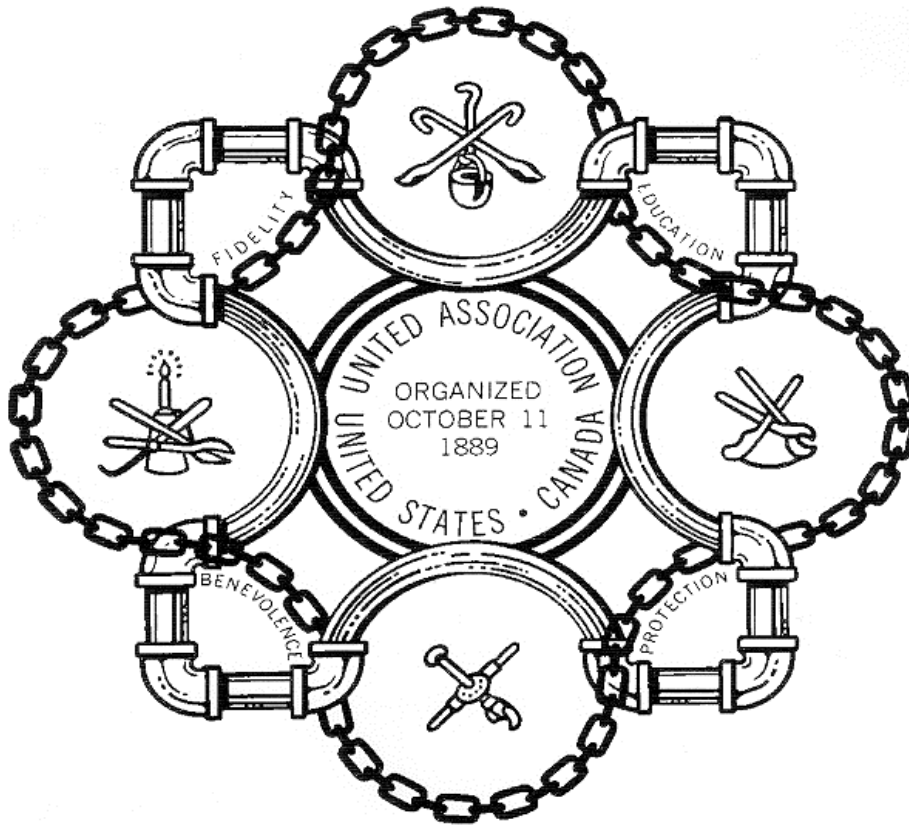


East Central Illinois Pipe Trades Health and Welfare Fund Summary Plan Description

2016 Edition



January 1, 2016

Claim Filing Procedure Overview

Every person must file one claim form per calendar year. Benefits may be withheld until a claim form is received.

Non-PPO Medical and Weekly Income Benefit (short-term disability) claims are filed with:

HealthSCOPE Benefits, Inc.
P.O. Box 50440
Indianapolis, IN 46250-0440
1-800-398-9936

If a PPO provider is used, the provider will file the claim for you. If a Non-PPO provider is used, you must file the claim.

To ensure prompt service:

- Get a claim form from your Local Union or the Fund Office.
- Complete the necessary portions of the form by filling in all requested information, including your Social Security Number, or ID Number, and signing on the line specified.
- Obtain from the Non-PPO provider, an itemized bill showing the diagnosis, the services and supplies provided, the charge for each item and the date of each charge. If possible, have the provider complete the appropriate portion of the claim form.
- Forward the completed form, with all attachments, to the address above.

Reimbursement for covered charges will be made to the provider of service, unless the bill is clearly marked "Paid in Full" by the provider. For more detailed medical claims and appeals information, see page 65. For Weekly Income Benefit claims information, see page 30.

Contact Information

If You Have A Question About...	Contact...
Medical Benefits	<ul style="list-style-type: none"><li data-bbox="829 321 1446 556">■ For claims: HealthSCOPE Benefits, Inc. P.O. Box 50440 Indianapolis, IN 46250-0440 1-800-398-9936 <li data-bbox="829 577 1446 724">■ For PPO provider network information: BCBS of Illinois at 1-800-571-1043 or www.bcbsil.com <li data-bbox="829 787 1446 934">■ For utilization review: Inetico (877) 885-2211
Prescription Drug Benefits	<ul style="list-style-type: none"><li data-bbox="829 980 1446 1228">■ For Retail Card and Mail Order Programs: Sav-Rx P.O. Box 8 Fremont, NE 68026 1-800-228-3108 www.savrx.com
Weekly Income Benefit Claims Death and Accidental Death & Dismemberment (AD&D) Benefit Claims	HealthSCOPE Benefits, Inc. P.O. Box 50440 Indianapolis, IN 46250-0440 1-800-398-9936

East Central Illinois Pipe Trades Health And Welfare Fund

c/o HealthSCOPE Benefits, Inc.
8901 Otis Avenue, Suite 200
Indianapolis, IN 46216
1-800-398-9936

Fund Administrator
HealthSCOPE Benefits, Inc.

Board Of Trustees

(Plan Administrator (as defined by law) And Agent For The Service Of Legal Process)

Union Trustees

Mr. D. Michael Doolan II
Plumbers Local 63
116 Harvey Ct
East Peoria, Illinois 61611

Mr. Evan Wooding
Steamfitters Local 353
6304 West Development Dr.
Peoria, Illinois 61604

Mr. Patrick Hardesty
Plumbers and Steamfitters Local 99
406 Eldorado Rd
Bloomington, Illinois 61704

Mr. John Haines
Plumbers Local 137
Post Office Box 3526
2880 East Cook
Springfield, Illinois 62708

Mr. Matt Langendorf
Plumbers and Pipefitters Local 149
P.O. Box 725
Savoy, Illinois 61874

Employer Trustees

Mr. Jody Alderman
Henson Robinson
3550 Great Northern Ave
Springfield, Illinois 62711

Mr. Brian Rich
G.A Rich & Sons
300 East First Street
Deer Creek, Illinois 61733

Mr. Brad Houk
Davis-Houk
1212 East University Ave
Urbana, Illinois 61802

Mr. Doug Kelleher
Commercial Mechanical, Inc.
50 First Street
Dunlap, Illinois 61525

Mr. Scott Larkin
Mid-Illini Mechanical Contractors Assoc.
Post Office Box 7
Lincoln, Illinois 62656

Fund Counsel

Cavanagh and O'Hara LLP

Consultant

Genesis Benefit Solutions, Inc.

Dear Participant:

The Board of Trustees of the East Central Illinois Pipe Trades Health and Welfare Plan is pleased to provide you with this booklet, which contains current health and welfare benefits information. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan's official Rules and Regulations.

It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to our participants and their families. This is becoming more challenging as health care costs continue to rise at double-digit rates. The Fund has implemented some cost-saving methods such as medical and prescription drug deductibles and a Hospital certification requirement to ensure that we can meet your current and future health care needs. You can do your part in helping the Fund manage health care costs by:

- **Visiting PPO network providers** – PPO providers including Hospitals, Physicians and other health care providers charge negotiated reduced rates. Also, the Plan pays a higher percentage when you use a PPO provider.
- **Using the prescription drug program** – When purchasing prescription drugs please be sure to use your health plan identification card at the pharmacy to obtain the Plan's negotiated discounts, and receive maximum benefits for your prescription. Also, please keep in mind generic drugs offer substantial cost savings over brand name drugs. You pay the lowest copayment when you select generic medications and you help to keep your healthcare costs from increasing. The Fund also offers a Mail Order Program for your maintenance medications, because the Mail Order Program charges lower rates than retail pharmacies.
- **Examining emergency treatment alternatives** – In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or an urgent care facility as in an emergency room. Keep your Physician's telephone number easily accessible and locate the urgent care facility nearest to you beforehand so you'll be prepared in case of emergency.

To help keep you and your family healthy, remember that the Wellness Benefit covers physicals, pap smears, prostate exams and immunizations for you, your spouse and Dependent children.

Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, contact the Fund Office.

Sincerely,
BOARD OF TRUSTEES

The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Eligible Employees will be notified in writing of any Plan changes.

The East Central Illinois Pipe Trades Health and Welfare Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered plan can preserve basic health coverage that was in effect when that law was enacted. Being a grandfathered health plan means that the Plan does not include certain consumer protections of the Affordable Care Act. 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 Plan Administrator at the office of the Third Party Administrator (TPA). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at www.healthreform.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Table Of Contents

Contact Information	2
Schedule of Benefits.....	9
Eligibility	12
Eligibility Rules for Active Employees.....	12
Dependent Eligibility	15
When Coverage Ends	16
Non-Work Hours.....	17
Reinstatement Of Eligibility.....	19
Self-Payment Option for Active Employees	20
Self-Payment Option for Disabled Participants.....	20
Retiree Self-Payments	22
COBRA Continuation Coverage Option.....	23
Death Benefit (Active and Retired Employees Only).....	28
Designating Your Beneficiary	28
Filing A Claim	28
Accidental Death & Dismemberment Benefit (Active Employees Only).....	29
Limitations.....	29
Filing A Claim	29
Weekly Income Benefit (Active Employees Only)	30
Benefit Amount.....	30
When Weekly Income Benefits Begin	30
Limitations On Weekly Income Benefits	30
Filing A Weekly Income Benefit Claim.....	31
Weekly Income Benefit Claim Decisions	31

Denial Of Weekly Income Benefit Claim	31
Your Weekly Income Benefit Appeal Deadline	32
Plan’s Deadline For Weekly Income Benefit Appeal Decision.....	32
Comprehensive Major Medical Expense Benefit (Employees/Retirees And Their Eligible Dependents)	34
Deductible.....	34
Benefits Payable (Coinsurance).....	34
Individual Coinsurance Maximum.....	34
Preferred Provider Organization (PPO).....	35
Utilization Review.....	36
Covered Charges	37
Charges Not Covered	42
Wellness Benefit (Employees/Retirees and Eligible Dependents).....	46
Benefits Bank Reimbursement Program.....	47
Prescription Drug Benefit (Employees/Retirees And Eligible Dependents).....	49
Covered Charges	49
Charges Not Covered	49
Benefits Payable.....	50
Retail Card Program.....	50
Mail Order Program	51
Definitions.....	53
Coordination Of Benefits.....	58
How Benefits Are Paid.....	58
Coordination Of Benefits With Medicare	60
Subrogation or Reimbursement.....	61
Filing Health Care Claims and Appeals.....	65

Filing Your Initial Claim	65
Types of Claims	65
When Benefits Are Paid	66
Your Claim Decision Notice.....	66
Denial Of Claims.....	67
Claims Appeal.....	67
Legal Proceedings	69
General Provisions.....	70
Notice of Claim.....	70
Requirement to Provide Necessary Information Regarding Eligibility	70
Privacy Policy	70
Proof Of Loss	75
Physical Examination And Autopsy	75
Payment of Claims	75
Gender	75
Assignment	76
Amendment And Termination	76
No Employment Guarantee	76
Administrative Information.....	77
Statement of ERISA Rights	79
Receive Information About Your Plan And Benefits	79
Continue Group Health Plan Coverage	79
Prudent Actions By Plan Fiduciaries.....	79
Enforce Your Rights.....	79
Assistance With Your Questions	80

Schedule of Benefits

Active Employees Only	
Death and AD&D Benefits	Coverage
Death Benefit	\$10,000
Accidental Death & Dismemberment Benefit	\$10,000
Weekly Income Benefit	
Weekly Benefit Amount	\$350
Maximum Number of Weeks	52 ⁽¹⁾
Benefits Begin	
Accident	First day
Sickness	Eighth day
Retired Employees Only	
Death Benefit (Under 65 and/or not entitled to Medicare)	\$10,000
Death Benefit (Entitled to Medicare)	\$5,000
Employees/Retirees And Eligible Dependents	
Comprehensive Major Medical Expense Benefits	Coverage
Calendar Year Deductible	
Per Person	\$500
Per Family	\$1,500
Coinsurance	Plan pays:
PPO Provider	80% of Network Allowable Charges
Non-PPO Provider ⁽²⁾	60% of Reasonable and Customary Charges
Individual Coinsurance Maximum ⁽³⁾	
For PPO Provider Charges (In-Network)	\$10,000 per person
For Non-PPO Provider Charges (Out-Of-Network)	\$10,000 per person
Annual Maximum Benefit	Effective August 1, 2014, Unlimited/No Limit on Essential Health Benefits*
	<small>*Any applicable limits for non-essential health benefits remain as part of the Plan</small>
Occupational Therapy	Covered, subject to deductible and coinsurance.
Acupuncture Treatment	\$25 per treatment; up to 15 treatments per calendar year
Chiropractic Care	\$850 per calendar year
Hearing Aids	\$1,500 per lifetime for all devices
Foot Orthotics	\$400 per calendar year
Sleep Study Participation	One per lifetime

Employees/Retirees And Eligible Dependents	
Bariatric Surgery ⁽⁴⁾	\$40,000 one per lifetime
Non-Emergency Use of Emergency Room	\$75 Copayment, then deductible applies, then 80% In-Network, 60% Out-of-Network
Mental/Nervous and Substance Abuse Treatment	Covered the same as any other illness (subject to deductible and coinsurance)
Home Health Care	Covered, subject to deductible and coinsurance.
Hospice Care	185 days per lifetime

Employees/Retirees and Eligible Dependents	
Wellness Benefit	Coverage
PPO Provider Non-PPO Provider Maximum	You pay: \$10 copayment per visit \$20 copayment per visit \$800 per calendar year (Charges in excess of maximum, deductible applies, then 80% In-Network, 60% Out-of-Network)
Prescription Benefit	Coverage
Calendar Year Deductible	\$100 per person
Retail Card Program (30-day supply or 100 units) Generic Drugs Brand-Name Drugs	<u>You pay:</u> \$10 copayment per prescription 20% copayment with \$30 minimum, up to \$100 maximum per prescription
Mail Order Program (90-day supply) ⁽⁵⁾ Generic Drugs Brand-Name Drugs Specialty Drugs (See the Definitions Section for an explanation of specialty drugs)	You pay: \$20 copayment per prescription \$70 copayment per prescription 20% copayment with \$70 minimum, up to \$200 maximum per prescription
Dental Benefit	Coverage
Calendar Year Deductible	\$50 per person
Basic and Routine Services Major Services Calendar Year Maximum	<u>Plan pays after deductible:</u> 80% of reasonable and customary charges 50% of reasonable and customary charges \$500 per person per calendar year
Vision Benefit	Coverage
Coinsurance Calendar year maximum	<u>Plan pays:</u> 75% of reasonable and customary charges \$300 per person per calendar year

- (1) *An independent medical exam is required for payment of Weekly Income Benefits after 26 weeks.*
- (2) *If there is no In-Network provider available to provide the required medically necessary services within a 25 mile radius of the participant's residence, then the In-Network Coinsurance will apply for services otherwise covered by the Plan.*
- (3) *The individual coinsurance maximum does not include the deductible amount or copayments for expenses required under the Prescription Drug and Wellness Benefits.*
- (4) *Bariatric Surgery is covered provided certain conditions are met, as specified in the Plan under the Charges Not Covered section. All charges, including complications resulting from the surgery, are limited to the lifetime maximum as specified.*
- (5) *You must use the Mail Order Program for all maintenance medications to have your prescription covered under the Plan.*

<p>There is a \$500 penalty for not certifying a Hospital stay. Call HealthSCOPE Benefits at 1-800-398-9936.</p>

Initial Eligibility Amount *	\$3,050
Continued Eligibility Amount *	\$2,285
Benefit Bank Maximum *	\$6,855

*Amounts may be changed at any time at the sole discretion of the Board of Trustees

Eligibility

You are eligible for benefits under the East Central Illinois Pipe Trades Health and Welfare Plan if:

- You perform work under a collective bargaining agreement or other written agreement that requires your Employer to contribute to the Plan on your behalf; and
 - Your Employer makes these contributions; and
 - You met the initial eligibility requirement;
- or*
- You had previously met the initial eligibility requirements and are now eligible to make self-payments; and
 - You make the required self-payments on time.

Eligibility Rules for Active Employees

Eligibility for coverage is offered in three-calendar month intervals, called eligibility quarters, ending on one of the following dates:

- April 30th;
- July 31st;
- October 31st; or
- January 31st.

Once you meet your *initial eligibility requirement* (described below), you will continue to be covered for each eligibility quarter, if the Fund receives the appropriate contributions on your behalf for Covered Work. To verify your eligibility, your contributions are recorded based on when you work, not when they are received by the Fund Office.

Except as specified below, the Fund will not accept contributions from an Employer who does not have an effective labor agreement (collective bargaining agreement) with a participating Union requiring the payment of contributions to the Fund. In addition, contributions will be accepted only if they are made on behalf of all of the Employees in the collective bargaining unit, unless first otherwise expressly authorized in writing by the Trustees.

Participants who are not covered by a collective bargaining agreement are considered to be non-bargaining unit employees. Non-bargaining unit employees may participate in the plan provided that the employer agrees, in writing, to participate in the Plan subject to the terms and conditions set forth in the applicable participation agreement that is applicable to such non-bargaining unit employees as determined by the Board of Trustees. The written agreement or participation agreement shall control, supplant, and supersede all rules of eligibility set forth in the summary plan description to the extent the terms and conditions of the participation agreement are inconsistent with rules in the Summary Plan Description. The written agreement, along with the terms of this plan, shall constitute the eligibility rules for non-bargaining unit employees.

In the event that an employer fails to agree, in writing, to participate in the Plan under the terms and conditions applicable to non-bargaining unit employees but submits contributions on behalf of its non-bargaining unit employees, then the Board of Trustees may, in its sole discretion, (1) deem all non-bargaining unit employees to have been ineligible to participate in the Plan, (2) refund all employer contributions less medical claims paid on behalf of covered employees and take such legal action to collect the difference, if any, from the employer and/or participant, and (3) take legal action to collect employer contributions due on behalf of all eligible non-bargaining unit employees under the terms of the non-bargaining unit participation agreement, plus liquidated damages, interest, attorney's fees and all other costs.

Initial Eligibility Requirement for Active Employees

You will become eligible for Plan benefits once the Fund receives:

- Within the most recent 12-consecutive month period, an amount greater than or equal to the "Initial Eligibility Amount", from participating employers. The "Initial Eligibility Amount" shall mean the amount set forth in the Schedule of Benefits.

Once you become eligible, coverage begins on the first day of the next month. Coverage continues for the balance of the eligibility quarter. Contributions are monies your Employer contributes to the Welfare Fund to maintain your eligibility for coverage.

Example

The Fund received enough contributions to meet the Initial Eligibility Amount, (Initial Eligibility Amount shall mean the amount set forth in the Schedule of Benefits), on John's behalf needed to meet the initial eligibility requirement. The hours were worked between January 1, 2015 and June 30, 2015. He will be covered by the Plan beginning July 1, 2015.

In the event that the Fund does not receive contributions from your employer, you may submit, in writing, a request to the Board of Trustees to receive credit for hours that you worked. The crediting of hours by the Board of Trustees shall be in accordance with and subject to the East Central Illinois Pipe Trades Health and Welfare Fund's Policy and Procedures for the Crediting of Hours, as amended from time to time. Please contact the Fund Office to obtain a copy of the policy and procedures.

Benefits Bank

Employer contributed monies received by the Fund are used to establish an individual Benefits Bank balance within the Fund. The individual balance is carried forward until used for benefits provided by the Fund to eligible participants. The individual Benefit Bank Maximum is specified in the Schedule of Benefits.

Once an individual Benefits Bank is established, monies can be forfeited. If you are not eligible for coverage during a twelve consecutive month period, amounts contributed to your Benefits Bank prior to the most recent twelve month period will be forfeited. As set forth in the Benefits

Bank Reimbursement Program section on page 47, amounts will also be forfeited if you fail to cash reimbursement checks within one (1) year of the date of issuance of the check.

The Benefit Bank is not a vested benefit and can be changed, altered, reduced and/or eliminated at any time at the sole discretion of the Board of Trustees.

If you engage in Prohibited Employment and work for a Non-Contributing Employer then you will forfeit the monies in your Benefits Bank and will lose your eligibility for Fund coverage at the end of the month in which you engaged in Prohibited Employment and work for a Non-Contributing Employer. If you lose your eligibility for coverage as a result of engaging in Prohibited Employment and later return to work for a contributing employer, you will have to satisfy the Fund's initial eligibility requirements. A Non-Contributing Employer is defined as any employer that performs work in the plumbing and pipefitting construction industry that is covered by an area-wide construction industry collective bargaining agreement but does not make contributions to this Fund. Public employers are not considered non-contributing employers. Prohibited Employment is defined as work that regularly and historically is performed by members of the Local Unions that participate in this Fund, but is not being performed through a contributing employer. Any employment that requires contributions to this Plan is not considered prohibited employment.

Newly Organized Groups for Active Employees

The initial eligibility requirement rules are waived for newly organized groups of Employees if:

- The Employees have been continually covered under an employer sponsored health care plan; and
- Employer contributions to this Fund begin on the first day of the initial contract between the Local Union and the Employer.

If you become covered under this exception and lose eligibility within two years of the date of the initial contract between the Local Union and your Employer, you will not have the option of self-paying to continue coverage as explained on page 20. You may continue coverage under COBRA Continuation Coverage as explained on page 23.

Continued Eligibility Requirements for Active Employees

Once you meet the initial eligibility requirements, you will continue to be covered for subsequent eligibility quarters if the Fund receives contributions greater than or equal to the "Continued Eligibility Amount" (Continued Eligibility Amount shall mean the amount set forth in the Schedule of Benefits). Amounts received in excess of the required contributions will be credited to your Benefits Bank. Your Benefits Bank can be used to continue coverage in quarters where you have not been credited with sufficient contributions to continue coverage. Contributions are non-refundable and must be used to purchase benefits through this Fund. Continued coverage for eligibility quarters is determined as outlined below:

Eligibility Quarter	Contribution Periods
<i>You will be eligible for coverage in:</i>	<i>If the Fund receives:</i>
February, March and April	<ul style="list-style-type: none"> ■ Sufficient contributions* through the month of December.
May, June and July	<ul style="list-style-type: none"> ■ Sufficient contributions through the month of March.
August, September and October	<ul style="list-style-type: none"> ■ Sufficient contributions through the month of June.
November, December and January	<ul style="list-style-type: none"> ■ Sufficient contributions through the month of September

* Sufficient contributions shall mean the amount set forth in the Schedule of Benefits as the Continued Eligibility Amount.

If you do not meet these requirements for a quarter, you may make self-payments for that quarter. Your self-payment is the difference between the amount in your Benefits Bank, if any, and the amount required to continue coverage. You may continue to make self-payments for up to 12 consecutive eligibility quarters.

Example

John initially met the eligibility requirement to become covered for the months of June and July. To continue eligibility for the August, September, and October quarter, the Fund requires \$2,285 to maintain eligibility. Through the work month of June, John has a total of \$1500 in contributions in his Benefits Bank. John will receive an invoice in the amount of \$785, which must be paid to the Fund Office by the 1st of the month following the date of the invoice to continue coverage.

Dependent Eligibility

Your Dependents are eligible for benefits if you are covered under the Plan. For a definition of Dependent, see page 53. The coverage for your Dependents will be effective on the later of the date:

- You become eligible;
- Your Dependent becomes an eligible Dependent (including children placed in your home for adoption); or
- A qualified Medical Child Support Order (QMSCO) is determined to be valid.

Please be advised that your dependent’s initial eligibility and continued eligibility under the Plan is conditioned upon you or your Dependents providing such information that is necessary for the

Plan (1) to verify your Dependent's eligibility for coverage, and (2) to comply with the Plan's reporting obligations under applicable law. Failure to provide necessary information may result in a termination of coverage. For more information regarding your responsibilities in this regard, please refer to the section entitled "Requirement to Provide Necessary Information Regarding Eligibility" under the General Provisions section of this summary plan description.

When you enroll your dependents for coverage, the Dependent benefits will become effective as follows:

- If an Employee has eligible Dependents on the effective date of his coverage and he has enrolled for Dependent benefits on or within 60 days of the Employee's effective date, then coverage for those Dependents will be effective on the date the Employee's coverage begins. Otherwise, Dependent benefits will be effective on the date the Employee enrolls for the Dependent benefits.
- If an Employee later acquires eligible Dependents, including newborns, and enrolls for Dependent benefits on or within 60 days of the acquisition, coverage will be effective on the date of the acquisition. Otherwise, Dependent benefits will be effective on the date the Employee enrolls for the Dependent benefits.

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an Employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

A QMCSO requires the Fund to cover an alternate recipient who might not otherwise be eligible for coverage. This Plan provides benefits according to the extent required by the QMCSO and by federal law. The Plan Administrator will notify you and alternate recipients if a QMCSO is received. You may obtain a copy of the Plan's QMCSO procedures, without charge, by calling the Fund Office.

When Coverage Ends

Coverage for you and your Dependents will end on the April 30th, July 31st, October 31st or January 31st that you do not meet any of the continued eligibility requirements. In addition, coverage for you and your Dependents will end if:

- You join active military service for more than 31 days; or
- The Plan ends.

Coverage for a Dependent ends when he or she no longer qualifies as a Dependent, as described on page 53.

When your or your Dependents' coverage ends, you or your Dependent will be provided with certification of your length of coverage under this Plan.

If coverage under the Plan ends, you and/or your Dependent may be eligible to continue coverage under either of two options – the self-payment option or the COBRA Continuation Coverage option.

You and your eligible Dependents will lose eligibility as of midnight of the effective date of a withdrawal if the parties to the collective bargaining agreement (Employer or Local Union) withdraw participation in the Fund, except in the case of a merger.

Non-Work Hours

If you become Disabled, join the military or take a leave under the Family and Medical Leave Act (FMLA), your eligibility for coverage may continue while you are not working.

If You Become Disabled (Active Employees)

If you cannot perform Covered Work because of a *Certified Disability*, your Benefits Bank may be credited with the equivalent of the minimum contribution required to continue eligibility, up to the maximum number of weeks specified in the Schedule of Benefits, for each week you are receiving a Weekly Income Benefit. *A Certified Disability is an injury or Sickness that prevents you from performing the material duties of your regular and primary occupation in which you were engaged at the onset of the injury or Sickness. Certified Disability does not include an injury or Sickness which is employment-related.*

Although the Weekly Income Benefit terminates after 52 weeks, you may receive additional credit (for up to a maximum of 52 weeks) in the amount of the minimum contribution required to continue eligibility for each week for which you continue to be unable to perform Covered Work because of a Certified Disability after termination of the Weekly Income Benefit (i.e., the initial 52 week period). The Plan may require you to provide medical records, a certification from your attending physician, or an independent medical exam to verify your continued disability at any time during the additional 52 week period.

If You Enter Military Service

If you enter the uniformed services of the United States, you may elect to continue your health coverage (medical, prescription drug and wellness), as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and you and your Dependents must make the required self-payment contribution for coverage. To elect to continue your health coverage you must contact the Fund Office.

Uniformed services include service in the United States Armed Forces, the Army National Guard and the Air National Guard or National Guard duty, the commissioned corps of the Public Health

Service and any other category of persons designated by the President in time of war or emergency. Service means the performance of duty on a voluntary or involuntary basis under competent authority and includes active duty, active duty training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

If you serve for 31 days or less, you will continue to receive coverage for up to 31 days, in accordance with USERRA.

If you serve for 31 days or more, you can continue coverage for you and your Dependents at your own expense for up to 24 months. Your eligible Dependents may continue coverage under the Plan by electing and making payments for COBRA continuation coverage.

Your coverage will continue until the earlier of:

- The date you or your Dependents do not make the required payments within 30 days of the due date;
- The Plan no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- The last day of the month after you have had the maximum coverage under USERRA (usually 24 months).

Your Dependents may continue coverage under the Plan during your term of service through COBRA Continuation Coverage under COBRA.

You need to notify the Fund Office in writing when you enter the uniformed services and when you return to covered employment.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

If you have any questions about taking a leave, please contact your employer. If you have any questions about how a leave affects your benefits, please contact the Fund Office.

If You Take A Leave Under The Family And Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) enables you to take up to 12 weeks (during any 12-month period) of unpaid leave for serious illness, birth or adoption of a child or to care

for a seriously ill spouse, parent or child, if you are eligible. The FMLA requires your Employer to continue making contributions for your health care coverage for the length of a qualified FMLA leave, as if you were still working.

You are eligible for FMLA benefits if you:

- Work for the same Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

When taking a leave under FMLA, you and your Employer need to inform the Trustees in writing so that your rights to health care coverage are protected during the leave.

If you return to work within 12 weeks, you will not lose health care coverage. If you do not return to work within 12 weeks, you will then qualify to continue your coverage under COBRA Continuation Coverage. You may self-pay for COBRA Continuation Coverage for up to 18 additional months. Contact the Fund Office for additional information about FMLA or continuing your coverage under COBRA Continuation Coverage.

If you and your Employer disagree over your eligibility or coverage under FMLA, your benefits may be suspended until the disagreement is resolved. Such disputes are between you and your Employer. The Trustees will not become involved in resolving this type of dispute.

Reinstatement Of Eligibility

If you lose eligibility, you will need to meet the initial eligibility requirements as set forth in the “Initial Eligibility Requirement for Active Employees” section on Page 13.

State, County, Federal, Municipal Or Civil Service Self-Pay Employees

If you work for any state, county, federal, municipal or civil service unit that is represented by a Local Union that is party to this Health and Welfare Fund for collective bargaining purposes, you may self-pay for coverage under this Plan for yourself and your eligible Dependents. You are eligible to self-pay if you are eligible for benefits under this Plan at the time you begin working for the state, county, federal, municipal or civil service unit. If you do not elect to self-pay when you first start working for the state, county, federal, municipal or civil service, you will need to reestablish your eligibility as a new Employee.

You must self-pay at the hourly rate required in the collective bargaining agreement covering Employees for a minimum of 40 hours per week (520 hours per eligibility quarter). You may mail or hand deliver your payment to the Fund Office. Payments received after the 15th of the month following the month you are paying for, as evidenced by the postmark, will not be accepted and your coverage will terminate.

Self-Payment Option for Active Employees

If after becoming initially eligible you are not credited with sufficient contributions from Covered Work due to involuntary unemployment, you may continue coverage for yourself and your family by making self-payments. Self-payments must be received at the Fund Office by the first of the month following the date of the invoice to continue your eligibility for benefits. Your self-payment will be the difference between the amount in your Benefits Bank, if any, and the amount required to continue coverage.

The self-payment option is available to you for up to 12 consecutive eligibility quarters. However, you must be available to work for a contractor who contributes to the East Central Illinois Pipe Trades Health and Welfare Plan or working within the jurisdiction of an affiliated Local Union that has a signed reciprocal agreement with the Health and Welfare Plan.

If you become covered under the Plan as a newly bargained group and lose eligibility within two years of the date of the initial contract between the Local Union and your Employer, you will not have the option of self-paying to continue coverage as explained above. You may continue coverage under COBRA Continuation Coverage as explained on page 23.

It is your responsibility to keep the Fund Office informed of your current address. Self-pay notices are sent to the last address the Fund has on file for you. Self-pay rates are set by the Trustees and are subject to change.

Self-Payment Option for Disabled Participants

If after becoming initially eligible for coverage you are not credited with sufficient contributions from Covered Work because you are Disabled as defined below you may continue coverage for yourself and your family by making self-payments. Self-payments must be received at the Fund Office by the first of the month following the date of the invoice to continue your eligibility for benefits. Your self-payment will be the difference between the amount in your Benefits Bank, if any, and the amount required to continue coverage.

You are considered Disabled for purposes of making self-payments if *you have an injury or Sickness that prevents you from performing the material duties of your regular and primary occupation in which you were engaged at the onset of the injury or Sickness.*

The self-payment option is available to you for up to 16 consecutive eligibility quarters. If you receive credit for any eligibility quarter because you have a Certified Disability as explained on page 17, then any eligibility quarters for which you receive credit shall count towards your 16 consecutive eligibility quarters so that your combined eligibility from credit and self-payments may not exceed the maximum 16 consecutive eligibility quarter limit.

When You Retire

When you retire, you and your eligible Dependents may be eligible for the East Central Illinois Pipe Trades Retiree Health and Welfare Plan if you:

- Are eligible for retirement under a qualified retirement plan sponsored by a participating Local Union within the jurisdiction of the Plan or with a state, county, federal, municipal or civil service retirement plan;
- Are retirement age; and
- Were eligible under the East Central Illinois Pipe Trades Health and Welfare Plan for the last five years before your retirement date or the approval of retirement, whichever is later; or
- Were eligible under the East Central Illinois Pipe Trades Health and Welfare Plan for five years out of last seven years before your retirement date or the approval of retirement, whichever is later.

If you are eligible for Retiree Health Coverage as set forth above:

- You must make the required self-payment amount per quarter as determined by the Board of Trustees, and
- You must complete an enrollment/change form requesting the change in status from Active to Retiree. The completed enrollment/change form, along with any other required documentation, must be submitted within 60 days following termination of eligibility as an Active Employee.

If you become eligible under the East Central Illinois Pipe Trades Retiree Health coverage and obtain other group medical coverage because of your subsequent employment, your coverage will terminate. Once coverage terminates, you cannot become eligible again under the Retiree coverage unless you return to active work for at least (2) two consecutive years.

Once you are eligible for Retiree coverage, your coverage will terminate at the end of the eligibility quarter when you and your eligible dependents are 65 years or older, and eligible for Medicare. In the event that you become eligible for Medicare prior to the end of the eligibility quarter, then you may request a refund of the pro-rata portion of your retiree quarterly self-payment if you elect to terminate your retiree coverage effective on the date of your eligibility for Medicare. If you elect to terminate your Retiree coverage, then you may receive a refund of the pro-rata portion of your retiree quarterly self-payment for the months for which you were eligible for Medicare coverage. Any refund of your retiree quarterly self-payment shall be made only in monthly increments. You must furnish proof of your eligibility for Medicare.

In the event your and/or your Dependent spouse's coverage ends due to turning 65 years of age and being eligible for Medicare, any covered Dependent child, incapable of self-sustaining employment by reason of developmental disability or physical handicap, will be allowed to remain covered by this Plan provided:

- Such incapacity began prior to the age of 26;
- Such incapacity began at a time when the child was a covered dependent under this Plan;
- Such Dependents are chiefly dependent upon the Employee for financial support and maintenance;
- Proof of incapacity was submitted to the Trustees as required in the Definitions section for “Unmarried children who are incapable of self-sustaining employment by reason of developmental disability or physical handicap”;
- The required self-payments to maintain eligibility are made on a timely basis; and
- The Dependent child is not eligible for other group coverage.

Disability Retirees

If you applied or are applying for a Total and Permanent Disability Pension from a participating Local Union within the jurisdiction of the Plan, you and your eligible Dependents may continue coverage under the East Central Illinois Pipe Trades Health and Welfare Plan by making continuous and timely self-payments.

The Trustees define Total and Permanent Disability on a case by case basis. The Trustees may consider the following facts to aid their determination, including, but not limited to:

- Determination by Social Security that you are permanently and totally disabled;
- Certification by a competent medical doctor;
- Affidavits;
- Observations; and/or
- Certification or examination by a competent independent medical doctor.

The Trustees may require you to re-certify your disability on a yearly basis.

Retiree Self-Payments

Once your eligibility for retirement coverage is approved by the Trustees of this Plan, you may continue eligibility by making quarterly self-payments at the quarterly rate determined by the Trustees. Your eligible spouse may continue eligibility under the East Central Illinois Pipe Trades Health and Welfare Plan after your death. Your spouse may make quarterly self-payments to the Fund in the amount determined by the Board of Trustees.

Self-payments must be received at the Fund Office by the first of the month following the date of the invoice to continue your eligibility for benefits. **ELIGIBILITY WILL BE PERMANENTLY TERMINATED IF YOU OR YOUR SPOUSE’S SELF-PAYMENT IS NOT RECEIVED BY THE REQUIRED DUE DATE.**

THE TRUSTEES RESERVE THE RIGHT TO MODIFY OR DISCONTINUE THE RETIREE COVERAGE AT ANY TIME. THIS INCLUDES THE REQUIREMENTS FOR PARTICIPATION. SELF-PAYMENT RATES ARE NOT GUARANTEED AND CAN BE INCREASED BY THE BOARD OF TRUSTEES.

COBRA Continuation Coverage Option

Under certain circumstances, coverage for you (the “Covered Employee”) or your eligible Dependents can be temporarily continued, at your expense, after it would normally end. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides you with the right to this continuation coverage. This Plan is automatically amended to conform with any changes made to the COBRA regulations.

COBRA Continuation Coverage is identical to the coverage you had under the Health and Welfare Plan. You may continue either the Comprehensive Major Medical Expense Benefit only or all of the health care benefits (Comprehensive Major Medical Expense, Wellness and Prescription Drug) you received under the Plan as a participant. The Death, Accidental Death & Dismemberment and Weekly Income Benefits cannot be continued. You pay the full cost of the continued coverage plus a small administrative charge.

Qualifying Events

If coverage ends for one of the following reasons or “qualifying events,” then you may elect to pay for COBRA Continuation Coverage for yourself and your eligible dependents:

- Your coverage ends due to your termination from employment, but not including termination due to gross misconduct;
- You are no longer eligible for coverage under the Plan due to your failure to work the required number of hours in the corresponding work period (including retirement);
- Your Death;
- Your divorce or legal separation from your spouse;
- Your dependent no longer qualifies for Dependent coverage under the terms of the Plan;
- You become entitled to Medicare benefits under title XVIII of the Social Security Act; or
- Title 11 bankruptcy of an employer who maintains the group health plan.

Additional COBRA Qualified Beneficiaries

If you have a newborn child, adopt a child, or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while COBRA continuation coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement and provide a completed enrollment form and other necessary documentation. (i.e., birth certificates, legal documents) to have this child added to your coverage. Children born, adopted, or placed for adoption or legal guardianship as described above, have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

Notice of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator determines that a qualifying event has occurred or has been notified that a qualifying event has occurred.

The Plan Administrator shall determine whether your termination (other than for gross misconduct), your failure to work the required number of hours in the corresponding work period, your death, your entitlement to Medicare benefits under title XVIII of the Social Security Act, or a Title 11 bankruptcy of an employer who maintains the group health plan is a “qualifying event.”

You must notify the Plan Administrator within 60 days of the date your spouse or dependent would lose coverage due to your divorce or legal separation from your spouse or if your dependent no longer qualifies for Dependent coverage under the terms of the Plan.

You must send this notice to Plan Administrator at the Fund Office address listed on page 77.

How COBRA Continuation Coverage Is Provided

Once the Plan Administrator determines that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s entitlement to Medicare benefits, divorce or legal separation, or a Dependent child’s losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

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 qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. However, the covered employee’s maximum coverage period will be 18 months. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment ends, COBRA continuation coverage for his or her 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 up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended that are explained in the next two paragraphs.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your 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 continuation period. You must notify the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator at the Fund Office address listed on page 77.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in your family can receive 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 is available to the spouse and any Dependent children receiving COBRA continuation coverage if:

- The employee or former employee dies;
- The employee or former employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both);
- The employee or former employee gets divorced or legally separated; or
- The Dependent child stops being eligible under the Plan as a Dependent child.

The extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure to notify the Plan Administrator at the Fund Office address listed on page 77 within 60 days after the second qualifying event occurs.

Electing Continuation Coverage

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. The rate for COBRA continuation coverage is a family rate and is the same amount for individual or for family coverage.

To elect continuation coverage, complete an Election Form provided by the Fund Office. Under federal law, you must have 60 days after the date of the notice to decide whether you want to elect COBRA continuation coverage under the Plan. Send the completed Election Form to the Fund Office.

The Election Form must be completed and returned by mail. If you do not submit a completed Election Form by the date shown on the Form, you will lose your right to elect continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Making Payments For COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment for COBRA continuation coverage with the election form. However, you must make your first payment for COBRA continuation coverage within 45 days after the date your election form is returned to the Fund Office. (This is the date the election form is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage within those 45 days, you will lose all COBRA continuation coverage rights under the Plan.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would have otherwise ended up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first day of the month for which payment is made. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. A COBRA payment will be considered on time if it is received within 30 days of the due date. A COBRA payment is considered made when it is mailed (postmarked) or personally delivered to the Fund Office.

Grace Periods For COBRA Payments

Although COBRA payments are due on the dates previously noted, you will be given a grace period of 30 days to make each COBRA payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA continuation coverage, as previously described. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and you submit a claim within that period, you may receive an

explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment.

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

When COBRA Continuation Coverage Ends

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- A qualified beneficiary becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B or both), or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate any other participant or beneficiary's coverage (such as fraud).

When your coverage under COBRA ends, you will be provided with a Notice of Credible Coverage, which may reduce any pre-existing condition limitations under another health plan.

If You Have Questions

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

Death Benefit (Active and Retired Employees Only)

In the event of your death, a benefit will be paid to your beneficiary as listed in the “Schedule Of Benefits,” if you were eligible for coverage under the Plan at the time of your death. A benefit will be paid upon receipt of proof of your death.

Designating Your Beneficiary

To designate your beneficiary, complete a form supplied by the Fund Office. You may name more than one beneficiary and indicate the percentage of the Death Benefit you want each beneficiary to receive. If you do not specify the percentage for each beneficiary, then your beneficiaries will share the benefit equally. If one of your beneficiaries predeceases you, the benefit will be split equally among your remaining beneficiaries. You can change your beneficiary at any time by submitting a new form to the Fund Office. Beneficiary designations are effective on the date you sign the form.

If there is no named beneficiary still surviving at the time of your death, your Death Benefit is divided equally among the members of the first surviving class listed below:

- Your spouse;
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

A legal guardian or administrator must be appointed by the court and the legal papers must be submitted to the Fund Office before the Death Benefit may be made to a beneficiary who is a minor child or when multiple beneficiaries are designated.

Filing A Claim

In the event of your death, your beneficiary must contact the Fund Office. The Fund Office will provide a claim form for your beneficiary to complete and return along with a copy of the death certificate.

Accidental Death & Dismemberment Benefit (Active Employees Only)

The Accidental Death & Dismemberment (AD&D) Benefit outlined below is paid if you sustain one of the losses listed below as a result of an Accident on or off the job (24-hour coverage). The loss must occur within 90 days after the Accident. This benefit is in addition to any other benefits you may receive from the Plan. If you die, the benefit is paid to your beneficiary, otherwise, the benefit is paid to you. The AD&D Benefit amount is listed in the “Schedule Of Benefits.”

For Loss Of:	AD&D Benefit:
Life	100% of benefit amount
Both hands, both feet or entire sight of both eyes	100% of benefit amount
One hand and one foot, one hand and entire sight of one eye or one foot and sight of one eye	100% of benefit amount
One hand, one foot or entire sight of one eye	50% of benefit amount

To qualify as a loss, severance must occur above the wrist joint or ankle joint. Loss of sight means the total and irrecoverable loss of sight. If more than one of the above losses is sustained as the result of the same Accident, benefits are paid only for the loss that pays the greatest amount.

Limitations

The benefits described above do not cover any loss caused by:

- An attempt at suicide or a self-inflicted injury or Illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition;
- An injury incurred during war or act of war while in combat;
- An injury resulting directly or indirectly from a self-inflicted or self-induced chemical substance or barbiturate consumption. Injury sustained due to intoxication by means of alcohol or other drugs will be considered self-inflicted;
- Injury incurred while in an aircraft, except when you are a passenger in a licensed aircraft (other than a chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier;
- Death caused directly or indirectly from sky-diving, competitive auto or sport car racing or motorcycle racing; or
- A felonious act or the result of a felonious act committed by you.

Filing A Claim

In the event of a loss under the Accidental Death & Dismemberment Benefit, you or your beneficiary must contact the Fund Office. The Fund Office will provide a claim form to complete and return along with any supporting documents.

Weekly Income Benefit (Active Employees Only)

The Weekly Income (Short-Term Disability) Benefit is payable if you are Disabled due to an injury or Sickness that prevents you from performing the material duties of your regular and primary occupation in which you were engaged at the onset of the injury or Sickness. Employment-related injuries are not covered under the Weekly Income Benefit.

Benefit Amount

If you are eligible for the Weekly Income Benefit, you will receive up to the maximum listed in the “Schedule Of Benefits” per week. The Weekly Income Benefit is paid for a maximum of 52 weeks for any one period of Disability. If the Disability extends beyond a 26 week period, an independent medical exam will be required by the Plan to verify continued disability, and allow payment of the maximum of 52 weeks.

Payment will be made for as many separate and distinct periods of Disability as may occur. A second Disability will be considered a separate and distinct Disability period if you return to full-time work for at least:

- 30 working days when the disabilities are due to the same or related causes; or
- One full day of active work when the disabilities are due to causes that are unrelated to the prior Disability.

The Weekly Income Benefit is taxable. The Fund will deduct the amount required by the Internal Revenue Service (IRS) for FICA (federal insurance contributions act) taxes.

When Weekly Income Benefits Begin

The Weekly Income Benefit begins on the

- First day of Disability due to an Accident; or
- Eighth day of Disability due to a Sickness or Illness.

Limitations On Weekly Income Benefits

Your benefits will be paid no later than the end of each two-week period. Benefits will not be paid:

- For any day of total disability that occurs while you are receiving any compensation; provided however, if you are retroactively found to be disabled by a third party and are retroactively awarded compensation (*e.g., from your Pension Plan or the Social Security Administration*), your benefits shall end on the day you begin receiving compensation, but your benefits shall not be retroactively terminated to the day that you were deemed to be disabled;
- If you retire or go on a paid leave of absence;

- If you become disabled from an Accident or Illness related to any employment;
- If you become disabled due to an Accident or Illness covered under Workers' Compensation or a similar law;
- For any disability you incur while committing a crime or as the result of a war or act of war (declared or undeclared);
- For any disability sustained in the Armed Forces of any country engaged in a war or other conflict;
- For expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted injury or Illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.
- For any injury or Illness for which you are not under the regular treatment of a qualified Physician or Surgeon.

Filing A Weekly Income Benefit Claim

You must submit a claim form that was completed by you or your Physician. The form may be obtained from the Local Union office or the Fund Office. The completed form should then be submitted to the Fund Office for consideration.

Once benefits are approved, benefits payable under the Plan for the Weekly Income Benefit will be paid no later than the end of each two-week period. If you have questions, contact the Fund Office at the phone number listed in the "Contact Information" section on page 2.

Weekly Income Benefit Claim Decisions

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.

In some instances the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

Denial Of Weekly Income Benefit Claim

If for any reason your claim is denied, in whole or in part, the Fund Office will send you a written notice. The notice will include:

- The specific reason or reasons your claim was denied;
- A reference to the specific Plan provisions on which the denial was based;
- A description of any additional information you need to submit in support of your claim;
- An explanation of why the additional information is needed;

- An explanation of the Plan’s claim review procedures and applicable time limits;
- A statement that you may request a review of the claim, review pertinent documents and submit issues and comments in writing; and
- A statement of your rights, under Employee Retirement Income Security Act of 1974 (ERISA), to bring a civil action.

Your Weekly Income Benefit Appeal Deadline

In general, you should appeal any claim as soon as possible, if your claim is denied or if you are otherwise dissatisfied with a determination under the Plan. You have up to 180 days from the date of the decision to file a written appeal.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

In addition, when filing an appeal, you have the right to be advised of the identity of any medical experts and you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
 - Was relied upon by the Plan in making the decision;
 - Was submitted, considered or generated (regardless of whether it was relied upon); or
 - Demonstrates compliance with the claims processing requirements.

If your claim is denied based on an internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information. In addition, if your claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

Plan’s Deadline For Weekly Income Benefit Appeal Decision

If you file your appeal on time and follow any applicable required procedures, the Trustees will review your claim appeal and advise you of their decision. The Trustees will issue a written decision reaffirming, modifying or setting aside the action you are appealing. The Trustees’ decision will be based on all information used in the initial determination as well as any additional information submitted.

Generally, a decision will be made within 45 days of submission of your written appeal. If special circumstances require an extension of time, a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

- Make its decision at the next quarterly meeting of the Board of Trustees; or
- If your appeal is received within 30 days of the closest meeting, make the decision at the following quarterly meeting.

The Plan will provide you with their written decision within five days after the decision is made. The written decision will include:

- Specific reasons for the decision,
- References to the Plan provisions on which the decision is based,
- A statement notifying you:
 - That you have the right to request a free copy of all documents, records and relevant information;
 - That you may bring a civil action suit under Employee Retirement Income Security Act of 1974 (ERISA); and
 - Of any additional voluntary appeal procedures offered by the Plan.

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain your benefits.

Comprehensive Major Medical Expense Benefit (Employees/Retirees And Their Eligible Dependents)

Your health care benefits cover most reasonable health care expenses that you and your eligible Dependents may incur. The following sections explain the details of the Plan's benefits, and any deductibles, copayments and limitations that may apply. The health care coverage benefits include the following:

- Comprehensive Major Medical Expense Benefit;
- Wellness Benefit; and
- Prescription Drug Benefit.

Your Comprehensive Major Medical Expense Benefit protects you and your family from potential catastrophic health care expenses.

Deductible

The deductible is the amount of covered medical charges that you and each of your eligible Dependents pay each calendar year before benefits begin. Deductible amounts are listed in the "Schedule Of Benefits."

The individual deductible applies to each member in your family every calendar year. However, once your family satisfies the family deductible, no additional deductible will be required for the remainder of the calendar year. In addition, if you or a member of your family incurs an expense that is used to satisfy the deductible during October, November and December, that amount will be used to satisfy the deductible for the following calendar year as well.

Benefits Payable (Coinsurance)

Once you pay the annual deductible, the Plan pays a percentage (as specified in the "Schedule Of Benefits") of covered expenses up to the Reasonable and Customary Charges. The percentage the Plan pays varies depending on whether you use a PPO (in-network) or non-PPO provider (out-of-network). In addition, some maximums apply to certain coverages.

Individual Coinsurance Maximum

You must pay the remainder of the coinsurance amount paid by the Plan, as listed in the "Schedule of Benefits", until the individual coinsurance maximum for covered charges is reached. However, the individual deductible for each person is not included in the individual coinsurance maximum. If you reach this annual individual coinsurance maximum, the Plan pays 100% of covered charges for the rest of the calendar year, subject to certain maximums and limitations.

Preferred Provider Organization (PPO)

To help control medical costs, the Health and Welfare Fund has an agreement with a Preferred Provider Organization (PPO). A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower than those normally charged by other Hospitals or providers. You may use any provider you wish, but the Plan pays a higher percentage when you use a provider in the PPO network (PPO provider).

To minimize your out-of-pocket costs, contact the PPO organization for information on which Hospitals and providers belong to the PPO. When you use PPO Hospitals and providers rather than non-PPO Hospitals and providers, you can reduce costs for both you and the Fund. The Plan pays a higher percentage of your Covered Charges when you use a Hospital or provider in the PPO network. When you use PPO providers, you do not need to file claims. The PPO files the claims for you. Call the Fund Office to find out if your Physician is a member of the PPO. If you need a listing of PPO providers, contact the Fund Office. A listing of PPO providers will be furnished to you free of charge. If you have a question about PPO network providers, see “Contact Information” on page 2.

Exceptions to Non-PPO or Out-Of-Network Level of Benefits

The following listing of exceptions represents services and supplies rendered by a Non-PPO Provider or an Out-of-Network Provider where eligible expenses shall be payable at the PPO Provider or In-Network Provider level of benefits:

1. Emergency treatment rendered at an Out-of-Network facility, or emergency room Physician services rendered by an Out-of-Network Provider when the facility rendering such services is an In-Network Provider;
2. Out-of-Network anesthesiologist if the operating surgeon is an In-Network Provider;
3. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by an Out-of-Network Provider when the facility rendering such services is an In-Network Provider;
4. Diagnostic laboratory and pathology tests performed by an Out-of-Network Provider when referred by an In-Network Provider;
5. Assistant surgeon services rendered by an Out-of-Network Provider when the facility rendering such services is an In-Network Provider;
6. If the Participant or Dependent is receiving services from an In-Network Provider hospital, a consultation from an Out-of-Network Provider requested by the In-Network Physician;
7. Medically necessary services and supplies which are not available through any In-Network Provider within the service area of the Preferred Provider Organization;

8. Eligible expenses incurred by Participant or a Dependent, if the Participant or Dependent resides more than twenty five (25) miles from an area serviced by the Preferred Provider Organization;
9. When the Participant or Dependent incurs non-emergency eligible expenses while traveling outside the area serviced by the Preferred Provider Organization, unless the purpose of the travel is the receipt of medical care; and
10. Medically necessary services and supplies which are not available through an In-Network Provider because the In-Network Provider is not available to provide such medically necessary services and supplies to the Participant or Dependent shall be payable at the In-Network level of benefits if the In-Network Provider verifies in writing to the Fund that such In-Network Provider was not available to provide such medically necessary services and supplies to the Participant or Dependent.

Utilization Review

The Health and Welfare Fund also has a utilization review agreement with the Utilization Review provider to certify Hospital admissions. There is a \$500 penalty for Hospital admissions that are not certified. Call the Utilization Review provider as listed on 23 to certify your Hospital stay.

Elective Hospital admissions must be certified before admission. An elective admission is one in which your condition permits adequate time to schedule the Hospitalization.

Urgent Hospital admissions and *emergency Hospital admissions* are reviewed after admission. **You or someone else must call the Utilization Review provider as listed on page 2 within 48 hours of an urgent or emergency Hospital admission.** An urgent admission is one in which you require immediate attention for the care and treatment of your physical or mental condition. Generally, you are admitted to the first available and suitable accommodation. An emergency Hospital admission is one in which the sudden onset of a severe medical condition requires immediate Hospital admission to prevent the patient from:

- Putting their health in permanent jeopardy;
- Incurring other serious medical consequences;
- Having a serious impairment of bodily functions; or
- Incurring serious permanent dysfunction of any bodily organ.

Covered Charges

Covered charges are the Reasonable and Customary Charges for the following Medically Necessary services and supplies received for the treatment of a non-occupational injury or Sickness when ordered and prescribed by a legally qualified Physician:

1. Hospital services and supplies for:
 - a. Room and board charges up to the Hospital's:
 - Regular daily semi-private rate; or
 - Charges for a private room, when required.
 - b. Drugs, medicines and other Hospital services for medical care and treatment exclusive of professional services, while Hospitalized.
 - c. Out-Patient Hospital charges including charges incurred for:
 - Out-Patient surgical procedures; and
 - Emergency treatment for an injury or Sickness.

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

This Plan only covers maternity benefits for female Employees or the spouse of male Employees.

2. Medical care and treatment performed or ordered by a legally qualified Physician.
3. Charges made by a Physician for medical services, including active services as an assistant Surgeon.
4. Charges made by a Physician or Surgeon for the performance of an operation or the repair of a dislocation or fracture. When more than one surgery is performed during the same surgical setting and through the same surgical opening, this Plan will consider 100% of the primary surgery as covered charges and 50% of all other surgical procedures. These charges, like all others, are subject to the Plan's reasonable and customary standards, deductible and the appropriate copayment.
5. Charges for the services of an anesthesiologist or professional anesthetist.
6. Charges made by a registered nurse (RN) or licensed practical nurse (LPN/LVN) other than one who ordinarily resides in your home or who is a member of your or your eligible Dependent's immediate family.

7. Ambulance service to and from the nearest Hospital that can provide treatment unique to the Illness or injury.
8. Diagnostic X-ray and laboratory services.
9. Whole blood or blood plasma and the cost of its administration, except that replaced by or for the patient. The handling charge for storing the patient's blood prior to surgery is also covered.
10. Radium, radioactive isotopes and X-ray therapy.
11. Treatment and surgery by a Physician, either in an office or Hospital, and by a dentist for the repair of damage to the jaw as a direct result of, and within six months after, an Accident.
12. Diabetic clinical testing monitors.
13. Speech therapy, except for treatment of a learning disorder, language disorder, remedial reading or special education or the result of a developmental delay.
14. Occupational therapy, up to the maximum as listed in the "Schedule Of Benefits."
15. Acupuncture treatment, when rendered by a professional who is licensed and certified in acupuncture, up to the maximum as listed in the "Schedule Of Benefits." Acupuncture treatment does not include any treatment for jaw problems, including temporomandibular joint syndrome (TMJ) or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other issues related to that joint.
16. Out-Patient cardiac rehabilitation following surgery.
17. Pulmonary rehabilitation when prescribed by the patient's primary Physician.
18. Rehabilitation therapy by a licensed physiotherapist following surgery for any injury.
19. Therapeutic ultra-sound or whirlpool treatment.
20. Sports therapy by a licensed physical therapist following surgery.
21. Chiropractic Care up to the calendar year maximum listed in the "Schedule Of Benefits." Chiropractic Care does *not* include:
 - a. Allergy therapy;
 - b. Diet or hair analysis;
 - c. Nutritional or food supplements not requiring a Physician's prescription;
 - d. Pillows, supports or similar devices; or
 - e. Booklets.

22. Casts, splints, braces, crutches, surgical supplies, colostomy bags, ileostomy supplies, catheters, cervical collars, head halters and other traction apparatus.
23. Artificial limbs and eyes, but not for their replacement, repair or maintenance.
24. Federal law requires plans that provide medical and surgical benefits for mastectomies to pay for the following, when requested by the patient in consultation with her Physician:
 - a. Reconstruction of the breast on which the mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Protheses and physical complications of all stages of mastectomy, including lymphedemas.
25. The following appliances and therapeutic equipment prescribed by a Physician:
 - a. Oxygen and the rental of equipment for its administration;
 - b. Hospital-type bed;
 - c. Kidney dialysis equipment;
 - d. Wheelchair; and
 - e. Other durable medical equipment.

The request must be approved before purchase or rental and accompanied by a Physician's statement describing the Medical Necessity of the appliance or equipment and the length the person is expected to use the appliance or equipment.

Such durable medical equipment must withstand repeated use, not be disposable, be appropriate for in-home use and not be useful in the absence of an injury or Sickness. **Rental reimbursement payments will not exceed the purchase price.** Replacement or repairs of the equipment is *only* covered when pre-approved by the Board of Trustees.

26. Allergy testing.
27. Hearing aids, up to a lifetime maximum listed in the "Schedule Of Benefits" for all devices, excluding the examination.
28. Foot Orthotics, up to the calendar year maximum listed in the "Schedule Of Benefits."
29. Growth hormone therapy when pre-approved by the utilization review company and obtained through the Prescription Drug Benefit.
30. Charges incurred as the result of participation in a sleep study and/or sleep clinic, limited to one per lifetime.
31. Home Health Care, when provided by a home health care agency following a covered Hospital confinement, up to the calendar year maximum listed in the "Schedule Of Benefits," for the following:
 - a. Evaluation by a registered nurse, Physician or medical social worker of the need for a home health care plan;

- b. Care by a home health care aide for the patient only, when supervised by a registered nurse (RN), licensed practical nurse (LPN) or medical social worker;
- c. Physical, respiratory and/or speech therapy;
- d. Medical supplies (including oxygen);
- e. Durable medical equipment;
- f. Drugs and medicines;
- g. Laboratory services;
- h. Special meals prescribed by a Physician, licensed nutritionist or dietician.

Each four hours of service by a home health care aide equals one visit. Each visit by any other member of the home health care agency team equals one visit.

- 32. Skilled Nursing Facility Care within seven days of release from a Hospital confinement for the following covered charges:
 - a. Room and board, up to a maximum of the charge for a semiprivate room in the Hospital to which the patient was confined just before the Skilled Nursing Care Facility;
 - b. General nursing care; and
 - c. Medical services and supplies.

- 33. Hospice Care for a terminally ill patient who is expected to die within six months, up to the maximum listed in the "Schedule Of Benefits," for the following in lieu of any other covered charges:
 - a. Room and board in a freestanding Hospital or hospice;
 - b. Home hospice care;
 - c. Services and supplies furnished by the hospice;
 - d. Counseling services by a licensed social worker or a licensed pastoral counselor;
 - e. Nutrition services, including special meals;
 - f. Part-time nursing care by or under the supervision of a registered nurse (RN); and
 - g. Services of a home health care aide.

- 34. Organ or tissue replacement for the following procedures:
 - a. Cornea transplants;
 - b. Artery or vein implants;
 - c. Kidney transplants;
 - d. Joint replacements;
 - e. Heart valve replacements;
 - f. Implantable prosthetic lenses in connection with cataracts;
 - g. Prosthetic bypass or replacement vessels;
 - h. Bone marrow transplants;
 - i. Heart and lung transplants; and
 - j. Liver transplants.

The procedure must not be considered Experimental or Investigational or for the patient's condition. Expenses incurred by the donor are not considered covered charges.

- 35. The following treatment for a mental/nervous condition or for substance abuse:

- a. Services ordered and prescribed by a legally qualified Physician only. Court ordered or school ordered care is not covered.
- b. Duly constituted Hospital confinement or partial Hospitalization (day treatment).
- c. Diagnosis and treatment by a licensed psychiatrist, clinical psychologist or licensed social worker. If care is provided by a clinical psychologist or licensed social worker, the care must be prescribed and supervised by a psychiatrist or other MD or DO.

Treatment is payable up to the maximum listed in the "Schedule Of Benefits."

36. Services and supplies provided under case management for the continuing care needs of catastrophic and chronic high-cost medical care cases. The case manager will work in conjunction with the attending Physician, the patient and patient's family to find less costly medical services and supplies, even though such alternatives are not specifically stated as covered charges by the Plan. This does not, however, cover charges that are considered Experimental or Investigational as explained on page 43 or are provided as a convenience to the patient, the patient's family or health care provider. Coverage for alternate care is subject to the same overall Plan benefit maximum, copayment and deductible requirements that apply to the medical care being replaced.

Although the case manager may suggest to the Physician less costly alternate means of medical care, the final decision on patient care and treatment is the responsibility of the patient, the patient's family and the attending Physician. If the case manager, patient, patient's family and Physician agree to a less costly alternative means of medical care, the Plan will reimburse at that rate. **Non-PPO provider expenses negotiated by a case manager are eligible under the Plan at the PPO provider level.**

37. Elective sterilizations.
38. Routine Preventative Care. Covered Charges incurred for routine physical examinations and related services, as described in the Wellness Benefit section on page 46.

Charges Not Covered

The Comprehensive Major Medical Expense Benefit does not cover any charge incurred for the following:

1. Loss caused by Accidental bodily injury or Sickness that arises out of or occurs in the course of any occupation or employment for wage or profit, or any Accidental bodily injury or Sickness for which you are entitled to any benefits under any Workers' Compensation or Occupational Disease Law. The Plan can withhold benefits for any injury, which may be questionable or compensable under Workers' Compensation or Occupational Disease Law until you have made a reasonable effort to exhaust your claim to benefits under Workers' Compensation or Occupational Disease Law.
2. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country.
3. Treatment or services for any injury caused directly or indirectly from unreasonably dangerous activities, including but not limited to sky diving, competitive auto or sports-car racing and motorcycle racing.
4. Loss incurred in the commission of any illegal act, or attempt to commit a felony, or while engaged in an illegal occupation by the person whose injury/Sickness is the basis of the claim; except that a Loss that is the result of an act of domestic violence will be covered by the Plan.
5. Charges prior to the person's effective date, In-Patient Hospital charges that started prior to the person's effective date.
6. Rest cures, domiciliary care, convalescent care or custodial care, which is care provided primarily for convenience, or to assist the patient in the activities of daily living, or custodial in nature when the constant attention of trained medical personnel is not required.
7. Confinement, treatment or service for disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) "V-Codes" section; except that services for diabetic education and nutritionist counseling which are incurred in connection with a diagnosed diabetic condition are Covered Charges. For more information and details regarding the specific disorders excluded hereunder, please contact the Plan Administrator.
8. Hospital confinements primarily for observation and/or diagnostic studies that could have been performed on an Out-Patient basis.
9. Care not considered Medically Necessary for the diagnosis/treatment or In-Patient care inconsistent with the condition requiring Hospitalization.
10. Charges in excess of the Reasonable and Customary Charges, this applies to out of network claims only.

11. Charges for which the person would not have a legal obligation to pay, if the person did not have coverage under this Plan.
12. Experimental care or a procedure, service or supply that is for research purposes.
13. Surgery for psychological or emotional reasons or to improve appearance (cosmetic), except as outlined under Covered Charges.
14. Charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim form or charges made for non-compliance with a cost containment program.
15. Travel expenses.
16. Personal services or supplies.
17. Personal convenience items such as special air conditioners, humidifiers, air filters, pillows, mattresses, physical fitness equipment and other such devices, whether or not ordered by a Physician.
18. Transsexual surgery.
19. Medications or prosthesis for sexual dysfunction, inadequacies or enhancements.
20. Care provided by a family member or a person who lives in the same household as the patient.
21. Tooth extractions, except impactions and anesthesia.
22. Other dental work or surgery that involves any tooth or tooth structure, including damage or replacement of tooth or teeth due to an Accident.
23. Treatment by any method of jaw joint problems, including temporomandibular joint syndrome or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint.
24. Contact lenses, except following cataract surgery.
25. Eye refractions or the fitting or cost of visual aids.
26. Muscular imbalance of the eyes, orthoptics, macular degeneration or surgery to correct nearsightedness or farsightedness.
27. Any expense or charge for the promotion of fertility, including (but not limited to) fertility tests, hormone therapy, artificial insemination, in vitro fertilization and embryo transfer.

28. Reversal of sterilization.
29. Elective abortion.
30. Over-the-counter drugs and medicines. Prescription drugs are covered under the Prescription Drug Benefit beginning on page 49.
31. Copayments and deductibles required under any other benefit under this Plan.
32. Vocational rehabilitation.
33. Routine foot care procedures such as trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet.
34. Any loss, expense or charge incurred for obesity, appetite control, diet programs, diet supplements/pills, nutritional supplements/vitamins, nutritional counseling, including surgeries or complications; except, Medically Necessary bariatric surgery for treatment of morbid obesity up to the maximum specified in the Schedule of Benefits, provided:
 - a. The patient is at least 18 years of age, or has documented completion of bone growth;
 - b. The patient must have a body mass index (BMI) of 35 or greater;
 - c. Documentation is provided of life threatening co-morbidity over at least the last three years prior to surgery (Severe sleep apnea that is poorly controlled, Pickwickian syndrome, Cardiomyopathy related to obesity, Diabetes Mellitus, Lumbosacral Disease, Total Knee Arthroplasty, Hypertension poorly controlled after adequate workup for other causes of hypertension);
 - d. Documentation is provided the patient has had a mental health assessment;
 - e. Documentation is provided regarding a physician supervised weight reduction and exercise program that occurred within one year of the proposed surgery, and that demonstrates evidence of recent active participation and reasonable compliance of at least one unsuccessful attempt of a medically supervised weight loss program, supervised by a professional other than the proposed bariatric surgeon. The program should include a duration of at least 12 weeks, regular weigh ins at 2 week intervals, and documentation of nutritional analysis, counseling, and education and low calorie menu plans by a licensed physician, nutritionist or dietitian (Weigh Watchers, Jenny Craig or similar programs are not considered physician supervised);
 - f. Documentation is provided the patient participated in an exercise program and includes details of the progress for at least 12 weeks, and the patient participated in behavioral therapy to reinforce dietary and exercise programs;
 - g. Any documentation must include the physicians dated progress notes showing the details of the above programs;
 - h. The patient must have no medical contraindications to surgery (e.g. significant heart, lung, liver or kidney disease; or a history of other than skin cancer), and have a pre and post operative multidisciplinary program available to them.

35. Medical care that is provided while a Dependent who has primary coverage under a Health Maintenance Organization (HMO) or similar organization fails to use the Health Maintenance Organization (HMO) or similar organization.
36. Treatment of complications resulting from non-covered care.
37. Comfort or convenience services or supplies.
38. Charges made for “stand by” medical personnel where no service is actually rendered.
39. Charges related to exposure to a hazardous material, unless a Subrogation Agreement is on file with the Fund Office and Fund Attorney.
40. Maternity benefits except for female employees or the spouse of male employees.

Note: This list is not meant to be all inclusive. Any exclusion/limitation stated does not necessarily include all charges that are excluded or limited. Only those charges listed as covered can be assumed payable.

Wellness Benefit (Employees/Retirees and Eligible Dependents)

The Wellness Benefit will pay up to the maximum listed in the “Schedule of Benefits” per calendar year, for you and each of your eligible Dependents. This benefit is meant to cover medical care and treatment not provided under the Comprehensive Major Medical Expense Benefit. This benefit covers the following charges:

- Routine physicals, including those for school or camp;
- Pap Smears;
- Gynecological Exams;
- X-Rays;
- Laboratory Blood Tests;
- Digital Rectal Exams;
- Colonoscopy;
- Immunizations;
- Mammograms; and
- Prostate exams.

Once you pay the physician or specialist office visit copayment for PPO or non-PPO providers as listed in the “Schedule Of Benefits,” the Plan will pay 100% of your expenses up to the maximum listed in the “Schedule Of Benefits.” Any expense above the maximum for Wellness Benefits, is covered at the Plan’s Coinsurance percentage, after the individual deductible is met.

Claims will be paid following the procedures on page 65.

Charges will only be considered under the Wellness Benefit when there is no diagnosis of illness or injury indicated with the service provided; therefore, the Participant must advise the Physician he is seeking wellness services and the billing must be coded as a wellness visit.

Note: Provided you (and covered spouse) meet the Plan’s requirements at the time of an annual wellness exam, the Fund may reduce the individual calendar year deductible for each family member. The Plan’s requirements are provided to all eligible Participants each calendar year for as long as this program remains in place.

Benefits Bank Reimbursement Program

Eligible participants may be reimbursed monies they have paid "out of pocket" for deductibles, copays, co-insurance, for eligible medical and prescription drugs from their Benefits Bank. The participant's and eligible dependent's dental, vision, and orthodontia expenses are also reimbursable if the services are administered by a physician and/or require a prescription for purchase. In order to be eligible for this benefit, the participant must have the prescribed amount in his/her individual Benefits Bank. The following rules apply to the Reimbursement Program:

- A. A participant will be eligible for reimbursement of any amounts that have been applied to the calendar year deductibles, copays and/or co-insurance, for covered medical and prescription drug services. Monies paid by the participant for orthodontia (braces), dental, and vision charges are reimbursable provided the services are administered by a physician and/or require a prescription for purchase. However, an eligible participant must have at least two (2) quarters of eligibility at the then current cost the program in his or her individual Benefits Bank when the reimbursement is calculated in order to utilize his or her Benefits Bank.
- B. A participant may utilize the credit in his/her Benefits Bank, but the amount of the Benefits Bank may not drop below the cost of providing two (2) quarters of coverage.
- C. Reimbursement will be made quarterly following the determination of eligibility for coverage and calculation of the Benefits Bank balance.
- D. If, after this calculation, funds are available for reimbursement, the Administrator will review all claims paid (considered) in the previous three (3) month period, and reimburse deductibles, copays, co-insurance applied to the calendar year for eligible medical expenses and prescription drugs. Also included are monies paid by the participant for dental, orthodontia (braces), and vision charges for themselves and their eligible dependents, provided that a claim for these services is filed with the Administrator's office, and the services were administered by a physician or the expenses required a prescription for purchase. The reimbursement will be made up to any amounts available in the Benefits Bank. Under no circumstances will reimbursement be made for periods preceding the most immediate three (3) month period.
- E. The claim must be paid (considered) by the Administrator's office within 6 months after December 31 of the year in which the claim was incurred.
- F. In no event will a payment of less than \$5 be issued.
- G. Any check or payment issued to the Participant from the Participant's Benefits Bank under the Benefits Bank Reimbursement Program must be cashed within one (1) year from the date of issuance of the check. Any check that is not cashed within one (1) year shall be void and the entire amount of the reimbursement shall be forfeited in its entirety such that the Participant or his or her dependents will not be entitled to any

reimbursement for the expenses covered by the reimbursement. Participants will not receive any notice that the payment has been forfeited.

Prescription Drug Benefit (Employees/Retirees And Eligible Dependents)

The Prescription Drug Benefit is administered by the provider listed in the “Contact Information” section on page 2. Two programs are available under the Prescription Drug Benefit – the Retail Card and Mail Order Programs.

Covered Charges

Both parts of the program cover prescriptions for the following:

- All federal legend drugs;
- Compound medications;
- Insulin on prescription;
- Insulin needles, syringes and lancets on prescription; and
- Federal legend oral contraceptives (birth control pills).

In addition, the following drugs are covered when accompanied by a statement from the Physician indicating that the drug is prescribed for the Medically Necessary treatment of a diagnosed condition:

- Retin-A (Tretinoin) for severe acne;
- Amphetamines and anorexiant not for weight loss purposes; and
- Smoking cessation drugs.

To find out if a drug is covered, contact the Fund Office.

Charges Not Covered

The following are excluded from coverage under this Prescription Drug Benefit, unless specifically listed under Covered Charges above:

- Fertility drugs or agents;
- Growth hormones;
- Over-the-counter (OTC) items;
- Amphetamines and/or anorexiant for weight loss;
- Retin-A (Tretinoin) for cosmetic purposes;
- Vitamins (prescribed or over-the-counter), including pre-natal vitamins;
- Devices or appliances (such items may be available under the Comprehensive Major Medical Expense Benefit);
- Drugs labeled “Caution – limited by federal law to investigational use” or Experimental drugs even though a charge is made to the individual;
- Medications for which the cost is recoverable under Workers’ Compensation or occupational law, or any state or governmental agency, or any other drug or medical service for which no charge is made; and
- Medications for sexual dysfunction, inadequacies or enhancements.

Benefits Payable

Before the Plan begins paying benefits, you need to satisfy a calendar year deductible as listed in the “Schedule Of Benefits.” Each covered Dependent must also meet the calendar year deductible before the Plan begins paying for prescriptions for that Dependent.

Once you pay the annual deductible, you pay a percentage as specified in the “Schedule Of Benefits” for your covered prescriptions and the Plan pays the rest. The deductible is for retail (network pharmacy) and mail order prescriptions combined.

Retail Card Program

The Retail Card Program offers benefits for short-term prescriptions. When you become eligible for benefits under the Prescription Drug Benefit, you will receive a prescription drug card. You and any of your Dependents who are covered by the Prescription Drug Benefit will be listed on the card. You may obtain up to two refills through the Retail Card Program.

All drugs must be obtained through a network pharmacy. Participating pharmacies include all Walgreens, Wal-Mart and Medicine Shoppe locations nationwide. You may obtain a listing of participating pharmacies, at no charge, by calling the telephone number listed in the “Contact Information” section on page 2. **If you obtain a prescription outside the network, you must file a claim with the prescription drug provider listed on page 2.**

Present your prescription drug card and your prescription to your pharmacist. Remember to use your card even if you haven’t reached your deductible so that the amount you pay will be counted toward your deductible. When you use a participating pharmacy, you will have to pay the full price of the medication until you reach the deductible. After you have met your deductible, you pay only the copayment listed in the “Schedule Of Benefits.”

If your prescription is more than the remaining deductible, then you will pay the remaining deductible and the copayment. In no event will you have to pay more than the cost of the medication.

Example

Jean has \$40 remaining to satisfy her deductible. She visits a network pharmacy and the generic medicine costs \$75. Jean will need to pay \$40 (the rest of her deductible) + \$10 (the generic copayment) = \$50.

The pharmacist will fill your prescription with a brand name drug only if your Doctor specified “*May Not Substitute*” or “*Dispense as Written (DAW)*” on the prescription form or otherwise specifically indicates that the brand name drug is Medically Necessary. In all other instances, your prescription will be filled with a generic drug, if available in that form.

Note: If you request a brand name drug for your own personal reasons, you must pay the cost difference between the generic equivalent and the charge of the brand name drug, plus the higher copayment.

You will receive the quantity prescribed by your Physician, up to the greater of a 30-day supply or 100-unit dose. No forms, receipts or submission of claims are necessary. The pharmacist will submit the claim. You simply pay the necessary copayment when you fill your prescription. The copayment is not reimbursable under the Comprehensive Major Medical Expense Benefit and does not count toward your individual coinsurance explained on page 34. **If you obtain a prescription outside the prescription drug network, you must file a claim with the prescription drug provider listed on page 2.**

Mail Order Program

You may order through the mail up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. **This service is required for maintenance medications and for the third refill under the Retail Card Program.** Maintenance medications are medications you or your Dependent takes for long periods of time for such chronic conditions as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your Physician prescribes a long-term medication that you need right away, ask the Physician to write two prescriptions – one prescription to be filled at a participating pharmacy using the Retail Card Program, and one prescription for the remainder of the medication to be submitted to the Mail Order Program.

When you use the Mail Order Program, you will have to pay the full price of the medication until you reach the deductible. After you have met your deductible, you pay the generic or brand name prescription copayment for each prescription as listed in the “Schedule Of Benefits.”

The pharmacist will fill your prescription with a brand name drug only if your Doctor specified “*May Not Substitute*” or “*Dispense as Written (DAW)*” on the prescription form. In all other instances, your prescription will be filled with a generic drug, if available in that form.

Note: If you request a brand name drug for your own personal reasons, you must pay the cost difference between the generic equivalent and the charge of the brand name drug, plus the higher copayment.

Follow these steps to obtain prescriptions through the mail:

- Request a form from the Local Union office or the Fund Office.
- Fill out all required information on the patient profile/registration form.
- Enclose the Physician’s prescription for a 90-day supply of medication.
- Enclose your original prescription and copayment and mail to the address listed on page 2.

To find out the amount of payment to send with your order, call the telephone number listed in the “Contact Information” section on page 2. When you call, ask the representative to make sure that your total includes any amounts necessary to satisfy your deductible.

For refills, a new order form and envelope will be included with each delivery, or call the telephone number in the “Contact Information” section listed on page 2.

Definitions

The following section contains definitions for terms used throughout this booklet.

Accident means an injury, such as a cut, break, sprain or bruise, caused by a sudden unexpected, undesirable and unavoidable act. The term Accident *does not include strained or aching arms and/or legs resulting from the overuse of muscles. Self-inflicted injuries and/or wounds are not covered.*

Board of Trustees and/or Trustees mean those individuals, collectively, designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the East Central Illinois Pipe Trades Health and Welfare Fund. The Trustees, collectively, are the “administrator” of this Plan as that term is used in the Employee Retirement Income Security Act of 1974 and as the “administrator,” “Plan Sponsor” and the “Named Fiduciaries” of the employee benefit plan established and maintained under the Trust Agreement.

Contributing Employer means:

- An Employer who is a member of, or is represented in collective bargaining by, the Association and who is bound by the collective bargaining agreement with the Union to make payments to the Trust Fund with respect to Employees represented by the Union;
- An Employer who is not a member of, nor represented in collective bargaining by the Association, but who is bound by a collective bargaining agreement with the Union to make payments to the Trust Fund with respect to Employees represented by the Union;
- The Union, for the purpose of making the required contributions into the Trust Fund for the Employees of the Union;
- An Employer who is required to make payments or contributions to the Trust Fund by any law or ordinance applicable to the State of Illinois or to any political subdivision or municipal corporation thereof, or because of any written agreement entered into by an Employer with such State or political subdivision or municipal corporation thereof.

Dependent means:

- Your lawful spouse; or
- Your child, stepchild, or foster child (provided you are the child’s legal guardian) under 19 years of age; or
- Your child, stepchild, or foster child (provided you are the child’s legal guardian) who is at least 19 years old, until his or her 26th birthday; or
- Your child who is adopted or placed for adoption prior to the age of 18 and who otherwise meets the eligibility criteria for a child or stepchild as described herein; or
- Your unmarried children, regardless of their age, who are incapable of self-sustaining employment by reason of a developmental disability or physical handicap provided:
 - Such incapacity began prior to the age of 26;
 - Such Dependents are chiefly dependent upon the Employee for financial support and maintenance; and

- Proof of incapacity is submitted to the Plan Administrator within sixty (60) days of the date such Dependents' eligibility would otherwise terminate. Proof of continued disability may also be requested.

You are responsible for notifying the Plan in the event of a divorce, legal separation or a child ceasing to be a Dependant as defined above.

An Employee's children also include those children named as alternate recipients under a Qualified Medical Child Support Order (QMSCO).

Note: This Plan does not provide coverage to children of Dependent children.

Disability means the inability of a covered Employee to perform all the duties of any occupation as a result of a non-occupational Illness or injury or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age or gender.

Employee and/or Member means a person on whose behalf contributions are required to be made to the Fund by a Contributing Employer.

Experimental or Investigative Treatment or Procedure means a service, procedure, drug, device or treatment modality for a specific diagnosis if:

- The drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The drug, device, medical treatment or procedure, or the patient's informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval; or
- *Reliable evidence* shows that the drug, device, medical treatment or procedure:
 - Is the subject of ongoing phase I or phase II clinical trials;
 - The research, Experimental study or investigational arm of on-going phase III clinical trials; or
 - Otherwise under study to determine its maximum tolerated dose, its efficacy, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis; or
- *Reliable evidence* shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only:

- Published reports and articles in the authoritative medical and scientific literature;
- The written protocol or protocols used by the treating facility; or

- Protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The Trustees have the authority to determine whether a service, procedure, drug, device or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

Hospital means a lawfully operating institution that meets all of the following requirements:

- Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, it is legally operated, has 24-hour supervision by a staff of Physicians, has 24-hour nursing service by registered graduate nurses and complies with one of the following:
 - Mainly provides general In-Patient medical care and treatment of Sick and injured persons by the use of medical, diagnostics and major surgical facilities; or
 - Mainly provides specialized In-Patient medical care and treatment of Sick and injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory); or
- Is an institution that provides care and treatment of a mental, psychoneurotic and personality disorders; alcoholism or drug abuse through one or more specialized programs and meets each of the following tests:
 - Is staffed by registered graduate nurses and other mental health professionals;
 - Provides for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which it is located; and
 - Each specialized program it provides must:
 - Provide treatment for no less than three hours nor more than 12 hours per day; and
 - Furnish a written, individual treatment plan that states specific goals and objectives; and
 - Maintain, at a minimum, ongoing, weekly progress notes that demonstrate periodic review and direct patient evaluation by the attending Physician; and
 - Meet either of these two tests:
 - ◆ Is accredited by the Joint Committee on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or
 - ◆ Is licensed, accredited or approved by the appropriate agency in the state in which it is located to provide the type of specialized program described above.

The term **Hospital** does not include a nursing home or an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care or for the aged;
- Furnishes mainly home like or custodial care, or training in the routines of daily living; or
- Is mainly a school.

In-Patient means a person who, while confined in a Hospital or Skilled Nursing Care Facility, is assigned a bed in any department of a Hospital or Skilled Nursing Care Facility other than in its

Out-Patient department and for whom a charge for room and board is made by the Hospital or Skilled Nursing Care Facility.

Medically Necessary means a service or supply that the Trustees and/or an independent review panel believe meet the following criteria:

- Is appropriate and consistent with the diagnosis and treatment of the person's injury or Sickness as recognized by community standards; and
- Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Medicare means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

Physician, Doctor and/or Surgeon means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs, under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license. These terms also include Doctors of Podiatry, Doctors of Dental Medicine, Doctors of Dental Surgery, Doctors of Ophthalmology, Certified Nurse Anesthetists, Nurse Practitioners, Nurse Assistants and Doctors of Chiropractic. Providers practicing within the scope of their license are permitted to perform services for which coverage is provided under this Plan. Psychologists and Social Workers are also included when practicing within the scope of their license if a MD or DO makes referral to the Psychologist or Social Worker.

Out-Patient means Hospital services and treatments incurred by a person who is not an In-Patient and/or is not charged room and board.

Plan and/or Welfare Plan mean this document as adopted by the Trustees and as hereafter amended by the Trustees for the administration of the Trust Fund and Plan. This Plan was established on August 1, 1965 in accordance with the Agreement and Declaration of Trust.

Reasonable and Customary Charge means the charge for the service or supply that is no higher than the usual amount charged in the locality where the charge is incurred for similar services or supplies. In determining a Reasonable and Customary Charge, the Fund also considers the complexity of the service. The Plan may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

Sickness or Illness means illness, pain or fever not caused by an Accident. This term also includes pregnancy and childbirth for female Members or spouses of male Members. Illnesses or Sicknesses resulting from and consequences of intentional acts, such as overdose of drugs, are excluded. Also excluded are voluntary, elective medical or surgical procedures other than elective sterilization.

Skilled Nursing Care Facility means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or injury, which provides room and board and 24-hour

nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (RN).

Union and/or Local Union mean any plumbers' or pipefitters' local union affiliated with United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

Welfare Fund, Fund and/or Trust Fund mean the **East Central Illinois Pipe Trades Health and Welfare Fund**, as it may, from time to time be constituted, including, but not limited to policies of benefit coverage, investments and income from any and all investments, Employer contributions and any and all other assets, property or money received by or held by the Trustees for the uses and purposes of this Fund.

Coordination Of Benefits

Under the Health and Welfare Plan, your benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents.

Another group plan or source refers to any plan providing benefits or services for or by reason of actual expenses which benefits or services are provided by:

- Group insurance;
- Group practice, group Blue Cross, group Blue Shield coverage individual practice offered on a group basis or other group prepayment coverage;
- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans;
- Any coverage under governmental programs including Medicare, Medicaid, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Deficit Reduction Act (DEFRA) and any coverage required by statute;
- Motor vehicle insurance; or
- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution.

How Benefits Are Paid

Benefits coordination insures that you receive maximum benefits and that benefits are not paid for more than 100% of the actual charges incurred.

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to its coordination of benefits rules. When secondary, this Plan pays the difference between your *allowable expenses* and what your primary plan paid. This Plan defines an allowable expense as any necessary, reasonable and customary item of expense for medical care or treatment, which is covered under at least one of the plans covering the eligible claimant. If a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

If you are covered or a Dependent is covered by another group plan or source, in addition to the East Central Illinois Pipe Trades Health and Welfare Fund, the order of benefit payment will be determined according to the guidelines outlined below.

Order Of Benefit Payment

For coordination with other plans the following rules apply:

1. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.

2. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a dependent.
3. For claims on behalf of Dependent children whose parents are not divorced or separated or for claims on behalf of Dependent children whose parents share custody and a court decree does not specify financial responsibility for medical expenses, the plan which covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.
4. For claims on behalf of Dependent children whose parents are divorced or separated, the following rules apply:
 - a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.
 - b. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary.
 - c. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:
 - The plan, if any, of the parent with custody is primary and pays benefits first;
 - The plan, if any, of the step-parent with custody pays benefits second;
 - The plan, if any, of the parent without custody pays benefits third; and
 - The plan, if any, of the step-parent without custody pays benefits fourth.
5. If none of the above rules applies, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

Implementation Rules

To implement the coordination of benefits rules, the Trustees, without consent of any person, will have the right to:

- Release or obtain information considered necessary;
- Authorize payment directly to another group plan or source that paid claims that should have been paid by this Plan; and
- Recover payments in excess of the amount that should have been paid by this Plan.

Any person claiming benefits under this Plan must furnish to the Trustees such information as may be reasonably necessary to implement these rules. **The Trustees are under no obligation to furnish any benefits under this Plan until such information has been received.**

Whenever payments have been made under any other plans that should have been paid by this Plan, the Trustees have the right, in their sole discretion, to pay the other Plan any amount determined to be warranted. Such payments will be deemed benefits paid under this Plan and the Plan will be fully discharged from liability for such charges.

Coordination Of Benefits With Medicare

The Plan has primary responsibility for claims of active Employees over age 65 and their Dependents. If you are entitled to Medicare solely because of an end stage renal disease (ESRD), this Plan has primary responsibility for your claims for the first 30 months and Medicare is secondary. After 30 months, Medicare has primary responsibility and this Plan is secondary. If you retire before the end of the 30-month period, Medicare will become primary. Medicare has primary responsibility for claims for retired Employees over age 65 and entitled to Medicare. Medicare also has primary responsibility for an eligible Employee who is disabled and entitled to Medicare because he or she has received Social Security Disability Income for 24 consecutive months.

ONCE YOU ARE RETIRED AND ARE ENTITLED TO MEDICARE, THE FUND PAYS BENEFITS AS IF YOU ARE ENROLLED IN MEDICARE. YOU MUST CONTACT YOUR LOCAL SOCIAL SECURITY ADMINISTRATION OFFICE FOR INFORMATION ON HOW TO ENROLL IN MEDICARE PART A AND PART B.

Subrogation or Reimbursement

Subrogation gives the Plan or Fund the right to recover all of the benefits it has paid to you or your dependent, or to those who provided your medical treatment, from another payment source or from you if you have received the payment directly. The Fund has the right to recover those payments, whether or not you have been fully paid for your treatment or other expenses from the same Injury.

For instance, if you are in an automobile accident, you may receive payment for your medical treatment from an automobile insurance company or from the person who was at fault for the accident. If the Fund paid for your expenses that the automobile insurance company is responsible for, the Fund has the right to recover those expenses from the automobile insurance company or from you if they were paid to you.

The following definitions apply to the terms used in this section only:

Another Person or Entity means any individual, corporation, municipality, other governmental entity, partnership, association, trust, or any other organization no matter how the person or entity has been identified.

Another Source means someone other than you or the Fund and includes:

- An insurance company that must pay the claims that result from the acts of Another Person, such as accident coverage, no fault coverage, uninsured or underinsured motorist coverage, personal injury protection, homeowners insurance, or school or athletic insurance;
- An employee health insurance plan or arrangement;
- A medical and/or hospital plan; or
- Another Person or any other entity (such as a company, organization, or corporation) that is responsible for the acts of the person that caused the expenses, such as a homeowner or other property owner.

Another Source does not include another employer group health plan that covers you, for example, through your spouse's employer, if that coverage is subject to the Plan's Coordination of Benefits provisions.

Compensable Injury means any Injury for which you may recover payment from Another Source.

Compensated Injury means any Injury for which your expenses has already been paid by Another Source before this Fund pays benefits toward the same claim.

Injury means either an Illness or an Injury if caused by the actions of Another Person or Entity. It also includes conditions that you may develop over time, such as from continued exposure to a harmful agent or a prolonged misdiagnosis of your condition.

Recovery means any payment from Another Source due to an Injury. It includes *any* judgment, award, or settlement, whether or not the judgment, award, or settlement specifically includes or excludes medical expenses or payments for disability. This definition applies no matter what the Recovery is called. For example, “loss,” “punitive damages,” “pain and suffering,” “medical expenses,” “attorney’s fees,” “costs,” etc. will all be defined as recoveries.

Subrogation means that the Fund has the right to take your place to ensure that any person or entity responsible for your Injury pays for the expenses of your Injury or reimburses the Fund for the amount it has paid on your behalf for that Injury.

Agreement to Reimburse Fund for Other Payments

Whenever you have an Injury expense that may be paid for by Another Person or Entity, you must complete a Reimbursement and Subrogation Agreement to receive benefits from the Fund. Signing the Agreement is not a guarantee of payments by the Fund. If your Dependent is a minor or is legally incompetent, you and the person who is legally authorized to act on his or her behalf must complete the Agreement. In the event of your or your Dependent’s death, the Fund’s right to reimbursement applies to your successors, assigns, executor and/or estate.

You must also comply with the following terms:

- You must agree to repay the Fund any benefits the Fund has paid because of your Injury. This provision applies even if the Recovery does not fully pay you for your Injury expenses. The Fund does not recognize the “make whole” doctrine.
- You will only be required to repay the amount of the benefits the Fund paid on the claim, or the amount you have recovered, whichever is less, without regard to attorneys’ fees and expenses you paid to obtain the Recovery. The Fund does not recognize the “common-fund” doctrine.
- The Reimbursement Agreement gives the Fund an equitable lien – or claim – on the money you recover from Another Source, both to the full extent of the Fund’s Subrogation rights and to the full extent of its right to repayment under the Agreement. The lien is valid whether or not the Agreement or the Fund’s Reimbursement and Subrogation rights are enforceable.
- You must protect the Fund’s right to reimbursement for benefits paid and do everything necessary for the Fund’s Recovery of benefits it paid. You must assist and cooperate with Fund’s representatives and sign all required documents to recover benefits paid by the Fund.
- If you receive a judgment or settlement, you must repay the Fund the lesser of the full amount of benefits paid by the Fund, or the amount of the Recovery. This provision applies, whether or not the source of the Recovery was legally responsible for paying those expenses. If you do not repay the Fund, the Fund may reduce future benefits for your claims until the Fund has recovered the benefits it paid, plus 10% interest per year. The Fund’s right to reduce future benefits is in addition to any other legal rights the Fund may pursue to recover benefits. If you obtain a recovery from another person or entity or another source, you must hold the recovery or an amount equal to the total claims and benefits paid by the Fund in a constructive trust pending reimbursement to the Fund

and/or pending resolution of the Fund's lien. Further, it will be considered and deemed to be held in trust for such purpose.

You, your Dependent or your Dependent's representative must:

- Not assign to any other person or entity your right to recover benefits from Another Source;
- Obtain the Fund's consent before releasing Another Person from liability for any Injury; and
- Not interfere with the Fund's claim and lien.

If you attempt to assign your right to Recovery of benefits, the Fund may pursue legal action against you and the person or entity to which you assigned your rights, to cancel your assignment and recover the benefits paid by the Fund.

The Fund is subrogated to your right to recover from Another Source.

The Fund will not be responsible for legal fees and expenses you pay to obtain a Recovery from Another Source, unless the Fund has previously agreed to that in writing.

The Fund may require your attorneys to sign an agreement that they will honor and enforce the terms of the Reimbursement Agreement before they disburse any money received as a Recovery from a Compensable Injury.

Fund's Subrogation Right

Your agreement to repay in the Reimbursement and Subrogation Agreement and the Fund's Subrogation rights are separate and distinct rights and obligations. If either the Agreement or the Fund's Subrogation right fails or is considered invalid in some way, it will not affect the validity of the other.

The provisions in the previous section, *Agreement to Reimburse Fund for Other Payments* also apply to the Fund's Subrogation right. If you fail or refuse to sign a Reimbursement Agreement, it does not affect the Fund's Subrogation rights or the Fund's right to claim a lien against and collect benefits from any source of possible Recovery.

The Fund has the right to intervene and participate in any legal action you bring against Another Source.

If you fail or refuse to take legal action against Another Source within a reasonable time, the Fund may do so in your name to recover amounts due under the Subrogation provision. If the Fund takes legal action, the Fund has the right to deduct its expenses, costs, and attorney's fees out of any Recovery or settlement. However, the Fund is not required, by this provision, to pursue your claim against Another Person.

If you recover benefits from Another Source and do not repay the Fund, the Fund may sue you to recover the amount of the amount paid. The Fund may also reduce any of your future benefits

until the Fund is fully repaid, regardless of whether or not the future claim is related to the Compensated Injury.

If the Trustees determine that Recovery from Another Source is not possible, the Fund will waive its Subrogation right and will pay its normal benefits for your claim.

The Trustees, or their authorized representative, have the sole discretion to interpret the Fund's Subrogation provisions and to settle any of the Fund's Subrogation claims and liens.

The Trustees have the sole discretion to make a determination regarding questions as to whether any benefit payment is related to a Compensable Injury. You must sign any and all necessary documents, releases, and waivers that relate to their determination, upon request.

Compensated Injuries

If Another Source has already paid you expenses toward treatment of your Injury, the Fund will not begin paying benefits until the total expenses for your Compensable Injury exceed the total amount you have recovered from the other source.

Any and all monetary Recovery you receive will first be applied to benefits payable under this Fund.

The Fund's Subrogation rights are enforceable, regardless of:

- Who begins the legal action against the person or entity that is responsible for the Injury;
- Who pays the amount of the Recovery;
- Whether the Recovery is in the form of a judgment, settlement, or otherwise; or
- Whether you receive the Recovery as an employee, Dependent, legally competent or incompetent person, or a representative of any such person.

Nothing in this section will interfere with or limit the Fund's Subrogation right for medical expenses that were incurred and paid before you recovered the expenses from your Injury.

Filing Health Care Claims and Appeals

This section describes information on health care (medical, wellness and prescription drug) claims filed on or after August 1, 2002. For information about Weekly Income Benefit claims, see page 30.

Filing Your Initial Claim

You or your Dependent must file claims for services provided by providers outside of the PPO network. PPO providers will take care of the paperwork for you.

You must file your initial claim for Plan benefits within one year after the date you received the services. If you do not meet this deadline, your claim will be invalidated or reduced.

Claims for benefits provided by the Plan may be filed by:

- You;
- Your Dependent; or
- Your or your Dependent's authorized representative.

When you or your Dependent use a provider outside the PPO network, you must file a claim. To file a claim:

- Complete the necessary portions of the form by filling in all requested information, including your social security number, and signing on the line specified.
- Obtain from the provider an itemized bill showing the diagnosis, the services and supplies provided, the charge for each item and the date of each charge. If possible, have the provider complete the appropriate portion of the claim form.
- Forward the completed form, with all itemized medical bills attached to the address listed in the "Contact Information" section listed on page 2.

If you incur an injury or Sickness for which you will make claims, you need to submit a written notice to the Fund Office as soon as possible after the date the treatment or services for that injury or Sickness began, but not later than one year. However, your claim will not be reduced or invalidated if you are able to show that you could not reasonably provide proof within this time.

Types of Claims

There are three basic types of health care claims:

- Pre-service;
- Post-service; or
- Concurrent care.

Pre-Service Claims. Pre-service claims are claims for Hospital admissions or stays where the Plan requires that you obtain certification. The Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain certification; or
- The certification process would jeopardize your life or health.

Post-Service Claims. Post-service claims are any claims for Plan benefits that are not pre-service claims. When you file a post-service claim, you have already received the services in your claim.

Concurrent Care Claims. A concurrent claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, the Plan Administrator must notify you:

- As soon as possible; and
- In time to allow you to have an appeal decided before the benefit is reduced or terminated.

When Benefits Are Paid

When you submit a claim for benefits, the Fund will determine if you are eligible for benefits and calculate the amount of the benefit payable, if any.

Generally, all health care benefits will be paid within 15 days for pre-service claims (30 days for post-service claims) after acceptable proof is received.

Reimbursement for covered charges will be made to the provider of service unless the bill is clearly marked “Paid-in-Full” by the provider. PPO providers handle all the paperwork for you. The provider will be paid directly and you will be billed the copayment and deductible if applicable.

If benefits are not paid directly to the provider of service, unpaid benefits for outstanding Hospital, nursing, medical or surgical claims are payable to you, if living. Otherwise, any outstanding claims will be payable to your estate.

Your Claim Decision Notice

If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for pre-service claims, the Plan must give you written notice of its decision about your claim.

Denial Of Claims

If your claim is denied (in whole or in part), the Plan must:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial of your claim, it must provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under Employee Retirement Income Security Act of 1974 (ERISA) following the review of your claim;
- A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

Notice Timeframes

The Plan must notify you of its initial decision within certain timeframes. The deadlines differ for the different types of claims. An initial determination will be made within 15 calendar days for pre-service claims (30 days for post-service claims) from receipt of your claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

Claims Appeal

You have the right to a full and fair review if your claim for benefits is denied, in whole or in part. While in general you should appeal any claim as soon as possible, if your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you have up to 180 days following the receipt of the decision to file a written appeal. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

When your claim is reviewed, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial benefit denial. An appropriate fiduciary of the Plan will conduct the review.

Medical Judgments In Appeals

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

In addition, you have the right to be advised of the identity of any medical experts and you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
 - Was relied upon by the Plan in making the decision;
 - Was submitted, considered or generated (regardless of whether it was relied upon); or
 - Demonstrates compliance with the claims processing requirements.

Appeal Timeframes

The Plan must notify you, in writing, of the decision on appeal within five calendar days. The Plan's determination of its decision must be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- ***Pre-Service.*** A determination will be made within 30 calendar days from receipt of your appeal. If the appeal process has two levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.
- ***Post-Service Claims.*** A determination will be made within 60 calendar days from receipt of your appeal. The determination will be made at the Fund's next quarterly meeting. If the appeal is received within 30 days of that meeting, a determination will be made by the date of the second quarterly meeting following receipt of your appeal.
- ***Concurrent Care Claims.*** A determination will be made before termination of your benefit.

You must follow the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain your benefits.

Legal Proceedings

You may not bring any action in court to recover benefits:

- Before you have exhausted all of your remedies under the Plan's claims and appeals procedures; and
- After three (3) years from the expiration of the time allowance within which you were required to file your claim with the Plan.

Notwithstanding the foregoing, any legal action must be initiated within 12 months of the date the Plan issues an adverse benefit determination on your appeal.

General Provisions

The following provisions are to protect your legal rights and the legal rights of the Plan.

Notice of Claim

Written notice of claim with information sufficient to identify the Employee and Dependent whose injury or Sickness is the basis of claim must be given to the Fund Office as soon as reasonably possible. Any claim not filed on a timely basis as required will not be paid. The Fund Office, upon receipt of such notice, will furnish forms for filing proof of loss. You will be considered to have complied with the requirements of the Plan as to proof of loss by submitting written proof of such loss in accordance with the provisions under Proof of Loss.

Requirement to Provide Necessary Information Regarding Eligibility

You and your Dependents will be covered by the Plan only if you and your Dependents provide such information as deemed necessary to determine your eligibility for medical coverage under the Plan or to enable the Plan to comply with reporting obligations under applicable law (e.g., social security number, address, etc.). If you or any of your dependents fail to provide the Plan with information which is necessary to enable the Plan to determine you or your Dependent's eligibility for coverage or continued coverage or you or your Dependents otherwise fail to provide information necessary for the Plan to comply with reporting obligations under applicable law (e.g., social security numbers, addresses, etc.), then your eligibility or the Dependent's eligibility shall terminate fourteen (14) calendar days following the date that the Plan notifies you, in writing via mail with a certificate of mailing, that your coverage will terminate as a result of you or your Dependent's failure to provide such necessary information. The fourteen (14) calendar day period specified above shall commence as of the date that such notice is *mailed*.

Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your protected health information.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice periodically, *as required* by HIPAA rules, or when changes are made to the policies and procedures.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization,

use or disclose your protected health information for employment-related actions and decisions or in connection with any other Plan benefit or employee benefit plan.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called “Business Associates,” to observe HIPAA’s privacy rules. In some cases, you may receive a separate notice from one of the Plan’s Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

Protection and Security of Protected Health Information (PHI)

The Plan Sponsor:

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

Plan’s Use and Disclosure of Protected Health Information (PHI)

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to a retirement plan, disability plan, reciprocal benefit plan, and/or workers’ compensation insurers for purposes related to administration of these plans.

Payment Defined

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

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

Health Care Operations Defined

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

- Quality Assessment;
- 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;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- 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);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

- 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 or development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:
 - Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;
 - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - Resolution of internal grievances; and
 - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

Other Uses and Disclosures of Protected Health Information (PHI)

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, release PHI for court proceedings, and releasing PHI for law enforcement or similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

Final HIPAA Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act generally referred to as the HIPAA Final Rule, are as follows:

- You have the right to be notified of a data breach relating to your unsecured health information.
- You have the right to ask for a copy of your electronic medical record in an electronic form provided the information already exists in that form.
- To the extent the Plan performs any underwriting, the Plan cannot disclose or use any genetic information for such purposes.
- The Plan may not use your PHI for marketing purposes or sell such information without your written authorization.

Plan's Disclosure of Protected Health Information (PHI) to the Board of Trustees

For purposes of the Plan's privacy rules, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only as long as this Plan Document incorporates the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as otherwise required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- 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;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- 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 Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

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

- The Plan Administrator; and
- Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Effective August 1, 2011 the medical arrangements shall comply with all mandates applicable to those arrangements under the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act (collectively “PPACA”), and all regulations promulgated thereunder by the Departments of Health and Human Services, Labor and Treasury. To determine the extent of the PPACA’s applicability to the terms of each arrangement, Plan Administrator will establish whether one or more of the medical arrangements are “grandfathered” health plans within the meaning of Section 1251 of the PPACA. The required disclosure set forth in 29 C.F.R. § 2590.715-1251(a)(2) for any arrangement that is determined to

be a grandfathered health plan will be included in any written materials provided to Participants describing the benefits provided under the arrangement.

Proof Of Loss

Written proof of loss must be furnished to the Fund Office in case of claim for loss within 12 months following the date the expenses of the loss were incurred. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible.

Physical Examination And Autopsy

The Trustees have the right and opportunity, at the Fund's expense, to have a Physician they designate examine the eligible Employee or Dependent whose injury or Sickness is the basis of a claim for Plan benefits, as often as they may reasonably require while the claim is pending. The Trustees also have the right to request an autopsy in case of death where it is not forbidden by law.

Payment of Claims

The claims administrator may pay all or a portion of any benefits provided for health care services to the provider, unless directed otherwise in writing by the time *Proof of Loss* is filed. The Plan does not require that the services be rendered by a particular provider. Benefits accrued on behalf of an Employee or Dependent upon death will be paid, at the Plan's option, to the first surviving class of the following:

- Your spouse;
- Your Dependent children, including legally adopted children;
- Your parents;
- Your brothers and sisters;
- Your estate.

The Plan will rely upon an affidavit to determine benefit payments, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the Plan in good faith will fully discharge it to the extent of such payment.

Gender

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

Assignment

Assignment of benefits may be made only with the Plan's consent. An assignment is not binding until the Plan receives and acknowledges in writing the original or copy of the assignment before payment of the benefit. The Plan does not guarantee the legal validity or effect of such assignment.

Amendment And Termination

While the Trustees fully intend to continue the Plan, they reserve the right to alter or, if necessary, discontinue the Plan. The provisions of the Plan may be amended from time to time by a majority vote of the Trustees. Amendments may include increases, modifications, reductions or the elimination, in whole or in part, of certain benefits.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

No Employment Guarantee

Your coverage by the Plan does not constitute a guarantee of your continued employment.

Forfeiture of Payments Issued

Any check or payment issued to a participant or beneficiary or to a provider of services on behalf of a participant or beneficiary must be cashed within one (1) year from the date of issuance of the check. Any check that is not cashed within one (1) year shall be void and the entire amount of the check payment shall be forfeited in its entirety. Notwithstanding the foregoing, a check or payment issued to a provider of services shall not be forfeited if a forfeiture is not permitted by an applicable provider and/or network agreement. The Fund will not provide any further notice that the payment has been forfeited.

Administrative Information

Plan Name	East Central Illinois Pipe Trades Health and Welfare Fund												
Board Of Trustees	<p>A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer representatives and Union representatives, the latter of which are selected by the Employees and the Union, which have entered into collective bargaining agreements that relate to this Plan. These collective bargaining agreements are described below. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:</p> <p>Board of Trustees East Central Illinois Pipe Trades Health and Welfare Fund c/o HealthSCOPE Benefits, Inc. 8901 Otis Avenue, Suite 200 Indianapolis, IN 46216</p> <p>As of January 1, 2016, the Trustees of this Plan are:</p> <table><thead><tr><th>Union Trustees</th><th>Employer Trustees</th></tr></thead><tbody><tr><td>Mr. D. Michael Doolan II</td><td>Mr. Brian Rich</td></tr><tr><td>Mr. Evan Wooding</td><td>Mr. Brad Houk</td></tr><tr><td>Mr. Patrick Hardesty</td><td>Mr. Jody Alderman</td></tr><tr><td>Mr. John Haines</td><td>Mr. Doug Kelleher</td></tr><tr><td>Mr. Matt Langendorf</td><td>Mr. Scott Larkin</td></tr></tbody></table>	Union Trustees	Employer Trustees	Mr. D. Michael Doolan II	Mr. Brian Rich	Mr. Evan Wooding	Mr. Brad Houk	Mr. Patrick Hardesty	Mr. Jody Alderman	Mr. John Haines	Mr. Doug Kelleher	Mr. Matt Langendorf	Mr. Scott Larkin
Union Trustees	Employer Trustees												
Mr. D. Michael Doolan II	Mr. Brian Rich												
Mr. Evan Wooding	Mr. Brad Houk												
Mr. Patrick Hardesty	Mr. Jody Alderman												
Mr. John Haines	Mr. Doug Kelleher												
Mr. Matt Langendorf	Mr. Scott Larkin												
Plan Sponsor and Administrator	The Board of Trustees is the Plan Sponsor and Plan Administrator.												
Employer Identification Number	37-0867221												
Plan Number	501												
Agent for Service of Legal Process	Service of Legal Process also may be made on the Board of Trustees or any individual Trustee at the above address.												
Source of Contributions	The benefits described in this booklet are provided solely through Employer contributions. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining												

agreements and the amount of monies necessary to provide the coverage required by the Plan.

Collective Bargaining Agreement

The Plan is maintained in accordance with a collective bargaining agreement between the Union or Unions and the Association. Other agreements may be in effect from time to time. The agreements specify the contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement.

Trust Fund

The Trust Fund consists of all assets that are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits in this Plan are provided on a self-funded basis.

The Plan's assets are managed by professional asset managers selected by the Board of Trustees.

Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on August 1 and ends on July 31.

Type Of Plan

This Plan is maintained for the purpose of providing death, disability and medical benefits in the event of Sickness or Accident. The Plan benefits are shown in the "Schedule of Benefits" on pages 9 - 11 of this booklet.

Eligibility

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described on pages 12 - 22 of this booklet.

Claim Procedures

The general procedures to follow for filing a claim for benefits are explained in this booklet. If all or any part of your claim is denied, you may appeal that decision.

Statement of ERISA Rights

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

Receive Information About Your Plan And Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA:

- Call 1-866-444-3272;
- Visit www.dol.gov/ebsa; or
- Send electronic inquiries to www.askebsa.gov.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan or insurance policies. All of the benefits of this Plan are made available to you and your eligible Dependents by the Trustees as a privilege and not as a right. You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement.

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant. Participants will be notified in writing of any Plan changes.

Subject to the stated purposes of the Fund and the provisions of the Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description, the terms used herein and the bylaws and regulations issued thereunder. Any such determination and any such construction adopted by the Trustees in good faith will be binding upon all of the parties hereto and beneficiaries hereof. No matters respecting the foregoing or any difference arising thereunder or any matter involved in or arising under the Trust Agreement or this Summary Plan Description will be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Association and the Union, provided, however, that this clause will not affect the rights and liabilities of any of the parts under any of such collective bargaining agreements.

It is the intent of the drafters of this Summary Plan Description that the Trustees possess the discretion to determine eligibility for benefits and to construe the terms of the Trust and/or Plan governing benefits. It is also the intent of the drafters of the Trust and Summary Plan Description, by adopting the discretionary power specified above, that the decisions of the Trustees as to the granting or denial of benefits and the construing of terms of the Trust and benefit plan, are reviewed given judicial deference pursuant to an "arbitrary and capricious" standard by a reviewing court, as enunciated by the United States Supreme Court in *Firestone Tire and Rubber Company et al. v. Richard Bruch*, 57 L W 4194 (Feb 21, 1989).