Disease or similar law. This applies even if the person is not covered by workers' compensation.

D. Illness contracted or accidental Injury sustained while on duty with any military, naval, or air force of any country or international organization unless otherwise required by the provisions of USERRA, or other similar law.

E. Cosmetic surgery, except for treatment by a Physician within six consecutive months following an Injury to correct a condition that resulted from an accident (unless the Physician recommends a delay beyond the 6-month period for correction of a condition), or in connection with reconstructive surgery as required by the Women's Health and Cancer Rights Act of 1998.

F. Procedures such as, but not limited to, radial keratotomy, Automated Lamellar Keratoplasty (ALK), Laser In-Situ Keratomileusis (LASIK), and similar procedures, or for implantable contact lenses.

G. Alcoholic disorders or disorders caused by any type of drug and/or substance misuse.

H. Functional nervous disorders of any type(excluding conditions covered under the Mental Health Parity and Addiction Equity Act).

I. Obstetrical procedures or treatment of maternity-related expenses incurred by a dependent child.

J. Attempted suicide or intentionally self-inflicted injury, intentional or unintentional drug overdose or the commission of, or the attempt to commit, a felony, unless any such action arises as a result of a physical or mental health condition or as a result of domestic violence.

K. Any charges for Hospital room and board or other services, procedures and/or supplies furnished by a Hospital that are incurred on any day of a patient's inpatient Hospital stay which extends beyond the number of days of inpatient Hospital stay determined by the Hospital review organization to be Medically Necessary.

L. Durable Medical Equipment in excess of $200 without pre-determination of benefits through the Fund Office.

1. The Fund shall not cover the repair or replacement of any Durable Medical Equipment unless the replacement is as a result of a change in the physical condition of an Employee or Eligible Dependent, or the physical growth of an Eligible Dependent child; and

2. Regardless of whether there has been a change in the physical condition of an Employee or Eligible Dependent or the physical growth of an Eligible Dependent child, the Fund shall not consider replacing an item of Durable Medical Equipment more frequently than once during a 5-year period.

M. Non-emergency Hospital admissions on a Saturday, a Sunday or a holiday.

N. Expenses for treatment related to gender reassignment (sex change) procedures.

O. Treatment of impotency.

P. Reversal of any sterilization procedure.

Q. Promotion of fertility, including but not limited to:

1. Fertility testing;

2. Attempts to cause pregnancy by hormone therapy, artificial insemination, in-vitro fertilization, embryo transfer or any other similar treatment or method.

R. In connection with obesity shall include, but not be limited to, charges attributable to Physicians, RNs, LVNs, LPNs, surgical procedures such as hypnosis, liposuction, gastric bypass or gastric bubble, bariatric clinics, health clubs, exercise equipment, weight-control and/or loss programs, diet foods, over-the-counter or prescribed drugs and/or medications.

S. In connection with smoking cessation and/or tobacco withdrawal shall include, but not be limited to, charges attributable to drugs, medicines or devices such as nicotine gum and/or patches.

T. Charges attributable to drugs that have not been prescribed in writing by a Physician and/or approved by the FDA.

U. Any portion of an expense that exceeds the PPO Allowed Charge or exceeds Reasonable and Customary charges.

V. Charges attributable to the services provided by an Assistant Surgeon/Surgical Assistant in excess of:

1. For Assistant Surgeons who are Non-PPO Physicians: 100% of the Medicare allowable amount;

2. For Assistant Surgeons who are PPO Physicians: 20% of the primary PPO Surgeon's Eligible Expense; or

3. For Assistant Surgeons who are not Physicians: 17% of the Primary Surgeons Eligible Expense.

W. Expenses for services or supplies for which a third party is required to pay.

X. Expenses for medical services or supplies determined by the Plan to be Experimental or Investigational.

Y. Expenses for construction or modification to a home, residence, or vehicle, including construction of ramps, handrails, chair lifts, hot tubs, air filtration, swimming pools, etc.

Z. Expenses that the covered individual is not required to pay or for which there would be no charge if the individual were not covered under this Plan.

AA. Expenses for physical examinations and testing required for employment, government purposes, insurance, school, camp, recreation, sports or by any third party.

BB. Expenses for services provided by the parent, Spouse, sibling (by birth or marriage) or child of the Employee or Eligible Dependent.

CC. Expenses for the services of a medical student, intern, fellow or resident.

DD. Expenses for a Health Care Provider who did not directly provide or supervise medical services, even if the Health Care Provider was available on a stand-by basis.

EE. Expenses for telephone calls between a health care provider and patient, other health care provider, utilization management company or representative of the Plan.

FF. Expenses incurred as a result of an Injury or Illness due to an act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.

GG. Expenses related to complications of a non-covered Illness or Injury.

HH. Expenses for acupressure.

II. Expenses for hypnosis, hypnotherapy, and biofeedback.

JJ. Expenses for services related to:

1. Dyslexia, learning disorders, and educational delays, including tests and related expenses to determine the presence or degree of such condition;

2. Court-ordered mental health care services or custody counseling; and

3. Marriage/couples/family counseling.

KK. Expenses for supplies that are considered disposable and limited to use by a single person or one-time use, including bandages, diapers, soap, cleansing solutions, etc.

LL. Expenses for Custodial Care.

MM. Expenses for oral surgery to remove teeth, gingivectomies, and root canals, except that coverage is provided for oral surgery to remove tumors, cysts, and abscesses.

NN. Expenses for foods and nutritional supplements, including formulas, diet foods, vitamins, herbs, and minerals (even if they require a prescription), except foods and nutritional supplements provided during covered hospitalization.

OO. Expenses for childbirth education and Lamaze classes.

PP. Expenses for job training and educational or vocational rehabilitation.

QQ. Expenses for massage therapy.

RR. Expenses incurred for inpatient rehabilitation for an individual who is comatose, or otherwise incapable of conscious participation in the therapy.

SS. Expenses for speech therapy to treat speech impediments, stuttering, lisping, stammering, etc.

TT. Expenses for treatment of delays in childhood speech development unless as a direct result of an Injury or surgery.

UU. Expenses for medical or surgical treatment of obesity, including gastric bypass, weight loss programs, etc., even if treatment is for a co-morbid or underlying health condition.

VV. Expenses for health club memberships, physical fitness programs, and exercise equipment.

WW. Expenses for partial hospitalization for the treatment of substance abuse.

ARTICLE XI – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

SECTION 11.01. ESTABLISHMENT OF HRA

A. Effective January 1, 2009, a Health Reimbursement Arrangement was established under the Plan. A Health Reimbursement Arrangement (HRA) is an Employer-funded health care reimbursement account that allows Employees to obtain reimbursement of Eligible HRA Expenses on a nontaxable basis.

B. The HRA is intended to qualify as a medical reimbursement plan under §105 and §106 of the Internal Revenue Code ("Code"), and regulations issued thereunder, and as an HRA, as defined under IRS Notice 2002-45, and will be interpreted and administered in accordance with the requirements set forth therein. Eligible HRA Expenses reimbursed under the HRA are intended to be eligible for exclusion from the Employee's gross income under Code §105(b).

C. The Plan will establish and maintain an HRA account with respect to each covered Employee but will not create a separate fund or otherwise segregate assets for this purpose. The HRA accounts will be merely record-keeping accounts with the purpose of keeping track of contributions and available reimbursement amounts for the participating Employee.

SECTION 11.02. ELIGIBILITY TO PARTICIPATE

A. An employee is generally eligible to participate in the HRA if the employee:

1. Is a covered Employee under the Plan as of January 1 of a given year (does not include a self-employed individual as defined in Code Section 401(c));

2. Has been continuously covered under the Plan for the six months prior to January 1; and

3. Does not engage in "competitive employment." Competitive employment means work for a non-Contributing Employer in the same trade and industry as the Employees covered by this Plan.

B. An Employee's participation in the HRA began on January 1, 2009 if the Employee was covered under the Plan on that date and satisfied the HRA eligibility requirements. If the Employee was not covered under the Plan on January 1, 2009, his or her participation in the HRA began/will begin on the date after January 1, 2009 that the Employee initially become covered under the Plan and satisfied the HRA eligibility requirements. An Employee's participation in the HRA will continue until it terminates, as described below.

SECTION 11.03. INTEGRATION REQUIREMENT

A. Covered Employees

In order for a covered Employee to obtain reimbursement from the HRA of Eligible Expenses, the HRA must be "integrated" with a group health plan that provides minimum value coverage, and the covered Employee must actually be enrolled in the group health plan that provides such coverage. Coverage under this Plan provides minimum value and satisfies the integration requirements.

B. Dependents

In order for expenses of an participating Employee's Dependents to eligible for reimbursement, the HRA must be integrated with a group health plan that provides minimum value coverage, and the participating Employee's Dependents must be enrolled in the group health plan that provides minimum value coverage. Coverage under this Plan meets the minimum value requirement and satisfies the integration requirement for the HRA. In addition, coverage under another group health plan not sponsored by the Fund may satisfy the integration requirement if such coverage provides minimum value coverage and the Dependent(s) is enrolled in the group health plan that provides minimum value coverage.

SECTION 11.04. TERMINATION OF ELIGIBILITY

A. An Employee's eligibility under the HRA will terminate on the ***earliest of*** the following to occur, subject to the Employee's right (if any) to continue coverage under COBRA:

1. The date the Employee's coverage as an Employee terminates;

2. The date the Employee becomes employed in competitive employment;

3. The date the Employee's coverage terminates because the Employee's Employer has withdrawn from participating in the Fund; or

4. The date on which the HRA is terminated in accordance with the termination provisions of the Plan.

B. If an Employee's eligibility under the HRA terminates, no further contributions will be credited to the Employee's HRA account. If the Employee does not again become eligible to participate in the HRA for at least one month in the applicable year, any balance remaining in the Employee's HRA account at the end of such calendar year will be forfeited and will not be reinstated. In order to restore

participation in the HRA, the Employee must again satisfy the eligibility requirements for participation in the HRA

SECTION 11.05. SOURCE OF CONTRIBUTIONS

A. Contributions to an Employee's HRA account will consist solely of Employer contributions made in accordance with the terms of a Collective Bargaining Agreement or Participation Agreement in effect with the Contributing Employer. No contributions from Employees or other persons are permitted for credit to the HRA.

B. If an Employee is eligible to participate in the HRA, contributions will be credited (in dollars) to the Employee's HRA account each year. The annual amount credited to each Employee's HRA account will be calculated by dividing (a) the total HRA allocation by (b) the total number of Employees eligible to participate in the HRA. The "total HRA allocation" will be established by the Board of Trustees for each year based on various elements, including the Fund's reserve levels, the estimated number of claims incurred but not reported (IBNR) for the preceding year, etc. The Trustees reserve the right to not make an HRA contribution for any given year, to amend, or terminate the HRA.

SECTION 11.06. ELIGIBLE HRA EXPENSES

An Employee may use his or her HRA account to obtain reimbursement for Eligible Expenses incurred by the Employee and/or the Employee's covered Dependents. The Employee will be reimburse for Eligible Expenses up to the unused amount in the Employee's HRA account. In no event will benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement of Eligible Expenses.

"Eligible Expenses" for purposes of the HRA include the following, to the extent the Employee or Eligible Dependent who incurs the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Plan, any other health plan, insurance or any other source:

A. Eligible Charges, as defined under the terms of the Plan, incurred by an Employee or Eligible Dependent, which are applied toward the annual Deductible (or other deductibles);

B. Coinsurance percentages of Eligible Charges incurred by an Employee or Eligible Dependent, which are not payable by the Plan;

C. Eligible Charges incurred by an Employee or Eligible Dependent, which are not payable by the Plan because the individual has reached an applicable per visit maximum, annual or lifetime maximum under the terms of the Plan;

D. Amounts in excess of the Reasonable and Customary Charges for Eligible Charges under the Plan; and

E. Self-payments for COBRA continuation coverage for the Employee or Eligible Dependents as provided under the terms of the Plan.

F. Self-payments for retiree coverage for the retired Employee and Eligible Dependents as provided under the terms of the Plan.

To be reimbursed from the HRA, Eligible Expenses must be incurred on or after the date the Employee or Eligible Dependent first becomes eligible to participate in the HRA.

To be reimbursed under the HRA, the Employee or Eligible Dependent must submit a claim for the reimbursement of the Eligible Expense(s) (other than COBRA/retiree coverage self-payments) to the Plan and/or any other health plan or insurance under which the Employee or Eligible Dependent is covered. The Employee or Eligible Dependent must obtain an Explanation of Benefits (EOB) form to be submitted to the HRA for substantiation of outstanding and reimbursable expenses. Only those expenses that are covered, but not paid, as shown on the EOB form, will be considered an Eligible Expenses under the HRA. With respect to reimbursement of premiums for COBRA/retiree self-payment coverage, the Employee or Eligible Dependent must complete a form (available from the Fund Office) to request reimbursement under the HRA.

In no event will "Eligible Expenses" include expenses that are not incurred for "medical care," as defined in Code §213.

SECTION 11.07. CARRYOVER/FORFEITURE OF HRA ACCOUNT BALANCES

If any balance remains in an Employee's HRA account after all reimbursements have been made for the applicable year, such account balance may be carried over to reimburse Employees for Eligible Expenses incurred during a subsequent calendar year. The carried over balance will be in addition to the annual contribution that would otherwise be attributable to the Employee's account for the applicable year.

However, if the Employee's participation in the HRA terminates and such Employee does not again become eligible to participate in the HRA for at least one month in any applicable year, any balance remaining in the Employee's HRA account will be forfeited, as described above, and will no longer be carried over for reimbursement in a subsequent year.

If an Employee's eligibility under the HRA terminates because he or she becomes employed in Competitive Employment, any balance remaining in the Employee's HRA

account will be forfeited on the effective date of the Employee's Competitive Employment.

SECTION 11.08. SUBMITTING A CLAIM FOR REIMBURSEMENT

An Employee may apply for reimbursement under the HRA by submitting a written claim to the Fund Office no later than March 31 following the end of the applicable year in which the Eligible Expense (other than COBRA/retiree coverage self-payments) was incurred. The claim must be submitted using an HRA Claim Form, which is available from the Fund Office. The Claim Form must be accompanied by an Explanation of Benefits (EOB) from this Plan or any other health plan or insurance (except as otherwise indicated above). Except for the final reimbursement claim for the applicable year, no claim for reimbursement may be made unless and until the total reimbursement amount is at least $50.

With respect to reimbursement of premiums for COBRA or retiree self-payment coverage, the Employee must complete a form requesting reimbursement and submit it to the Fund Office no later than March 31 following the end of the applicable year in which the COBRA/retiree coverage self-payment was made.

SECTION 11.09. REIMBURSEMENT BY THE PLAN

A. In order to receive reimbursement under the HRA for Eligible Expenses, the Employee (or, in the event of the Employee's death, the Employee's estate or surviving Dependents) must submit a written claim to the Fund Office, in accordance with the filing requirements described in Section 11.08, above, by March 31 following the close of the applicable year in which the Eligible HRA Expense was incurred.

B. Within 30 days after the Fund Office receives a claim for reimbursement, the Plan will reimburse the Employee (or the appropriate claimant in the event of the Employee's death) for the Eligible Expenses if the claim is approved, or will notify the Employee (or claimant, as applicable) that the claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan, including cases where a reimbursement claim is incomplete. The Plan will provide written notice of any extension within the first 30 days after receipt of the claim, including the reasons for the extension, and will allow the Employee (or claimant, as applicable) 45 days in which to complete an incomplete reimbursement claim.

C. If a claim for reimbursement under the HRA is wholly or partially denied, the Employee or other claimant may appeal the determination and receive a full and fair review in accordance with the Appeal Procedures under the terms of the Plan. For purposes of appealing a denial under the HRA, a claim for reimbursement under the HRA will be treated as a Post-Service Claim.

SECTION 11.10. REIMBURSEMENTS AFTER TERMINATION OF ELIGIBILITY

When an Employee's eligibility under the HRA terminates (except in the event the Employee becomes employed in Competitive Employment, as described above), the Employee may receive reimbursements from any balance remaining in his or her HRA account for Eligible Expenses incurred prior to termination. The Employee must claim reimbursement for such Eligible Expenses in accordance with Sections 11.08 and 11.09, above.

SECTION 11.11. COORDINATION OF BENEFITS

Reimbursements available under the HRA are intended to be solely for Eligible Expenses not previously reimbursed or reimbursable from any other source. To the extent an Eligible Expense is payable or reimbursable from another source, the other source must pay or reimburse the Eligible Expense prior to any payment being made or reimbursed from the HRA.

SECTION 11.12. EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an individual, the allocations made to the account of any Employee, the amount of benefits paid, including to be paid to an Employee or other person, the Plan shall cause to be allocated, withheld, accelerated, or otherwise make adjustment of, such amounts as it determines in its judgment is properly accorded to such Employee or other person or the HRA account, to the extent that it deems it administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law,.

SECTION 11.13. AMENDMENT AND TERMINATION

The HRA has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Board of Trustees reserves the right to amend or terminate all or any part of the HRA at any time for any reason. Employees do not have a vested right to a HRA account or the contributions credited to the account.

SECTION 11.14. TAX CONSEQUENCES

The Plan makes no guarantee that any amounts paid to, or for the benefit of, an Employee or any other person under the Employee's HRA account will be excludable from the payee's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Employee or other payee to determine whether payments under the HRA are excludable, and to notify the Plan if he or she has any reason to believe that such payment is not so excludable.

If an Employee or other payee receives reimbursement under the HRA on a tax-free basis, and the payment does not qualify for tax-free treatment under the Code, such Employee or other payee will be required to indemnify and reimburse the Plan for any liability it incurs for failure to withhold federal income taxes, Social Security taxes, or other applicable employment taxes.

SECTION 11.15. NON-ASSIGNABILITY OF RIGHTS

The right of an Employee or other person to receive reimbursement under the HRA shall not be alienable by the Employee or other person by assignment or any other method, and shall not be subject to claims by the Employee's or other person's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

SECTION 11.16. NONDISCRIMINATION

Reimbursements to "highly compensated individuals," as defined under Code §105(h), may be limited or treated as taxable compensation to comply with Code §105(h), as determined by the Plan.

SECTION 11.17. SUSPENSION OF HRA ACCOUNT

An Employee may elect to suspend his or her HRA account by notifying the Fund Office in writing. The Employee's suspension election will remain in effect for the entire period to which it applies, and the Employee may not modify or revoke the election during that period. The Employee will not receive reimbursements for any Eligible Expenses incurred during the period to which the suspension election applies.

If an Employee suspends his or her HRA account for a period of time, medical care expenses incurred before the beginning of the suspension period may be reimbursed during the suspension period, subject to the claims procedures contained herein, as long as no suspension election was in effect for the date(s) on which such expenses were incurred.

SECTION 11.18. PERMANENT OPT-OUT

In lieu of a temporary suspension of the HRA Account, the Employee may elect to permanently opt out of, and waive future reimbursements from his or her HRA Account. If the Employee make such an election, the Fund will discontinue contributions to his or her HRA account and the Employee will not receive reimbursements for any medical care expenses incurred after the effective date for opt-out election.

Eligible HRA Expenses incurred before the effective date of opt-out election may be reimbursed, subject to the claims procedures contained herein, as long as no suspension election was in effect for the date(s) on which such expenses were incurred.

The opportunity for an Employee to make a permanent opt-out election will be allowed at least annually. Contact the Fund Office for details on how to make a permanent opt-out election.

ARTICLE XII – MEDICARE SUPPLEMENT BENEFIT PLAN FOR RETIREES AND SPOUSES OVER THE AGE OF 65

SECTION 12.01. ELIGIBILITY

Employees who retire under the Plumbers Local Union No. 68 Pension Plan and who are eligible for Plan benefits on the date of retirement may continue Plan participation by making monthly self-payments until such time as the Retiree becomes eligible for Medicare.

In the event the Eligible Dependents of the Retiree do not become eligible for Medicare until a date which is later than the Medicare eligibility of the Retiree, the Retiree may continue to make self-payments to the Plan to continue coverage for the Eligible Dependents until they are either no longer eligible for benefits under the terms of the Plan, or become eligible for Medicare.

In any event, upon becoming eligible for Medicare, the Retiree may continue making self-payments to the Plan to continue coverage for himself or herself and his or her Eligible Dependents provided all Medicare-eligible individuals register for Part A of Medicare and enroll in either Part B or Part C of Medicare.

SECTION 12.02. BENEFITS

A. **Not Medicare Eligible.** The benefits and terms under the Plan applicable to the Retiree will be the same as those provided to Employees and their Eligible Dependents.

B. **Medicare Eligible.** The benefits otherwise provided by Medicare will be supplemented.

ARTICLE XIII - COORDINATION OF BENEFITS

SECTION 13.01. APPLICATION

In the event any individual covered under this Plan, which shall include this Plan and any other Medical, Dental and/or Vision care expense benefits provided through or by this Plan, shall also be covered under one or more other plans, the benefits payable with respect to him or her under this Plan shall be coordinated with benefits payable with respect to him or her under all other plans. All other plans shall include but are not limited to Scheduled Prescription Drug co-payments, Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and Dental Maintenance Organizations (DMOs) and Medicare Parts A, B and C regardless of whether or not the Medicare-eligible individual has registered for Medicare Part A and/or enrolled in either Medicare Parts B or C. In the event an Eligible Individual participates in the Medicare Part D Prescription Drug program, Coordination of Benefits provisions shall not apply.

Coordination shall apply in determining the benefits payable with respect to an individual for any claim determination period provided, for the allowable expense incurred during that period, the sum of the benefits which would be payable under:

A. This Plan in the absence of coordination; and

B. All other plans in the absence of provisions for coordination in those plans, would exceed those allowable expenses.

Except as provided in the following paragraph, when Coordination of Benefits applies to the benefits payable with respect to an individual for a claim determination period, the benefits that would be payable for eligible expenses incurred during that period under this Plan in the absence of Coordination of Benefits shall be reduced to the extent necessary so the sum of those reduced benefits and all the benefits payable for those eligible expenses under all other plans shall not exceed the total of those eligible expenses. Benefits payable under all other plans include the benefits that would have been payable had claim been properly made for them.

For purposes of Coordination of Benefits between this PPO Plan and any other PPO plan, the term “eligible expense” means the amount of the billed charges made by a preferred provider for services rendered, procedures performed and/or supplies furnished less any contractual discount applicable to either or both plans.

In the event, in coordinating the benefits of this Plan with those of another plan, the provisions set forth in the following paragraph would require this Plan to determine its benefits before the other plan and the other plan which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, then the benefits of the other plan shall be ignored for the purposes of determining the benefits of this Plan.

SECTION 13.02. ORDER OF BENEFIT DETERMINATION

The rules establishing the order of benefit determination are:

A. Rule 1: No Coordination of Benefit Provision

If the other plan that covers the Employee, Spouse or Dependent Child does not have a Coordination of Benefits provision that coordinates benefits, the Plan will always be the primary plan.

B. Rule 2: Coverage as an Employee and as a Dependent

If the Eligible Dependent, Child (children) is covered under one plan as a subscriber and under the other plan as a Dependent, the plan that covers such individual as a subscriber will be primary.

C. Rule 3: Dependent Covered Under More Than One Plan

If the Employee, Spouse, or Eligible Dependent child is covered as a dependent under two plans, then the rules are as follows:

1. The coverage of the parents whose birthday is first in the year will be primary and the parent whose birthday is later in the year will be secondary. The word birthday refers only to the month and day in a calendar year; not the year in which the person was born;

2. If both parents have the same birthday, the benefits of the plan in effect longer will be primary;

3. If the other plan does not have this rule, but instead has a rule based upon the parents' gender; and if as a result, the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of payment for the claimed benefits.

D. Rule 4: For a Child of Separated or Divorced Parents

If the terms of a court decree specify which parent is responsible for the healthcare coverage and expenses of the child, and that parent's plan has actual knowledge of the Court Order, then that parent's plan shall be primary. If no such court decree exists, or if the plan of the parent designated under such a court decree as responsible for the child's healthcare coverage and expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

1. First, the plan of the parent with custody of the child;

2. Then, the plan of the Spouse of the parent with custody of the child;

3. Finally, the plan of the parent not having custody of the child.

E. Rule 5: Coverage of Active Employee and/or Employee's Dependent

A plan that covers you as an active Employee or as a dependent is primary. A plan that covers you as a laid-off or retired Employee (or that Employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this Rule 5 is ignored.

F. Rule 6: Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the plan that covered you longer is primary.

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan, and does not start over as the result of a change:

1. In the amount or scope of a plan's benefits;

2. In the entity that pays, provides or administers the plan; or

3. From one type of plan to another.

SECTION 13.03. COORDINATION WITH MEDICARE

The allowable expense shall be based on the primary/secondary position that shall be determined by the provisions applicable to Medicare.

When Coordination of Benefits operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to an individual covered under this Plan, each benefit that would have otherwise been payable in the absence of Coordination of Benefits shall be reduced proportionately and the reduced amount shall be charged against any applicable benefit limit of this Plan.

In any event, the benefits that would be payable for allowable expenses incurred during that period under this Plan in the absence of Coordination of Benefits shall be reduced to the extent necessary so the sum of those reduced benefits and all the benefits payable for those allowable expenses under all other plans shall not exceed the total of those allowable expenses.

In the event an Eligible Individual participates in the Medicare Part D Prescription Drug program, Coordination of Benefits provisions shall not apply.

SECTION 13.04. COORDINATION WITH MEDICAID

For purposes of coordinating with Medicaid, this Plan will assume primary payer status for any Participant or Alternate Recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Participant or Alternate Recipient will be made in accordance with any assignment of rights made by or on behalf of such Participant or Alternate Recipient as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or Alternate Recipient for payment of such benefits. The provisions of Section 1908 of the Social Security Act apply to the extent such provisions are in accordance with state Medicaid law.

SECTION 13.05. MILITARY INSURANCE COVERAGE

The Plan will cover the Employee's Spouse and/or Eligible Dependents of an Employee who is on active duty in any armed forces if the Employee elects to self-pay coverage during the period of Military leave. If a covered individual is covered by both this Plan and Military coverage only, this Plan pays first (Primary) and the Military coverage pays second (Secondary).

SECTION 13.06. VETERANS AFFAIRS FACILITY SERVICES

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits related to the illness or injury are not payable by the Plan.

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Reasonable And Customary.

SECTION 13.07. MOTOR VEHICLE NO-FAULT COVERAGE REQUIRED BY LAW

If the Employee, Spouse, or Eligible Dependent Children are involved in a motor vehicle accident and the Employee (or injured individual) has, or is required by state law to have, basic reparation coverage, the insurance carrier will be primarily liable for lost wages, medical, surgical, hospital, and related charges.

Regardless of whether the Plan described in this SPD and Amended and Restated Rules and Regulations of the Plan is Primary or Secondary, the Employee, Spouse, or

Eligible Dependent Child (if an adult) may be required to sign a Reimbursement Agreement and Consent to Lien before any claims relating to the accident will be paid by the Plan. The Reimbursement Agreement permits the Plan to receive reimbursement for expenses paid by the Plan that you recover through litigation or settlement with another party or insurance company

SECTION 13.08. COVERAGE BY A PREFERRED PROVIDER ORGANIZATION (PPO), HEALTH MAINTENANCE ORGANIZATION (HMO) OR A DENTAL MAINTENANCE ORGANIZATION (DMO)

In the event this Plan is secondary to any other plan that has a contractual agreement that results in a discounted incurred claim, the amount payable by this Plan shall be determined based upon the lesser of the discounted allowed expenses of this Plan and the discounted allowed expenses of the other plan. In any event, under no circumstances shall the benefit amount payable by this Plan be calculated based upon the undiscounted billed charges made by any PPO provider whose charges have been otherwise reduced as a result of a contractual agreement.

This Plan shall consider HMO and DMO co-payment receipts and/or Explanations of Benefits (EOBs) to be incurred claims and shall apply the Plan's Coordination of Benefits Provisions as stated in this Article.

SECTION 13.09. COPAYMENT AND NON-SCHEDULED PRESCRIPTION DRUG PROVIDERS

This Plan shall consider copayment receipts and/or Explanations of Benefits (EOBs) detailing the prescription drug, the quantity dispensed and the amount of the scheduled co-payment as incurred claims payable at 100% after the Deductible Amount provided the prescription has been written by a Physician and is for other than a non-formulary drug, the cost of which has been reduced to a scheduled copayment. In the event the prescription is for a non-formulary drug and/or as a result shall be non-scheduled, the Plan shall pay such incurred claim at 80% of the Reasonable and Customary expense after the Deductible Amount. An EOB and/or receipt shall not be required.

SECTION 13.10. RELEASE OF INFORMATION

For purposes of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Plan may, without the consent of or notice to any individual, release to or obtain from an insurance company or other organization or individual any information concerning any individual, which the Plan shall consider to be necessary for those purposes. Any individual claiming benefits under this Plan, shall furnish to the Plan such information as may be necessary to implement the above provisions.

SECTION 13.11. PAYMENT TO INSURANCE CARRIERS

Whenever payments which should have been made under this Plan in accordance with the above provisions are made under any other plan or plans, the Plan shall have the right, exercisable alone and in its sole discretion to pay to any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions, and such amounts paid in this manner shall be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan shall be fully discharged from liability under this Plan.

SECTION 13.12. RECOVERY

Whenever payments have been made by the Plan at any time, the allowable expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Plan shall have the right to recover these payments, to the extent of the excess, from among one or more of the following, as the Plan shall determine:

A. Any individuals to or for or with respect to whom these payments have been made;

B. Any other insurance companies; or

C. Any other organizations.

In addition, if the Plan pays any amount to or on behalf of an Employee or Eligible Dependent to which the Employee or Eligible Dependent is not entitled, the Plan may reduce future payments due to, or on behalf of, such Employee or any of his or her Eligible Dependents by the amount of any such erroneous payment. This right of offset shall not, however, limit the rights of the Plan to recover such overpayments in any other manner.

ARTICLE XIV – SUBROGATION

A. Subrogation and Recovery

The Plan's subrogation rights may be exercised regardless of whether the Plan has paid claims on behalf of an Employee or a Dependent. The Plan shall retain the right of first reimbursement, that shall be the first priority, dollar-for-dollar, for any and all services, procedures, supplies and/or benefits provided, arranged or paid for by the Plan. This reimbursement shall be out of any and all recovery, either full or partial, that the Employee or Dependent, shall be able to obtain from a third party or parties, and including coverage for underinsured, uninsured, med pay, PIP or any other source of recovery or insurance policy even if the Employee or Dependent is not made whole. The Employee or Dependent shall not engage in conduct that prejudices, or interferes with, the Plan rights outlined herein. Further, the Employee or Dependent shall execute and deliver instruments, papers, and whatever else is necessary to secure such rights. If the Plan chooses to pay any expenses without the signed Subrogation Agreement, this shall not be considered a waiver of the Plan's Subrogation rights.

B. Authorization

If requested in writing by the Trustees, the Employee or Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity with said action to be taken in the name of the Employee or the Dependent. The Trustees, in their sole discretion, shall reserve the right to prosecute an action in the name of the Employee or Dependent against any third parties and/or entities potentially liable to the Employee or Dependent in an effort to recover monies paid by the Plan.

C. Reimbursement

The Plan shall, from the first reimbursement right, be reimbursed 100% first to the extent of any and all services, procedures, supplies and/or benefits provided, arranged, or paid for by the Plan on behalf of an Employee or Dependent. In the event any balance remains, such excess shall apply as a credit against liability of the Plan for further payments to, or on behalf of, the Employee or Dependent, which has arisen or may arise from the Injury that forms the basis of the claim asserted by, or on behalf of, the Employee or Dependent. Any further excess shall be paid to the Employee or Dependent.

D. The Plan shall retain 100% of its first reimbursement right, regardless of attorneys' fees paid by the Employee or Dependent, should the Employee or Dependent retain the services of an attorney to obtain full or partial recovery from a third party or parties. In short, nothing in this clause shall be construed to

suggest that the Plan shall reduce its right of first reimbursement in the amount, or a portion thereof, of any attorney's fees expended by the Employee or Dependent in obtaining its full or partial recovery from a third party or parties. Third parties include the participant's uninsured, underinsured, PIP, and med pay coverages.

E. The Trustees shall have the absolute discretion to interpret and settle Subrogation claims on any basis they deem warranted and appropriate under the circumstances.

ARTICLE XV – COBRA CONTINUATION COVERAGE

Important Note: COBRA continuation coverage is offered as an alternative to Retiree coverage. Once you elect COBRA continuation coverage as an alternative to retiree coverage, you and your Eligible Dependents will not be eligible to elect retiree coverage upon termination of the COBRA continuation coverage. If you would prefer to elect retiree coverage instead of COBRA continuation coverage, please refer to Section 1.15, "Retirees."

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SECTION 15.01. YOUR RIGHT TO COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage is offered to each person who is a "qualified beneficiary." Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The Employee, Dependent spouse, and Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. A Dependent child who is born to, or placed for adoption with, the Employee during a period of COBRA coverage is also a qualified beneficiary. If a qualified beneficiary with COBRA coverage acquires a family member who could be enrolled in the Plan if the qualified beneficiary were an Employee, the qualified beneficiary may add such family member to his or her COBRA coverage for the remainder of the coverage period. In addition, if a qualified beneficiary who is self-paying for COBRA coverage has a Dependent who: (1) was eligible but did not enroll in the Plan at the time of the qualified beneficiary's initial enrollment because the Dependent had other group health plan or insurance coverage; and (2) lost the other coverage due to exhaustion of COBRA, or loss of eligibility or termination of Employer Contributions (but not due to a failure to pay timely any required premiums or termination of coverage for cause), the qualified beneficiary may add that Dependent to his or her COBRA coverage, for the remainder of the coverage period, within 30 days after termination of the Dependent's other coverage.

A. As an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

   1. You do not work the required number of hours in Covered Employment to maintain coverage under the Plan; or

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

B. Your Dependent spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

1. You die;

2. You do not work the required number of hours in Covered Employment to maintain coverage under the Plan;

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

4. You become entitled to Medicare benefits; or

5. You and your spouse divorce (it is your responsibility to notify the Fund Office of your divorce. If you fail to do so, you must reimburse the Fund for any claims payments for your spouse after the date of your divorce).

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

1. You die;

2. You do not work the required number of hours in Covered Employment to maintain coverage under the Plan;

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

4. You become entitled to Medicare benefits;

5. You and your spouse divorce (it is your responsibility to notify the Fund Office of your divorce. If you fail to do so, you must reimburse the Fund for any claims payments for your spouse after the date of your divorce); or

6. The child stops being eligible for coverage under the Plan as a Dependent.

SECTION 15.02. YOU MUST PROVIDE NOTICE TO THE PLAN OF CERTAIN COBRA QUALIFYING EVENTS

The Employee or his or her Dependent must provide the Fund Office with timely notice of the following qualifying events:

A. Your divorce.

B. A dependent child ceasing to be covered under the Plan as a Dependent.

C. The occurrence of a second qualifying event after an individual has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include your death, entitlement to Medicare, divorce, or a child losing Dependent status.

D. When an individual entitled to COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled.

E. When the Social Security Administration determines that an individual is no longer disabled.

The Employee or his or her Dependent must notify the Plan of any of the five events listed above. Failure to provide the proper notice within the required time frames described below may prevent you or your Dependent from obtaining or extending COBRA coverage.

SECTION 15.03. NOTIFICATION PROCEDURES

A. In order to notify the Plan of these qualifying events, the Employee or his or her Dependent must send a letter to the Fund Office containing the following information:

1. The covered Employee's name and/or the qualified beneficiary's name,

2. The type of qualifying event for which the individual is providing notice, and the date of the event.

3. In the event of divorce, the Employee must also submit a copy of the divorce decree.

4. In the event of a Social Security Administration determination of disability, the Employee must submit a copy of the Social Security determination.

5. In the event of death, the Employee, Spouse or Dependent Child must submit a copy of the death certificate.

B. If the Employee or other qualifying beneficiary is providing notice due to: (1) a divorce; (2) a dependent losing eligibility for coverage; or (3) a second qualifying event, the notice must be postmarked **no later than** 60 days after the later of:

1. The date on which the relevant qualifying event occurs; or

2. The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

C. If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked **no later than** 60 days after the latest of:

1. The date of the disability determination by the Social Security Administration;

2. The date on which the qualifying event occurs; or

3. The date on which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event;

Note: The notice must be provided before the end of the first 18 months of continuation coverage.

D. If you are providing notice of a Social Security Administration determination that the individual is no longer disabled, the notice must be postmarked **no later than** 30 days after the date of the final determination by the Social Security Administration.

Notice may be provided by the Employee, his or her Dependent, or any representative acting on behalf of the Employee or his or her Dependent. Notice from one individual will satisfy the notice requirement for all individuals affected by the same qualifying event.

Within thirty (30) days after receiving timely notice of a qualifying event, the Fund Office will furnish the Employee or his or her Dependent with specific information on when and how to elect continuation coverage, including the cost. Notice given to the Employee or his or her Dependent spouse will be deemed to be notice to all affected Dependent children living with you or your Dependent spouse.

Within thirty (30) days after the Employee or his or her Dependent loses eligibility due to the Employee's death, termination of employment, or insufficient hours worked, the Fund Office will furnish the Employee or his or her Dependent with specific information on when and how to elect continuation coverage, including the cost. Notice given to the Employee or his or her Spouse will be deemed to be notice to all affected Dependent children living with the Employee or his or her Dependent spouse. An Employer is not required to submit notice of a qualifying event to the Fund Office on account of your death, termination of employment or insufficient hours.

In order to continue coverage, the Employee and/or his or her Dependents must make a written election with the Plan within sixty (60) days after **the later of**:

1. The date coverage would otherwise terminate due to the qualifying event; or

2. The date the individual is notified of the right to continue coverage.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If an individual waives continuation coverage during the 60-day election period, he or she may revoke the waiver and elect continuation coverage at any time within the 60-day period. However, coverage may be provided only from the date of revocation and not retroactive to the date of termination.

SECTION 15.04. HOW IS COBRA COVERAGE PROVIDED?

When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits, the Employee and spouse's divorce, or a dependent child's losing eligibility as a Dependent, COBRA continuation coverage lasts for up to a total of 36 months for spouses and dependents who are qualified beneficiaries.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the loss of coverage caused by the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If the Employee or anyone in his or her family covered under the Plan is determined by the Social Security Administration to be disabled and the Employee notifies the Fund Office, as described in Section 15.03, "Notification Procedures," the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If the Employee's family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in the Employee's family who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children (if they are qualified beneficiaries) receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits, or gets divorced, or if the dependent child stops being eligible under the Plan as a Dependent child.

SECTION 15.05. BENEFITS

Medical, Prescription Drug, Vision, and Life Insurance Benefits may be continued by Employees and Eligible Dependents. Accidental Death and Dismemberment Benefits may be continued by Employees only. The benefits that are available during the continuation coverage period will be the same as those being provided under the Plan to similarly situated Participants with respect to whom a qualifying event has not occurred.

SECTION 15.06. PAYMENT FOR CONTINUATION COVERAGE

Continuation coverage is optional on the part of you and your Eligible Dependents. In the event you elect not to continue coverage, each of your Eligible Dependents will be entitled independently to elect to continue coverage. Any individual who elects to continue coverage must pay the required self-payment on a timely basis in order for coverage to continue.

The first self-payment is due within 45 days of the date continuation coverage is elected. It must cover the cost of coverage from the date coverage would otherwise have terminated through the end of the last month for which payment is made. All subsequent self-payments are payable on a monthly basis and due on the first business day of each month for which coverage is intended. Payment must be made by money order or cashier's check – there will be no exceptions. Payment will be considered timely and coverage will be reinstated retroactively if payment is received within 30 days of the first day of the calendar month for which coverage is sought. A Participant who fails to make the required timely self-payment will lose the right to continue self-pay coverage.

SECTION 15.07. SELF-PAYMENT COST

If a Participant elects to continue coverage, he or she must pay the amount of self-payment determined by the Plan. In general, the self-payment amount will not exceed 102% of the Plan's cost of coverage. However, if the Employee and/or his or her Eligible

Dependents extend coverage from 18 to 29 months due to disability, the Plan may charge up to 150% of the Plan's cost of coverage for the additional 11 months.

The required self-payment amounts may be increased if the costs to the Plan increase, but generally will be fixed in advance of each 12-month premium cycle. Any Participant who is eligible to continue coverage on a self-pay basis will be notified of the cost prior to making an election and prior to any changes in the amount payable.

SECTION 15.08. INTERACTION OF COBRA AND THE AFFORDABLE CARE ACT – OTHER OPTIONS

If the Employee lose group health coverage under the Plan and become eligible for COBRA coverage, the Employee and his or her Eligible Dependents may also become eligible for other coverage options that may cost less than COBRA coverage. For example, the Employee and his or her family may be eligible to buy an individual plan through the Health Insurance Marketplace (the "exchange"), Medicaid, or other group health plan coverage (such as a spouse's plan) through a 30-day "special enrollment period," even if the other plan generally does not accept late enrollees. If the Employee and/or his or her Eligible Dependents enroll in coverage through the Marketplace, the Employee or his or her Dependents may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The Employee can learn more about many of these options and about your rights under the Affordable Care Act at www.healthcare.gov.

SECTION 15.09. WHEN COBRA CONTINUATION COVERAGE ENDS

A. Continuation coverage under COBRA will end on the earliest of the following dates:

   1. The first day of the period for which the individual fails to make a timely self-payment;

   2. The date, after continuation coverage is elected, on which the individual first becomes covered under Medicare;

B. If an individual is extending coverage from 18 to 29 months due to disability, the last day of the month that includes the 30th day following a Social Security Administration determination that the individual is no longer disabled.

C. If an individual is affected by or experiences multiple qualifying events, continuation coverage will not be provided for more than 36 months from the initial loss of coverage; and

D. The date the Plan no longer provides group health coverage to any Participant.

E. When an individual becomes covered under another Plan.

SECTION 15.10. NAME, ADDRESS AND TELEPHONE NUMBER OF THE PARTY RESPONSIBLE FOR COBRA ADMINISTRATION

The Plumbers Local Union No. 68 Welfare Fund
468 Link Road
Post Office Box 8726
Houston, Texas 77249-8726
(713) 869-2592 or (800) 833-2980

SECTION 15.11. UNAVAILABILITY OF COVERAGE

If the Employee provides notice to the Fund Office of a qualifying event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

SECTION 15.12. NOTICE OF TERMINATION OF COBRA

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the Fund Office's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

SECTION 15.13. KEEP THE FUND INFORMED OF ADDRESS CHANGES

In order to protect the rights of the Employee family's rights, the Employee should keep the Fund Office informed of any changes in the addresses of his or her family members. The Employee should also keep a copy, for his or her records, of any notices the Employee sends to the Fund Office.

SECTION 15.14. IF YOU HAVE QUESTIONS

Questions concerning the Employee's Plan or his or her COBRA continuation coverage rights should be addressed to the Fund Office. For more information about the Employee's 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.)

ARTICLE XVI – CLAIMS AND APPEALS PROCEDURES

SECTION 16.01. DEFINITIONS

A. Adverse Benefit Determination

"Adverse Benefit Determination" means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. An Adverse Benefit Determination also includes any rescission of disability benefit coverage that has a retroactive effect, except to the extent the rescission is attributable to a failure to timely pay required contributions towards the cost of coverage. This rule applies whether or not there is an adverse effect on any particular benefit at that time.

B. Claim

"Claim" means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of Plan shall not be considered Claims. Nor shall a request for a determination of whether an individual is deemed eligible for benefits under the Plan be a Claim. However, in the event a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination shall be considered a Claim.

A request for prior approval or pre-certification of a benefit that does not require prior approval by the Plan shall not be considered a Claim. However, requests for prior approval of a benefit where the Plan requires prior approval (e.g., there are monetary penalties for not obtaining prior approval) shall be considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures below.

C. Concurrent Claim

"Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of a benefit.

D. Disability Claim

"Disability Claim" means a Claim that requires a finding of disability as a condition of eligibility (e.g., short-term disability claims). Furthermore, waivers of life insurance premiums during total disability and disability pension claims shall be considered Disability Claims unless the determination of disability is made by a party other than the Plan for purposes other than a benefit determination under the Plan (e.g., a Social Security Administration determination).

E. Post-Service Claim

"Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Concurrent, Urgent or Disability Claim, and for which the treatment, services, procedures and/or supplies have already been received or have been obtained.

F. Pre-Service Claim

"Pre-Service Claim" means a Claim for a benefit for which the Plan requires approval or pre-certification before medical care may be obtained.

G. Relevant Documents

"Relevant Documents" include documents pertaining to a Claim provided such documents have been relied upon in making the benefit determination, have been submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations or constitute the policy or guidance of the Plan with respect to the denied treatment option or benefit. Relevant Documents may include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the rules of the Plan have been appropriately applied to a Claim.

H. Urgent Claim

"Urgent Claim" means a Claim for medical care or treatment that, provided normal Pre-Service standards were applied, would seriously jeopardize the life or health of the participant or the ability of the participant to regain maximum function or, in the opinion of a Physician with knowledge of the participant's medical condition, subject the participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

SECTION 16.02. ASSIGNMENT

Employees and/or their Eligible Dependents may authorize the Plan to pay benefits under this Plan applicable to expenses for Medical and Dental care and treatment directly to the institution or person on whose behalf a claim is based.

SECTION 16.03. CLAIMS PROCEDURES

The Employee and his or her Eligible Dependents must submit all benefit claims on claim forms made available from the Fund Office. The Employee and his or her Eligible Dependents must also include any information or proof requested and reasonably required to process the claims that the Employee have submitted.

No Employee, Eligible Dependent, Beneficiary or other person has any right or claim to benefits from the Welfare Plan other than as stated in the Plan's Amended and Restated Rules and Regulations. Any dispute as to eligibility, type, amount or duration of benefits under the Plan's Amended and Restated Rules and Regulations or any amendment to the Plan will be resolved according to the provisions contained in the Amended and Restated Rules and Regulations, the Trust Agreement and/or any claims procedure adopted by the Board of Trustees.

A. Pre-Service Claims

The term Pre-Service Claim means a Claim for a benefit for which the Plan requires approval before medical care is obtained. The Plan requires that Hospital admissions be pre-certified, thus, pre-certification of a Hospital admission is treated as a Pre-Service Claim. Pre-Service Claims for the pre-certification of Hospital admissions must be submitted by calling PROVIDED PRE-CERTIFICATION FACILITY. Emergency admissions must be certified within 72 hours of the admission (or the next working day if the admission occurs over a weekend or on a holiday).

For properly filed Pre-Service Claims, the claimant shall be notified of a decision within 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of PROVIDED PRE-CERTIFICATION FACILITY. The claimant shall be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

In the event an extension is required because PROVIDED PRE-CERTIFICATION FACILITY needs additional information from the claimant, the claimant shall be notified, before the end of the initial 15-day period, of the information needed. The claimant shall have at least 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim shall be denied. During the period in deadline for making a decision on the Claim shall be suspended. The deadline shall be suspended from the date of the extension notice until the earlier of: (1) the end of the period in which the claimant is allowed to supply additional information; or (2) the date the claimant responds to the request.

PROVIDED PRE-CERTIFICATION FACILITY shall then have 15 days to make a decision on the Claim and notify the claimant of the determination. In the event a claimant improperly files a Pre-Service Claim, the claimant shall be notified as soon as possible but not later than five days after receipt of the claim, of the proper procedures to be followed in filing a Claim. The claimant shall only receive notice of an improperly filed Pre-Service Claim if the claim includes the patient’s name and member’s identification number, the patient’s specific medical

condition or symptom and the patient's specific treatment, service or product for which approval is requested.

Unless the claim is refiled properly, it shall not constitute a Claim.

B. Urgent Claims

Urgent Claims must be submitted by calling PROVIDED PRE-CERTIFICATION FACILITY.

PROVIDED PRE-CERTIFICATION FACILITY shall determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, in the event a Physician with knowledge of the patient's medical condition shall determine that the Claim is an Urgent Claim, and notifies PROVIDED PRE-CERTIFICATION FACILITY of such, it shall be treated as an Urgent Claim. PROVIDED PRE-CERTIFICATION FACILITY shall respond to the claimant with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim by PROVIDED PRE-CERTIFICATION FACILITY. The determination shall also be confirmed in writing.

In the event an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, PROVIDED PRE-CERTIFICATION FACILITY shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant shall be given at least 48 hours to provide the specified information. In the event the information is not provided to PROVIDED PRE-CERTIFICATION FACILITY within the specified time frame, the Claim shall be denied. Notice of the decision shall be provided no later than 48 hours after PROVIDED PRE-CERTIFICATION FACILITY has received the specified information or the end of the period given for the claimant to provide this information, whichever shall be earlier. In the event a claimant improperly files an Urgent Claim, PROVIDED PRE-CERTIFICATION FACILITY shall notify the claimant as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a Claim. Unless the claim is refiled properly, it shall not constitute a Claim.

C. Concurrent Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) shall be made by PROVIDED PRE-CERTIFICATION FACILITY as soon as possible. In any event, the participant shall be given

enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend an approved Urgent Claim shall be acted upon by PROVIDED PRE-CERTIFICATION FACILITY within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment that does not involve an Urgent Claim shall be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

D. Post-Service Claims

A Post-Service Claim must be submitted to the Fund in writing, using the appropriate claim form, no later than March 31 of the Calendar Year following the Calendar Year during which the expenses are incurred. A claim form may be obtained by contacting the Fund Office. Failure to file a Post-Service Claim within the time required shall not invalidate or reduce any Claim, provided it is shown that it was not reasonably possible to file the Claim within such time. However, in that case, the Claim must be submitted as soon as reasonably possible from the date the charges were incurred.

The claim form must be completed in full in order for the request for benefits to be considered a Claim. An itemized bill must be attached to the claim form and must include the following information for the request to be considered a Claim:

1. Patient's name and member's identification number;

2. Date of service;

3. Type of service or CPT-4 code;

4. Diagnosis or ICD-9 code;

5. Billed charge;

6. Provider's Federal Taxpayer Identification Number (TIN); and

7. Provider's billing name and address.

Post-Service Claims shall be considered to have been filed when the Fund Office receives them. Claims should be submitted to the Fund Office at the following address:

Plumbers Local 68 Welfare Fund
P. O. Box 8726
Houston, TX 77249-8726

Ordinarily, claimants shall be notified of decisions on Post-Service Claims within 30 days from the Fund's receipt of the Claim. This period may be extended one time by the Fund for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. In the event an extension is necessary, the claimant shall be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

In the event an extension is required because the Fund needs additional information from the claimant, the Fund shall issue a Request for Additional Information that specifies the information needed. The claimant shall have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim shall be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim shall be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days or until the date the claimant responds to the request (whichever is earlier). The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

In the event the Fund determines that additional information is required from the claimant, the Fund may issue a combined Request for Additional Information and Notice of Adverse Benefit Determination. The Notice of Adverse Benefit Determination would only be applicable in the event the claimant fails to provide any information within 45 days. In this case, the Fund shall not issue a separate Notice of Adverse Benefit Determination if the claimant failed to submit any information within 45 days. The combined notice shall clearly state that the Claim will be denied if the claimant fails to submit any information in response to the Fund's request and shall satisfy the content requirements of both the Request for Additional Information and the Notice of Adverse Benefit Determination. When the combined notice is used, the timeframe for appealing the Adverse Benefit Determination begins to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

E. Disability Claims

Disability Claims must be submitted to the Fund Office in writing, using the appropriate claim form. A claim form may be obtained by contacting the Fund Office. The claimant must complete "Part A" of the form and have his or her Physician complete "Part B" of the form.

The Plan will ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to

evaluating professionals (for example, claims adjudicators or medical or vocational experts) will not be made based on the likelihood that the individual will support the denial of disability claims.

The Fund Office shall make a decision on the Disability Claim and notify the claimant of the decision no later than 45 days after receipt of the Claim. In the event the Fund Office requires an extension of time due to matters beyond its control, it shall notify the claimant of the reason for the delay and indicate when the decision shall be made. This notification shall occur before the expiration of the 45-day period. A decision shall be made within 30 days from the time the Fund Office notifies the claimant of the delay. If the Fund Office requires an additional extension of time due to matters beyond its control, the period for making a decision may be delayed an additional 30 days, provided the Fund Office notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund Office expects to render a decision.

In the event an extension is needed because the Fund Office needs additional information from the claimant, the Fund Office will notify the claimant before the expiration of the initial 45-day determination period. The extension notice shall specify the information needed. In that case, the claimant shall have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim shall be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim shall be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date the claimant responds to the request (whichever is earlier). Once the claimant responds to the request for information, he or she shall be notified of the decision on the Claim within 30 days.

F. Authorized Representatives

An authorized representative, such as a spouse or an adult child, may submit a Claim on behalf of a participant in the event the participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative Form, which may be obtained from the Fund Office, must be used to designate an authorized representative. The Fund may request additional information to verify that the designated person is authorized to act on the participant's behalf.

A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the participant having to complete the Appointment of Authorized Representative Form.

G. Discharge

Any payment by the Plan in accordance with these provisions shall discharge the Plan from all further liability to the extent of the payment made.

H. Facility of Payment

In the event an Employee or his or her Eligible Dependent dies while benefits provided for Hospital, nursing, Medical, surgical, Dental or Vision services remain unpaid, the Plan may, at its option, make direct payment to the individual or institution on whose charges claim is based or to the surviving spouse of an Employee, or if none, to his or her surviving children (including legally adopted children) share and share alike, or if none, to the executors or administrators of the Employee's estate.

I. Filing Limitations

All Medical, Dental and Vision expenses incurred during a Calendar Year must be filed with the Plan no later than March 31 of the following year unless the reason for the delinquent claim filing, satisfactory to the Board of Trustees, is submitted with the claim.

J. Forms

Upon receipt of written notice of a claim, the Plan shall furnish a claim form to the Employee and/or Eligible Dependents. In the event the claim form is not received within 30 days after receipt by the Plan of the notice of a claim, the Employee and/or Eligible Dependents shall be considered to have complied with the requirements of this Plan for filing proof of loss, upon submitting written proof covering the occurrence, character and extent of the loss for which a claim is made.

K. Legal Actions

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after proof of loss has been filed. The claimant may not file a lawsuit to obtain benefits until after he or she has requested an appeal and a final decision has been reached on the appeal, or until the appropriate timeframe described above has elapsed since the claimant filed a request for review and has not received a final decision or notice that an extension shall be necessary to reach a final decision. No lawsuit may be commenced more than one year after an appeal has been denied by the Board of Trustees.

L. Minor or Incompetency

In the event, in the opinion of the Plan, an Employee and/or Eligible Dependents is not competent to give a valid receipt for payment of any benefit due or if the Eligible Dependents is a minor age child and has no then living legal guardian to give a valid receipt for payment of any benefit due him or her, and if no request for payment has been received by the Plan from a legally appointed representative, the Plan may, at its option, make direct payment to the individuals or institutions appearing to the Plan to have assumed the custody or the principal support of that person.

M. Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity to examine the person of any individual whose Illness or Injury is the basis of a claim when and as often as it may reasonably require during the pendency of a claim and to have an autopsy performed by a licensed Physician in case of death where it is not forbidden by law.

N. Proof of Loss

Written proof of loss should be furnished to the Plan within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time shall neither invalidate nor reduce any claim in the event it is shown that it was not reasonably possible to furnish written proof of loss within that time, provided such proof is furnished as soon as reasonably possible.

O. Recovery

Whenever payments have been made by the Plan at any time, the allowable expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Plan, the Plan shall have the right to recover these payments, to the extent of the excess, from among one or more of the following, as the Plan Trustees shall determine:

1. Any individuals to or for or with respect to whom these payments were made;

2. Insurance companies or other organizations.

P. Time Limitations

In the event any time limitations included in the Plan for giving notice of claims, furnishing proof of loss or for bringing any action by law or in equity is less than that permitted by the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

Q. Notice of Adverse Benefit Determination

The claimant shall be provided with written notice of the initial benefit determination. In the event the determination is an Adverse Benefit Determination, the notice shall include:

1. The specific reasons for the determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is deemed necessary;

4. A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;

5. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

6. In the event an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy shall be available upon request at no charge;

7. In the event the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination shall be available upon request at no charge;

8. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification);

9. For Disability Claims:

   a. The claim involved;

   b. The Plan standard that was used, if any;

   c. A statement of your right to an opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;

d. A discussion of the Plan's initial claim decision, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

SECTION 16.04. CLAIMS APPEAL PROCEDURES

In the event a Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision.

A. Post-Service or Disability Claims

The appeal of a Post-Service or Disability Claim must be submitted in writing to the Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

1. The patient's name and address and member's identification number;

2. The claimant's name and address, if different;

3. A statement that this is an appeal of a decision by the Board of Trustees;

4. The date of the Adverse Benefit Determination; and

5. The basis of the appeal, i.e., the reasons why the Claim should not be denied.

B. Pre-Service or Urgent Claims

Appeals of Adverse Benefit Determinations regarding Pre-Service or Urgent Claims may be made orally within 180 days after receipt of the Notice of Adverse Benefit Determination by calling PROVIDED PRE-CERTIFICATION FACILITY.

C. Concurrent Claims

Appeals of Adverse Benefit Determinations regarding Concurrent Claims may be made orally by calling PROVIDED PRE-CERTIFICATION FACILITY. For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set timeframe for appeal; however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim

regarding an extension of care, the appeal timeframe shall be the timeframe for an Urgent, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

D. Rights of the Claimant

The claimant must have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination. The claimant shall be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

E. Review Rights

A different person shall review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer shall not give deference to the initial Adverse Benefit Determination. The decision shall be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

F. Denial of Claim Based on Medical Necessity

In the event the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine shall be consulted. Upon request, the claimant shall be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on his or her Claim, without regard to whether the advice was relied upon in deciding the Claim.

SECTION 16.05. TIMEFRAMES FOR NOTICES OF APPEAL DETERMINATIONS

A. Pre-Service Claims

PROVIDED PRE-CERTIFICATION FACILITY shall send notice of the appeal determination for Pre-Service Claims within 30 days of receipt of the appeal by PROVIDED PRE-CERTIFICATION FACILITY.

B. Urgent Claims

PROVIDED PRE-CERTIFICATION FACILITY shall send notice of the appeal determination for Urgent Claims within 72 hours of receipt of the appeal by PROVIDED PRE-CERTIFICATION FACILITY.

C. Concurrent Claims

Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care shall be sent by PROVIDED PRE-CERTIFICATION FACILITY before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care shall be sent by PROVIDED PRE-CERTIFICATION FACILITY based on the timeframes for an Urgent, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

D. Post-Service Claims

Ordinarily, decisions on appeals involving Post-Service Claims shall be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, in the event the request is received within 30 days of the next regularly scheduled meeting, it shall be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant shall be advised in writing in advance if this extension shall be necessary. Once a decision on the appeal has been reached, notice of the appeal determination shall be sent as soon as possible, but no later than five days after the decision has been reached.

E. Disability Claims

Ordinarily, decisions on appeals involving Disability Claims shall be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, in the event the request is received within 30 days of the next regularly scheduled meeting, it shall be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant shall be advised in writing in advance if this extension shall be necessary. Once a decision on the appeal has been reached, notice of the appeal determination shall be sent as soon as possible, but no later than five days after the decision has been reached.

The Plan will provide, free of charge and prior to the Plan's adverse benefit determination on appeal, any new or additional evidence or rationale for denial considered, relied upon, or generated by (or at the direction of) the Plan or other person making the benefit determination in connection with the appeal. This evidence or rationale will be provided as soon as possible and sufficiently in advance of the date that the Plan's decision on appeal is due, in order to give the claimant a reasonable opportunity to respond to such new or additional evidence or rationale.

SECTION 16.06. CONTENT OF APPEAL DETERMINATION NOTICES

The determination of an appeal shall be provided to the claimant in writing. The notice of a denial of an appeal shall include:

A. The specific reason for the determination;

B. Reference to the specific Plan provisions on which the determination is based;

C. A statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

D. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

E. In the event an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge;

F. In the event the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;

G. With respect to Disability Claims, a discussion of the Plan's initial claim decision, including the basis for disagreeing with (i) any disability determination by the Social Security Administration; (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

SECTION 16.07. DECISION OF THE BOARD OF TRUSTEES IS FINAL AND BINDING

The decision of the Board of Trustees with respect to the appeal will be final and binding upon all parties including the Employee or his or her Eligible Dependent and any person claiming on behalf of the Employee or his or her Eligible Dependent. These provisions will apply and include any and every claim to benefits from the Plan and any claim or right asserted under the Plan, or against the Plan, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

SECTION 16.08. WHEN A LAWSUIT MAY BE FILED

The Employee and/or his or her Eligible Dependents may not file a lawsuit to obtain benefits until after the Employee and/or his or her Eligible Dependents have requested an appeal and a final decision has been reached on the appeal, or until the appropriate timeframe described above has elapsed since the Employee and/or his or her Eligible Dependents filed a request for review and have not received a final decision, or notice that an extension will be or was necessary to reach a final decision.

No lawsuit may be commenced more than one year after an appeal has been denied by the Board of Trustees..

ARTICLE XVII – DEFINITIONS

SECTION 17.01. BIRTHING CENTER

"Birthing Center" means:

A. A facility that is equipped and operated solely to:

1. Provide pre-natal care;

2. Perform uncomplicated, spontaneous deliveries; and

3. Provide immediate postpartum care.

B. A Birthing Center must either be licensed by the state or must satisfy all of the following:

1. Be directed by at least one Physician specializing in obstetrics or gynecology;

2. Have a Physician or Nurse Mid-Wife present during each birth;

3. Provide skilled nursing services in the delivery and recovery rooms (under the direction of a Registered Nurse (RN) or Nurse Mid-Wife);

4. Have at least two birthing rooms or beds, diagnostic x-ray and laboratory equipment (or a contract to use that of an area medical facility) and emergency equipment;

5. Admit only patients with low-risk pregnancies (and contract with an area Hospital for transfer of emergency cases); and

6. Regularly charge patients for services, procedures and/or supplies.

SECTION 17.02. CALENDAR YEAR

"Calendar Year" means the period of time beginning on January 1 of a year and ending on December 31 of the same year.

SECTION 17.03. CONTRIBUTING EMPLOYER OR EMPLOYER

"Contributing "Employer" or "Employer" means:

A. A sole proprietor, partnership, corporation or any other legal entity doing business in the geographical jurisdiction of the Fund who is a member of, or may

be represented in collective bargaining by an association or an employer, and who has duly executed, or may execute, or is bound by a Collective Bargaining Agreement, Participation Agreement or other written agreement with one of the local unions providing for contributions to the Fund on behalf of its Employees represented by the Union;

B. The Union, and associated Trust Funds which for the purpose of making the required contributions into the Fund, shall be considered the Employer of its Employees;

C. A sole proprietor, partnership, corporation or any other legal entity doing business in the geographical jurisdiction of the Fund who, while not generally recognizing the Union as the representative of its Employees, is bound to make contributions on behalf of certain of its Employees, by virtue of a written agreement with the Union or the Fund.

SECTION 17.04. COVERED EMPLOYMENT

"Covered Employment" means employment for which an Employer is obligated to contribute to the Fund on behalf of an Employee for participation in the Plan, and which is either:

A. Within the geographical area and occupational jurisdiction of the Union signatory to the Collective Bargaining Agreement executed by the Employer; or

B. In the case of a Non-Bargaining Unit Employee, is covered by a Participation Agreement executed by the Employer.

SECTION 17.05. CUSTODIAL CARE

"Custodial Care" means services and supplies, including room and board and other institutional services, furnished to a Participant primarily to assist him or her in the activities of daily living, whether or not he or she is disabled. These services and supplies are Custodial Care regardless of the practitioner or provider who prescribed, recommended or performed them.

SECTION 17.06. DENTIST

"Dentist" means a person who is a Doctor of Dentistry (DDS or DMD degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy. The terms Doctor of Dentistry, Doctor of Medicine or Doctor of Osteopathy, as used herein, shall have the meaning assigned to them by the Insurance Code of Texas.

SECTION 17.07. DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment that is:

A. Designed for repeated use; and

B. Mainly and customarily used for Medical purposes; and

C. Not generally of use to a person in the absence of Illness or Injury.

D. Durable Medical Equipment includes; but is not limited to:

1. Hospital beds;

2. Wheelchairs;

3. Breathing assistance apparatuses;

4. Traction apparatuses;

5. Intermittent positive pressure breathing machines;

6. Braces;

7. Crutches.

E. The following items are examples of some; but not all, of the types of Durable Medical Equipment that this Plan does not consider to be Eligible Expenses:

1. Air conditioners;

2. Air purifiers;

3. Heat lamps;

4. Heating pads;

5. Bed boards;

6. Orthopedic shoes;

7. Corrective devices for use in shoes;

8. Gravity traction devices;

9. Exercise bicycles;

10. Weight lifting equipment;

11. Swimming pools, spas or whirlpool baths; and

12. A specially equipped vans, cars or trucks.

SECTION 17.08. ELIGIBLE EXPENSE

"Eligible Expense" 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 individual for whom a claim is made. The term "Eligible Expense" also means any PPO allowed amount.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered to be both an Eligible Expense and a benefit paid.

SECTION 17.09. ELIGIBLE DEPENDENT

"Eligible Dependent" means:

A. The lawful spouse of an Employee.

B. Each child between the ages of birth and 26 years, provided the dependent child shall not be eligible as an Employee and neither the spouse nor the child shall be on full-time active duty in the military service of any country.

C. A child who is age 19 or older will not be eligible for coverage under the Plan if the child is eligible for employer-based coverage (including employer-based coverage through the adult dependent's spouse) other than coverage through a parent.

D. Eligible Dependent children are covered from birth for charges for the treatment of a hereditary abnormality or as a result of premature birth, excluding routine nursery care furnished to a newborn child during the period of the mother's confinement in the Hospital, provided there is medical necessity as confirmed by a separate diagnosis.

E. The word "child" shall include a natural born child, legally adopted child, child placed in the Employee's home for the purpose of adoption prior to the child's adoption, stepchild or foster child, provided legal documentation has been submitted to and received by the Fund Office; and

F. Medical benefits can be continued for never married children who are incapable of earning a living because of a disability and who shall be chiefly dependent on the Employee for support on the date they ceased to be eligible for Medical benefits due to attainment of the limiting age provided the incapacity began while the Eligible Dependent was otherwise eligible for the benefits of this Plan.

Coverage for such children can be continued for the duration of the incapacity provided coverage does not terminate for any other reason.

SECTION 17.10. EMERGENCY CONFINEMENT

"Emergency Confinement" means an inpatient Hospital confinement for a condition for which, unless immediately treated only on an inpatient basis, would jeopardize the life of the patient or cause serious impairment to the bodily functions of the patient.

SECTION 17.11. EMPLOYEE

"Employee" means any person who, by reason of his or her employment under the terms of a Collective Bargaining Agreement requiring contributions to this Plan, meets the eligibility requirements as specified in Article I and as amended from time to time. The term "Employee" also means a Non-Bargaining Unit Employee as defined in this Article XVII. "Employee" also means an employee of a contributing employer as defined in this article.

SECTION 17.12. EXPERIMENTAL OR INVESTIGATIONAL

"Experimental or Investigational" means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are meant to investigate or are limited to research. This term also means techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies or procedures that are not proven in an objective manner to have therapeutic value or benefit. Any procedure or treatment whose effectiveness is medically questionable is also deemed experimental.

SECTION 17.13. EXTENDED CARE FACILITY

"Extended Care Facility" means an institution, or a distinct part thereof, which:

A. Shall be licensed pursuant to the state and local laws;

B. Shall be operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from an Illness or an Injury;

C. Shall be approved by and be a participating Extended Care Facility of Medicare;

D. Shall be organized facilities for medical treatment and shall provide 24-hour nursing service under the full-time supervision of a Physician or Registered Nurse (RN);

E. Shall maintain daily clinical records on each patient and shall have available the services of a Physician under an established agreement;

F. Shall provide appropriate methods for dispensing and administering drugs and medicine;

G. Shall have a transfer agreement with one or more hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group that shall include at least one Physician; and

H. Shall exclude any institution that shall be other than incidentally a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

SECTION 17.14. EXPENSES INCURRED

"Expense Incurred" means an expense that shall be considered to be incurred at the time the confinements, treatments, services, procedures and/or supplies to which it relates shall have been provided, rendered, performed and/or supplied and shall be for the treatment of an Illness or an Injury.

SECTION 17.15. HOME HEALTH AGENCY

"Home Health Agency" means a public or private agency that specializes in providing nursing and other therapeutic services in the Employee's or Eligible Dependent's home, provided that the agency is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

SECTION 17.16. HOSPITAL

"Hospital" means an institution constituted and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, surgery, 24-hour continuous nursing service by Registered Nurses (RNs), and 24-hour continuous supervision by a staff of at least two Physicians licensed to practice medicine (other than ones whose license limits their practice to one or more specified fields) and which shall provide, for compensation, medical and surgical treatment for Illnesses and Injuries. The term Hospital shall not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

SECTION 17.17. HOSPITAL CONFINEMENT

"Hospital Confinement" means the Employee or Eligible Dependent shall be registered as a bed patient in a Hospital upon the recommendation of a Physician and shall be a patient in a Hospital because of a surgical operation or is receiving emergency care in a Hospital for an Injury within 48 hours after the injury occurred.

SECTION 17.18. ILLNESS

“Illness” means a sickness or a disease of an eligible individual, which first manifests itself while the Plan is in force with respect to that individual and which results in a loss covered by the Plan.

SECTION 17.19. INJURY

“Injury” means accidental Injury of an Employee or Eligible Dependent, which results from an accident occurring while the Plan shall be in force with respect to that individual and which shall result in a loss covered by the Plan.

SECTION 17.20. LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

“Licensed Practical or Vocational Nurse (LPN or LVN)” means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he or she performs such services, other than one who ordinarily resides in the home of the Employee and/or the Eligible Dependent or who is a member of the immediate family of either the Employee or the Eligible Dependent.

SECTION 17.21. MAINTENANCE THERAPY

“Maintenance Therapy” means repetitive medical services required to maintain function. Therapy is Maintenance Therapy where there is no medically appropriate expectation that the Participant's condition will improve significantly from a continued therapy in a reasonable and generally predictable period of time based on a Physician’s assessment of the Participant's restoration potential.

SECTION 17.22. MEDICAL EMERGENCY

“Medical Emergency” means medical treatment within 48 hours of an Injury or the first symptoms of an Illness. The Injury or Illness must be of an unexpected nature and one in which failure to receive immediate medical care would reasonably result in deterioration to the point of placing the Participant’s life in jeopardy or causing serious impairment of bodily functions.

SECTION 17.23. MEDICAL EXPENSE

“Medical Expense” shall refer to and shall include only that portion of Eligible Expenses that have been incurred during a Plan year, which exceed the applicable Deductible Amounts and shall be subject to all of the limitations of the Plan. Eligible Expenses must also be of the type and nature of medical care and treatment available in the United States. Eligible Expenses may not be experimental or investigational in nature.

SECTION 17.24. MEDICALLY NECESSARY OR MEDICAL NECESSITY

"Medically Necessary" means a service or supply that is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it, or Dentist if a dental service or supply is involved, and is determined by the Plan to be

A. Necessary in terms of generally accepted American medical and dental standards;

B. Consistent with the symptoms or diagnosis and treatment of an Illness or Injury;

C. Not provided solely for the convenience of the patient, Physician, Dentist, or Hospital;

D. "Appropriate" given the patient's circumstances and condition; and "Cost-efficient," safe, and effective for the Illness or Injury for which it is used.

"Appropriate" and "Cost-efficient" are further defined by the Plan. The fact that a Physician or Dentist provides or recommends a service or supply does not mean that the service or supply will be considered Medically Necessary for Plan coverage purposes. For example, inpatient treatment in a Hospital will not be considered Medically Necessary if the treatment can safely and appropriately be furnished in a less costly setting.

SECTION 17.25. NON-BARGAINING UNIT EMPLOYEE

"Non-Bargaining Unit Employee" means the Employee of an employer who is signatory to the Collective Bargaining Agreement provided said employer also employs at least one Employee whose employment is governed by the terms and provisions of a Collective Bargaining Agreement, unless otherwise permitted under the terms and provisions of the Trust Agreement.

SECTION 17.26. NURSE MID-WIFE

"Nurse Mid-Wife" means a person who is certified by the American College of Nurse Mid-Wives or is licensed as such by the state in which services are rendered.

Reasonable and customary Nurse Mid-Wife charges that are considered as Eligible Expenses include, but are not limited to:

A. Pre-natal visits;

B. Routine pre-natal and post-partum laboratory tests; and

C. Delivery.

SECTION 17.27. OTHER COVERAGE

"Other Coverage" means:

A. Any other contract or policy or employee welfare benefit plan under which the Employee and/or Eligible Dependent shall be eligible for protection for Medical, Dental and/or Vision expenses by virtue of his or her membership in or relation to a particular group, whether or not issued by an insurance company and/or other health care provider, and whether or not the benefits are in the nature of indemnity or prepaid services.

B. Any governmental program existing by statutory authority, under which he or she shall be entitled to Medical, Dental and/or Vision benefits.

C. The term shall not be applicable to any coverage held by the Employee or Eligible Dependent for Medical, Dental and/or Vision expenses that are written as a part of, or in conjunction with, any personal insurance policy or automobile casualty insurance policy.

SECTION 17.28. PHYSICIAN

"Physician" means a practitioner of the healing arts who is duly licensed in the state where he or she is practicing and who is treating the Employee and/or Eligible Dependent within the scope and limitation of that license. The term Physician shall not include the Employee, spouse, children, brothers, sisters, or parents; nor any person residing in the household of the Employee and/or the Eligible Dependent.

Unless a Surgical Assistant is duly licensed in the state where he or she is practicing and is practicing within the scope of such license, the Fund shall not consider charges resulting from services rendered by a Surgical Assistant as Eligible Expenses.

SECTION 17.29. PLAN

"Plan" means any of the following types of coverage providing Medical, Dental and/or Vision benefits or services:

A. Group, blanket or franchise insurance coverage;

B. Group Hospital service prepayment, group medical service pre-payment, group practice or other group pre-payment coverage;

C. Group coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employment benefit plans;

D. Coverage under governmental programs or coverage required or provided by any statute; or

E. Coverage provided through a school or other educational institution.

The term "Plan" shall also be construed separately with respect to each policy, contract or other arrangement for benefits or services, separately with respect to that portion of a 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 separately with respect to that portion which does not reserve the right.

SECTION 17.30. PRE-ADMISSION/POST-ADMISSION HOSPITAL CERTIFICATION

"Pre-Admission/Post-Admission Hospital Certification" means an evaluation made by an independent hospitalization certification organization to determine the number of days of inpatient Hospital confinement considered reasonably necessary for the care or treatment of an eligible individual's diagnosed Illness or Injury.

SECTION 17.31. REASONABLE AND CUSTOMARY

"Reasonable and Customary" means 100% of the Medicare UCR for Out of Network services.

SECTION 17.32. REGISTERED NURSE (RN)

"Registered Nurse (RN)" means a professional nurse who is entitled to use the designation of Registered Nurse (RN) other than one who ordinarily resides in the home of the Employee or the Eligible Dependent or who is a member of the immediate family of the Employee or the Eligible Dependent.

SECTION 17.33. ROOM AND BOARD

"Room and Board" shall include all charges commonly made by a Hospital on its own behalf for room, meals and all general services and activities essential to the care of registered bed patients.

SECTION 17.34. SKILLED NURSING FACILITY

"Skilled Nursing Facility" means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

A. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility;

B. It is regularly engaged in providing room and board, and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician;

C. It provides services under the supervision of Physicians;

D. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times;

E. It maintains a daily medical record of each patient who is under the care of a licensed Physician;

F. It is not (other than incidentally) a home for Maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill; and

G. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

SECTION 17.35. TOTAL DISABILITY

"Total Disability" means an:

A. Employee is completely unable, as a result of Illness or Injury, to engage in any gainful occupation for which he or she is reasonably fitted by education, training or experience, and is not performing work of any kind for wage or profit.

B. Eligible Dependent shall be considered totally disabled, if because of a non-occupational Illness or Injury, he or she is prevented from engaging in all the normal activities of a person of like age and sex who is in good health.

ARTICLE XVIII – INTERPRETATION, AMENDMENT, TERMINATION AND MAXIMUM LIABILITY

SECTION 18.01. INTERPRETATION

The Trustees have full and exclusive authority in their sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Trustees also have full power and sole discretion to construe the provisions of the Agreement and Declaration of Trust for the Plan and the Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Trustees shall be binding on all entities and beneficiaries of this Plan.

SECTION 18.02. AMENDMENT AND TERMINATION

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Employees and their Eligible Dependents, the Board of Trustees expressly reserves the right in its sole discretion at any time and from time to time to:

A. Terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims that have already accrued.

B. Alter or postpone the method of payment of any benefit.

C. Amend or rescind any other provisions of these Amended and Restated Rules and Regulations.

SECTION 18.03. MAXIMUM LIABILITY OF THE PLAN

The Medical, Disability, Dental, and Prescription Drug benefits described in these Amended and Restated Rules and Regulations are not insured by any contract of insurance and there shall be no liability upon the Board of Trustees, or any individual or entity, to provide benefit payments over and beyond the funds held in the Plan that were collected from contributions plus any investment earning, and that are available for such purposes.

ARTICLE XIX – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION 19.01. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR HEALTH CARE TREATMENT, PAYMENT FOR HEALTH CARE, AND HEALTH CARE OPERATIONS

The Plan shall use Protected Health Information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time. Specifically, the Plan shall use and shall disclose PHI for purposes related to health care treatment, Payment for Health Care and Health Care Operations.

A. Payment for Health Care

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

1. Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Subrogation of health benefit claims;

5. Establishing employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, shall include auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (PHI that may be disclosed for payment purposes is limited to: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan); and

13. Reimbursement to the Plan.

B. Health Care Operations

"Health Care Operations" includes, but is not limited to, the following activities:

1. Quality assessment;

2. 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;

3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

4. 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);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. 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;

7. Business management and general administrative activities of the entity, shall include, but shall not be limited to:

a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

b. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

c. Resolution of internal grievances; and

d. 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, shall become a covered entity.

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents.

SECTION 19.02. USE AND DISCLOSURE BY AUTHORIZATION

The Plan shall use and shall disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

SECTION 19.03. USE OF PHI BY THE PLAN SPONSOR

For purposes of the Plan, the Joint Board of Trustees that sponsor the Plan shall be the "Plan Sponsor." With respect to PHI, the Plan Sponsor shall:

A. Not use or further disclose the information other than as permitted or required by this Plan document or as required by law;

B. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor shall provide 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 that is inconsistent with the uses or disclosures provided for of which it becomes aware;

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 available the information 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 Plan with HIPAA; and

J. Where feasible, shall return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. In the event the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

SECTION 19.04. SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees shall be given access to PHI:

A. The Plan;

B. Fund Office staff designated by the Plan and Plan Trustees.

C. The persons described in this Section may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

D. In the event the persons described in this Section do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions.

SECTION 19.05. COMPLIANCE WITH HITECH ACT

The Plan shall comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA).

ARTICLE XX – PRIVACY NOTICE

PURPOSE OF THIS NOTICE AND EFFECTIVE DATE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date. The effective date of this Notice is January 1, 2019.

This Notice is required by law. The Plumbers Local No. 68 Group Protection Plan ("the Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

A. The Plan's uses and disclosures of Protected Health Information (PHI);

B. Your rights to privacy with respect to your PHI;

C. The Plan's duties with respect to your PHI;

D. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS); and

E. The person or office you should contact for further information about the Plan's privacy practices.

YOUR PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) Defined. The term "Protected Health Information (PHI)" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

When the Plan May Disclose Your PHI. Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

A. **At your request.** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.

B. **As required by HHS.** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

C. **For treatment, payment or health care operations.** The Plan and its business associates will use PHI in order to carry out treatment, payment, or health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating physician specialist the name of your primary physician so that the specialist may obtain your medical records from the primary physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If the Plan contracts with third parties to help with payment operations, such as a physician that reviews medical claims, the Plan will also disclose information to them. These third parties are known as "business associates."

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions.

Disclosure to the Plan's Trustees. The Plan will also disclose PHI to the Plan's Board of Trustees (the "Plan Sponsor") for purposes related to treatment, payment, and health care operations, and has amended the Plan documents to permit this use and disclosure as required by federal law. For example, the Plan may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization. The Plan must generally obtain your written authorization before::

A. Using or disclosing psychotherapy notes about you from your psychotherapist;

B. Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed; and

C. Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release. Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose, without your written consent or authorization, is allowed under federal law if:

A. The information is directly relevant to the family or friend's involvement with your care or payment for that care; and

B. You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required.

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

A. **When required by applicable law.** The Plan may use and disclose the PHI as required by Federal, State or local law.

B. **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

C. **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

D. **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

E. **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

F. **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).

G. **Law enforcement emergency purposes.** For certain law enforcement purposes, including:

1. Identifying or locating a suspect, fugitive, material witness or missing person; and

2. Disclosing information about an individual who is or is suspected to be a victim of a crime.

H. **Determining cause of death and organ donation.** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

I. **Funeral purposes**. When required to be given to funeral directors to carry out their duties with respect to the decedent.

J. **Research.** For research, subject to certain conditions.

K. **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

L. **Workers' Compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

M. **Specialized Government Functions.** When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Any other Plan uses and disclosures not described in this Section, "Your Protected Health Information," will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization.

Other Uses or Disclosures. The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the plan for reviewing your appeal of a benefit claim or for other reasons regarding the

administration of this Plan. The Plan Sponsor is the Board of Trustees of the Plumbers Local No. 68 Group Protection Plan.

YOUR INDIVIDUAL PRIVACY RIGHTS

Breach Notification. If a breach of your unsecured PHI occurs, the Plan will notify you.

You May Request Restrictions on PHI Uses and Disclosures. You may request the Plan to:

A. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations; or

B. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan or Privacy Official determines it to be unreasonable.

Make such requests to the Fund Office using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

You May Request Confidential Communications. The Plan will accommodate an individual's reasonable request to receive communications of PHI ***by alternative means or at alternative locations*** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Fund Office using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

You May Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI.

The Plan must provide the requested information within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. You may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI.

Requests for access to PHI should be made to the Fund Office using the address and phone number at the beginning of this Summary Plan Description ("SPD") and Amended and Restated Rules and Regulations of the Plan.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Designated record set includes your medical records and billing records that are maintained by or for a covered health care provider. **Records** include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI. You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund Office using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

You or your personal representative will be required to submit a written request to amend PHI and to provide a reason to support the requested amendment.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures. At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI. The Plan does not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request. To receive a separate paper copy of this Notice, contact the Fund Office using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan. This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by contacting the Fund Office using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules, and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without the individual having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor except in a few types of situations. A spouse or a parent recognized as a personal representative may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Plan restrict information that goes to family members as described above at the beginning of this Notice.

THE PLAN'S DUTIES

Maintaining Your Privacy. The Plan is required by law to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

This notice is effective beginning on January 1, 2019 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

If material changes are made to this Notice, it will be posted on the Plan's website no later than the effective date of the revision and thereafter sent in the Plan's next annual mailing.

Material changes are changes that are made to:

A. The uses or disclosures of PHI;

B. Your individual rights;

C. The duties of the Plan; or

D. Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

A. Disclosures to or requests by a health care provider for treatment;

B. Uses or disclosures made to you;

C. Uses or disclosures made pursuant to your written authorization;

D. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under the Health Insurance Portability and Accountability Act (HIPAA);

E. Uses or disclosures required by law; and

F. Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

A. Does not identify you; and

B. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

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

a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Compliance with HITECH Act. The Plan shall comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA).

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Fund Office, using the address and phone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

You may also file a complaint with the Secretary of the U. S. Department of Health and Human Services ("HHS"). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, or visit the HHS website at www.hhs.gov. Instructions for filing a complaint with HHS are available at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

For more information about how to file a complaint, contact the Fund Office using the address and telephone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan. The Plan will not retaliate against you for filing a complaint.

IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Fund Office using the address and telephone number at the beginning of this SPD and Amended and Restated Rules and Regulations of the Plan.

CONCLUSION

PHI use and disclosure by the Plan is regulated by the Federal Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the Regulations. The Regulations will supersede this notice if there is any discrepancy between the information in this notice and the Regulations.

ARTICLE XXI – INFORMATION REQUIRED UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information concerning the Plan is being provided to you in accordance with government regulations:

A. Name and Type of Administration of the Plan

The Plumbers Local Union No. 68 Welfare Fund is administered by a Joint Board of Trustees consisting of Union representatives and Employer representatives.

B. Type of Welfare Plan

The Plumbers Local Union No. 68 Welfare Fund Plan is a group health plan, which provides medical, dental, and vision benefits, as well as life insurance, accidental death and dismemberment insurance, and disability benefits.

C. Name and Address of the Plan

Board of Trustees
c/o Trust Fund Administrative Office
468 Link Road
Houston, TX 77009

D. Names and Business Addresses of the Trustees

Union Trustees	**Employer Trustees**
Mr. Jeffrey LaBroski Plumbers Local Union No. 68 502 Link Road Houston, TX 77009	Mr. Chuck Fell CFI Mechanical, Inc. 6109 Brittmoore Road Houston, TX 77041
Mr. Richard Lord Plumbers Local Union No. 68 502 Link Road Houston, TX 77009	Mr. Jim Humphrey Humphrey Company 6877 Wynnwood Houston, TX 77008
Mr. Wayne Lord Plumbers Local Union No. 68 502 Link Road Houston, TX 77009	Mr. Jim Letsos Letsos Company 8435 Westglen Drive Houston, TX 77063
Mr. William A. Venable II Plumbers Local Union No. 68 502 Link Road Houston, TX 77009	Mr. Tony McCorvey, Jr. Way Engineering 8610 Wallisville Road Houston, TX 77029

E. Agent for the Service of Legal Process

Patrick M. Flynn, Esq.
Attorney and Counselor At Law
1225 North Loop West, Ste. 1000
Houston, TX 77008

Legal process may also be served on the Board of Trustees or upon any member of the Board of Trustees.

F. Employer Identification Number / Plan Number

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 74-6038640. The Plan Number assigned by the Board of Trustees is 501.

G. Plan Year End

For purposes of maintaining the Plan's fiscal records, the plan year end date is June 30.

H. Funding Medium

Benefits are provided from the Plan's assets, which are accumulated under the provisions of Collective Bargaining Agreements, Participation Agreement and the Trust Agreement and held in a trust fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

I. Insurance Companies

The Plan's life insurance benefits and accidental death and dismemberment benefits are provided under a group insurance policy issued to the Fund by:

Union Labor Life Insurance Company ("ULLICO")
8403 Colesville Road
Silver Spring, MD 20910

The Plan's vision benefits are provided under a group insurance policy issued to the Fund by:

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

J. Contribution Source

1. All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements between various employers and Local Union Number 68; or, participation agreements with the Plan.

2. The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour worked. The Participation Agreements also require contributions to the Plan at a fixed rate.

3. The Plan will provide you, upon written request, with information as to whether a particular Employer is contributing to this Plan on behalf of Employees working under the Collective Bargaining and/or Participation Agreements.

4. See the section titled "Plan Documents and Reports" below if you wish to obtain additional information about the Collective Bargaining and/or Participation Agreements.

K. Plan Documents and Reports

Employees may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;

2. Collective Bargaining and Participation Agreements;

3. Plan Documents and all Amendments;

4. Form 5500 or full Annual Report filed with the Internal Revenue Service and the Department of Labor; and

5. List of Contributing Employers.

Employees may also obtain copies of these documents by writing for them. The cost of the copies will be up to 25¢ per page. If you prefer, you can arrange to examine these reports, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. A summary of the Annual Report, which gives details of the financial information about the Plan's operation is furnished free of charge to all participants.

L. List of Network Providers

You may obtain a listing of network providers, free of charge, by contacting the Fund Office.

M. Statement of ERISA Rights

As a Participant in the Plumbers Local Union No. 68 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

1. Receive Information About Your Plan and Benefits

   a. Examine without charge at the Plan's office and at other specified locations, such as worksites and union halls, all documents governing the Plan including insurance contracts, if any, Collective Bargaining and Participation Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor.

   b. Obtain, upon written request to the Plan, copies of documents governing the operation of the Plan, including insurance contracts, if any, and Collective Bargaining and Participation Agreements and an updated Summary Plan Description. The Plan may charge up to 25¢ per page for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Participant with a copy of this summary annual report free of charge.

2. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or other Eligible Dependent if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Eligible Dependents may have to pay for this coverage. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation of Coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Welfare Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Plan benefit or exercising your rights under ERISA.

4. Enforce Your Rights

a. If your claim for a Health and Welfare Plan 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.

b. Under ERISA, there are steps you can take to enforce the above rights. For instance, in the event you request materials from the Plan and do not receive them within 30 days, you may file a suit in a Federal court. In such a case, the court may require the Plan 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 Plan. In the event you have a claim for a Health and Welfare Plan benefit that is denied or ignored, in whole or in part, you may file suit in Federal court.

c. In addition, in the event you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations and/or medical child support order, you may file suit in a Federal court. In the event it should happen that Plan fiduciaries misuse the Plan's money, or 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.

d. The court shall decide who should pay the court costs and legal fees. In the event you are successful, the court may order the person you have sued to pay these costs and fees. In the event you lose, the court may order you to pay these costs and fees, for example, in the event it finds your claim is frivolous.

5. Assistance with Your Questions

In the event you have any questions about your Plan, you should contact the Plan. In the event you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. You may contact the nearest area office of EBSA in Dallas, Texas at (972) 850-4500.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR SOLE DISCRETION, CONDITIONS SO WARRANT.

NOTICE

This Plan will not be deemed to constitute a contract of employment or give any Employee of an Employer the right to remain in the service of the Employer or to interfere with the right of the Employer to discharge any Employee. These issues are covered by your Collective Bargaining and/or Participation Agreement.

You MUST satisfy all eligibility provisions in order to be eligible for the benefits of this Plan. Possession of the SPD and Amended and Restated Rules and Regulations of the Plan does not automatically entitle you or your Eligible Dependents, if any, to Plan benefits.

The Trustees have full and exclusive authority in their sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Trustees also have full power to construe the provisions of the Agreement and Declaration of Trust for the Plan, the SPD, and the Amended and Restated Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Trustees is binding on all entities and beneficiaries of this Plan.

The Disability, Medical, Dental, and Prescription Drug benefits described in this SPD and Amended and Restated Rules and Regulations of the Plan are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and above the amount in the Plan available for such purpose.

Life Insurance Conversion Privilege. Although the benefits underwritten by the insurance carrier may not exactly duplicate the Life insurance benefits now being provided by the Plan, you have the right to convert the Life insurance benefits to an individual policy through ULLICO. You have 31 days from the date you lose eligibility with the Plan to notify the insurance carrier and pay the first month's premium. The Plan will answer any questions regarding conversion privileges.

BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Mr. Jeffrey LaBroski	Mr. Chuck Fell
Mr. Wayne Lord	Mr. Jim Humphrey
Mr. Richard Lord	Mr. Jim Letsos
Mr. William A. Venable II	Mr. Tony McCorvey, Jr.

TRUST FUND ADMINISTRATIVE OFFICE

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Houston, Texas 77249-8726
(713) 869-2592 or (800) 833-2980

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