Local 434 Health & Welfare Fund

HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

Effective June 1, 2014

LOCAL 434 HEALTH & WELFARE FUND

To All Active Employees and Retirees:

We are happy to provide you with this new Summary Plan Description (SPD or Summary) incorporating all Plan changes adopted through June 1, 2014. In easy-to-understand language, it tells you how to become and remain eligible for benefits, explains the benefits available, and gives you instructions on how to apply for benefits. If there should be any inconsistencies between this simplified Summary and the more technical legal Plan Document and Trust Agreement, the legal documents will govern. The Trustees have the right to change, add, or to delete benefits, self-payment rates, Eligibility Rules, or any other provisions relating to the operation of the Plan or terminate the Plan at any time by written amendment in an effort to best serve all Plan participants.

The benefits described in this Summary Plan Description are self-funded. Self-funded benefits payable are limited to Trust Fund assets available for such purposes.

Please Note: Benefits for life insurance and accidental death and dismemberment are insured. Your Certificate of Coverage is enclosed. It details the policy provisions, including eligibility for such coverage.

The Eligibility Rules and benefits are maintained at levels in line with Trust Fund income and assets and they are reviewed regularly to provide the best protection possible within the Fund's financial means. The Eligibility Rules and other Plan provisions have been updated as necessary to comply with legal requirements, including the Patient Protection and Affordable Care Act (the "Affordable Care Act").

Please read the information in this SPD booklet carefully to have a clear understanding of your Plan and then keep it handy for future reference. If you have questions at any time regarding the Plan, please contact the Fund Office.

Yours sincerely,

The Board of Trustees

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Russ Boos
Greg Erickson
Terry Hayden
Christopher Ignatowski
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Office Hours
Monday - Friday 8:00 a.m. - 5:00 p.m.

IMPORTANT MESSAGE

It is important that any change of eligibility for yourself and/or any of your eligible dependents be reported as soon as possible to the Fund Office.

You must notify the Fund Office in writing of any changes in eligibility, such as:

- a change in marital status due to marriage, death, divorce, or legal separation;
- the death or disability of you or any of your dependents;
- your retirement; and
- the birth or adoption of a dependent child, or the addition of a stepchild due to marriage.

IF YOU ARE A RETIRED MEMBER and you become eligible for Medicare benefits by age or disability, contact the Fund Office as soon as possible.

IF YOU ARE LAID OFF, contact the Fund Office immediately.

For specific details regarding eligibility/enrollment, termination, and continuation/extension of coverage, refer to the section of this booklet beginning at Eligibility Rules and Effective Date of Coverage on page 16.

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SCHEDULE OF BENEFITS

CLASSES A AND C MEDICAL BENEFITS		
	PPO Provider[1,2]	**Non-PPO Provider**[1,2]
Deductible per calendar year[3]		
Per covered person	$ 500	$1,000
Aggregate maximum per family	$1,500	$3,000
Plan's Coinsurance	85% (you pay 15%)	65% (you pay 35%)

[1] Services of Non-PPO PEAR (Pathologists, Emergency room physicians, Anesthesiologists, and Radiologists) group providers are payable at the PPO level of benefits when a PPO hospital is utilized.

[2] All emergency services are payable at the PPO level of benefits even if services are obtained at a non-PPO provider.

[3] Amounts satisfied at a PPO provider will be applied to the amount required at a non-PPO provider and amounts satisfied at a non-PPO provider will be applied to the amount required at a PPO provider. Deductibles and coinsurance satisfied under either the full Plan benefits option or the reduced cost option will be applied to the other option if you change from one option to another during the calendar year.

CLASSES A AND C MEDICAL BENEFITS		
	PPO Provider[1,2]	**Non-PPO Provider**[1,2]
Out-of-Pocket Limit per calendar year[3] (including deductible and emergency room copayments but NOT including prescription drug copayments)		
Per covered person	$2,500	$5,000
Aggregate maximum per family	$7,500	$11,000
The out-of-pocket limit represents the total number of dollars paid by you and/or all your covered dependents towards the satisfaction of the coinsurance provisions. When you reach this limit, the Plan will pay 100% of covered expenses on a customary, usual, and reasonable fee basis thereafter for the remainder of the same calendar year, subject to Plan maximums.		

[1] Services of Non-PPO PEAR (Pathologists, Emergency room physicians, Anesthesiologists, and Radiologists) group providers are payable at the PPO level of benefits when a PPO hospital is utilized.

[2] All emergency services are payable at the PPO level of benefits even if services are obtained at a non-PPO provider.

[3] Amounts satisfied at a PPO provider will be applied to the amount required at a non-PPO provider and amounts satisfied at a non-PPO provider will be applied to the amount required at a PPO provider. Deductibles and coinsurance satisfied under either the full Plan benefits option or the reduced cost option will be applied to the other option if you change from one option to another during the calendar year.

CLASSES A AND C
MEDICAL BENEFITS

The following medically necessary covered expenses are payable on a customary, usual, and reasonable basis, subject to the deductible, coinsurance, and out-of-pocket limit, whether incurred at a PPO or Non-PPO provider:

- hospital benefits and outpatient hospital;
- physician (including office visits due to bodily injury or sickness, hospital visits, surgery, and anesthesia);
- assistant surgeon (payable at 25% of the customary, usual, and reasonable fee allowed for the primary surgeon);
- routine care in addition to routine physical examinations as specifically stated on pages 57 and 58;
- routine physical examinations for employee and dependent spouse (payable at 100% with no deductible requirement at PPO providers; subject to Medical Benefits deductible, coinsurance, and out-of-pocket limit at non-PPO providers);
- routine physical examinations for dependent children (payable at 100% with no deductible requirement at PPO providers; subject to Medical Benefits deductible, coinsurance, and out-of-pocket limit at non-PPO providers);
- free-standing surgical facility;
- x-ray and laboratory tests;
- ambulance service;
- pregnancy benefits, newborn benefits, and birthing centers, except that certain preconception and prenatal services as listed on pages 57 and 58 are payable at 100%;
- convalescent nursing home benefit (PPO and Non-PPO provider covered expenses aggregate to a maximum of 30 days per confinement after each and every hospital confinement of at least one day);
- home health care (PPO and Non-PPO provider covered expenses aggregate to a maximum of 40 visits per covered person per calendar year--each four consecutive hours of home health service or part thereof in a 24-hour period is considered one visit);

CLASSES A AND C MEDICAL BENEFITS (continued)
• hospice care (for terminally ill patients with six months or less to live); • psychological disorder or substance abuse benefits; • treatment of morbid obesity, up to an aggregate maximum of $20,000 per each covered person's lifetime; • wigs after chemotherapy, up to a maximum of $300 per covered person per sickness; • hospital emergency room visits, subject to a separate $50 copayment per visit, which does not apply towards satisfaction of deductible (copayment waived if admitted to hospital as inpatient); • chiropractic care, subject to the age requirements on page 73, up to a maximum of $1,000 per covered person per calendar year; • physical, speech, and occupational therapy, up to an aggregate maximum of $3,000 per covered person per calendar year (expenses in excess of such maximum will be payable subject to medical necessity review); • temporomandibular joint disorder (TMJ) treatment, up to $1,000 per covered person per calendar year; and • other covered expenses.

CLASSES A AND C MEDICAL BENEFITS (continued)	
Coverage for Organ Transplants	
Donor(s)' services	$25,000 of reasonable expenses for all donors per transplant benefit period
Maximum daily limit for lodging and meals	$100 per day for one companion; $200 per day for patient and one companion
Aggregate maximum for transportation, lodging, and meals	$10,000 of reasonable expenses per transplant benefit period
Maximum for private nursing care	$10,000 of reasonable expenses per transplant benefit period
All other covered services	Payable under the Plan the same as for any other disability

CLASSES A , C, AND D (FOR PERSONS NOT ENROLLED FOR MEDICARE PRESCRIPTION DRUG BENEFITS) PREFERRED PROVIDER PHARMACY PROGRAM[1]	
BENEFIT	**BENEFIT PAYABLE**
Class D only: Prescription drug calendar year deductible per covered person (does not apply to drugs covered at a $0 copayment)	$50
Covered person's copayment at a retail network pharmacy[2], the Specialty Pharmacy, or through the mail service pharmacy[3]	
Generic	15%[4] (minimum copayment of $5.00 for generic medications that cost $5.00 or more)
Brand name (including brand name contraceptives for women)	25%[4]

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[1] Benefits are payable for 100% of the cost of shingles vaccinations obtained at a retail network pharmacy for covered persons age 60 and over.

[2] To the extent consistent with the Affordable Care Act, benefits are payable for 50% of the cost of prescription tobacco cessation medications purchased in conjunction with the Quit for Life Program described on page 84, up to a maximum of a 90-day supply per calendar year, subject to the preventive care requirements of the Affordable Care Act.

[3] The following are covered at a $0 copayment through both retail network pharmacies and the mail service pharmacy, upon a physician's written prescription and subject to the provisions stated on pages 87 and 88: OTC aspirin; federal legend fluoride; OTC folic acid; OTC iron supplements; and generic contraceptives and contraceptives for which there is no generic alternative for women.

[4] If a covered person does not present his Fund ID at the time of purchase or uses a non-network pharmacy, he/she must pay the entire cost of the prescription at the time of purchase and then submit the claim to the PPRx for reimbursement. An administrative fee of $1.50 per prescription will apply. In addition, a covered person's copayment will be increased by 10% for claims filled through a non-network pharmacy. Claims from a non-network pharmacy will be reimbursed up to a 34-day supply and up to the amount allowable at a network pharmacy.

CLASSES A, C, AND D (FOR PERSONS NOT ENROLLED FOR MEDICARE PRESCRIPTION DRUG BENEFITS) PREFERRED PROVIDER PHARMACY PROGRAM	
OTC Prilosec, OTC loratadine, OTC Prevacid, OTC Zegerid, and OTC Allegra/Allegra-D products upon a physician's written prescription and prescription/legend omeprazole (deductible does not apply)	$0[1]
Prescription Proton Pump Inhibitors (PPIs), other than those listed above, and prescription non-sedating antihistamines	50%[1]

[1] If a covered person does not present his Fund ID at the time of purchase or uses a non-network pharmacy, he/she must pay the entire cost of the prescription at the time of purchase and then submit the claim to the PPRx for reimbursement. An administrative fee of $1.50 per prescription will apply. In addition, a covered person's copayment will be increased by 10% for claims filled through a non-network pharmacy. Claims from a non-network pharmacy will be reimbursed up to a 34-day supply and up to the amount allowable at a network pharmacy.

REDUCED COST OPTION		
The reduced cost option is available to Class A bargaining unit employees continuing coverage while unemployed and available for work, upon their Dollar Bank having less than one month of benefit eligibility, subject to the Eligibility Rules.		
SHORT-TERM DISABILITY BENEFITS	No Coverage	
MEDICAL BENEFITS	**PPO Provider**	**Non-PPO Provider**
Deductible per calendar year[1]		
Per covered person	$3,000	$ 6,000
Aggregate maximum per family	$9,000	$18,000
Plan's coinsurance	75% (you pay 25%)	55% (you pay 45%)
Out-of-Pocket Limit per calendar year[1] (including deductible and emergency room copayments but NOT including prescription drug copayments)		
Per covered person	$ 6,000	$12,000
Aggregate maximum per family	$12,700	$36,000
PREFERRED PROVIDER PHARMACY PROGRAM		
Covered person's copayment at retail network pharmacy or through mail service pharmacy		
Generic	25%, minimum $15	
Brand name	35%, minimum $30	
(Copayment is increased by 10% for out-of-network claims.)		

[1] Deductibles and coinsurance satisfied under either the full Plan benefits option or the reduced cost option will be applied to the other option if you change from one option to another during the calendar year.

RESIDENTIAL EMPLOYEES	
A residential employee will have the following options for participating in the Plan as described on pages 45 through 48:	
Option A:	Life Insurance/Accidental Death and Dismemberment Benefits and Short-Term Disability Benefits
Option B:	Reduced Cost Option Medical Benefits only
Option C:	Class A Medical Benefits, Life Insurance/Accidental Death and Dismemberment Benefits, and Short-Term Disability Benefits

CLASSES A, C, AND D

OPTIONAL DENTAL CARE BENEFITS – DELTA DENTAL PLAN

The benefits of your dental plan will depend on the dentist you choose. PPO dentists agree to accept payment based on a reduced schedule, which means your out-of-pocket costs will be less. The coinsurance amounts listed in the Delta PPO column apply. Also, the maximum benefit per year is higher if you use a PPO dentist, as stated in the following table.

Other dentists not listed in the PPO dentist directory will charge you any balance of their fee remaining after Delta's payment. Payment is based on the lesser of the dentist's fee or the maximum plan allowance (MPA). The coinsurance amounts listed in the Non-PPO column apply and the maximum benefit is lower.

	Delta PPO	Non-PPO
Deductible (except orthodontics and Coverage A)		
Per covered person per calendar year	$ 75	$ 100
Per family per calendar year	$ 225	$ 300
Maximum benefit		
Per covered person per calendar year	$1,500	$1,000
Orthodontic maximum benefit		
Per covered person's lifetime	$1,500	$1,500
Coinsurance		
Coverage A: Diagnostic and Preventative Services	100%	70%
Coverage B: Basic Restorative Services	80%	70%
Coverage C(1): Crowns, Inlays, and Onlays	80%	70%
Coverage C(2): Bridges and Dentures	80%	70%
Coverage D: Orthodontic Services	100%	100%

Orthodontics is a covered benefit for your dependent children to age 19 only.

CLASSES A, C, AND D	
OPTIONAL VISION CARE BENEFITS	**BENEFIT PAYABLE**
Vision Examination One per covered person per calendar year	$50
Lenses One set per covered person each two calendar years	
Single vision, each lens	$30
Bifocal, each lens	$40
Trifocal, each lens	$50
Lenticular, each lens	$80
Contact, each lens	$80
(Or, disposable contact lenses, up to the maximum for one set of contact lenses each two calendar years)	
Frames One set per covered person each two calendar years, up to a maximum payment per set	$50

CLASS D MEDICAL BENEFITS

MEDICARE BENEFITS SUPPLEMENT

NOTE: Only Medicare-approved charges will be considered a covered expense unless otherwise specified.

BENEFIT	BENEFIT PAYABLE
Out-of-Pocket Limit per calendar year for Medicare-participating providers (NOT including prescription drug deductible or prescription drug copayments)	
Per covered person	$ 6,350
Aggregate maximum per family	$12,700
Hospital Confinement	
Medicare Inpatient Deductible	Reimbursed at 100%
61st-90th Day Inpatient Coinsurance	Reimbursed at 100%
91st Day and Beyond Inpatient Coinsurance per Each Lifetime Reserve Day, up to 60 Days per Lifetime	Reimbursed at 100%
Skilled Nursing Home Care	
Medicare Part A Coinsurance from 21st Day Through 100th Day of Post-Hospital Extended Care	Reimbursed at 100%
Beyond 100 Days	30 days per calendar year on a customary, usual, and reasonable basis at 100%

CLASS D MEDICAL BENEFITS
(continued)

BENEFIT	BENEFIT PAYABLE
Home Health Care 40 Visits per Calendar Year	 Balance of Medicare-approved charges after Medicare's payment
Psychological Disorders or Substance Abuse Inpatient: Outpatient:	 Balance of Medicare-approved charges after Medicare's payment Balance of Medicare-approved charges after Medicare's payment
Medical, Home, and Other Health Services Medicare Part B Deductible Eligible Expense in Excess of Medicare Part B Deductible Including, But Not Limited to, Outpatient Diagnostic Services, Physicians' Services, and Outpatient Treatment of Psychological Disorders, Chemical Dependence, or Alcoholism	 Reimbursed at 100% Balance of Medicare-approved charges after Medicare's payment
Temporomandibular Joint Disorder (TMJ) Benefit	$1,000 per covered person per calendar year on a customary, usual, and reasonable basis at 100%
Shingles Vaccinations (age 60 and over only)	Reimbursed at 100%

SHORT-TERM DISABILITY BENEFITS

Short-Term Disability Benefits are not payable for alumni and non-bargaining unit employees or for the reduced cost option.

SCHEDULE OF SHORT-TERM DISABILITY BENEFITS Class A Employees Only	
Weekly Short-Term Disability Benefit	66% of your basic salary, not to exceed $350 per week.
Elimination Period-- Benefits are payable from:	
Day 1	Bodily injury
Day 1	Hospital confinement due to sickness or bodily injury
Day 1	Outpatient surgery due to sickness or bodily injury if disability is expected to last seven days or more. If disability lasts six days or less, no Short-Term Disability Benefits are payable.
Day 8	Sickness
Maximum Period Payable	26 weeks during each period of disability

Basic salary means the employee's basic wage, salary, or earnings from his or her employer who sponsors the group plan. Basic salary does not include commissions, bonuses, overtime, or any other special payment.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life Insurance and Accidental Death and Dismemberment Benefits are not payable for the reduced cost option.

IMPORTANT NOTICE

The benefits shown on this Schedule of Benefits for Life and Accidental Death and Dismemberment Benefits are not intended to be a full description of benefits available. Surviving spouses are not eligible for life insurance and accidental death and dismemberment benefits. Refer to page 107 for additional information.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Classes A and C Employees Only	
Life Insurance Benefit	$10,000
Accidental Death and Dismemberment Benefit Principal Sum	$10,000
Class D Employees Only	
Life Insurance Benefit	$ 5,000
Accidental Death and Dismemberment Benefit Principal Sum	$ 5,000
Classes A and C Dependents	
Life Insurance Benefit only	
Spouse to age 70	$ 2,500
Unmarried dependent children age 15 days to 26 years	$ 2,500

ELIGIBILITY RULES AND EFFECTIVE DATE OF COVERAGE

PERSON WHO MAY BE COVERED

A person who may be covered by the Plan is one who is working under the jurisdiction of, or is a member of, the Local 434 Plumbers - Steamfitters - Refrigeration Workers and Service Technicians requiring periodic payments to the Local 434 Health & Welfare Fund and who works for a signatory employer who is making contributions on that person's behalf to the Fund as required by a certain collective bargaining agreement and/or a participation agreement to the Local 434 Health & Welfare Fund.

All employees working for a contributing employer within the jurisdiction of any participating union or within a classification covered in an approved participation agreement will be eligible to receive benefits under the Plan after meeting the following eligibility requirements. This includes alumni and non-bargaining unit employees. Sole proprietors and partners are not eligible to participate in this Plan. The terms for the participation of employees who perform work under the National Agreement for Residential and Light Commercial Construction ("residential employees") are described on pages 45 through 48.

The surviving spouse of a retired employee will be considered eligible to participate in the Plan. The surviving spouse of an active employee also will be considered eligible if the deceased employee had at least five years of continuous and uninterrupted participation in the Plan. If the surviving spouse remarries, eligibility will terminate at the end of the month following 90 days after the date of marriage. A surviving spouse is not eligible for the Plan's life insurance benefit.

ESTABLISHMENT OF AN INDIVIDUAL ACCOUNT (DOLLAR BANK)

The Trustees will establish an individual account (dollar bank) for each eligible bargaining unit employee. That account will be credited with the dollar amount of any contributions made to the Fund on his/her behalf by an employer. The Trustees, in their discretion, may credit the dollar banks with earnings generated by the assets therein.

Each individual account will be debited on a monthly basis for the purpose of establishing and maintaining benefit eligibility for the employee in an amount to be determined by the Trustees. Self-payments submitted by the employee also will be taken into account for purposes of maintaining benefit eligibility.

The dollar bank also will serve as a health reimbursement arrangement as described on pages 108 through 113.

As a result of such crediting and debiting, each eligible employee will have an account balance, although the balance may from time to time be zero.

An employee's dollar bank only will be forfeited in the following circumstances:

(a) If an employee begins to work in covered employment for an entity that is not required to contribute to the Fund, the employee will have his/her dollar bank eligibility and his/her dollar bank credits terminated on the last day of the month in which such employment commenced or is discovered, whichever is earlier. "Covered employment" is defined as work in a position for which an employer would be required to contribute to the Fund or a similarly situated multiemployer health and welfare fund (including those that have entered into a reciprocity agreement with the Fund).

(b) If an employee continues employment, of any kind, with a former contributing employer for whom the employee worked prior to the employer withdrawing from the Fund, and the employer is no longer obligated to contribute to the Fund, the employee will have his/her dollar bank eligibility terminated and his/her dollar bank credits cancelled on the last day of the month in which the contributing employer's obligation to contribute to the Fund ceases.

(c) For five consecutive years there have been no contributions to the dollar bank and neither the employee nor his/her dependents have submitted any claims for reimbursement from the account pursuant to pages 108 through 113.

(d) If you elect to opt out of the Dollar Bank Reimbursement Program consistent with the provisions stated on page 112.

(e) The date the Group Plan terminates.

The Trustees may reinstate a forfeited dollar bank described under the prior paragraph (a) or (b) if the affected employee returns to work with an employer in a position covered by the Fund and requalifies for eligibility in the Fund within twelve months of the date on which the Fund cancels his/her dollar bank credits and eligibility.

Any monies remaining in a deceased employee's dollar bank will be available to maintain eligibility for the employee's surviving spouse and other dependents, who also may utilize the account in the manner described on pages 108 through 113. Any balance in the dollar bank following the employee's death (or, if applicable, following the death or loss of eligibility of the deceased employee's surviving dependents) will forfeit to the Fund.

Employees only may utilize their dollar bank account balance to establish or maintain eligibility under the Plan, or to receive reimbursement of medical expenses as described on pages 108 through 113. An employee may not: (a) assign, transfer, or alienate his/her dollar bank assets other than pursuant to pages 114 and 115; (b) receive a taxable distribution of assets from his/her dollar bank; or (c) provide for a taxable distribution of assets from his/her dollar bank to a third party. Employees are prohibited from "freezing" their dollar bank with the exception of limited instances reflected in the Plan Document. Further, the Trustees may adopt rules that restrict an employee's access to his/her dollar bank, or that impose conditions on the ability of an employee to access or utilize his/her dollar bank.

INITIAL ELIGIBILITY AND EMPLOYEES' EFFECTIVE DATE OF COVERAGE FOR ACTIVE EMPLOYEES

For bargaining unit employees: You and your dependents will become initially eligible for benefits on the first day of the second month following a one-month period during which you work and are credited with at least 130 employer contribution hours. *For example, you will become eligible for benefits effective June 1, 2014, if you worked at least 130 contributory hours in April 2014.* This provision may be subject to change from time to time by the Trustees. Employees will be notified of any change and it will be recorded in the

appropriate Trustee minutes. Anyone who meets the minimum eligibility requirements automatically is covered under the Plan; you are not allowed to waive coverage.

You are permitted to "buy-in" for initial eligibility by making a full or partial self-payment. Coverage would be effective as of the date of your employment.

Alumni and non-bargaining unit employee: Such person will become eligible for coverage effective the first day of the calendar month following the first required monthly contribution by the employer on his/her behalf.

All eligible employees initially will be covered by Class A coverage. An eligible employee's effective date of coverage is his/her eligibility date.

DEPENDENT SPECIAL ENROLLMENT

If you are a covered employee or an otherwise eligible employee, you have the opportunity to enroll any newly acquired dependents when due to any of the following family status changes:

(a) marriage;

(b) birth; or

(c) adoption or placement for adoption.

You may elect coverage under this Plan that is effective on the date of the acquisition event, provided enrollment is within 60 days from the acquisition event. You **must** provide proof that the acquisition event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective no later than the first day of the first calendar month after the date the completed request for enrollment is received.

DEPENDENT EFFECTIVE DATE OF COVERAGE

The employee may cover dependents only if the employee also is covered. A dependent is eligible if he/she meets the requirement of a dependent as defined on pages 168 and 169. A dependent's eligibility date normally is the same as the employee's eligibility date

(unless the dependent enrolls under a special enrollment). Check with the Fund Office immediately on how to enroll for dependent coverage. Each dependent must be enrolled on forms furnished and accepted by the Fund Office.

Each dependent's effective date of coverage is determined as follows:

(a) If the completed enrollment forms are received by the Fund Office **before** the dependent's eligibility date, that dependent is covered on the date he/she is eligible.

(b) If the completed enrollment forms are received by the Fund Office **after** the dependent's eligibility date, but within 60 days from that date, that dependent is covered on the date he/she is eligible.

(c) If the completed enrollment forms are received by the Fund Office more than 60 days after the dependent's eligibility date, the dependent's coverage is effective on the first of the month after the completed enrollment forms are received by the Fund Office.

No dependent's effective date will be prior to the covered employee's effective date of coverage.

CONTINUING ELIGIBILITY

Bargaining Unit Employees: Contributions for hours you work in any month are due from your employer by the 15th of the following month, and will determine your eligibility for the first of the month following the month in which the contributions are due.

For example: Contributions for hours you work in July must be received by August 15th and determine eligibility for the month of September.

Dollars contributed by an employer on your behalf for hours worked are recorded in your dollar bank. The actual contribution remains a Fund asset at all times while it is held in the Fund's Trust account. Each month, the Fund will reduce your dollar bank by the amount necessary to provide you with one month's coverage. Dollars recorded in your dollar bank may accumulate and be used to cover

future monthly eligibility costs for months where sufficient contributions are not contributed on your behalf.

If you are active or retired, you may self-pay to maintain your eligibility for months when there are insufficient dollars recorded in your dollar bank as described on pages 23 through 25.

To remain eligible, you must be credited with employer contributions for at least 130 hours per month.

Alumni and non-bargaining unit employees (NBUEs): You and your dependents will continue to be eligible under the Plan during each successive calendar month for which a contribution at the proper rate is made to the Fund on your behalf pursuant to the terms of the participation agreement, provided your employer is complying with all conditions of its participation agreement. Alumni contributions are required on all hours worked, subject to a minimum of 130 hours per month.

Please note that an employee may lose benefit coverage under the Plan due to various circumstances, including the instance where a contributing employer discontinues contributions to the Fund on the employee's behalf. An employee is **not** eligible to use his/her individual credits in his/her dollar bank if his/her employer discontinues participation in the Fund (i.e., no longer is signatory to the appropriate collective bargaining agreement which provides the Fund with third-party beneficiary rights).

In such circumstances unless the employee in question is terminated, laid off, takes a leave of absence, or is unable to work because he/she is ill, any individual credits accumulated in his/her account may not be used.

RETIREE ELIGIBILITY

Special Provisions for Retirees: Except when otherwise prevented by law, retiree coverage is subject to change or discontinuation based on Trustee review. The Trustees retain the right in their sole discretion to modify or discontinue, in part or in whole, retiree eligibility rules, types and amount of benefits, terms and conditions under which benefits are payable, and self-payment rates at any time.

These provisions also are subject to modification as may be required by law.

Retirement is defined as ceasing active employment, and the Trustees will determine what constitutes ceasing active employment in a consistent and non-discriminatory manner.

A bargaining unit employee may receive alternate retiree benefits through the Fund, provided:

(a) he/she has been covered by the Fund for the five years immediately preceding retirement;

(b) he/she has had employer contributions made on his/her behalf to the Fund during the five-year period for at least 5,000 hours;

(c) he/she has attained age 55; and

(d) he/she is eligible for retirement benefits under his/her respective qualified pipefitters retirement plan, or he/she is in receipt of a determination from the Social Security Administration that he/she has qualified for Social Security Disability Benefits.

Alumni and non-bargaining unit employees also may receive retiree benefits, provided they satisfy the prior requirements (a), (b), and(c) and make the appropriate self-payments.

Upon retirement, an employee has a one-time option of continuing medical, life, accidental death and dismemberment and the optional dental and vision care benefits. If an employee elects not to continue benefits at the time of his/her retirement, he/she may not enroll at a later date unless he/she attains eligibility as an active bargaining unit employee and re-satisfies the retiree eligibility provisions as a bargaining unit employee.

An employee must provide written notice of his/her retirement to the Fund Office. To continue to receive such benefits, the retiree must pay the current monthly self-payment to the Fund for such benefits, in the manner prescribed by the Trustees.

You may have your retiree self-payments automatically deducted from your checking or savings account each month. If you are interested in using this option, call the Fund Office to request the necessary forms.

No person described in this retirement provision who retired prior to January 1, 1993, will receive any individual credits described previously.

If you or your dependent enroll for Medicare Prescription Drug Benefits, you and your dependent will become ineligible for Class D Prescription Drug Benefits upon the effective date of your Medicare Prescription Drug Benefits. If you or your dependent do not enroll for Medicare Prescription Drug Benefits, you and your dependent will continue eligibility for Class D Prescription Drug Benefits, provided you and your dependent otherwise are eligible for Class D Benefits. If you lose eligibility for the Plan's prescription drug benefits due to enrollment for Medicare Prescription Drug Benefits, your prescription drug benefits under the Plan will be reinstated if you later drop or terminate coverage for Medicare Prescription Drug Benefits, provided you maintained continuous medical coverage under the Plan.

SELF-PAYMENTS

If employer contributions have not been received for you for the required number of hours of work to maintain eligibility, and if there are insufficient credits in your dollar bank, you may make self-payments to maintain your and your dependents eligibility with either Self-Payment Option 1 or Self-Payment Option 2. You must elect one option or the other. If you elect Option 1, you cannot subsequently elect Option 2 unless you experience a second Qualifying Event.

Self-Payment Option 1: Bargaining Unit Employees

A bargaining unit employee may use Self-Payment Option 1 to continue eligibility under the following circumstances and terms. Self-payment notices are sent monthly to you if you do not have the required contributions to maintain eligibility. The due date for self-payments is 15 days from the date of the notice. Self-payments will be accepted under this provision only if you are immediately available for work under the terms of the collective bargaining agreement.

(a) When Employed Less Than 130 Hours Per Month

You will be allowed to make self-payments to the Fund to continue full Class A coverage, provided you are immediately available for work under the terms of the collective bargaining

agreement. The self-payment amount is equal to the difference between credited hours for the month and 130 hours, multiplied by the current hourly contribution rate.

There currently is no limit on the number of consecutive self-payments that you can make to maintain eligibility, but the Trustees are authorized to amend the Plan to impose such limits.

(b) When Completely Unemployed and Your Dollar Bank Has Less Than One Month of Benefit Eligibility

The following two options are available provided you are completely unemployed, your dollar bank has less than one month of benefit eligibility, and you are immediately available for work in the Fund's jurisdiction under the terms of the collective bargaining agreement.

(1) All Class A benefits as described in the Schedule of Benefits;

(2) Class A Medical Benefits, Preferred Provider Pharmacy Benefits, and optional Dental and Vision Benefits, but at increased deductible and coinsurance as described in the Schedule of Benefits, Reduced Cost Option.

Self-payments for full Class A benefits will be in an amount equal to the current hourly contribution rate multiplied by 130 hours.

Trustees will set the self-payment rate for the reduced cost option from time to time.

If after being unemployed you resume limited employment, employer contributions for hours worked while eligible under the reduced cost option will apply to your self-payment for the eligibility month that corresponds to the month in which the hours are worked.

If you select and are eligible for the reduced cost option, you may continue coverage under such option for as long as you are completely unemployed and available for work in the Fund's

jurisdiction under the terms of the collective bargaining agreement.

If you are continuing coverage under the reduced cost option, you only may be reinstated to full Class A benefits again when you return to work and work sufficient hours to qualify for Class A benefits according to initial eligibility requirements for a bargaining unit employee (first day of the second month following a one-month period during which you worked and are credited with at least 130 employer contribution hours).

Deductibles and coinsurance satisfied under either the full Class A benefits option or the reduced cost option will be applied to the other benefit option if you change from one option to another during the calendar year.

If you lose coverage under the reduced cost option due to a second qualifying event as defined under Self-Payment Option 2 (COBRA), COBRA coverage will be that provided for under the reduced cost option.

Self-Payment Option 2: THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

A covered person may use Self-Payment Option 2 to continue eligibility under the following circumstances and terms.

Continuation of Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires the Fund to offer employees and/or their dependents who are qualified beneficiaries continuation of medical, optional dental and vision coverage, and FAP coverage at group rates in certain instances where there is a loss of coverage.

Eligibility

A qualified beneficiary under COBRA law means an employee, employee’s spouse, or dependent child covered by the Plan at the time of the qualifying event. A qualified beneficiary under COBRA law also includes a child born to or placed for adoption with the employee during the employee’s COBRA coverage period.

Employee: An employee covered by the employer's Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

(a) termination (for reasons other than gross misconduct) of the employee's employment; or

(b) reduction in the hours of employee's employment.

Spouse and Dependent Children: A spouse and each dependent child covered by the Plan has the right to elect continuation coverage if the coverage is lost due to one of the following qualifying events:

(a) death of the employee;

(b) termination of the employee's employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment with the employer;

(c) divorce or legal separation from the employee;

(d) employee's entitlement to Medicare Benefits (under Part A, Part B, or both); or

(e) a dependent child ceases to meet the definition of dependent under the Plan.

Notices and Election

The Plan provides that coverage terminates for a spouse or for a child due to certain events. Under the law, the employee or a dependent has the responsibility to inform the Fund Office if one of these qualifying events has occurred. The employee or the dependent must give this notice within 60 days of the date of the event. This notice can be provided to the Fund Office by telephone, facsimile, or in writing at the address listed on page ii. The notice must contain the qualified beneficiary's name, the employee's name (if different), the qualified beneficiary's address and telephone number, the nature of the event (i.e. divorce, legal separation, child loss of eligible dependent status, Social Security disability, or second qualifying event), and the date of the event. The Fund Office will advise the qualified beneficiary if additional supporting documentation is required. When the Fund Office is notified that one of these events

has happened, it is the Fund Office's responsibility to notify the employee/dependent of the right to elect continuation coverage no later than 30 days after receipt of such notice. Failure to notify the Fund Office within 60 days of the qualifying event causes a person to lose the opportunity to continue coverage.

For termination of employment, reduction in work hours, or the employee becoming covered by Medicare Benefits (under Part A, Part B, or both), it is the Fund Office's responsibility to notify the employee/dependent of the right to elect continuation coverage not later than 30 days after receipt of such notice from the employee's employer.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after receipt of the COBRA Notice. The election should be communicated to the Fund Office in writing on an Election Form provided. If continuation coverage is not elected within the 60-day period, the right to elect coverage under the Plan will end.

A covered employee or the spouse of the covered employee may elect continuation coverage for all dependents who are qualified beneficiaries. The covered employee, his or her spouse, and dependent child, however, each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election and makes the applicable self-payment, coverage will be provided from the date that coverage otherwise would have been lost. If coverage is waived before the end of the 60-day election period and the waiver revoked before the end of the 60-day election period, coverage will be effective on the date the election of coverage is sent to the Fund Office. Therefore, the employee or the dependents may incur a gap in coverage.

In considering whether to elect COBRA, the employee should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to him/her by other group health plans if he/she has more than a 63-day gap in health coverage. If he/she elects COBRA, he/she may not have such a gap. Second, he/she will lose the guaranteed right to purchase individual

health insurance policies that do not impose such pre-existing condition exclusions if he/she does not get COBRA coverage for the maximum time available to him/her. (Please Note: There are limitations on plans imposing a preexisting condition exclusion and such exclusions will become prohibited in plan years beginning on and after January 1, 2014, for all participants under the Affordable Care Act.) Finally, he/she should take into account that he/she has special enrollment rights under federal law. He/she has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by his/her spouse's employer) within 30 days after his/her group health coverage under the Plan ends because of the qualifying event. He/she also will have the same special enrollment right at the end of the COBRA coverage if he/she receives COBRA coverage for the maximum time available.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace effective as of January 1, 2014, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost

coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You also can end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Maximum Continuation Coverage Period

Coverage may continue up to:

(a) 18 consecutive months from the date employment terminated or hours were reduced for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment.

(b) This 18-month period may be extended up to 29 months of disability for all qualified beneficiaries during the disability of the employee, spouse, or dependent child, provided:

(1) the Social Security Administration (SSA) determines that any of the qualified beneficiaries are disabled under the Social Security Act either: at the time employment terminated or hours were reduced; or at any time within 60 days of such qualifying event and the disability lasts at least until the end of the 18-month period of continuation coverage; and

(2) the qualified beneficiary notifies the Fund Office within 60 days of the latest of: the date the SSA determines he/she is disabled; or the date of the employee's termination of employment or reduction of hours and before the end of the first 18 months of continuation coverage and provides a copy of the Social Security Disability Determination to the Fund Office.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, the qualified beneficiary must notify the Fund Office in writing within 30 days after the SSA determination.

Failure to provide notice of a disability may affect the right to extend the period of continuation coverage.

(c) 36 consecutive months for a spouse or dependent child whose coverage ended due to the death of the employee or retiree, divorce or legal separation, the employee becoming entitled to Medicare Benefits (under Part A, Part B, or both) at the time of

the initial qualifying event, or the child ceasing to meet the definition of dependent under the Plan.

(d) A spouse or dependent child, as a qualified beneficiary, may experience more than one qualifying event. However, the combined continuation coverage period for all such events may not exceed 36 consecutive months from the date of the original qualifying event. The second or later events, provided they occur within the continuation period provided as a result of the original qualifying event, entitle a qualified beneficiary to continue coverage for an additional period but not longer than 36 months from the date of the original qualifying event. The dependent must provide proper notice of the second qualifying event.

If, following a qualifying event, you elect to continue coverage under the Fund's standard self-payment provisions (Option 1) described on page 23 rather than under COBRA continuation, COBRA coverage need not be offered at the end of the alternative coverage period, unless you experience another COBRA qualifying event.

Special Rule Involving Employee's Entitlement to Medicare Benefits

If the employee is entitled to Medicare Benefits at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other qualified beneficiaries is the later of 36 months from the date of Medicare Benefits entitlement, or 18 months from the date of the qualifying event. If, on the other hand, the employee becomes entitled to Medicare Benefits during the initial continuation period of 18 or 36 months following the original qualifying event, then the other qualified beneficiaries will be entitled to continuation not to exceed 36 months from the date of the original qualifying event. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. A qualified beneficiary must notify the Fund Office within 60 days of the date of the event after a second qualifying event occurs if he/she wants to extend his/her continuation coverage and must provide any supporting documentation the Fund may request. This provision does not apply in the case of a reduction in work hours followed by a termination of employment.

Types of Continuation Coverage and Self-Payments

If continuation coverage is elected, the coverage must be identical to the coverage provided under the employer's Plan to similarly situated active employees and their dependents who have not experienced a qualifying event. This means that if the coverage for similarly situated active employees and dependents is modified, coverage for the individual on continuation will be modified.

The initial self-payment for continuation coverage is due to the Fund Office not later than 45 days following the election to continue coverage (which is the post-mark date, if mailed). Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the qualifying event or loss of eligibility and will cause loss of all continuation coverage rights under the Plan. The amount of the first self-payment is for the time period beginning with the date of the qualifying event and extending through the month in which payment is made.

Subsequent monthly self-payments must be made to the Fund Office by the first day of the month for that month of coverage. The Plan allows a 31-day grace period for making self-payments. Continuation coverage will be provided for each coverage period as long as payment for that period is made before the end of the grace period for that payment. However, if a periodic payment is made later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. Any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. Failure to make subsequent self-payments before the end of the grace period will cause coverage and eligibility to terminate at the end of the month for which a timely self-payment last was made and will cause loss of all rights to continuation coverage under the Plan. The Fund Office must provide the individual with a quote of the total monthly self-payment amount.

Self-payments for continuation coverage may be increased; however, the self-payment may not be increased more than once in any determination period. The determination period is a 12-month period established by the Plan.

The individual continuing coverage is responsible to pay all the monthly self-payments for the coverage directly to the Fund Office. This includes the employee's share and any portion previously paid by the employer. Monthly self-payments must be a reasonable estimate of the cost of providing coverage, had termination not occurred. The employer may include a 2% administration charge. The Plan may charge qualified beneficiaries up to 150% of the applicable cost for the additional 11 months of special coverage following the first 18 months for those individuals eligible for such disability extension.

Termination of Continuation Coverage Period

Self-payments no longer are accepted and continued eligibility under COBRA will terminate on behalf of all qualified beneficiaries (unless specifically stated otherwise) when:

(a) The Plan no longer provides group health care coverage to any of its employees.

(b) The required notice of a qualifying event is not provided by the qualified beneficiary within 60 days of its occurrence.

(c) The election for continuation is not made within 60 days following the date of coverage termination or the receipt of the COBRA Notice, whichever is later.

(d) The initial or subsequent self-payments are not paid timely as specified.

(e) A qualified beneficiary becomes covered, after electing continuation coverage, under another group health care plan that does not impose any pre-existing condition exclusion for pre-existing conditions of the qualified beneficiary. NOTE: The federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage. A pre-existing condition exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once you obtain health care coverage, you will be able to use evidence of that coverage to reduce or eliminate any pre-existing condition exclusion period (under certain circumstances) when you move from one health plan to another.

(f) A qualified beneficiary becomes entitled to Medicare Benefits (under Part A, Part B, or both) after such person's COBRA election date (although other family members not entitled to Medicare Benefits will continue to be eligible for COBRA continuation). However, if a qualified beneficiary becomes entitled to Medicare Benefits due to End Stage Renal Disease (ESRD), continuation coverage will not terminate automatically because of eligibility for Medicare Benefits. In the case of ESRD, the Plan will be the primary source of coverage for up to 30 months from the date of ESRD-based Medicare Benefits entitlement, provided the person is an active eligible employee or dependent or is covered under the Plan with COBRA continuation coverage. In the event the Plan's liability as the primary source of coverage for ESRD ends before the COBRA continuation period expires, the Plan will become secondary to Medicare Benefits for the balance of the continuation coverage for such person.

(g) The maximum continuation coverage period is reached.

(h) For a qualified beneficiary who was entitled to the additional 11 months continuation coverage based on a disability extension--eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists. However, continuation coverage will not end until the month that begins more than 30 days after the determination.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a covered person not receiving continuation coverage (such as fraud).

Other Notices

If an employee or dependent notifies the Fund Office of a possible qualifying event and continuation coverage is unavailable, the employee or dependent will receive a notice explaining why the employee or dependent is ineligible for continuation coverage. This notice is subject to the same timing requirements as an election notice.

If continuation coverage will end before the maximum COBRA period, the qualified beneficiary will receive notice as soon as

administratively practicable after the termination decision is made. This notice will explain why and when continuation coverage will terminate and describe any rights available to the qualified beneficiary upon termination.

Other Information

Employees should contact the Fund Office for any questions regarding continuation coverage and notify the Fund Office of any changes in marital status or a change of address.

REINSTATEMENT OF ELIGIBILITY

Upon failure to maintain continuous uninterrupted coverage in Class A as stated previously, a person once again must requalify as stated under Initial Eligibility to be eligible for coverage provided by the Fund.

CAP ON CREDITS

The Trustees, at their discretion, may from time to time establish maximum levels beyond which an eligible employee will not accumulate additional credits, as long as such action is taken in a non-discriminatory manner. Currently, there is no cap on the amount you may accumulate in your individual account (dollar bank). Contributions not needed to maintain your eligibility are credited to your dollar bank within the Plan rules. However, the Fund will retain the interest earned which is used to offset claims and administrative expenses.

You can access the funds accumulated in your individual account to reimburse you for certain out-of-pocket Plan-related expenses. See page 108 for details.

CONTINUATION OF COVERAGE IF YOU TRANSFER LOCALS

If you transfer to another local, you may continue coverage under this Health Fund provided the local labor organization that you transfer to is affiliated with the same international labor organization with which this local is affiliated. You may use your banked dollars, if any, or make self-payments to this Fund to continue your eligibility until you become eligible for benefit coverage from your new health fund, or up to 18 months from the date your self-payments or use

of banked dollars began, whichever is earlier. There also may be some instances in which you can transfer your banked dollar credits to a dollar bank program maintained under another plan jointly sponsored by an affiliated local (see the Dollar Bank Transfers section on page 114).

COVERAGE WHILE ON FAMILY AND MEDICAL LEAVE (FMLA)

The federal Family and Medical Leave Act of 1993 (FMLA) requires certain covered employers to provide unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

If you become eligible for leave according to the FMLA, your coverage under the Plan may be continued for the number of weeks mandated by law, provided your employer:

(a) is subject to the FMLA;

(b) makes the required contribution (or you do so); and

(c) files the appropriate notification and certification forms with the Fund Office.

If your leave is eligible under the FMLA, and you do not return to work after the leave, then for COBRA continuation coverage purposes, the date of the qualifying event will be the last day of your FMLA leave or the day you give notice of your intent not to return to work, if earlier. This provision will apply whether or not you elect to continue coverage under the Plan during the leave.

To be subject to the Act, an employer must have at least 50 employees within 75 miles for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year. Employees are eligible if they have worked for the same covered employer for at least one year and for 1,250 hours over the previous 12 months.

For additional information regarding rights under the Family and Medical Leave Act, you may contact your employer or the nearest office of the Wage and Hour Division, listed in

most telephone directories under "U.S. Government, Department of Labor."

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

(a) the date the Group Plan terminates;

(b) the end of the period for which any required contribution or self-payment was due and not paid;

(c) the date you enter full-time military, naval, or air service;

(d) the date you fail to be in an eligible class of persons according to the eligibility requirements of the Plan;

(e) for all employees, immediately following your retirement, unless retiree coverage is selected;

(f) for your dependents, the date your coverage terminates;

(g) for a dependent, the date the dependent enters full-time military, naval, or air service to the extent allowed under the Affordable Care Act;

(h) for a dependent, the date such covered person no longer meets the definition of dependent;

(i) for a retiree, the date you request termination of coverage to be effective for yourself and/or your dependents; or

(j) for any benefit, the date the benefit is removed from the Plan.

IF YOU OR ANY OF YOUR COVERED DEPENDENTS NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, YOU ARE RESPONSIBLE FOR NOTIFYING THE FUND OFFICE OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF NOTICE HAS NOT BEEN GIVEN TO THE FUND OFFICE.

Certificate of Creditable Coverage: In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will issue a certificate of creditable coverage to you and your dependents when your regular health care benefits coverage or COBRA continuation coverage terminates (and also upon request, within 24 months thereafter). The certificate provides information on the period of your coverage under the Local 434 Health & Welfare Fund that may be credited on your behalf to satisfy any applicable pre-existing condition limitations of a new health plan in which you enroll.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

(The USERRA provisions will control in the event there are any inconsistencies between the Act and the Plan.)

(a) Eligibility Status

(1) You, or an appropriate officer, must submit advance notice of military service to the Fund Office (unless such notice is prevented by circumstances of military necessity as determined by the Defense Department, or is otherwise impossible or unreasonable under the circumstances).

(2) If you, or an appropriate officer, do not submit such notice, your dollar bank, if any, will be applied until exhausted to further extend your eligibility and the eligibility of your dependents. Your coverage will terminate on the date your dollar bank has been exhausted. If you subsequently submit notice in a reasonable time period, the use of your dollar bank will cease.

(3) For military leaves which are less than 31 days in duration and for which you, an appropriate officer, or an employer submit the required notice and otherwise satisfy the reemployment requirements described as follows, coverage for you and your eligible dependents will be continued as though you are actively at work for the duration of such leave.

(4) For military leaves which are 31 or more days in duration and for which you, an appropriate officer, or an employer

submit the required notice, coverage for you and your eligible dependents will cease and your eligibility status will be frozen as of the date you leave employment for the purposes of performing military service with the uniformed services of the United States, unless you elect to continue coverage as described in the following subsection (b).

(5) Your eligibility will be reinstated on the date you return to work for a participating employer (or upon making yourself available for work if no such work is available) within the applicable time limits stated in the following subsection (c), provided you otherwise satisfy the reemployment requirements necessary to qualify for reemployment rights under USERRA (e.g., provide evidence of honorable discharge, cumulative military service of no longer than five years). If your dollar bank has been exhausted, you will be allowed to make self-payments under Self-Payment Option 1 to be immediately reinstated in the Plan until you earn sufficient dollar bank credits to sustain Plan coverage.

(b) Continuation of Coverage

(1) If you fail to provide advance notice of your military service, your coverage will terminate on the date your accumulated dollar bank has been exhausted and you will not be eligible to continue coverage under this section unless your failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if your failure to provide advance notice is excusable under the circumstances and may require that you provide documentation to support the excuse. If the Trustees determine that your failure to provide advance notice is excused, you may elect to continue coverage, in accordance with this subsection (b), retroactive to the date you left employment for the purpose of performing services with the uniformed services of the United States, provided that you elect such coverage and pay all amounts required for the continuation coverage.

(2) When the Fund Office has been notified that you are entering the military service, you will be given the option of continuing your same class of coverage under the Plan. Continuation coverage under this subsection (b) is very similar to the continuation coverage described under

Self-Payment Option 2, COBRA continuation coverage. The rules for election of and payment for continuation coverage are the same as the COBRA election and payment rules, provided the COBRA rules do not conflict with USERRA. If you do not elect continuation coverage and do not submit payment for all amounts required to continue coverage within the applicable COBRA timeframe, you will lose your right to continue coverage under this section and such right will not be reinstated.

(3) You will have the option of using your dollar bank, if available, to continue coverage. If you do not have any dollar bank available or you choose not to use it, you are required to make timely self-payments at the COBRA rate determined by the Trustees from time to time to purchase COBRA continuation coverage. If you elect to use your dollar bank to pay for continuation coverage and you exhaust your dollar bank prior to the end of the maximum coverage period described in the following paragraph (5), you may make self-payments to continue coverage through the end of your maximum coverage period.

(4) The COBRA continuation coverage rules apply to payment for continuation coverage under this subsection (b) provided that the COBRA payment rules do not conflict with USERRA. You must make all required self-payments within the COBRA timeframe described under Self-Payment Option 2 in this SPD to continue coverage under this subsection (b) unless the COBRA payment rules conflict with USERRA.

(5) You and your eligible dependents may continue coverage for a period ending the earlier of:

(i) the date that the Plan no longer provides group health care coverage to any employees;

(ii) the day after the date you fail to elect continuation coverage as required by the COBRA continuation coverage election rules;

(iii) the first day of the month for which a timely self-payment has not been received and your dollar bank has been exhausted;

(iv) 24 months from the first date of absence due to military service; or

(v) the day after the date you fail to apply for reemployment with a participating employer within the applicable time period allowed under the following subsection (c) or otherwise cease to have USERRA reemployment rights.

The right to freeze eligibility and make self-payments under this provision ceases when you provide notice that you do not intend to return to work for a participating employer after uniformed service.

(c) Status Upon Return from Military Service

If you are eligible for benefits when you enter the military service and you have a sufficient dollar bank or make timely self-payments to maintain coverage upon your return to work, you and your eligible dependents again will be eligible for benefits on the date of your return to work for a participating employer within the following time periods, provided you satisfy the other reemployment requirements of USERRA:

(1) For periods of military service of less than 31 days, you must report to the employer not later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of military service plus eight hours, after a period allowing for safe transportation from place of military service to place of your residence.

(2) For periods of military service of more than 30 days but less than 181 days, you must apply for reemployment not later than 14 days after military service is completed.

(3) For periods of military service of more than 180 days, you must apply for reemployment not later than 90 days after military service is completed.

Such time periods may be extended up to two years for injuries or sicknesses, as determined by the Secretary of Veteran Affairs, to have been incurred or aggravated during your service in the uniformed services.

If you exhaust your dollar bank prior to your return from military service and you do not have USERRA reemployment rights, you will be treated as a new employee.

If you exhaust your dollar bank prior to your return from military service and you satisfy the USERRA reemployment requirements, you will be eligible for benefits on the date of your return to work within the required time periods, provided you make self-payments required to continue eligibility under Self-Payment Option 1. If you fail to make self-payments as required upon reinstatement in the Plan, your eligibility for coverage will terminate as of the last date of the period for which a timely payment was received and you then will be treated as a new employee.

These rules are intended to comply with the requirements of USERRA. The USERRA provisions will control in the event there are any inconsistencies between the Act and the Plan.

The Plan will provide continuation coverage and reinstatement rights to the extent required by USERRA. You also may have continuation coverage rights under COBRA. Although the COBRA and USERRA provisions are similar, COBRA continuation coverage and USERRA continuation coverage are not identical. As long as you remain eligible simultaneously for both COBRA and USERRA continuation coverage, you will receive the more generous benefit rights that apply under these statutes. COBRA and USERRA continuation periods will run concurrently.

OTHER SPECIAL ENROLLMENT RIGHTS

An employee or dependent will be entitled to special enrollment rights if:

(a) the employee or dependent had other health coverage and either later had a loss of eligibility for such coverage or employer contributions toward such other coverage were terminated;

(b) the employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption;

(c) the employee or dependent had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") and lost eligibility for that coverage; or

(d) the employee or dependent became eligible for financial assistance through Medicaid or CHIP for coverage under the Plan.

The effective date of coverage for a qualifying event described in the prior (a), (c), or (d) will be the first day of the month following receipt of the request for enrollment. The effective date of coverage for a qualifying event described in the prior (b) will be the date of marriage, birth, adoption, or placement for adoption. Special enrollment must be requested within 30 days of a qualifying event described in (a) and (b) and within 60 days of a qualifying event described in (c) and (d).

OPT-OUT FOR DEPENDENTS FOR HIGH DEDUCTIBLE HEALTH PLAN

(a) Opt-Out Eligibility Rules

A dependent who satisfies the eligibility requirements set forth in the definition of dependent on pages 168 and 169 may elect to opt out of coverage under this Plan if he/she can provide the Fund Office with acceptable written proof that he/she is enrolled or eligible to enroll in a High Deductible Health Plan ("HDHP") offered by the dependent's employer in conjunction with a Health Savings Account ("HSA") upon waiver of Plan benefits and the dependent satisfying all of the following requirements:

(1) The dependent must complete and sign an opt-out election form acknowledging that he/she is opting out of coverage under this Plan and the Dollar Bank Reimbursement Program.

(2) The dependent's coverage under this Plan (and the Dollar Bank Reimbursement Program) will terminate at the end of the last day of the month during which a completed and signed opt-out election form is received by the Fund Office.

(3) The dependent's opt-out election automatically will renew each year until the dependent again reinstates coverage under the terms of the opt-in provision stated in the following subsection (b).

(4) If a dependent elects to opt-out of coverage under this Plan, no dollar bank reimbursement will be made for any health care expenses incurred on the dependent's behalf, including dental, vision, or preventive care benefits, even if such health care expense would qualify as being a reimbursable expense under the Dollar Bank Reimbursement Program.

(b) Reinstatement (Opt-In) Eligibility Rules

A dependent who has opted out of Plan coverage according to the prior subsection (a) may later reinstate coverage under the Plan, including its Dollar Bank Reimbursement Program, provided all of the following requirements are satisfied:

(1) The dependent's coverage under the HDHP and HSA plan of his/her employer has terminated, the dependent provides satisfactory written proof to the Fund Office, and the individual continues to qualify as a dependent eligible for Plan coverage.

(2) The dependent must complete and sign an opt-in election form.

(3) Coverage under this Plan as a dependent will be effective for the dependent on the first day of the month following the date a completed and signed opt-in form and satisfactory written proof of termination of coverage under the HDHP and HSA plan are received by the Fund Office. The dependent will not be covered under the Plan for any health care expenses, including any applicable dental, vision, or preventive care benefits, incurred prior to the effective date of reinstatement of coverage, except according to the special enrollment rights stated on page 42.

PARTICIPATION REQUIREMENTS AND OPTIONS FOR RESIDENTIAL EMPLOYEES

Employees who work under the National Agreement for Residential and Light Commercial Construction ("residential employees" and "residential agreement") may participate in the Plan either on a limited or full basis according to the following provisions.

(a) Standard Rule. Unless a residential employee timely elects an option described in the next section, then the residential agreement provides that the residential employee is subject to the Plan's general Eligibility and Effective Date of Coverage Rules described on pages 16 through 48 of the Summary Plan Description.

A residential employee has the one-time only option to elect coverage for both Vision Care and Dental Care Benefits at the time he/she begins working under the residential agreement or by making a timely election during an annual open enrollment period under his/her employer's cafeteria plan. The cost of Optional Vision Care and Dental Care Benefits is based on 130 hours per month and the employee pays the full cost. You must keep this coverage for a minimum of two years.

(b) Residential Employee Benefit Election Options. Employees are permitted to elect one of the three options described in this section (Option A, B, or C) **provided they make their election before performing their first hour of service covered by the residential agreement. An employee who fails to elect Option A, B, or C before performing his/her first hour of service under the residential agreement will be subject to the Standard Rule described in the previous section and will not have the ability to elect an option again**. You should contact either your residential employer or the Fund Office to obtain an election form. Your ability to elect an option is limited as will be further described.

A residential employee who timely elects Option A, B, or C only may change that election:

(1) annually during the open enrollment period under his/her employer's cafeteria plan;

(2) if a special enrollment event as defined under Plan Document Section 3.4 or 3.16 applies; or

(3) if the employee becomes subject to a Qualified Medical Child Support Order. Your employer's cafeteria plan will likely provide that a prior election will remain in effect for a future year unless it is changed.

A residential employee who elects Option A, B, or C and who then later participates in the Plan under the Standard Rule will not be permitted to select a future option under his/her employer's cafeteria plan to participate in medical benefits.

A residential employee will have the following options for participating in the Plan:

(1) Option A: Life Insurance/Accidental Death and Dismemberment Benefits and Short-Term Disability Benefits only (150 hours per month required);

(2) Option B: Medical Benefits only, Reduced Cost Option (150 hours per month required); or

(3) Option C: Medical Benefits, Class A, including Life Insurance/Accidental Death and Dismemberment Benefits and Short-Term Disability Benefits (150 hours per month required).

A residential employee must enroll in one of the Plan's Medical Benefits Options B or C unless such employee certifies on a form provided by the Plan that he/she maintains other major medical coverage, in which case he/she can enroll in Option A.

A residential employee's election of an option will authorize his/her employer to forward the applicable contribution rate to the Plan to cover the cost of the coverage. The cost of Plan benefits is determined by the Trustees. Plan benefits are funded pursuant to the collective bargaining agreement that governs the terms of a residential employee's employment. The cost of Plan benefits is subject to change.

A residential employee also has the one-time only option to elect coverage for both Vision Care and Dental Care Benefits at the

time he/she begins working under the residential agreement or by making a timely election during an annual open enrollment period under his/her employer's cafeteria plan. A residential employee only can elect Vision Care and Dental Care Benefits if the residential employee also elects Medical Benefits under either Option B or C. The cost of Optional Vision Care and Dental Care Benefits is based on 150 hours per month and the employee pays the full cost.

A residential employee will become initially eligible for coverage on the first day of the month following receipt of the required contribution for 150 hours of work performed under the residential agreement. For example, contributions for work performed in January are due by February 15th and determine eligibility for March.

Residential employees timely electing an option must authorize their employers to deduct contributions from their wages to cover their Plan costs. An employer has the ability to adopt a cafeteria plan to enable these payments to be made on a pre-tax basis.

The employer will deduct the required amount per hour for every hour an employee works. If he/she works more than the required eligibility hours for Plan benefits in any month, the excess will go into his/her dollar bank. Such excess in the dollar bank is applied to purchasing the next month's coverage.

Only dollar bank credits in excess of the $1,800 floor required solely for eligibility are available for reimbursement under the Plan's Dollar Bank Reimbursement Program. Any contributions deposited into the dollar bank pursuant to an option under the residential agreement will be the first amounts applied for future premium payments and, therefore, will not accumulate to become available for dollar bank reimbursement.

If a residential employee works less than the required eligibility hours for Plan benefits in any month, the shortage will be deducted from his/her dollar bank. If he/she does not have sufficient funds in his/her dollar bank, he/she will be sent a self-payment notice. If he/she does not make the appropriate self-payment, his/her coverage will lapse. His/her coverage will resume consistent with the Plan's general initial Eligibility Rule (i.e., first day of the month following the month in which the Plan

receives at least 150 hours of contributions at the rate established by the Trustees).

Notwithstanding the prior, an employee may enroll or re-enroll in advance of the next open enrollment period if he/she dropped coverage while on a FMLA or military leave; he/she may re-enroll when he/she returns from that leave. In addition, he/she also may enroll or re-enroll within 30 days of a special enrollment event as described in Section 3.16 of the Plan Document. A residential employee also may enroll or re-enroll if he/she is subject to a Qualified Medical Child Support Order which requires him/her to provide Plan benefits.

(c) General Rule for Residential Employees. With the exception of the ability to elect an option, all other Plan rules apply to the residential employees and their dependents, including the termination of Eligibility Rules.

MEDICAL BENEFITS

HOW TO APPLY FOR BENEFITS

You will receive an identification (ID) card. It will show your name and group number. Show your ID card to the hospital, clinic, or physician's office for medical services. When you present your ID card at a preferred provider, the provider will submit your claim directly to Anthem Blue Cross and Blue Shield for discounting; then Anthem automatically will forward all PPO claims to the Fund Office for payment.

Pre-service claims: You must obtain prior approval from the Fund Office for all organ transplants and you must obtain prior authorization for certain prescription drugs as specified on pages 86 through 89. Claims such as this are called "pre-service claims," which means any claim which requires approval of the benefit in advance of obtaining medical care. Claims requiring prior approval must be submitted in writing to the Fund Office.

Urgent care claims: *Please note that there are special provisions in the Claims Procedure Regulations for "urgent care claims" (referred to under the Plan as "emergencies"), but, by definition, these provisions do not apply to your Plan because the Plan does not require precertification of emergency admissions.*

Post-service claims: Any claim for benefits that is not a pre-service claim is considered a "post-service claim." You must submit all post-service claims in writing within 90 days of the occurrence of the accident or sickness, or as soon thereafter as is reasonably possible. In no event (except in the absence of legal capacity) can you submit a claim later than one year after the date proof of loss otherwise is required.

Post-service claims must be submitted in writing to the appropriate party as follows.

Send all medical claims for services obtained in Wisconsin to:

Anthem Blue Cross and Blue Shield
P.O. Box 34210
Louisville, KY 40232-4210

Send all other medical claims for services obtained outside Wisconsin to your local Blue Cross and Blue Shield Plan.

Claims should be complete. They should contain, at a minimum:

(a) Fund name (Local 434 Health & Welfare Fund);

(b) employee's name and ID number;

(c) full name (including "Jr.," if applicable) and date of birth of the covered person who incurred the covered expense;

(d) name and address of the service provider;

(e) federal tax identification number of provider;

(f) diagnosis of the condition;

(g) procedure or nature of the treatment;

(h) date of and place where the procedure or treatment has been provided;

(i) amount billed and the amount of the covered expense not paid through coverage other than this Plan, as appropriate; and

(j) evidence that substantiates the nature, amount, and timeliness of each covered expense that is in a reasonably understandable format and is in compliance with all applicable law.

Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address. A general request for an interpretation of Plan provisions will not be considered a claim for benefits. Eligibility determinations are not treated as claims for benefits.

You or an authorized representative can pursue a claim. You may authorize a representative by submitting a written authorization to the Trustees in a form acceptable to the Trustees.

Miscellaneous Medical Charges

If you accumulate bills for medical items you purchase yourself, send them in to the Fund Office at least **once every three months** during the year (quarterly).

PAYMENT OF CLAIMS

The Fund Office will make direct payment to the hospital, clinic, or physician's office, unless you have already paid the bill. If you have paid the bill please submit proof of payment with the original statement and send it directly to the Fund Office. You will receive a written explanation of the benefit determination. The Fund Office reserves the right to request any information required to determine benefits or process a claim. You or the provider of services will be contacted if additional information is needed to process your claim.

When an employee's child is subject to a Qualified Medical Child Support Order, the Fund Office will make reimbursement of eligible expenses paid by the child, the child's non-employee custodial parent or legal guardian to that child, or the child's custodial parent or legal guardian. A copy of the written procedures for determining whether or not an order is qualified is available from the Fund Office upon request at no charge.

Payment of benefits under this Plan will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Benefits accrued on behalf of you or your covered dependent upon death will be paid, at the Plan's option, to any family member(s) or your estate.

The Fund Office will rely upon an affidavit to determine benefit payment, 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 Fund Office in good faith will fully discharge it to the extent of such payment.

VERIFICATION OF OTHER COVERAGE

The Fund Office requests verification of other coverage for an employee's spouse and/or dependents **on an annual basis**, **if its records do not indicate that the spouse and/or dependents have other coverage**. To avoid any delays in payment of claims, if you do not have other coverage, please write a letter to the Fund Office stating this information. Also, if you do have other coverage and that coverage information has changed, please be sure to contact the Fund Office as well. It is important to have this information on file so that the other party who is responsible to pay the bill first does so.

PREFERRED PROVIDER NETWORK

Through the Anthem Blue Cross and Blue Shield point-of-service network, the Fund has access to a network of hospitals, physicians, and other health care providers that have contracted to provide all necessary covered services at significantly reduced rates. You also have access to the BlueCard program which provides a broad national network. In addition to hospitals and physicians, Anthem offers reduced rates for outpatient surgery centers, chiropractors, home infusion therapy, home health care, durable medical equipment, radiology and laboratory facilities, physical therapists, skilled nursing facilities, and urgent care centers.

Benefits are payable for covered expenses at the applicable percentage of the preferred provider's negotiated charge according to the contract in effect at the time charges are incurred as stated in the Schedule of Benefits. The Plan pays a greater amount of benefits for covered expenses incurred at an Anthem preferred provider.

The list of preferred providers in the network is subject to change based on the contractual agreement between the agent and the participating providers. It is recommended that you contact Anthem prior to incurring covered expenses to make sure the hospital, physician, or other health care provider you choose is a preferred provider. Call Anthem at 1-800-810-BLUE (2583) or visit their website: www.anthem.com.

You may select any provider to provide your medical care. The Fund does not make any representation regarding the quality of service provided by a preferred provider.

CASE MANAGEMENT

The Plan will send selected claims to Case Management Specialists, Inc. (CMS), a firm they have chosen to provide large case management services. Catastrophic or other suitable cases are reviewed by the case manager for medical necessity. The case manager will contact you, your physician, and the Fund Office to discuss treatment options and to identify available community resources. If you and your physician approve, the case manager will coordinate the necessary services.

It is often hard to make decisions about ongoing care. Case management allows you to discuss your concerns openly and makes you aware of all your options. Also, both you and the Fund may save money if a less costly setting is appropriate.

DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, on a customary, usual, and reasonable basis at the applicable coinsurance percentages and up to the maximum benefits as stated in the Schedule of Benefits.

Deductible

The deductible applies to each covered person each calendar year. Only charges which qualify as a covered expense may be used to satisfy the deductible. The amount of the deductible is stated in the Schedule of Benefits. Any covered expense incurred during the last three months of the calendar year that is used to satisfy all or part of the deductible for that year also may be used to satisfy all or part of the deductible for the following calendar year.

Maximum Family Deductible

The total deductible applied to all covered persons in one family in a calendar year is subject to an aggregate maximum. The maximum is stated in the Schedule of Benefits.

Coinsurance

After satisfaction of the deductible amount, the Plan provides for payment of reasonable expenses incurred for covered charges at the applicable percentage stated in the Schedule of Benefits. The covered person is responsible for the remaining coinsurance and any charges in excess of reasonable expenses. In the case of a provider participating in the preferred provider network, the covered person is not responsible for any amounts which exceed the provider's negotiated charge.

Out-of-Pocket Limit

When the out-of-pocket expenses for reasonable expenses incurred for covered charges per person or per family (NOT including prescription drug copayments or, for Class D, not including prescription drug deductible or copayments) reach the maximum stated in the Schedule of Benefits in any one calendar year, the Plan will pay 100% of the balance of covered reasonable expenses which exceed such out-of-pocket limit for such covered person(s) for the remainder of that calendar year.

MEDICAL COVERED EXPENSES

Benefits are payable for reasonable expenses incurred by a covered person for the following services and supplies which are medically necessary for treatment of a bodily injury or sickness.

HOSPITAL BENEFITS

Charges made for the following services or supplies furnished by a hospital and recommended by the attending physician are payable up to the maximums stated in the Schedule of Benefits.

Room and Board

Daily semi-private, ward, intensive care unit, isolation, or coronary care room charges for each day of confinement. Benefits for a private or single-bed room are limited to the customary, usual, and reasonable charge for a semi-private room in the hospital while a registered bed patient.

Hospital Miscellaneous Charges

Charges made by the hospital on its own behalf for services and supplies furnished for your treatment during confinement including the following charges, whether billed directly or separately by the hospital:

(a) professional services of a radiologist or pathologist for diagnostic x-ray examinations or laboratory tests;

(b) professional services of an anesthesiologist;

(c) drugs and medicines; and

(d) other hospital miscellaneous services and supplies not included in the room charges, if used while confined in the hospital as a resident patient.

PHYSICIAN SERVICES

Benefits include charges made by a physician when incurred for:

(a) administration of anesthesia;

(b) diagnostic x-ray or laboratory tests;

(c) physician inpatient hospital visits and other covered medical services received from or at the direction of a physician;

(d) a surgical procedure by a physician, including post-operative care; and

(e) multiple or bilateral procedures by a physician, including post-operative care.

For individuals receiving mastectomy-related benefits, coverage will be provided on the same basis as other medical and surgical procedures covered by the Plan and in a manner determined in consultation with the attending physician and the patient for all stages of reconstruction of the breast and nipple of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses; and

treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Benefits also will be payable for prophylactic mastectomies, breast reconstruction, and oopherectomy (removal of ovaries) for covered persons at high-risk for breast or ovarian cancer, according to guidelines maintained at the Fund Office which are subject to change. Prior authorization by the Fund Office is recommended.

If multiple surgical procedures are performed at one operative session, the amount considered for these procedures will be limited to the customary, usual, and reasonable charge for the greater procedure and 50% of the customary, usual, and reasonable charge for the lesser procedure when performed independently. However, no additional payment will be made for an incidental procedure performed through the same incision.

Charges made by a qualified practitioner for services in performing certain oral surgical operations due to bodily injury or sickness are covered as follows:

(a) excision of partially or completely unerupted impacted teeth;

(b) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examination;

(c) surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;

(d) reduction of fractures and dislocation of the jaw;

(e) external incision and drainage of cellulitis;

(f) incision of accessory sinuses, salivary glands, or ducts;

(g) reduction of, dislocations of, and excision of the temporomandibular joints (TMJ);

(h) frenectomy (the cutting of the tissue in the midline of the tongue); and

(i) extraction of natural teeth in conjunction with radiation therapy of the head and/or neck for the treatment of malignant lesions.

ROUTINE CARE

The following expenses are payable for you or your covered dependent as stated in the Schedule of Benefits, subject to all terms and provisions of the Plan, except the exclusion for services which are not medically necessary, if you are not confined in a hospital or qualified treatment facility and if such expenses are not incurred for diagnosis of a specific bodily injury or sickness. Benefits are payable at 100% with no deductible requirement and no calendar year maximum for services obtained at a PPO provider. For such services obtained at a non-PPO provider, benefits are payable subject to the Medical Benefits deductible, coinsurance, and out-of-pocket limit as stated in the Schedule of Benefits.

For purposes of routine care, the Plan pays for preventive care services recommended by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as required by federal regulations, as well as other screenings as specifically provided in the Plan, such as routine pap smears; routine hearing exams; routine physical exams, including office visits and routine x-rays and laboratory tests; and colorectal cancer screening, including routine colonoscopy and flexible sigmoidoscopy but specifically excluding CT colonography (virtual colonoscopy).

In addition to the preventive services previously described under this routine care section, the following additional evidence-informed preventive care and screening services for women are covered, as recommended by the Health Resources and Services Administration (as updated) and required by the Affordable Care Act:

(a) Annual well-women preventive care visits unless more than one is needed to obtain all necessary services. This includes visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

(b) Gestational diabetes screening for pregnant women between 24 and 28 weeks gestation and who are identified at high risk for diabetes at first prenatal visit.

(c) Human papillomavirus (HPV) DNA screening for women age 30 or older, once every three years.

(d) Annual screening and counseling on HIV and sexually transmitted infections (STIs) for sexually active women.

(e) Contraception counseling, injectable hormones, implanted devices, and sterilization for women with reproductive capacity.

(f) Lactation support and counseling for pregnant and postpartum women, and breastfeeding equipment. Electric or manual breast pumps are limited to one every five calendar years.

(g) Annual screening and counseling for interpersonal and domestic violence.

For information on whether a specific preventive service or immunization is covered at 100%, you can contact the Fund Office or visit the federal government's website at: http://www.healthcare.gov/law/about/provisions/services/lists.html.

The Plan may apply reasonable medical management techniques to determine coverage limitations, if any, in cases where the recommendations or guidelines for a recommended preventive service do not specify the frequency, method, treatment, or setting for the provision of that service.

No benefits are payable under this routine care benefit for:

(a) routine eye exams;

(b) any dental examinations;

(c) hearing exams, other than routine;

(d) medical examination for bodily injury or sickness; or

(e) medical examination caused by or resulting from pregnancy, unless specifically provided under the Affordable Care Act.

OUTPATIENT HOSPITAL

Outpatient hospital benefits include the following services or facilities.

Hospital miscellaneous charges for services and supplies of a hospital and the emergency room charge also will be covered when incurred for:

(a) Pre-admission testing.

(b) A surgical procedure.

(c) Emergency accident treatment rendered within 48 hours of the accident.

(d) Treatment of a sickness following a medical emergency. A medical emergency is the sudden and unexpected onset of acute conditions requiring medical care such as heart attacks, cardiovascular accident, poisoning, loss of consciousness, or respiration.

(e) Regularly scheduled treatment such as chemotherapy, inhalation therapy, and radiation therapy as ordered by your attending physician.

(f) Hospital emergency room visits, subject to a separate copayment per visit stated in the Schedule of Benefits which does not apply to the deductible. The copayment is waived if you are admitted to the hospital as an inpatient.

FREE-STANDING SURGICAL FACILITY

Charges made by a free-standing surgical facility, on its own behalf, for surgical procedures performed and for hospital miscellaneous services rendered in the facility.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and laboratory tests which are not covered under the Hospital Benefits provision of the Plan. These covered expenses do **not** include premarital tests or examinations; routine physical exams for occupation, employment, travel, or the

purchase of insurance; and school physicals; unless specifically provided under the Plan.

Medically necessary amniocentesis and chorionic villus sampling (CVS) are covered in high-risk pregnancies. Guidelines for payment of amniocentesis and CVS are maintained at the Fund Office and are subject to change. Prior authorization by the Fund Office is recommended. Amniocentesis is not covered as a routine procedure to ensure absence of hereditary or congenital defects or for sex determination in the absence of a risk for X-linked disorder.

BRCA testing for certain high-risk individuals is covered, according to guidelines maintained at the Fund Office which are subject to change. Prior authorization by the Fund Office is recommended.

AMBULANCE SERVICE

Local professional ground or air ambulance service is covered. If the bodily injury or sickness requires special treatment not available in a local hospital, appropriate transportation to the nearest hospital equipped to provide the treatment is payable.

PREGNANCY BENEFITS

Pregnancy is a covered expense for any covered female person payable as stated in the Schedule of Benefits.

Complications of pregnancy are payable as any other covered sickness at the point the complication sets in for any covered female person.

Pregnancy benefits are subject to all terms and provisions of the Plan.

In accordance with federal law, benefits for the inpatient hospital stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section and it no longer may be required that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the previously stated periods. 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 or 96 hours, as applicable.

NEWBORN BENEFITS

Benefits for newborns are subject to the Dependent Special Enrollment and Dependent Effective Date of Coverage sections on page 19 of this SPD booklet, as well as all terms and provisions of the Plan.

Well-Newborn

Well-newborn covered expenses incurred during the newborn child's first five days of life are: hospital charges for nursery room, board, and care; the physician's charges for circumcision of the newborn child; and the physician's charges for routine examination of the newborn child before release from the hospital.

Sick-Newborn

Sick-newborn covered expenses incurred for the following: bodily injury or sickness; medically necessary care and treatment for premature birth; medically diagnosed birth defects and abnormalities; and surgery to repair or restore any body part necessary to achieve normal body functioning. Covered expenses do **not** include expense incurred for plastic or cosmetic surgery, **except** surgery for:

(a) reconstruction due to bodily injury, infection, or other disease of the involved part; or

(b) congenital disease or anomaly of a covered dependent child which resulted in a functional defect.

BIRTHING CENTERS

Charges made within 24 hours after confinement by a birthing center for services and supplies furnished for prenatal care and delivery of child(ren) are payable as stated in the Schedule of Benefits, subject to any applicable maximum.

A Birthing Center is a licensed facility which:

(a) provides:

(1) prenatal care;

(2) delivery and immediate postpartum care; and

(3) care of a child born at the birthing center;

(b) is directed by a physician specializing in obstetrics and gynecology;

(c) has a physician or certified nurse midwife present at all births and during the immediate postpartum period;

(d) extends staff privileges to physicians who practice obstetrics and gynecology in the area;

(e) has at least two beds or birthing rooms for use by patients during labor and delivery;

(f) provides full-time skilled nursing services [directed by a registered nurse (R.N.) or certified nurse midwife] in the delivery and recovery rooms;

(g) provides diagnostic x-ray and lab services for the mother and newborn;

(h) has capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear);

(i) is equipped and staffed to handle medical emergencies and provide immediate life support measures;

(j) accepts only patients with low risk pregnancies;

(k) has a written agreement with an area hospital for emergency transfer of patients and ensures its staff is aware of such procedures;

(l) provides an ongoing quality assurance program; and

(m) keeps a medical record on each patient.

CONVALESCENT NURSING HOME CARE

Definitions

Convalescent nursing home confinement is a confinement in a convalescent nursing home which:

(a) begins while you or an eligible dependent is covered under this benefit;

(b) begins within 24 hours after discharge from a hospital confinement or a prior covered convalescent nursing home confinement;

(c) is necessary for care or treatment of the same bodily injury or sickness which caused the prior confinement; and

(d) occurs while you or an eligible dependent are under the regular care of the physician who certified the required convalescent nursing home confinement.

Convalescent nursing home is an institution which maintains and provides:

(a) permanent and full-time bed care facilities for resident patients;

(b) a physician's services available at all times;

(c) a registered nurse (R.N.) or physician in charge and on full-time duty and one or more registered nurses (R.N.) or licensed vocational or practical nurses on full-time duty;

(d) a daily record for each patient; and

(e) continuous skilled nursing care for injured or sick persons during their convalescence from bodily injury or sickness.

Convalescent nursing home also is a lawfully run home in the jurisdiction where located.

A convalescent nursing home is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of chemical dependence or alcoholism.

Benefits Payable

Expense incurred for daily room and board and general nursing services for each day of confinement in a convalescent nursing home are payable for up to 30 days per confinement after each and every hospital confinement of at least one day. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services.

HOME HEALTH CARE

Expense incurred for home health care described as follows is payable under the Plan. The maximum weekly benefit for such coverage may not exceed the usual and customary weekly cost for care in a convalescent nursing home.

Covered expenses are payable for up to 40 visits per covered person in any calendar year. Each visit by a person providing services under a home health care plan or evaluating the need for or developing a plan will be considered as one home health care visit. Up to four consecutive hours in a 24-hour period of home health care service is considered one home health care visit. A home health care visit of four hours or more is considered as one visit for every four hours or part thereof.

Home health care will not be covered unless the physician certifies that:

(a) hospitalization or confinement in a skilled nursing facility otherwise would be required if home care were not provided;

(b) necessary care and treatment are not available from members of your immediate family or other persons residing with you without causing undue hardship (immediate family means your spouse, children, parents, grandparents, brothers and sisters, and their spouses); and

(c) the home health care services will be provided or coordinated by a state-licensed or Medicare-certified home health care agency or certified rehabilitation agency.

If you were hospitalized immediately prior to the commencement of home health care, the home health care plan also will be initially recommended by the physician who was the primary provider of services during the hospitalization.

The home health care plan must consist of:

(a) part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);

(b) part-time or intermittent home health care services which are medically necessary as part of the home health care plan, under the supervision of a registered nurse (R.N.) or medical social worker, which consist solely of caring for the patient;

(c) physical, respiratory, occupational, or speech therapy;

(d) medical supplies, drugs, and medicines prescribed by a physician and laboratory services by or on behalf of a hospital, if necessary under the home health care plan, to the extent such items would be covered under the Plan if you or your dependent had been hospitalized;

(e) nutrition counseling provided under the supervision of a registered dietician where such services are medically necessary as part of the home health care plan; and

(f) the evaluation of the need for and the development of a plan by a registered nurse (R.N.), physician assistant, or medical social worker for home health care when recommended or requested by the attending physician.

HOSPICE CARE

Hospice services must be furnished in a hospice facility or in your home. A physician must certify that you are terminally ill with a life expectancy of six months or less.

For hospice services only, your immediate family is considered to be your parents, spouse, and your children or stepchildren.

The following hospice services are payable as stated in the Schedule of Benefits, subject to any applicable maximum:

(a) room and board and other services and supplies;

(b) part-time nursing care by or supervised by a registered nurse (R.N.) for up to eight hours per day;

(c) counseling services by a licensed clinical social worker or pastoral counselor for the hospice patient and the immediate family, limited to 15 visits per family;

(d) psychological and dietary counseling;

(e) consultation and case management services by a physician;

(f) physical or occupational therapy;

(g) part-time home health care service for up to eight hours in any one day; and

(h) medical supplies, drugs, and medicines prescribed by a physician.

Special Limitations on Hospice Care Benefits

Hospice care benefits do **not** include private or special nursing services, a confinement not required for pain control or other acute chronic symptom management, funeral arrangements, or financial or legal counseling, including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services, including a sitter or companion services, housecleaning, household maintenance, services of a social worker other than a licensed clinical social worker, services by volunteers or persons who do not regularly charge for their services, and services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he/she is called as a pastor or minister.

Hospice care program means a written plan of hospice care which is established and reviewed by the physician attending the covered person and the hospice care agency and provides palliative and supportive care to hospice patients. It offers supportive care to the families of hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program, and has a physician on call at all times.

A hospice facility provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of these requirements:

(a) has obtained any required certificate of need;

(b) provides 24-hour-a-day, 7-day-a-week service supervised by a physician;

(c) has a full-time coordinator;

(d) keeps written records of services provided to each patient;

(e) has a nurse coordinator who is a registered nurse (R.N.), who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and

(f) has a licensed social service coordinator.

A hospice care agency will establish policies for the provision of hospice care, assess the patient's medical and social needs, and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients, and use volunteers trained in care of and services for non-medical needs.

PSYCHOLOGICAL DISORDER OR SUBSTANCE ABUSE BENEFITS

Expense incurred during a plan of treatment for psychological disorder or substance abuse is payable for:

(a) charges made by a physician;

(b) charges made by a hospital;

(c) charges made by a qualified treatment facility; and

(d) charges for drugs and medications which may be obtained only on the written prescription of a physician.

Covered expenses while confined as a registered bed patient in a hospital or qualified treatment facility or for outpatient treatment received while not confined in a hospital or qualified treatment facility are payable subject to the Medical Benefits deductible, coinsurance, out-of-pocket limit, and any applicable maximum stated in the Schedule of Benefits.

Limitations

No benefits are payable under this provision for treatment of nicotine habit or addiction (unless otherwise provided under the Affordable Care Act), marriage counseling, gambling addiction, or for treatment of being overweight or obese.

Treatment must be provided for the cause for which benefits are payable under this provision of the Plan.

ORGAN TRANSPLANTS

Organ transplant surgery and related covered costs for a human organ or tissue transplant during the transplant benefit period to a recipient who is a covered person, not to exceed the amounts stated in the Schedule of Benefits. A transplant benefit period consists of five days before and eighteen months after the date of a transplant or in the case of a bone marrow transplant, a period beginning thirty days prior and eighteen months after the date of a transplant. If the transplant decision has been approved as specified later in this section, but the eligible transplant procedure has to be delayed for

reasons such as the recipient's medical condition or an organ not being available, the transplant benefit period may be extended to include more than the stated five (or 30) days prior to the transplant. In addition, the costs for stem cell collection will be payable up to one year preceding the benefit period for bone marrow transplants.

Organ transplant benefits are payable provided each of the following conditions is satisfied:

(a) You or your dependent receives two written opinions by Board-certified specialists in the involved field of surgery on the necessity for transplant surgery.

(b) The specialists certify in writing that alternative procedures, services, or courses of treatment would not be effective in the treatment of your condition.

(c) All decisions related to the transplant surgery satisfy applicable state requirements.

(d) The Board of Trustees approves the transplant decision, based on the specialists' certification and the recommendation of the large case manager and may designate approved transplant facilities.

Transplants of the following human organs or tissues are covered when transplanted to a covered person:

- cornea;
- kidney;
- bone marrow (except bone marrow transplants caused by T-cell leukemia);
- liver;
- heart;
- heart/lung (single or double);
- lung (single or double);
- pancreas;
- pancreas/kidney; and
- small bowel.

Covered expenses include reasonable expenses incurred for the following services and supplies:

(a) Donor-related services include:

    (1) testing to identify suitable donor(s);

(2) life support of a donor pending the removal of a usable organ(s);

(3) transportation for a living donor or a donor on life support;

(4) human organ and tissue procurement, including removing, preserving, and transporting the donated organ or tissue; and

(5) expenses related to the treatment of a condition resulting from the donation of an organ or tissue.

Benefits for donor-related services also will be payable to compensate an organ or tissue bank for the procurement, preservation, and transportation of an organ.

However, benefits will not be payable for any financial consideration to a donor other than for payment of a covered expense which is incurred in the performance of, or in relation to, transplant surgery of a covered person.

Payment for donor(s)' services for each eligible transplant procedure will not exceed the applicable maximum amount stated in the Schedule of Benefits. Benefits are payable under this section only if the transplant recipient is a covered person.

(b) Transportation, lodging, and meals (according to IRS guidelines) for the recipient and an immediate family member or significant other person to and from the transplant site, as well as lodging and meal costs incurred during the recipient's hospital stay by the companion, up to the maximums stated in the Schedule of Benefits. Mileage will be reimbursed at the IRS standard mileage rate for medical purposes. For these benefits to be payable, itemized receipts for charges are required.

(c) Private nursing care for the recipient by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), up to the maximum stated in the Schedule of Benefits.

(d) Postoperative follow-up expenses, including immuno-suppressant drug therapy. After the transplant benefit period, the Plan will cover expenses for such drugs, subject to applicable requirements.

(e) Use of circulatory assist devices, such as Left Ventricular Assist Devices (LVADs) and hepatic assist devices, to sustain a covered person while waiting for a transplant.

(f) All other covered services for the recipient will be payable under the Plan the same as for any other bodily injury or sickness, up to any applicable maximum stated in the Schedule of Benefits.

Multiple transplants during one operative session are payable in the same manner as are other multiple procedures during the same anesthesia period. Benefits for replacement transplant(s) if the first organ fails or is rejected are payable in the same manner as the first organ, unless failure or rejection is due to physician or hospital error in which case no benefits are payable.

Benefits are payable for the temporary use of mechanical equipment which is not experimental pending the acquisition of "matched" human organ(s).

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be payable for charges incurred during the duration of the delay because of a medical condition or up to the date of death for the organ and tissue procurement, transportation, lodging, and meals as stated in this section.

No organ transplant benefits are payable for:

(a) services not ordered by a physician;

(b) any expenses for a transplant when approved alternative courses of treatment are available or when other specified conditions are not satisfied;

(c) animal or mechanical organs for transplantation;

(d) investigational drugs;

(e) any items specified in the Plan's Limitations and Exclusions on pages 76 through 81 of the SPD;

(f) purchase of the organ or tissue; or

(g) the temporary use of experimental mechanical equipment.

OTHER COVERED EXPENSES

The following are other covered expenses:

(a) Services of a registered nurse (R.N.) for nursing care ordered by a physician.

(b) Blood and/or plasma provided it is **not** replaced by donation, and administration of blood and blood products including blood extracts or derivatives.

(c) Oxygen and rental of equipment for its administration.

(d) Physician home and office calls.

(e) Drugs and medications that are required by law to be obtained on the written prescription of a physician. This includes investigational new drugs which have reached a Phase 3 clinical investigation for the treatment of HIV infection. Prescription drug expenses are not subject to the deductible and do not apply to the out-of-pocket limit. Prescription drug copayments are stated in the Schedule of Benefits. Routine administration of drugs is **not** a covered expense. See page 86 for details of the Preferred Provider Pharmacy Program.

If you are eligible to use the United States Department of Veterans Affairs (V.A.) prescription drug program, the Plan will reimburse 100% of the amount charged by the V.A. for each prescription. Note: This provision is eliminated for prescriptions filled on or after January 1, 2015.

(f) Initial replacement for the loss of natural limbs and eyes. The expense must be incurred within 90 days of the date of the accident.

(g) Casts, splints, surgical dressings, trusses, braces, and crutches.

(h) Special supplies when prescribed by your attending physician, including:

(1) catheters;

(2) colostomy bags, rings, and belts;

(3) flotation pads;

(4) needles and syringes; and

(5) initial contact lenses or eyeglasses following cataract surgery.

(i) Rental of wheelchair, hospital bed, positive pressure ventilator, or other durable medical equipment, up to the total purchase price. The equipment must be needed for therapeutic treatment and be able to withstand repeated use, be primarily and customarily used to serve a medical purpose, and not generally be useful to a person except for the treatment of bodily injury or sickness.

(j) Dental services rendered by a qualified practitioner, dentist, or dental surgeon for treatment of a fractured jaw or bodily injury to natural teeth, including replacement of such teeth within six months after the date of the accident.

(k) Mechanical medical devices surgically implanted in a body cavity to replace or aid the function of an internal body organ.

(l) Chiropractic care for treatment of a bodily injury or sickness, up to the maximum stated in the Schedule of Benefits. There is no coverage for chiropractic care for infants and dependent children ages five and under; coverage is provided for chiropractic care for dependent children ages six to 12 for treatment of documented injuries only, unless medically necessary as determined by a physician.

(m) Installation and use of an insulin pump, other equipment or supplies in the treatment of diabetes, and diabetic self-management education programs. Coverage for an insulin infusion pump is limited to the purchase of one pump per calendar year and the pump must be in use for 30 days before purchase.

(n) Elective sterilization.

(o) Elective abortions when the pregnancy is caused by rape or incest, the pregnancy is a life-threatening physical condition of the covered female person, or the results of an amniocentesis indicate a fetal abnormality. Medical documentation verifying the test results will be required.

(p) Temporomandibular joint disorder (TMJ) surgery or non-surgical treatment including but not limited to, appliances, therapy, and splints for any jaw joint problem including any temporo-mandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; treatment of the facial muscles, used in expression and mastification functions, for symptoms including but not limited to, headaches. Benefits available do not include charges for orthodontic services. Benefits are limited to $1,000 per covered person per calendar year.

(q) Physical, speech, and occupational therapy when medically necessary to restore a function lost due to bodily injury or sickness, up to the aggregate maximum stated in the Schedule of Benefits. Expenses in excess of such maximum will be payable subject to a review for medically necessary services.

(r) Mastectomy bras, up to four per covered person per calendar year.

(s) Jobst stockings, up to four pair per covered person per calendar year.

(t) Orthopedic shoes/custom-molded inserts/orthotics: one pair until worn out and another pair is prescribed by a qualified practitioner.

(u) Wigs after chemotherapy, up to the maximum stated in the Schedule of Benefits.

(v) Prosthetic dental restoration, using partials and/or dentures, following the extraction of natural teeth in conjunction with radiation therapy of the head and/or neck for the treatment of malignant lesions.

(w) Contraceptives that are administered or inserted by a physician, including contraceptive injections, implant systems, and

intrauterine devices to the extent not covered in subsection (e) of Routine Care on page 58.

(x) Treatment of morbid obesity, up to the lifetime maximum stated in the Schedule of Benefits. Benefits are payable to a covered person who is determined to be morbidly obese. Morbidly obese is defined as an individual age 21-64 with a history of severe obesity, and who has a body mass index (BMI) of 40 or above or who is 100 pounds over his/her ideal body weight as determined by a physician. The Plan will cover surgical operations or procedures only for morbidly obese covered persons who have participated in other weight loss efforts that have failed as documented by a physician.

The lifetime maximum will include the following related charges for the treatment of morbid obesity:

(1) pre-surgery psychological examination performed in connection with surgery for morbid obesity;

(2) pre-operative visits within seven days of the surgery;

(3) intraoperative services that are medically necessary as part of the procedure;

(4) anesthesia services;

(5) hospital charges;

(6) surgical fees by a physician; and

(7) post-operative pain management.

Coverage by the Plan will not include nutritional counseling or cosmetic surgery and/or corrective surgery for removal of excess skin that results from the weight loss following the surgery, regardless of whether or not such cosmetic or corrective surgery is deemed medically necessary. Procedures not eligible include, but are not limited to, abdominoplasty, breast reductions or lifts, and liposuction.

LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions stated within specific sections of Medical Benefits, the Plan does not provide benefits for:

(a) Services and supplies:

(1) furnished while you are not under the regular care of a physician;

(2) not authorized or prescribed by a physician;

(3) for which no charge is made, or for which you would not be required to pay if you did not have coverage;

(4) furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare Benefits or Medicaid); or

(5) furnished for a military service-connected bodily injury or sickness by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs.

(b) Routine eye exams, services to correct eye refractive disorders, eyeglasses, hearing aids or the fitting or repair of any hearing aid or eyeglasses, and routine foot care unless specifically provided under the Plan. See page 57 for routine care covered by the Plan.

(c) Premarital tests or examinations, routine physical exams for occupation, employment, school, travel, or the purchase of insurance, unless specifically provided under the Plan.

(d) Gender change operations, or the reversal of voluntary sterilization.

(e) Any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which:

(1) benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law; or

(2) coverage was available under any Worker's Compensation or Occupational Disease Act or Law regardless of whether such coverage actually was applied for.

However, if the covered person has been denied Worker's Compensation or Occupational Disease benefits and the covered person and his/her attorney execute an agreement provided by the Fund stating and agreeing to repay and reimburse the Fund for all benefits paid by the Fund on behalf of the covered person for said bodily injury out of any recovery proceeds, whether by settlement or otherwise, then the Fund will cover such expense, subject to the terms and conditions of the Plan.

Failure by the covered person to comply with the agreement allows the Fund, at its discretion, to any of the following:

(1) Take a credit against future claims of the covered person up to the amount of the Fund's expenditures on such expense;

(2) Initiate legal proceedings to recover the Fund's expenditures; or

(3) Exercise the Fund's right to reimbursement, including but not limited to, claims for restitution, unjust enrichment, or a constructive trust over any recovery by the covered person, to the extent of the Fund's expenditures, whether the recovery is paid to, or in the possession of, the covered person, the covered person's attorney, or any other individual or entity.

(f) Plastic or cosmetic surgery unless for reconstructive surgery due to bodily injury, infection, or other disease of the involved part; or congenital disease or anomaly of a covered dependent child which resulted in a functional defect.

(g) Dental care or treatment, including dental implants, except as specifically described.

(h) Any loss caused or contributed to by:

(1) war or any act of war, whether declared or not; or

(2) any act of international armed conflict, or any conflict involving armed forces or any international authority.

(i) Subject to the provisions for an approved clinical trial under the Affordable Care Act as described in the definition of “experimental” on page 170, any drug or medicine which has not been approved by the United States Food and Drug Administration by issuance of a New Drug Application or other formal approval.

(j) Subject to the provisions for an approved clinical trial under the Affordable Care Act as described in the definition of “experimental” on page 170, any medical or surgical procedure which is not considered a generally accepted procedure by the medical community in the United States.

(k) Services provided by a person who ordinarily resides in your home or is a family member.

(l) Custodial care and maintenance care.

(m) Charges in excess of the customary, usual, and reasonable charge for the service or supply.

(n) Any medical expense incurred after the date your coverage under the Plan terminates, except as specifically described.

(o) Any medical expense due to commission or attempt to commit a civil or criminal battery or felony.

(p) Services not medically necessary for diagnosis and treatment of a bodily injury or sickness, unless specifically provided under this Plan.

(q) Private-duty nursing while confined in a hospital or other qualified treatment facility.

(r) Any service which is experimental, investigational, or for research purposes, unless specifically indicated in Other Covered Expenses beginning on page 72. Notwithstanding the foregoing, to the extent required under the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose

additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial. Qualified Individuals must use a PPO Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial. See the definition of "experimental" on page 170 for defined terms used in this subsection.

(s) Charges incurred for vision therapy and orthoptic treatment (eye exercises).

(t) Expenses incurred for which you are entitled to receive benefits during any extension period of your previous dental or medical plan.

(u) Birth control drugs and devices, except as specifically stated.

(v) Any artificial means to achieve pregnancy, including but not limited to, invitro fertilization, GIFT, artificial insemination, and all related fertility testing and treatment.

(w) Any charges, including physician charges, which are incurred due to a Friday or Saturday admission to a hospital unless you are admitted as the result of a medical emergency or treatment or surgery is performed on the day you are admitted.

(x) Bodily injury or sickness for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage. Payments made by any other coverage will be credited toward any applicable calendar year deductible and coinsurance for the year the bodily injury or sickness initially was sustained.

(y) Loss caused by or resulting from mental deficiency, mental retardation, developmental deficiencies, or any treatment for learning disabilities, except as specifically stated.

(z) Charges incurred for any special education rendered to any covered person regardless of the type of education, except as specifically stated.

(aa) Charges for telephone conversations/telephone consultations or virtual clinics, except for those furnished by the LiveHealth Online Program through Anthem.

(bb) Charges for special home construction to accommodate a disabled covered person.

(cc) State or local taxes incurred on covered expenses, and shipping and handling charges.

(dd) Charges incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a physician or other provider of medical services or supplies.

(ee) Charges incurred for any of the following list of items, regardless of intended use: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, dehumidifiers, allergy-free pillows, blankets or mattress covers, electric heating units, orthopedic mattresses, exercise equipment, gravity lumbar reduction chairs, vibratory equipment, elevators or stair lifts, stethoscopes, clinical thermometers, scales or blood pressure monitors, and magnetic devices.

(ff) Any losses incurred by a covered person or dependent at a time that a covered person owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by a covered person, or where such person has failed to honor the Plan's right of subrogation or reimbursement or otherwise failed to cooperate with the Plan as specified.

(gg) Acupuncture.

(hh) Charges incurred for travel, whether or not recommended by a physician, except if specified as covered under the Plan.

(ii) All enteral feedings and other nutritional and electrolyte supplements or formula whether or not prescribed by a physician.

(jj) Expenses resulting from suicide or attempted suicide unless the end result of an underlying medical condition.

(kk) Repair and maintenance of durable medical equipment (DME), duplicate DME rental or purchase, batteries, and ancillary supplies. However, the repair of DME may be covered when DME damage is not due to neglect or abuse, the cost of the repair is projected to be less than the replacement cost of the DME, and the Plan authorized repair of the DME in advance.

(ll) Genetic testing or genetic counseling, except as specifically stated.

(mm) Abortions except when the pregnancy is caused by rape or incest, the pregnancy is a life-threatening physical condition of the covered female person, or the results of an amniocentesis indicate a fetal abnormality. Medical documentation verifying the test results will be required.

(nn) Habilitation services.

(oo) Long-term care.

(pp) Non-emergency care when traveling outside the United States.

(qq) Infertility treatment.

(rr) Weight loss programs, except services for treatment of morbid obesity.

FAMILY ASSISTANCE PROGRAM

Health Systems Management (HSM) helps you cope with the stress, disruption, emotional exhaustion, and financial drain caused by serious illness. HSM recognizes that these conditions affect not only you, but also your family members. To assist you and your family members, HSM offers the Family Assistance Program ("FAP").

The HSM FAP program has two parts: (a) the family assistance services to help you and your family address behavioral health and substance abuse issues and reach appropriate professionals to treat these conditions; and (b) the patient advocacy services to provide you with information regarding your medical conditions, possible physicians and treatment facilities, and network status of those facilities.

Medical, Behavioral Health, and Substance Abuse Assistance

HSM provides confidential assessment and referral services for you and your eligible family members if you are experiencing a personal problem, behavioral health problem, or substance abuse problem. Licensed, professional counselors will assess your needs, either face-to-face or over the phone. When you and the counselor agree that it is appropriate and medically necessary for you to receive further services, HSM will contact and arrange an appointment with an in-network provider who has the necessary expertise to help you. The FAP counselor will contact you at regular intervals thereafter to ensure you are satisfied with the provider and that progress is being made toward treatment objectives.

If you find yourself in a crisis situation, HSM provides live 24-hour telephone crisis counseling at: 1-877-961-1121.

HSM also can assist you with other work/life issues, such as finding a legal or financial counselor. (Note: The actual financial or legal counseling is not covered by the Plan.)

Medical Patient Advocacy Services

HSM Patient Advocacy Services focuses on assisting you and your eligible family members as you deal with medical issues. HSM does not provide medical advice, but rather acts as a resource for

information to help you work with your primary care physician, specialist, or case manager in making decisions that are appropriate for you. Services include, but are not limited to, providing:

(a) basic answers to your medical questions;

(b) information on the diagnostic tests used to determine the seriousness of a medical condition;

(c) information on treatment options and information regarding the best candidates for the various treatment options;

(d) information on a health care provider's experience in diagnosing and treating certain conditions;

(e) information on and evaluation of health care providers and facilities where treatment options are available for certain conditions; and

(f) assistance in finding a network provider who specializes in treating a specific condition.

In integrating these services under one program, HSM finds that patients, families, and medical and behavioral health professionals can work together more easily to benefit patients when medically necessary, appropriate, and desired by the patient. This FAP program is voluntary and strictly confidential.

Professional medical, behavioral health, and substance abuse staff are available to help you and your family 24 hours a day, seven days a week. The medical staff available to help you include: physician specialists and sub specialists; nurses; and experienced medical researchers. You and your family members can use these resources as often as you need. There is no extra charge to you.

To contact HSM, you can visit their website at: http://www.hsminc.net.

For behavioral health and substance abuse assistance, call toll-free: 1-877-961-1121.

For medical questions and help, call toll-free: 1-855-511-0259.

TOBACCO CESSATION PROGRAM

Applies to All Employees, Spouses, and Dependents (age 18 and over)

The Quit For Life Program is the nation's leading tobacco cessation program. It is proven as an effective method you can use to quit tobacco because it treats tobacco use as an addiction, not just a bad habit. With personal help from a Quit Coach you will have the support and resources to help you make good decisions about medications, develop new thinking skills, and learn how to behave differently in situations where you normally use tobacco.

When you enroll in the program, you will receive the following:

(a) Five scheduled calls with a Quit Coach who will develop a quit plan for you and provide support and information to help you quit.

(b) Unlimited toll-free access to Quit Coaches, who offer as much or as little support as you need.

(c) Recommendations on type, dose, and duration of medication if appropriate including:

(1) Free nicotine replacement therapy (patch/gum) mailed directly to your home, if appropriate. These products are provided by and mailed to you from the Quit For Life Program, so they will not be available under the Plan's pharmacy benefit.

(2) The Plan will provide coverage for 50% of the cost of prescription medications, if appropriate, including Chantix and Buproprion (generic Zyban) if you enroll in the Quit For Life Program. Prescription medications may be filled under the Plan's prescription program with Catamaran. Present your Plan ID card to a participating pharmacy along with a physician's written prescription to fill such medications. Please note that these medications only will be payable when it is confirmed that you are enrolled in the Quit For Life Program. A maximum of a 90-day supply will be payable each calendar year.

(d) Printed Quit Guides to help you stay on track between calls.

(e) Access to Web Coach, a private online community where you can complete activities, watch videos, track your progress, and join in discussions with others in the program.

Benefits payable are subject to the preventive care provisions of the Affordable Care Act.

Call: 1-866-QUIT-4-Life (1-866-784-8454) or log on to: www.quitnow.net for details or to enroll.

PREFERRED PROVIDER PHARMACY PROGRAM

Catamaran provides full management of the Plan's prescription drug card program. It offers a nationwide network of pharmacies where you can use your identification card to purchase your prescription drugs at reduced rates. The network includes most of the major chain stores and most independent pharmacies.

When you purchase prescription drugs at a Preferred Provider Pharmacy (PPRx), benefits are payable subject to the following terms and conditions.

Benefits are payable for the following upon a written prescription executed by a physician and dispensed by a licensed pharmacist:

(a) federal legend drugs;

(b) compounded medications of which at least one ingredient is a prescription legend drug;

(c) insulin;

(d) insulin syringes/needles and other diabetic supplies, such as lancets, lancet pens, blood sugar and acetone test strips, and tes-tape for covered persons who are not covered by Medicare;

(e) injectable medications;

(f) acne medications, such as Tretinoin products (e.g., Retin-A or Renova) preparations through age 35 and then after such age only if medically necessary;

(g) prenatal prescription vitamin preparations;

(h) immunosuppressants (anti-rejection drugs);

(i) migraine medications;

(j) influenza medications;

(k) human growth hormone (provided you obtain prior authorization);

(l) epinephrine injections;

(m) appetite suppressants (provided you obtain prior authorization);

(n) contraceptive medications and devices for women that are obtainable at the pharmacy and require a physician's written prescription, including oral and transdermal contraceptives, diaphragms, and vaginal hormone rings;

(o) emergency contraceptives for women (Plan B);

(p) over-the-counter (OTC) Prilosec, OTC loratadine, OTC Prevacid, OTC Zegerid, and OTC Allegra/Allegra-D products upon a physician's written prescription; and

(q) prescription tobacco cessation medications upon a physician's written prescription and confirmation of your enrollment in the Quit For Life Program, at the copayment and up to the maximum stated in the Schedule of Benefits.

For each prescription purchased at a PPRx, you will pay the copayment per prescription as stated in the Schedule of Benefits for either generic drugs or brand name per prescription for, up to a 34-day supply. You can order maintenance prescriptions through Catamaran's mail service program, Catamaran Home Delivery, for up to a 90-day supply, and pay the copayment per prescription as stated in the Schedule of Benefits.

There is a separate copayment as stated in the Schedule of Benefits for: OTC Prilosec, OTC loratadine, OTC Prevacid, OTC Zegerid, and OTC Allegra/Allegra-D products upon a physician's written prescription and prescription/legend omeprazole; and for other prescription Proton Pump Inhibitors (PPIs) and prescription non-sedating antihistamines.

The following are covered at a $0 copayment through both retail network pharmacies and the mail service pharmacy, upon a physician's written prescription:

(a) over-the-counter (OTC) aspirin up to 325mg once per day to prevent cardiovascular disease for men and women age 45 and older (generic only);

(b) federal legend fluoride for dependent children age five and younger to prevent dental cavities;

(c) OTC folic acid for doses of 0.4mg-0.8mg once per day for women age 55 and younger who are planning or capable of pregnancy;

(d) OTC iron supplements for dependent children up to one year old to treat/prevent anemia; and

(e) generic contraceptives and contraceptives for which there is no generic alternative for women.

In addition, shingles vaccinations obtained at a retail network pharmacy will be covered at 100% for Covered Persons age 60 and over.

For Class D Covered Persons: If you do not enroll for Medicare Prescription Drug Benefits, prescriptions obtained through a network pharmacy or the Mail Service Pharmacy Program will be payable after satisfaction of the applicable deductible stated in the Schedule of Benefits. If you enroll for Medicare Prescription Drug Benefits, you will become ineligible for the Plan's prescription drug benefits and no benefits will be paid for any charges incurred for prescription drugs. Your prescription drug benefits under the Plan will be reinstated if you later drop or terminate coverage for Medicare Prescription Drug Benefits, provided you maintained continuous coverage under the Plan.

If a covered person is eligible to use the United States Department of Veterans Affairs (V.A.) prescription drug program, the Plan will reimburse 100% of the amount charged by the V.A. for each prescription. NOTE: This provision is eliminated for prescriptions filled on or after January 1, 2015.

If you obtain a prescription at a PPRx but do not use your card or you have your prescription filled by a non-network pharmacy, you must pay the full retail price and submit a request for reimbursement to Catamaran on one of their reimbursement forms. If you did not use

your card at a PPRx, you will be reimbursed at 100% of the billed charges less the applicable copayment. If you did not use a network pharmacy, you will be reimbursed up to a 34-day supply and only up to the amount that would have been allowable at a network pharmacy.

You are required to purchase specialty medications through the BriovaRx Specialty Drug Management Program as stated in the Schedule of Benefits, subject to prior authorization. Specialty drugs are prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions such as cancer, Hepatitis C, HIV/AIDS, multiple sclerosis, psoriasis, and rheumatoid arthritis. The BriovaRx Specialty Drug Management Program not only provides access to high-cost injectable and specialty medications, it ensures that you receive the most appropriate treatment for your condition and/or prescribed therapy. BriovaRx gives you personalized service to help you get the special treatment you need. A pharmacist or nurse will call you when they receive your first prescription to discuss your treatment plan, dosing, and potential side effects. They will regularly follow up with you and your physician and always be there to remind you of refills and answer any questions you may have. You can purchase one 30-day supply of a specialty medication at a network retail pharmacy; then each 30-day supply must be filled through BriovaRx Specialty Pharmacy. BriovaRx Specialty Pharmacy provides the convenience of receiving your specialty medications through express delivery to the location of your choice. You can choose to have your medication delivered to your home, physician's office, or to your local network retail pharmacy for pick-up. To receive a specialty medication through BriovaRx Specialty Pharmacy, please call 1-855-427-4682 **at least 14 calendar days** before your current prescription is due to run out to enroll or visit their website at: BriovaRx.com. **If you are having trouble affording your specialty drug copay, ask a BriovaRx representative if they can help with any available patient assistance.**

Catamaran has a formulary program through which the manufacturer offers rebates on certain drugs. You will be sent a list of these prescriptions periodically which you may show to your physician. If he/she prescribes any of the medications on the list, the Fund will receive the rebate and, ultimately, the savings are passed on to you by way of reduced costs to the Fund.

If you use the PPRx while ineligible according to the Plan's Eligibility Rules, the Plan will recover the ineligible payments from you according to the Right of Recovery provision stated on page 127.

If a covered person has other health coverage that is primary to this Plan, the PPRx will reject the claim at the point-of-service. You must first request that the claim be submitted to your primary coverage. If a Preferred Provider Pharmacy is utilized, the pharmacist will be able to process the claim through both plans at the point-of-service.

After such claim is processed by the primary coverage, the balance will be considered for benefits by the Fund.

Benefits are not payable under the PPRx Program for the following:

(a) non-legend (OTC) drugs other than insulin, diabetic supplies, Prilosec, loratadine, Prevacid, Zegerid, and Allegra/Allegra-D products;

(b) drugs purchased at the hospital pharmacy for you at the time of discharge;

(c) covered prescription medications which are not self-administered or are administered in a hospital, long-term care facility, assisted living facility, or other inpatient setting;

(d) implantable contraceptives, regardless of intended use;

(e) subject to the provisions of an approved clinical trial under the Affordable Care Act as described in the definition of “experimental” on page 170, experimental or investigational drugs or any medication that has not been approved by the Food and Drug Administration;

(f) immunization agents, except as specifically stated;

(g) professional charges for the compounding, administration, or injection of any medication;

(h) prescription drugs or medicines covered under any Worker’s Compensation Law or similar laws or any municipal, state, or federal program, even if the patient chooses not to claim such benefits;

(i) refills of covered drugs which exceed the number of refills the prescription order calls for, or refills after one year form the original date;

(j) prescriptions deemed not medically necessary for the diagnosis or treatment of an injury or sickness;

(k) smoking deterrents (unless you are enrolled in the Quit For Life Program described on page 84), subject to the preventive care provisions of the Affordable Care Act;

(l) prescription vitamins, other than prenatal;

(m) prescription fluoride preparations, except as specifically stated;

(n) medications obtained outside the United States;

(o) topical minoxidil preparations, whether commercially prepared or compounded;

(p) blood or plasma-related products;

(q) oxygen;

(r) allergy desensitization agents or allergy serum;

(s) durable or disposable medical equipment, devices, appliances, and supplies, even if prescribed by a qualified practitioner;

(t) infertility medications;

(u) medications for cosmetics purposes, including hair growth products and skin lightening or de-pigmenting products;

(v) medication needed for foreign travel;

(w) hypodermic syringes and/or needles except when dispensed for use with insulin;

(x) impotence medications, such as Viagra; and

(y) anorexiants (weight control products).

The toll-free phone number for contacting Catamaran Customer Service is: 1-866-795-6816. You can order refills for your mail service prescriptions by calling Catamaran Home Delivery at: 1-866-814-7105.

You also can access their website at: www.mycatamaranrx.com to refill mail service prescriptions, find information on specific drugs, view your prescription history, locate a participating pharmacy in the retail network and get driving directions, compare prices at local pharmacies, and find the lowest copays. Your Rx Group is: PLUM434. Bin # 006947. PCN: CLAIMCR. Register with your pharmacy member ID number.

You also can download the Catamaran mobile app to provide easy on-the-go access to your personal health information. The mobile app allows you to: set reminders so you do not miss a dose of your medications, prescription or over-the-counter; remind you of refills so you can quickly contact your pharmacy; show your physicians what medications you are taking; pull up a medication history any time; learn medication side effects and interactions; find network pharmacies by zip code or location; check to compare current prices; and even order refills from Catamaran Home Delivery. **Download the mobile app by searching for Catamaran, formerly Catalyst.**

If you have any questions, contact Member Services at: 1-888-869-4600.

OPTIONAL DENTAL AND VISION CARE BENEFITS

The optional benefits are a combined option and the Dental Care and Vision Care Benefits are not available separately.

Notwithstanding the following provisions, residential employees will have a one-time opportunity to enroll:

(a) during an annual enrollment period as designated under their employer's cafeteria plan;

(b) if a special enrollment event as defined on page 19 or 42 applies; or

(c) if they become subject to a Qualified Medical Child Support Order.

There will be an annual open enrollment in which you can elect these benefits. If you enroll during an open enrollment, you will be required to keep the optional benefits for a minimum of two years. If you enroll when you become initially eligible, you will be required to keep the optional benefits until the next open enrollment after you have had the benefits for two full years.

The cost of these benefits is subject to change. Active employees will have the option of having the payment payroll deducted on a pre-tax basis by their employer or having the payment deducted from their dollar bank. The additional payment amount will be included in the monthly self-payment notice of retirees who elect to participate.

Once you elect a payment option, you may not change that payment option for two years. So, if you elect to have your payment payroll deducted, you cannot later decide that you would rather have the payment deducted from your dollar bank.

For Pre-Tax Payroll Deduction, your employer will deduct an additional amount per hour for every hour you work. If you work more than 130 hours in any month, or 150 hours if a residential employee, the excess will be used to determine the next month's eligibility. If you work less than 130 hours in any month, or 150 hours if a residential employee, the shortage will be deducted from your dollar

bank. If you do not have sufficient funds in your dollar bank, you will be sent a self-payment notice. If you do not make the appropriate self-payment, your coverage will lapse and you will not be eligible to re-enroll in the optional dental and vision coverage until the next open enrollment following two full years without coverage.

For Dollar Bank Deduction, the Fund Office will deduct the necessary monthly payment from your dollar bank each month. If you do not have sufficient funds in your dollar bank, you will be sent a self-payment notice. If you do not make the appropriate self-payment, your coverage will lapse and you will not be eligible to re-enroll in the optional dental and vision coverage until the next open enrollment following two full years without coverage. Notwithstanding the prior, you may enroll or re-enroll in advance of the next open enrollment if you dropped coverage while on a FMLA or military leave; you may re-enroll when you return from that leave. In addition, you also may enroll or re-enroll within 30 days of a special enrollment event in which you gain a new dependent or you lose coverage under another dental or vision plan. You also may enroll or re-enroll if you are subject to a qualified medical child support order which requires you to provide dental or vision benefits.

OPTIONAL DENTAL PLAN – DELTA DENTAL PLAN OF WISCONSIN

Delta Dental Plan of Wisconsin has been selected to administer your optional dental coverage. The Group Dental Contract issued to the Fund is the complete document of coverage and governs all claims processing. You can find a participating network dentist and access benefit information (such as eligibility and claim status) by calling: 1-800-236-3712 or visiting: www.deltadentalwi.com. You may request a current list of participating providers from the Fund Office at no charge.

Selecting a Dentist

Delta Dental PPO offers a benefit to those patients receiving treatment from a Delta Dental PPO dentist. A PPO Dentist List is provided to you periodically from which you may choose a PPO Dentist. However, you and your eligible dependents may select any dentist on a treatment by treatment basis, whether or not the dentist is included on the PPO Dentist List. The Fund makes no

representations regarding the quality of service provided by a PPO Dentist.

IT IS IMPORTANT TO REMEMBER YOUR OUT-OF-POCKET COSTS MAY BE LOWER WHEN YOU SEE A PPO DENTIST.

DELTA DENTAL PPO DENTIST: is a licensed dentist who has signed an agreement with Delta Dental to accept payment based on a reduced fee schedule. Delta Dental's payment and the patient's payment, if any, are accepted by the Delta Dental PPO Dentist as payment in full. Delta Dental's payment is sent directly to the Delta Dental PPO Dentist.

DELTA DENTAL PREMIER DENTIST: is a licensed dentist who has signed a contract with Delta Dental agreeing to accept direct payment from Delta Dental. He/she also has agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). MPA means the total dollar amount allowed under the contract for a specific benefit. You will be responsible for coinsurance amounts, deductibles, and services not covered by your particular Group Dental Contract. You will receive an Explanation of Benefits form indicating the amount Delta Dental has paid to the Delta Dental Premier Dentist and the amount, if any, you owe.

NONCONTRACTED DENTIST: If your dentist has not signed a contract with Delta Dental, payment will be calculated based on the MPA but will be sent directly to you. You are responsible for reimbursing your dentist through his/her usual billing procedure. If the fee charged is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on the dentist's overhead, skill, and experience. Therefore, not every dentist will have fees that fall within the MPA fee range.

For dental benefits and services provided by an out-of-state dentist, Delta Dental will pay directly to the dentist the applicable percentage of the reduced fee schedule. The difference between Delta Dental's payment and the out-of-state dentist's full fee is your financial responsibility.

Filing Claims

To file a claim, simply present your I.D. card to the receptionist at the dental office or give your Social Security number. Delta Dental

accepts any standard claim form and will provide claim forms to your dentist on request.

Predetermination of Benefits

After an examination, your dentist will recommend a treatment plan. If the services involve crowns, fixed bridgework, partial/complete dentures, or orthodontics, ask your dentist to send the treatment plan to Delta Dental, including x-rays. The available benefits will be calculated and printed on a Predetermination of Benefits form, which will be returned to your dentist.

Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by Delta Dental and your financial obligation for the proposed treatment. The Predetermination of Benefits is valid for 90 days from the date of issue, provided you maintain your eligibility under the Plan.

Optional Treatment

In all cases in which a patient selects a more expensive service than is customarily provided, or for which Delta Dental does not believe a valid need is shown, Delta Dental will pay the applicable percentage of the fee for the service which is adequate to restore the tooth or dental arch to contour and function. The patient is responsible for the entire remainder of the dentist's fee.

Description of Services

The following services are covered, subject to the maximums stated in the Schedule of Benefits, the limitations described within each coverage category, and the Limitations on pages 99 and 100.

Coverage A - Diagnostic and Preventative Services

(a) Examinations, no more frequently than twice in a calendar year.

(b) Full mouth x-rays once each three years; either individual films or panoramic film, including bitewings.

(c) Bitewing x-rays, no more frequently than twice in a calendar year (limited to a set of four films).

(d) Dental prophylaxis (teeth cleaning), no more frequently than twice in a calendar year.

(e) Topical fluoride applications, no more frequently than twice in a calendar year for dependent children to age 19.

(f) Space maintainers for retaining space when a primary tooth is prematurely lost.

Coverage B - Basic Restorative Services

(a) Emergency treatment to relieve pain.

(b) Extractions and other oral surgery (cutting procedures) including pre-operative and post-operative care, except those procedures covered under Medical Benefits.

(c) Amalgam (silver) restorations, one placement per tooth surface in a 12-month period.

Composite (tooth-colored) restorations in anterior (front) teeth - one placement per tooth surface in a 12-month period.

Stainless steel prefabricated crowns - one per tooth surface in a three-year period.

(d) Topical application of sealants for dependents to age 14. Application is limited to the occlusal surface of permanent molars which are free of decay and restorations. Benefits are limited to one application per tooth per lifetime.

(e) Local anesthetic is covered as a part of a dental procedure. General anesthetics or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures).

(f) Endodontics includes root canal treatments and root canal fillings, once per tooth in a two-year period.

(g) Periodontics includes procedures necessary for the treatment of disease of the gums and bone supporting teeth. Non-surgical treatment is limited to once each 24 months. Surgical treatment is limited to once each three years except those procedures covered under Medical Benefits. Periodontal prophylaxis is a

benefit four times each calendar year, when medically necessary.

(h) Dental implants.

Coverage C - Major Restorative Services

(a) Crowns, inlays, or onlays are provided when teeth are broken down by dental decay or accidental injury and no longer may be restored adequately with a filling material.

(b) Prosthetics includes fixed bridgework, partial dentures, and complete dentures to replace missing permanent teeth.

    (1) Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a benefit once in any 36-month period.

    (2) Porcelain veneers on crowns or pontics are covered benefits only on the six front teeth, bicuspids, and upper first molars.

    (3) Coverage for the purpose of replacing a defective existing crown, inlay, onlay, fixed bridge, or partial/complete denture will be provided only after a five-year period from the date on which it was last supplied, whether or not it was benefited by Delta Dental.

    (4) Fixed bridges and partial/complete dentures are provided where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when necessary to replace missing teeth. Fixed bridges will be a benefit only if the use of a removable prosthetic appliance is inadequate.

Coverage D - Orthodontic Services

Includes orthodontic appliances and treatment, related services for orthodontic purposes to include examinations, x-rays, extractions, photographs, study models, etc., for your dependent children to age 19.

Coverage includes orthodontic treatment in progress. Liability for orthodontic treatment in progress extends only to the unearned portion of the treatment in progress. Delta Dental will be the sole determinant of the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered.

If orthodontic treatment is stopped for any reason before it is complete, Delta Dental will pay only for services and supplies actually received. There are no benefits available for charges made after coverage stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: 25% of the total case fee is considered the initial payment to be paid by Delta Dental and the patient at the stated coinsurance percentage. Remainder of the allowed fee is divided by the months of treatment. Monthly payments are made by Delta Dental at the stated coinsurance percentage, up to the orthodontic maximum benefit.

Limitations

Coverage is not provided under the Optional Dental Care Benefits for:

(a) Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability Laws.

(b) Prescription drugs, premedications, and relative analgesia; charges for anesthesia other than charges by a licensed dentist for administering general anesthesia in connection with covered oral surgery (cutting procedures); preventive control programs; charges for failure to keep a scheduled visit with the dentist; charges for completion of forms; charges for consultation.

(c) Charges by any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility.

(d) Treatment of or services related to temporomandibular joint dysfunction (TMJ).

(e) Services which are determined to be partially or wholly cosmetic in nature.

(f) Cast restorations placed on covered persons under age 12; prosthetics placed on covered persons under age 16.

(g) Appliances or restorations for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations for temporary dental procedures; or for splints, unless necessary as a result of accidental injury.

(h) Treatment by other than a licensed dentist, his/her employees, or agents.

(i) Dental care injuries or disease caused by war or acts of war, riots or any form of civil disobedience; injuries sustained while committing a criminal act; injuries intentionally inflicted; dental care injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.

(j) Treatment rendered outside of the United States or Canada.

(k) Replacement of lost or stolen dentures or charges for duplicate dentures.

(l) Those services and benefits not specifically provided under the Contract and/or excluded by the rules and regulations of Delta Dental, including the processing policies, which may change periodically and are printed on the Explanation of Benefits form and Claim Payment Voucher.

(m) Services or appliances, including prosthetics (crowns, bridges, and dentures), started prior to the date the patient became eligible under the Local 434 Health & Welfare Fund Optional Dental Plan.

Claims not submitted to Delta Dental Plan of Wisconsin within 90 days of the date of service still will be accepted and processed within 15 months of the date of service.

Termination of Coverage

All benefits cease on the date coverage terminates, except for completion of operative procedures in progress at the time of termination. Operative procedures are defined as and limited to

individual crowns, dentures, and bridges, and are considered in progress only if all procedures for commencement of lab work have been completed and all operative procedures are completed within 60 days of termination. The benefits payable, however, still are subject to provisions and limitations of the Plan.

Settlement of Disputes

In the event of a dispute between Delta Dental Plan of Wisconsin and the dentist with respect to any of the terms, conditions, or benefits of this Plan, the facts will be presented by the Plan or the dentist, with notice given to the other party, to the local Peer Review Committee of the local dental society for adjudication by such Committee. If the Plan or the dentist is not satisfied with the judgment of the local Peer Review Committee, an appeal may be made to the State Peer Review Committee. All disputes will be settled in this manner before any action at law is taken by the Plan.

Plan Liability

Delta Dental acts only as the intermediary between dentists, the Group, and our covered persons. In no instance will Delta Dental be liable for any conduct, including but not limited to, tortuous conduct, negligence, wrongful acts or omissions of any person, including but not limited to, covered persons, dentist, dental assistant, dental hygienist, hospital or hospital employee, receiving or providing services. In no instance will Delta Dental be liable for services of facilities which, for any reason, are unavailable to the covered person.

Grievance Procedures

A grievance is any dissatisfaction with the administration or claims practices of this Plan submitted to us in writing. Delta Dental will acknowledge a grievance within 10 days of receiving it. All grievances will be resolved within 30 days from the date the grievance is received. Should Delta Dental be unable to resolve the grievance within that time, we will notify you when a resolution may be expected, within 30 additional days, and the reason for the delay. Delta Dental will notify you in writing of the resolution of the grievance. You have the right to appear in person before the Grievance Committee to present written and oral information and ask questions of those people responsible for the determination which

resulted in the grievance. Delta Dental will provide written notice of the meeting place and time at least seven days before the meeting.

Your dental claims also are subject to the Plan's claim appeal procedure described beginning on page 156.

OPTIONAL VISION CARE BENEFITS

Benefits are payable up to the maximum amounts and for the time periods stated in the Schedule of Benefits for reasonable expenses related to vision exams, lenses, and frames. Services and supplies must be furnished by an optician, optometrist, or ophthalmologist acting within the usual scope of such practice.

Vision Examination

You and each of your dependents are entitled to one vision examination each calendar year.

Lenses and Frames

When a vision examination indicates and a prescription is issued, you and each of your dependents are entitled to one set of lenses and frames every two calendar years, up to the amount stated in the Schedule of Benefits.

In lieu of conventional lenses and frames, you and each of your dependents are entitled to one set of contact lenses, disposable contact lenses, or safety lenses every two calendar years, if warranted by prescription, up to the amount stated in the Schedule of Benefits.

Limitations

In addition to the Limitations and Exclusions on pages 76 through 81, Vision Care Benefits do not cover the following:

(a) services, treatment, or supplies furnished by or at the direction of the United States Government or any agency thereof, any state, territorial, commonwealth government or political subdivision thereof, or a foreign government or agency thereof;

(b) services, treatment, or supplies received from a vision care or medical department maintained by the Trustees, a mutual benefit association, or labor union;

(c) services, treatment, or supplies which are payable or furnished under any other coverage with this Fund or any insurance company, or any other medical benefit plan or service plan for which the Trustees, directly or indirectly, have paid for all or a portion of the cost;

(d) orthoptics, vision training, or aniseikonia;

(e) sunglasses, plain or prescription;

(f) expenses incurred for services performed or supplies furnished by other than an optician, optometrist, or ophthalmologist; or

(g) services, treatment, or supplies rendered or furnished:

    (1) before you or your dependent became a covered person; or

    (2) after termination of your or your dependent's eligibility.

SHORT-TERM DISABILITY BENEFITS AND TERM LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

SHORT-TERM DISABILITY BENEFITS
(Class A Employees Only)

Short-Term Disability Benefits are not payable for alumni and non-bargaining unit employees and also are not payable under the reduced cost option as stated in the Schedule of Benefits.

How To Claim Short-Term Disability Benefits

Notify the Fund Office as soon as you are unable to work due to an accident or sickness and request a claim form. Fill out the claimant portion and have your physician fill out his/her portion. The claim form should be returned to the Fund Office.

Notification of loss must be made within 20 days of the date of your loss, or as soon as is reasonably possible. The written claim must be submitted within 90 days of the date of loss. The Fund Office reserves the right to have a physician examine the claimant whenever it may be required during the period in which benefits are claimed. Payment will be made directly to you.

Benefits Payable

Subject to the following terms, you will receive Short-Term Disability Benefits if you become totally disabled because of a covered bodily injury or sickness while covered under the Plan. The Short-Term Disability Benefit is stated in the Schedule of Benefits. The maximum benefit period payable begins on the first day you receive Short-Term Disability Benefits. A daily benefit is one-seventh of the amount of the weekly benefit. After completion of the elimination period, benefits will continue until the earliest of the following:

(a) the date you cease to be under the regular care of a physician;

(b) the date you cease to be totally disabled; or

(c) the last day of the maximum benefit period as stated in the Schedule of Benefits.

Short-Term Disability Benefits are **not** payable for a total disability commencing on or after the date you cease to be eligible as a Class A employee.

Elimination Period

The elimination period is stated in the Schedule of Benefits. The elimination period begins on the first full day on which you are totally disabled. Benefits are not payable for this period.

Reduction in Benefits

Short-Term Disability Benefits will be reduced by any benefits paid or payable under any State Statutory benefits or Social Security benefits you are eligible to receive while totally disabled. Social Security benefits payable to or on behalf of your covered dependents will not be included. Benefits will not be reduced by a general level increase of Social Security benefits during the period you receive Short-Term Disability Benefits. These benefits, combined from all other sources for the same total disability, will not exceed the percentage rate stated in the Schedule of Benefits of your basic salary.

Period of Disability

If you are totally disabled due to more than one bodily injury or sickness at one time, you are eligible to receive only one Short-Term Disability Benefit.

Total disability due to the same cause or causes will be considered the same period of total disability unless you return to your regular occupation for more than two weeks. If you become totally disabled due to a cause(s) unrelated to the prior totally disability, you are eligible for a separate maximum period of disability provided you return to your regular occupation for one full day. You must complete a separate elimination period for each separate period of total disability.

Continuation

Short-Term Disability Benefits will continue up the maximum benefit period if your coverage under the Plan terminates for any reason and total disability began before such termination date.

Limitations

Short-Term Disability Benefits do **not** cover any disability due to:

(a) Bodily injury or sickness for which you are not under the regular care of a physician.

(b) Bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which:

  (1) benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law; or

  (2) coverage was available under any Worker's Compensation or Occupational Disease Act or Law regardless of whether such coverage actually was applied for.

(c) Intentionally self-inflicted bodily injury or self-induced sickness.

(d) Bodily injury or sickness which arises from war or any act of war.

(e) Cosmetic surgery or plastic surgery, unless otherwise specifically stated or for reconstructive surgery (incidental to or following surgery) due to:

  (1) bodily injury, provided expense is incurred within 90 days of the date of the accident; or

  (2) sickness caused by infection or disease of the involved part, provided expense is incurred within 90 days of the date the sickness began.

(f) Commission or attempt to commit a civil or criminal battery or felony.

(g) Bodily injury or sickness for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage.

(h) Accidental bodily injury or sickness for which you have a blood, breath, or urine alcohol or substance concentration equal to or in excess of the state's legal limits where the accident occurs or 0.08%, whichever is less.

TERM LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Term Life Insurance Benefits and Accidental Death and Dismemberment Benefits are not payable under the reduced cost option as stated in the Schedule of Benefits.

Term Life Insurance Benefits and Accidental Death and Dismemberment Benefits are insured by Anthem Life Insurance Company under policy number 000KQR834 and are described in the enclosed certificate of coverage. If there are any inconsistencies between this document and the insurance policy, the terms of the insurance policy will govern.

In addition, there is a new program available to participants covered by the Anthem Life Insurance policy called "Resource Advisor." Please note that Resource Advisor is available only to active participants, not to retirees. You can call 1-888-209-7840 to talk to a Resource Advisor who can: give you advice and arrange for up to three visits with a counselor if you need it; put you in touch with a financial advisor if you have money problems; or connect you with a lawyer if you need legal help. This program also offers services to help with identity theft as well as beneficiary services to your loved ones for extra support after you are gone. Plus there is online help available to you at: ResourceAdvisor.Anthem.com.

DOLLAR BANK REIMBURSEMENT PROGRAM

You have the option of requesting reimbursement for certain out-of-pocket medical care expenses for qualifying medical expenses to be paid with "pre-tax" dollars from your dollar bank.

Any expense that is considered “medical care” under Section 213(d) of the Internal Revenue Code is eligible for reimbursement, unless it is specifically listed as excluded by the Dollar Bank Reimbursement Program. “Medical care” means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. You cannot be reimbursed for any medical expenses that you incurred before the Dollar Bank Reimbursement Program was established or before you became a participant in the Dollar Bank Reimbursement Program. Qualifying medical expenses eligible for reimbursement include, but are not limited to, the following:

(a) medical and prescription drug expenses that are covered by other provisions of the Plan, but which were applied to your deductible and coinsurance;

(b) over-the-counter drugs and medicines that are for treatment of a medical condition (not only for general well-being) upon a physician’s written prescription (except insulin does not require a prescription);

(c) dental expenses, including orthodontics;

(d) eye examinations, glasses, or contact lenses;

(e) LASIK eye surgery;

(f) hearing examinations and hearing aids;

(g) vaccinations;

(h) acupuncture; and

(i) wheelchairs.

Ineligible medical expenses include, but are not limited to: teeth whitening; cosmetic surgery; and vitamins, fitness programs, weight loss programs, and exercise equipment, unless prescribed by a physician as medically necessary. Expenses for: long-term care or long-term care insurance premiums, and individual insurance premiums for health care coverage while an active employee are not eligible for reimbursement under the Dollar Bank Reimbursement Program. Please refer to IRS Publication 502 (www.irs.gov/pub/irs-pdf/p502.pdf) for additional details on what the IRS considers medical care while keeping in mind the specific exclusions under the Dollar Bank Reimbursement Program.

In addition to out-of-pocket medical expenses, the Dollar Bank Reimbursement Program also may reimburse certain qualifying premium expenses including: self-payments or COBRA continuation coverage under the Plan if the premiums are paid by you on an after-tax basis; COBRA coverage under a spouse's plan if the premiums are paid by the spouse on an after-tax basis; for retired employees and dependents of retired employees or deceased employees only, premiums for individual and supplemental health and accident policies, including Medicare Part B and Part D premiums; insurance for the replacement of glasses and contact lenses. No reimbursements are allowed for any premiums that are paid or could be paid under a cafeteria plan arrangement on a pre-tax basis. In addition, no reimbursements are allowed for disability insurance, fixed indemnity cancer insurance, or hospital indemnity insurance.

Amounts eligible for reimbursement only will be those amounts: which you or your dependent are required to pay; which are not payable under the regular medical benefits provided by this Plan or by any other insurance or group health benefits available to you or your dependent; for which you or your dependent have not previously taken a tax deduction; and are not expenses for long-term care services. For example, if your spouse has health benefit coverage, the amount paid by your spouse's coverage is not eligible for reimbursement. You will be required to submit the Explanation of Benefits (EOB) from your spouse's health plan, so be sure to save the EOBs for charges incurred. The total combined reimbursement for all benefit/insurance plans when added to the amount of the dollar bank reimbursement cannot exceed 100% of the billed amount. If your spouse has a health flexible spending account or a health reimbursement arrangement through his or her employer

which also reimburses uninsured medical expenses, you cannot, under IRS rules, be reimbursed for the same expense from both your and your spouse's account. Also, you first should submit the expense for reimbursement to the Dollar Bank Reimbursement Program before submitting it to your spouse's health flexible spending account. If you misuse the policy and, as a result, receive reimbursement for more than 100% of the billed amount, you will be solely responsible for any tax or other regulatory penalty assessed as a result of your action.

You must submit your reimbursement request to the Fund Office with a properly completed request form. You can obtain the form by contacting the Fund Office. You also must include a copy of the itemized bill when applicable. Any reimbursement request for a covered person with other health care coverage, regardless of whether the other coverage is primary or secondary, must be accompanied by an Explanation of Benefits (EOB) from the other health care plan. For over-the-counter medications, your physician's prescription (except for insulin) must be included when you submit your reimbursement request form. "Prescription" for over-the-counter medications means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state where the medical expense is incurred and is written by an individual who is legally authorized to issue a prescription in that state.

You have the option of authorizing automatic reimbursement of deductibles and coinsurance amounts from your General Reimbursement Account when the Fund Office possesses sufficient substantiation for the expense. You may request an election form from the Fund Office if you wish to use the automatic reimbursement option.

If there is any question as to whether an expense for which you are requesting reimbursement is allowable, or if medical necessity or any other documentation is required, you are solely responsible for obtaining the necessary substantiation or documentation, including any expense associated with obtaining such substantiation or documentation.

You may request reimbursement for expenses eligible under the Dollar Bank Reimbursement Program on a monthly basis (or more

frequently as may be permitted by the Trustees), according to a schedule of which you are notified by separate Notice. Expenses must be submitted so that they are received no later than the last day of the calendar year following the year in which the expenses are incurred.

Upon receipt of a properly completed reimbursement request, the Plan will issue you a reimbursement check and will deduct the amount of the reimbursement from your dollar bank. If there is an insufficient amount in your dollar bank to cover the reimbursement request, it is your responsibility to resubmit the balance during the next quarter if you then have a sufficient balance in your dollar bank.

If a claim for reimbursement is denied, you will be notified of the denial and your right to appeal the denial within certain time limits under the claims procedures for the Plan. If you become ineligible for coverage under the Plan, you will be notified of your COBRA continuation rights for the Dollar Bank Reimbursement Program.

The Dollar Bank Reimbursement Program is intended to meet certain requirements of federal tax law under which the reimbursements you receive from your dollar bank generally are not taxable to you. However, the Plan cannot guarantee the tax treatment to any given participant since individual circumstances may produce a different tax result. You should consult a tax advisor if you have any questions about the possible taxation of any benefits.

For Class A, your individual account will consist of two subaccounts: a General Reimbursement Account for the reimbursement of qualifying medical expenses and, in certain circumstances, qualifying premium expenses, while an employee and a Post-Retirement Reimbursement Account for the reimbursement of qualifying medical expenses and certain qualifying premium expenses while retired. Assets in excess of $1,800.00 in your dollar bank will be considered the General Reimbursement Account (previously referred to as the individual account) and it will be designated for the reimbursement of your current out-of-pocket medical care expenses. An employee with a positive balance in his/her General Reimbursement Account may access amounts in the General Reimbursement Account for the reimbursement of qualifying medical expenses while an employee. A retired employee may access amounts in the General Reimbursement Account for the

reimbursement of qualifying medical expenses and qualifying premium expenses. The first $1,800.00 in your dollar bank is available solely to purchase monthly Plan eligibility as described on pages 16 and 17 and assets will be transferred monthly from the General Reimbursement Account to the dollar bank to the extent necessary to maintain the $1,800.00 balance in the dollar bank.

The Post-Retirement Account is designated for the reimbursement of eligible expenses solely after your retirement. It will be funded with employer contributions specified in the collective bargaining agreement as a post-retirement contribution. The accounts are subject to the following forfeiture rules:

(a) If you die, the entire balance of your General Reimbursement Account and your Post-Retirement Reimbursement Account immediately becomes available to your spouse and/or other dependents for the reimbursement of qualifying medical expenses or qualifying premium expenses. In no event will the amounts in the Post-Retirement Reimbursement Account be paid in cash to any person for other than reimbursement of an eligible expense. For example, there are no lump sum distributions of your account balance as a death or termination benefit. The balance will be forfeited if you have no spouse or other dependents.

(b) Your General Reimbursement and Post-Retirement Reimbursement Account are subject to the forfeiture provisions of the dollar bank previously stated on pages 17 and 18.

Opt Out of Dollar Bank Reimbursement Program

To comply with guidance from the Internal Revenue Service under the Affordable Care Act, you will be given the opportunity to opt out of the Dollar Bank Reimbursement Program and waive all future reimbursements annually. If you elect to opt out of the Dollar Bank Reimbursement Program to receive a premium subsidy for coverage in the Health Insurance Marketplace (the “Exchange”), any amounts remaining in your dollar bank will be forfeited and will not be reinstated if you subsequently choose to reenroll in the Dollar Bank Reimbursement Program. Contributions under the Program are not available in cash upon opt out.

Additionally, you will be given a one-time only opportunity to opt out of the Dollar Bank Reimbursement Program when you lose eligibility under the Plan and when you retire. Your dependents will be given an opportunity to opt out upon your death.

DOLLAR BANK TRANSFERS

You may voluntarily transfer a portion of your individual account credits to the account of another eligible employee, provided all of the following conditions are satisfied:

(a) At the time of the transfer, the employee receiving the credits must have lost eligibility as a result of a catastrophic illness and have insufficient individual account credits to continue eligibility. An employee who has lost eligibility because his or her employer discontinues participation in the Fund is not eligible for an individual account transfer. For the purposes of this provision, catastrophic illness is defined as a bodily injury or illness that Trustees or their delegate determine, in their discretion, incapacitates the employee and creates a financial hardship, or a bodily injury or illness that incapacitates the dependent of the employee if it results in the employee being required to terminate employment or reduce his/her hours of employment for an extended period of time to care for the dependent. The employee will be required to submit medical proof or other documentation requested by Trustees to evidence the catastrophic illness.

(b) The eligible employee transferring individual account credits only can transfer one month's eligibility from his/her account at a time.

(c) The employee transferring individual account credits must sign a form acceptable to Trustees waiving all rights and claims arising out of the transfer of credits from his/her individual account and confirming that he/she has not received, and will not receive, any consideration for the transfer from any party (such as, but not limited to, money or payments of any other kind).

(d) The employee receiving the transfer may receive no more than the value of one month's eligibility each month from all sources.

(e) The employee transferring individual account credits must have a minimum of two months eligibility remaining after the transfer.

If you are interested in transferring individual credits to another eligible employee who is in danger of losing eligibility due to a

catastrophic illness, please call the Fund Office to request the necessary form.

In addition, the Fund's Trust Agreement permits the Trustees in their discretion to enter into dollar bank transfer agreements with other health and welfare plans that maintain a dollar bank program and that are jointly sponsored by an affiliated local union. You should contact the Fund Office if you are interested in pursuing such a transfer.

GENERAL PROVISIONS

COORDINATION OF BENEFITS (COB)

Benefits Subject to this Provision

Benefits described in this Plan are coordinated with benefits provided by other plans for which you also are covered. This is to prevent the problem of overinsurance and a resulting increase in the cost of health care coverage.

Effect on Benefits

Benefits will be reduced under certain circumstances when you are covered both under this Plan, as described, and other plans, defined as follows, which provide similar benefits. Reimbursement will not exceed 100% of the total allowable expenses incurred under this Plan and any other plans included under this provision.

Definitions

For this purpose a plan is one which covers medical, prescription drug, dental, or vision expenses and provides benefits or services by group, blanket or franchise insurance coverage or any hospital or medical service plan or other prepayment coverage including group practice, group Blue Cross, group Blue Shield, or other group prepayment coverage or group service plans. This includes group-type contracts not available to the general public obtained and maintained only because of the covered person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage arranged through the following:

(a) labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans and professional association plans;

(b) any other employee welfare benefit plans as defined by the Employee Retirement Income Security Act of 1974, as amended;

(c) any coverage provided by a health maintenance type of organization;

(d) Medicare or other governmental programs, and any coverage required or provided by any statute (a "plan" will not include a state plan under Medicaid or a governmental plan which by law provides benefits that are in excess of those of any private or other non-governmental plan); and

(e) automobile reparation (no-fault) insurance required under any applicable law and provided through arrangements other than a court decree establishing financial responsibility for medical expenses, but only to the extent of benefits required under such no-fault insurance law.

The term "plan" will be construed separately for each plan, and also between that part of any plan which applies anti-duplication provisions and that part which does not.

How Coordination of Benefits Works

One of the plans involved will pay the benefits first. This is called the primary plan. The other plans then will make up the difference, up to the total allowable expense. These plans are called secondary plans.

Allowable expense means any necessary, reasonable, and customary item of expense, a portion of which is covered under one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered and each supply furnished will be both an allowable expense and a benefit paid. No plan will pay more than it would have paid without this provision. Benefits payable under another plan include the benefits that would have been payable even if no claim actually was filed with the other plan.

Order of Benefit Determination

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, the eligible employee must report such duplicate group health care coverage on the claim form which is submitted to secure reimbursement of allowable expenses incurred. This Plan has established the

following rules to decide which group plan will calculate and pay its benefits first.

(a) If a patient is eligible as an active or retired employee in one plan and as a dependent in another, the plan covering the patient as an employee will determine its benefits first. Notwithstanding anything herein to the contrary, if the covered person also is a Medicare beneficiary and, as a result of the rule established by the Title XVIII of the Social Security Act and implementing regulations, Medicare is:

    (1) secondary to the plan covering the covered person as a dependent; and

    (2) primary to the plan covering the covered person other than as a dependent (e.g., a retired employee);

    then the benefits of the plan covering the covered person as a dependent are determined before those of the plan covering the covered person as other than a dependent.

(b) If a patient is eligible as a dependent child in two plans, the plan covering the patient as the dependent of that parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will determine its benefits first.

(c) When parents are divorced or separated, the order of benefit determination is:

    (1) The plan of the parent who has primary physical placement pays first.

    (2) If the parent having primary physical placement has remarried, the order is:

        (i) the plan of the parent having primary physical placement;

        (ii) the plan of the spouse of the parent having primary physical placement;

        (iii) the plan of the parent not having primary physical placement; then

(iv) the plan of the spouse of the parent not having primary physical placement.

However, when a Qualified Medical Child Support Order names and directs one of the parents to be responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses OR if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent (and the entities obligated to pay or provide the benefits of the respective parent's plans have actual knowledge of those terms), benefits for the dependent child will be determined according to the prior subsection (b).

(d) If rules (a), (b), and (c) do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan that has covered the patient for a shorter time.

There is one exception to this rule: A plan that covers a person other than as a laid-off or retired employee, or a dependent of such person, will determine its benefits first, even if it has covered the eligible person for the shorter time.

In addition, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan which covers the person as an employee will be determined before the benefits under the continuation coverage.

Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy.

Nonrecognition of Benefit Limitations

(a) Benefit Limit Clauses. If the other group plan, which is sponsored, maintained, or contributed to by a covered person's employer, contains a provision which:

(1) modifies, limits, or reduces its benefits for the covered person due to coverage under another plan; or

(2) has the effect of either: shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan; or avoiding the customary operation of this Plan's coordination of benefit rules;

this Plan will consider such a provision to have no force or effect. This Plan will coordinate the benefits payable under this Plan with the benefits which would have been payable under the other group plan if such a provision had not existed.

(b) Eligibility Exclusion Clauses. If the other group plan, which is sponsored, maintained, or contributed to by a covered person's employer, contains a provision which:

(1) excludes the covered person from eligibility under the other group plan due to coverage under another plan; or

(2) has the effect of either: shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan; or avoiding the customary operation of this Plan's coordination of benefit rules;

this Plan will consider such a provision to have no force or effect. This Plan will coordinate the benefits payable under this Plan with the benefits which would have been payable under the other group plan if such a provision had not existed.

MEDICARE BENEFITS PROVISIONS

Covered persons who are retired or disabled are required to enroll in Part A and Part B of Title XVIII of the Social Security Amendments of 1965 (Medicare Benefits) in the event they become entitled to such coverage by reason of attained age, qualifying disability, or End Stage Renal Disease (ESRD). A retired participant must notify the

Fund Office when he or she becomes eligible to enroll in Medicare. Retirees also will become eligible for Medicare Prescription Drug Benefits. Unlike Medicare Benefits, retirees are not required to enroll for Medicare Prescription Drug Benefits. If the retiree does not enroll in Medicare Prescription Drug Benefits, the retiree will continue eligibility to receive the Plan's prescription drug benefits, provided he/she is otherwise eligible for Class D benefits. If the retiree or dependent of a retiree does enroll in Medicare Prescription Drug Benefits, the Plan will provide no prescription drug benefits for that person. However, if that person later drops or terminates coverage for Medicare Prescription Drug Benefits, his/her prescription drug benefits under the Plan will be reinstated, provided he/she maintained continuous coverage under the Plan.

In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits, nor will the combined amounts payable by Medicare and the Plan exceed the eligible expenses incurred by the covered person as the result of any one bodily injury or sickness. For the purpose of this section, benefits payable by Medicare include those which would have been payable if the covered person had properly enrolled when eligible to do so.

For covered persons for whom Medicare Benefits are the primary source of coverage, the benefits payable under this Plan for services incurred at a Veterans Administration (VA) facility for non-service-connected disabilities, will be reduced by the amount that would have been payable by the Medicare Benefits had the services been rendered by a Medicare-approved facility.

For covered persons for whom Medicare Benefits are the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare Benefits, but which are privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by the Medicare Benefits.

For covered persons for whom Medicare Benefits are the primary source of coverage and who have enrolled in a Medicare Advantage plan: the benefits payable under this Plan for services otherwise covered by Medicare Benefits, but which are not covered under the Medicare Advantage plan because the covered person did not obtain services at a network provider and/or did not comply with that plan's managed care requirements, will be limited to the amount that would

have been payable by the Plan had the services been payable by the Medicare Benefits.

To facilitate Plan payments in the absence of Medicare Benefits payments, it may be necessary for the Trustees to estimate Medicare Benefits payments.

Neither the covered person nor the Plan will be responsible for paying any charges which exceed legal limits set by the Medicare Physician Payment Reform Act which limits the amount that physicians can bill Medicare patients above the Medicare Benefits allowance for a particular procedure or service, unless services are privately contracted.

(a) Persons Initially Entitled to Medicare Benefits by Reason of Attained Age or Qualifying Disability (Other than ESRD) and Eligible Under the Plan Through Self-Payments

In the event a person eligible under the Plan solely because of self-payments becomes initially entitled to Medicare Benefits due to attained age or a qualifying disability (other than ESRD), benefits payable under this Plan will be reduced by the amount of benefits paid or payable by Medicare Benefits.

In the event such person subsequently becomes entitled to Medicare Benefits due to ESRD, Medicare Benefits will continue to be the primary source of coverage.

(b) Persons Initially Entitled to Medicare Benefits by Reason of Attained Age or Qualifying Disability (Other than ESRD) and Eligible Under the Plan Through Employer Contributions

Plan benefits will not be reduced for persons eligible through employer contributions even though they also may become initially entitled to Medicare Benefits due to attained age or a qualifying disability (other than ESRD).

In the event such person subsequently becomes entitled to Medicare Benefits due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period specified in the following subsection (c).

However, an employee or dependent spouse eligible through employer contributions who becomes initially entitled to Medicare Benefits due to attained age will have the right to reject the Plan and retain Medicare Benefits as their primary source of coverage. In such case, the Plan is legally prohibited from supplementing Medicare Benefits coverage.

(c) Persons Initially Entitled to Medicare Benefits by Reason of ESRD and Eligible Under the Plan Through Either Self-Payments or Employer Contributions

In the event a covered person becomes initially entitled to Medicare Benefits because of ESRD (or when ESRD-based Medicare Benefits entitlement occurs simultaneously with attained age or other qualifying disability-based entitlement), benefits will be provided subject to the following terms. The same terms apply in the event a covered person becomes initially entitled to Medicare Benefits due to ESRD and subsequently becomes entitled to Medicare Benefits due to attained age or another qualifying disability.

(1) The Plan will be the primary source of coverage for covered charges incurred for up to 30 consecutive months from the date of ESRD-based Medicare Benefits entitlement.

(2) Benefits payable under the Plan beginning with the 31st month of ESRD-based Medicare Benefits entitlement will be reduced by the amount of benefits paid or payable by Medicare Benefits.

SUBROGATION AND REIMBURSEMENT

(a) **Fund's Rights to Subrogation and Reimbursement.** The Fund will be entitled to subrogation or reimbursement with regard to all rights of recovery of a covered person or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the covered person (collectively, for purposes of this Section, "Individual"), to the extent of any amounts which the Fund has paid or may become obligated to pay on account of any claim against any person, organization, or other entity in connection with the bodily injury,

sickness, accident or condition, including accidental death and dismemberment, to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility and any employer of the Individual under the provisions of a Worker's Compensation or Occupational Disease Law, and an individual policy of insurance maintained by the Individual, which also may include uninsured and/or underinsured insurance coverages. The Fund also will be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment, or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights will apply on a priority, first dollar basis to any recovery whether by suit, settlement, or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and will apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. Once the Fund makes or is obligated to make payments on behalf of an Individual on account of the claim, the Fund is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the Individual from any Source.

(b) **Action Required of Individual.** If requested in writing by the Trustees, the Individual will take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Fund from any Source and will hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Fund to be paid to the Fund immediately upon recovery thereof. The Individual will not do anything to impair, release, discharge, or prejudice the rights referred to in this Section. The Individual will assist and cooperate with representatives designated by the Fund to recover payments made by the Fund and will do everything that may be necessary to enable the Fund to exercise its subrogation and reimbursement rights described herein.

The completion and/or execution of any documents requested by the Fund will be a condition to receiving Benefits. If information requested by the Fund is not provided, the Fund will withhold future Benefit payments pending receipt of all requested information.

The Trustees also may require the Individual to execute a Subrogation and Reimbursement Agreement (“Agreement”), in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Fund’s request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may suspend all benefit payments. However, in its sole discretion, if the Fund advances claims in the absence of an Agreement, or if the Fund advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund’s rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person’s parent, the Individual (in the case of a minor dependent child), the Individual’s spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Fund. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Individual agrees that out of any Source, as described in the prior subsection (a), the identified amount that the Fund has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Fund’s benefit and that the Fund will have an equitable lien by agreement which will be enforceable if necessary under legal, equitable, and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Fund’s subrogation and reimbursement rights will apply regardless whether the Individual executes an Agreement.

(c) **Enforcement of Rights.** The Fund has the right to recover amounts representing the Fund’s subrogation and reimbursement interests under this Section through any appropriate legal or equitable remedy including, but not limited to, the initiation of a recognized cause of action under ERISA section 502(a)(3) (including injunctive action to ensure the claim amounts that the Fund has advanced are preserved and not disbursed) or applicable federal or state law, the imposition of a

constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment, or otherwise. The Fund's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Further, in the event an Individual receives monies as the result of a bodily injury, sickness, accident or condition and the Fund is entitled to such monies in accordance with this Section and is not reimbursed the amount it has paid for such bodily injury, sickness, accident or condition, the Fund will have the right to reduce future payments due to such Individual or the employee of whom such Individual is a dependent or any other dependent of such employee by the amount of benefits paid by the Fund. The right of offset however, will not limit the rights of the Fund to recover such monies in any other manner described in this Section.

The Individual or the Fund may make a claim against a Source or commence an action against a Source and join the other as provided under Section 803.03 of the Wisconsin Statutes or applicable state or federal law.

(d) **Individual's Attorney's Fees.** The Fund's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual will be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying bodily injury, sickness, accident or condition, and the Fund's recovery will not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Fund's claim by an agreed upon amount of such fees or expenses.

(e) **Disavowal of Common Law Defenses.** The Fund specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Fund will have a priority, first dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such bodily injury, sickness, accident or condition.

In the event an Individual makes a recovery in a claim from any party and the proceeds are not allocated according to the prior paragraphs, the Trustees will have the right to take a credit on future Fund obligations to the Individual to the extent of such recovery. This credit will not be limited to future obligations of the Fund to the actual recipient of such recovery but also may be taken against any future obligations to the covered employee or any of his/her dependents.

RIGHT OF RECOVERY

Whenever the Plan has made unauthorized payments or payments in excess of the maximum amount applicable at that time (overpayments), the Trustees have the right to recover such unauthorized or overpayments from one or more of the following sources:

(a) any persons to or for whom such payments were made, including by making deductions from benefits which may be payable to or on behalf of a covered person in the future;

(b) any insurance companies; or

(c) any other organizations.

TERMINATION OF PLAN

This Plan may be terminated:

(a) in its entirety--by Trustee action and when the Trustees determine that the Trust Fund is inadequate to carry out the intent and purpose of the Trust Agreement or is inadequate to meet the payments due or to become due employees and/or dependents under the Trust Agreement or under the Plan Document;

(b) as to employees (and their dependents) in a particular collective bargaining unit--by agreement of the Union and Employer Association (or individual employers, where applicable) which negotiate the labor agreements covering such collective bargaining units;

(c) for a particular employer and his/her non-bargaining unit or alumni employees--when the Trustees determine that an employer, signatory to a participation agreement to cover non-bargaining unit or alumni employees, no longer meets the requirements of such participation agreement and related policies; or

(d) at any other time permitted by the Trust Agreement.

Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of the participating employees and their dependents covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

PROHIBITION AGAINST ASSIGNMENT TO PROVIDERS

You, as a covered person, participant, or beneficiary, may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies, except as specifically stated. The prohibition against assignment of such rights includes, but is not limited to, the right to:

(a) receive benefits;

(b) claim benefits in accordance with Plan procedures and/or federal law;

(c) commence legal action against the Plan, Trustees, Fund, its agents, or employees;

(d) request Plan documents or other instruments under which the Plan is established or operated;

(e) request any other information that a participant or beneficiary as defined in Section 102 of ERISA may be entitled to receive upon written request to a Plan Administrator; and

(f) any and all other rights afforded a covered person, participant, or beneficiary under the Plan, Restated Trust Agreement, federal law, and state law.

However, a covered person, participant, or beneficiary may assign appeal rights to a provider of services or supplies, provided the appropriate authorization agreement is completed.

This provision does not have the effect of prohibiting the Administrative Manager or the Trustees from mailing payment of benefits under the Plan directly to a provider of services or supplies.

GENERAL INFORMATION

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

Time Limit on Certain Defenses

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

Clerical Error, Misstatement of Age or Gender

If it is determined that information about you or your dependents was omitted or misstated in error, the amount of coverage for which you are properly eligible will be in effect. An equitable contribution adjustment will be made. This provision applies equally to you and to

the Plan. If the error was determined after six months from the effective date of your coverage, no adjustment will be made.

Worker's Compensation Not Affected

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by, any Worker's Compensation or Occupational Disease Act or Law.

Physical Examination

The Plan, at its own expense, has the right to have you examined as often as the Plan deems reasonably necessary.

Legal Actions

You must exhaust all levels of the claim appeal procedure before you may bring an action at law or equity, unless the Plan fails to follow such procedures. You must bring legal action within 12 months of the Plan's written adverse benefit determination on appeal.

Assignment

Assignment of benefits may be made only with the Fund Office's consent, except as may be required by applicable law. An assignment is not binding until the Fund Office receives and acknowledges in writing the original or copy of the assignment before payment of the benefit. The Fund Office does not guarantee the legal validity or effect of such assignment. The Plan will treat any document attempting to assign a covered person's rights, or to alienate a claim for benefits to a provider, as an authorization for direct payment by the Plan to the provider. In the event that the Plan receives a document claiming to be an assignment of benefits on behalf of a provider, the Plan may send payments for the claims to the provider, but will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to the covered person. Notwithstanding the preceding, the Trustees reserve the right to make payments directly to the covered person without regard to an authorization or assignment executed by a covered person directing payment to the provider. If the Trustees take such actions, then all purported payment assignments to a provider will be null and void, and unenforceable.

Worker's Compensation

The Plan contains a limitation which states that if you are eligible to receive Worker's Compensation benefits for a bodily injury or sickness sustained in the course of any occupation or employment, no benefits are payable under the Plan.

However, if benefits are paid by the Plan and it determines you received Worker's Compensation for the same incident, the Plan has the right to recover as described under the recovery rights provision. The Plan will exercise its right to recover against you.

The Plan reserves its right to exercise the recovery rights even though:

(a) the Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;

(b) no final determination is made that bodily injury or sickness was sustained in the course of or resulted from your employment;

(c) the amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or

(d) the medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify the Fund Office of any Worker's Compensation claim you make, and that you agree to reimburse the Plan as described previously.

Medicaid

This Plan will not take into account the fact that an employee or dependent is eligible for medical assistance Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment otherwise would be due under this Plan, payment of benefits under this Plan will be made in accordance

with a state law which provides that the state has acquired the rights with respect to a covered employee to the benefits payment.

Use of Personal Pronoun

The masculine personal pronoun is used solely as a grammatical convenience. It includes the feminine where appropriate. Similarly, the singular personal pronoun includes the plural.

Genetic Information Nondiscrimination Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act of 2008 (GINA). GINA relates to genetic nondiscrimination in health insurance and group health plans as well as employment. GINA prohibits a group health plan from:

(a) adjusting premium or contribution amounts for a group on the basis of genetic information;

(b) requesting or requiring an individual's family member to undergo a genetic test; and

(c) requesting, requiring, or purchasing genetic information for underwriting purposes or for any individual prior to his or her enrollment in the Plan.

Nondiscrimination Provisions Against Any Health Care Provider Acting Within the Scope of His/Her License or Certification

To the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

SECURITY REGULATIONS

The federal Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security

of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

These regulations work in conjunction with the Medical Data Privacy Regulations. While the Plan always has taken care to secure your health information, the new regulations require the Plan, along with the Administrative Manager, to take some additional steps in addition to those required by the Privacy Regulations, to maintain the electronic, physical, and technical security of your protected health information. The following information outlines the additional steps the Plan has taken to secure your health information in compliance with the HIPAA Security Regulations.

Policies to Protect Electronic Health Information: The Plan, in conjunction with the Administrative Manager, has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI) in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain, or transmit on behalf of the Plan. The Trustees also ensure that there is adequate separation between the information that is received from the Plan and other employment information and discussions and this separation is supported by reasonable and appropriate security measures. They also ensure that any agent, including any subcontractor, to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect this information. The Trustees will report to the Plan any security incident of which they become aware.

Business Associates: The Plan will enter into agreements with other entities known as "Business Associates" to perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical, and technical security of your electronic PHI be maintained.

Access to ePHI for Plan Administrative Functions: The Plan will give access to PHI to the Board of Trustees. Any such disclosures of your electronic PHI to the Trustees are supported by reasonable and appropriate security measures. If any Trustee fails to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance.

If You Have Any Questions: The Administrative Manager (as named on page 148) is largely responsible for maintaining the security of your electronic PHI. If you have any questions regarding the security of your electronic PHI, you may contact the Administrative Manager.

NOTICE OF PRIVACY PRACTICES

The Local 434 Health & Welfare Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

(a) the Plan's uses and disclosures of Protected Health Information (PHI);

(b) your privacy rights with respect to your PHI;

(c) the Plan's duties with respect to your PHI;

(d) your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

(e) the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment, and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment, and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) also may disclose the following to the Plan's Board of Trustees: (a) PHI for purposes related to Plan administration (payment and health care operations);

(b) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (c) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your x-rays from the treating radiologist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review, and preauthorizations).

For example, the Plan may tell a physician whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend, or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of

agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization, or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(a) For treatment, payment, and health care operations.

(b) Enrollment information can be provided to the Trustees.

(c) Summary health information can be provided to the Trustees for the purposes previously designated.

(d) When required by law.

(e) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI also may be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(f) When required by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(g) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative, or criminal

investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(h) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(i) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(j) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(k) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(l) When authorized by, and to the extent necessary, to comply with Worker’s Compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not previously described only will be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it only will be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2
Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set" for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision, and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative then may submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan also will provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (a) to carry out treatment, payment, or health care operations; (b) to individuals about their own PHI; (c) pursuant to your authorization; (d) prior to April 14, 2003; and (e) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Privacy Practices Notice Upon Request

You have the right to obtain a paper copy of this Privacy Practices Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

(a) a power of attorney for health care purposes;

(b) a court order of appointment of the person as the conservator or guardian of the individual; or

(c) an individual who is the parent of an unemancipated minor child generally may act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3
The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice of Privacy Practices is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same

manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan's website, you also will receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan, or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

(a) disclosures to or requests by a health care provider for treatment;

(b) uses or disclosures made to the individual;

(c) disclosures made to the Secretary of the U.S. Department of Health and Human Services;

(d) uses or disclosures that are required by law; and

(e) uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending, or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses, or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official stated on page 145.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Local 434 Health & Welfare Fund
Wilson-McShane Corporation, Fund Administrator
3001 Metro Drive, Suite 500
Bloomington, MN 55425
1-800-535-6373 or (952) 854-0795

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

ERISA INFORMATION
(Employee Retirement Income Security Act of 1974)

PLAN DESCRIPTION INFORMATION

(a) Name of Plan: Local 434 Health & Welfare Fund
(Plumbers, Pipefitters, Refrigeration Workers Service Techs Local 434 Health and Welfare Trust)

(b) Plan Administrator and Named Fiduciary:

Board of Trustees of the
Local 434 Health & Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Telephone: 1-800-535-6373 or
(952) 854-0795

(c) Plan Identification Numbers

The Employer Identification Number (EIN) is: 39-1856935. The Plan Number (PN) is 501.

(d) Fiscal Year of the Plan

The Plan's fiscal year begins on June 1 and ends on May 31.

(e) Agent for Service of Legal Process:

Terry Hayden
Plumbers & Steamfitters Local 434
2406 Ridge Road
Eau Claire, WI 54701
Telephone: (715) 832-1014

(f) Names and Addresses of the Trustees

Union Trustees

Todd Bencke
Plumbers & Steamfitters
Local 434
912 North View Drive
Mosinee, WI 54455

Russ Boos
Plumbers & Steamfitters
Local 434
2406 Ridge Road
Eau Claire, WI 54701

Greg Erickson
Plumbers & Steamfitters
Local 434
2417 South 16th Street
La Crosse, WI 54601

Terry Hayden
Plumbers & Steamfitters
Local 434
2406 Ridge Road
Eau Claire, WI 54701

Christopher Ignatowski
7836 Puff Creek Boulevard
Arpin, WI 54410

Mitch Runge
Plumbers & Steamfitters
Local 434
912 North View Drive
Mosinee, WI 54455

Employer Trustees

Mark Dahms
Halverson Brothers
1020 North Broadway Street
Menomonie, WI 54751

Charles Falch
Bartingale Mechanical, Inc.
P.O. Box 1027
Eau Claire, WI 54702-1027

Jeff Gaecke
Mechanical Contractors
Association of NW WI
3315 North Ballard Road,
Suite D
Appleton, WI 54911-8499

Gail Gerhardt
Mechanical Contractors
Association of NW WI
3315 North Ballard Road,
Suite D
Appleton, WI 54911-8499

Ray Withbroe
Tweet/Garot Mechanical, Inc.
2545 Larsen Road
Green Bay, WI 54307-1767

You also may contact the Board of Trustees at the address and telephone number stated on page 146.

(g) Parties to the Collective Bargaining Agreement

Local 434 Plumbers - Steamfitters - Refrigeration Workers and Service Technicians and participating contractors.

Participants may obtain, upon written request to the Administrative Manager, information as to the address of a particular employer and whether that employer is required to pay contributions to the Plan.

The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time. It is provided, however, that the foregoing will not modify the provisions of any collective bargaining agreement which may be made by the employer with the bargaining representative of any employees. A copy of the collective bargaining agreement will be made available by the employer for review, upon written request.

(h) Plan Sponsor

The Plan Sponsor is the Board of Trustees of the Local 434 Health & Welfare Fund. This Fund is maintained by several employers and one or more employee organizations, and is administered by a Joint Board of Trustees. A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Administrative Manager, and is available for examination by participants and beneficiaries at the Fund Office.

(i) Type of Plan Administration

The Fund Administrative Manager is responsible for performing certain delegated administrative duties, including the processing of claims. The Fund Administrative Manager is:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Plan benefits are provided under the terms of the Plan Document and under a group policy purchased from an insurance company selected by the Trustees: Anthem Life Insurance Company.

(j) Sources of Trust Fund Income

The Plan's contributions are paid by the employer with the exception of certain self-payments set forth in this SPD. Benefits under the Plan are provided through the Trust Fund of the Local 434 Health & Welfare Fund.

(k) The Plan Can Be Changed

The Plan benefits and/or self-pay contributions may be modified or amended from time to time, or may be terminated by the Plan Administrator. Any changes to the Plan or termination of the Plan will be communicated to participants of the Plan immediately.

(l) Type of Plan

The Plan is a self-funded group health and welfare plan established pursuant to ERISA. It is maintained for the exclusive benefit of the employees and provides medical, vision, dental, prescription drug, family assistance program, short-term disability, life, and accidental death and dismemberment benefits for participating employees and their enrolled dependents. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Affordable Care Act, and other laws applicable to health and welfare plans.

(m) Method of Funding Benefits

All Plan benefits except Life Insurance Benefits and Accidental Death and Dismemberment Benefits for Classes A, C, and D are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan. Self-funded benefits payable are limited to Fund assets available for such purposes.

Benefits for Life Insurance for Classes A, C, and D as described on page 107 and Accidental Death and Dismemberment Benefits for Classes A, C, and D (employees only) as described on page 107, are provided subject to Group Policy No. 000KQR834 through Anthem Life Insurance Company, P.O. Box 182361, Columbus, OH 43218-2361. Benefits eligible under the Life Insurance and Accidental Death and Dismemberment policy are submitted to the Fund Office and paid by Anthem Life directly to you, if living, otherwise to your beneficiary.

(n) Procedures To Be Followed in Presenting Claims for Benefits Under the Plan

The procedures for filing for benefits are described on page 49.

If a participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are found on pages 156 through 164.

(o) Authority and Discretion of Trustees

Under the Plan and the Trust Agreement, the Trustees have broad discretion and sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan, the Trust Agreement and any other regulations, procedures, or administrative rules adopted by the Trustees. Benefits under the Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be given the most deferential standard of review.

STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA.

ERISA sets forth certain minimum standards for the design and operation of privately-sponsored health care plans. The law also spells out certain rights and protections to which you are entitled as a participant.

The Trustees want you to be fully aware of your rights, and for this reason a statement of your rights follows. As a participant in the Local 434 Health & Welfare Fund:

(a) You automatically will receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

(b) If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

(c) Each year you automatically will receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

(d) You may examine, without charge, all documents relating to the operation of this Plan. These documents include: the legal Plan Document, insurance contracts, collective bargaining agreements, participation agreements, and copies of all documents filed by the Plan with the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

    Such documents may be examined by request at the Fund Office (or at other required locations such as worksites or union halls) during normal business hours.

    In order to ensure that your request is handled promptly and that you are given the information you want, the Trustees have adopted certain procedures which you should follow:

(1) Your request should be in writing.

(2) It should specify what materials you wish to look at.

(3) It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any worksite or union location at which 50 or more participants report to work. Allow 10 days for delivery.

(e) You may obtain copies of any Plan document governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Just ask the Fund Office.

(f) You have the right to continue health care coverage for yourself, your 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.

(g) You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

(h) No one including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way or take any action which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

(i) In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim. These procedures appear on pages 156 through 164 of this booklet. These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented in your behalf.

  (1) If your claim for a health care benefit is denied, in whole or in part, you have a right to know why this was done, you will receive a written explanation of the reason(s) for the denial, and you have a right to obtain copies of documents relating to the decision without charge.

  (2) Then, if you still are not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's appeal procedure.

(j) In addition to creating rights for Plan participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as “fiduciaries.” They have the duty to operate your Plan with reasonable care and look out for your best interests as a participant under the Plan and the best interests of other Plan participants and beneficiaries under the Plan. The duties of a fiduciary are complex and are constantly changing as new laws and regulations are adopted applicable to employee benefit plans. Be assured that the Trustees of this Plan will do their best to know what is required of them as “fiduciaries” and to take whatever actions are necessary to ensure full compliance with all state and federal laws.

(k) Under ERISA, you may take certain actions to enforce the rights previously listed.

(1) For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

(i) the request actually was received;

(ii) the material was mailed to the right address; or

(iii) the failure to send the material was not due to circumstances beyond the Trustees' control.

If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

(2) Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

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 if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

However, before exercising this right, you must have exhausted all of the claims procedures (including the external review procedures) provided under the Plan. If you still are not satisfied, then you may wish to seek legal advice.

(3) If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you 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 are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

If you have any questions about your Plan, you should contact the Trustees by writing to:

The Board of Trustees
Local 434 Health & Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Or phone: (952) 854-0795
Call toll-free: 1-800-535-5373

Or, if you have questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Trustees, you may contact the nearest office of the Employee Benefits Security Administration (EBSA) at U.S. Department of Labor listed in your telephone directory or at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You also may find answers to your Plan questions, your rights and responsibilities under ERISA, and a list of EBSA field offices by contacting the EBSA by: calling 1-866-444-3272; sending electronic inquiries to www.askebsa.dol.gov; or visiting the website of the EBSA at www.dol.gov/ebsa/.

INTERNAL CLAIM APPEAL PROCEDURE

For pre-service claims, the Plan will notify you of an adverse benefit determination within 15 days of the date the claim is filed, regardless of whether all necessary information was included with the claim.

If the Plan needs additional time to determine whether an expense is covered, the Plan may take one 15-day extension. The Plan will notify you of the circumstances requiring a delay in the decision and set a date by which you can expect to receive a decision. If, during the review, additional information is required from you, you will be notified within the required time period for notice of a decision detailed previously. You will have at least 45 days to provide such information. After you provide the necessary information or the time period for providing the necessary information expires, the Plan will issue a written notice of the decision.

For post-service claims, the Plan will notify you of an adverse benefit determination within a reasonable period of time, but not later than 30 days of the Plan's receipt of a claim.

If the Plan needs additional time to determine whether a claim is a covered expense for reasons beyond the Plan's control, the Plan may take one 15-day extension. The Plan will notify you prior to the expiration of the initial 30-day notification period, as applicable, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If an extension is needed due to your failure to submit necessary information to decide the claim, the Plan, in the notice of extension, will specifically describe the required information needed. The time period for making the determination is suspended from the date on which the notice of the necessary information is sent to you until the date you respond. You have at least 45 days from receipt of the notice to respond to the request for information. Once you respond, the Plan will decide the claim within the 15-day extension period. Your claim will be denied if you do not respond in a timely manner. The Plan may take only one extension for group health claims and may not further extend the time for making its decision unless you agree to a further extension.

A concurrent care claim is a claim that is reconsidered after the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and the reconsideration results in the reduction or termination of the treatment

(other than by Plan amendment or termination) before the scheduled end of the treatment. If the Plan reduces or terminates treatment before the end of the course of the treatment, the Plan will notify you far enough in advance of the termination or reduction of treatment to allow you to appeal the adverse benefit determination and obtain a determination on review before the termination or reduction takes effect. The Plan must continue to cover you for a concurrent care claim for ongoing treatment pending the outcome of an internal appeal.

For disability claims, the Plan has a reasonable period of time, not in excess of 45 days, to provide written notice of an adverse benefit determination for any claim for disability benefits under the Plan. The Plan may extend the decision-making period for up to an additional 30 days for reasons beyond the Plan's control but the Plan will notify you in writing before the expiration of the 45-day period of the reason for the delay and when the decision will be made. A second 30-day extension is allowable if the Plan still is unable to make the decision for reasons beyond its control. You will be provided, before the expiration of the first 30-day extension period, a notice that details the reasons for the delay and the date as of which the Plan expects to render a decision. If an extension is needed because the Plan needs additional information from you, the extension notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and specify the additional information needed to resolve those issues, in which case you will have 45 days from receipt of the notification to provide the requested information. The Plan will issue its decision within 30 days of the date you submit your information (subject to the 30-day extension previously described). Your claim will be denied if you do not submit the requested information in a timely manner.

Rescission of Coverage: This provision is intended to comply with the provisions of the Patient Protection and Affordable Care Act (“PPACA”) and Health Care and Education Reconciliation Act of 2010 (“HCERA”), collectively, the “Acts”, as further clarified in regulations and other guidance issued by the federal government. The Plan will not rescind health coverage under the Plan with respect to you (including a group to which you belong or family coverage in which you are included) once you are covered under the Plan, unless you (or persons seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud or you make an intentional misrepresentation of material fact as prohibited by the terms of the

Plan. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage for health benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if due to a delay in administrative recordkeeping if you do not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactive to the date of divorce.

The Plan is required to provide at least 30 days advance written notice to each covered person who is affected by a rescinding of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.

Insured Benefits: Please note that for your fully insured life insurance benefits and your accidental death and dismemberment benefits, the claim will be decided by the benefit provider as described in the insurance policy (not the Board of Trustees), in accordance with Section 503 of ERISA and state insurance law. You will be apprised of the initial claims decision within 90 days of the receipt of your claim unless you are notified that a 90-day extension is required for more information within the initial 90-day period. You have 60 days to appeal the initial decision in writing. Your appeal must explain the reasons you disagree and include any supporting documents. You will receive a decision on the appeal within 60 days of its receipt by the benefit provider (or within 120 days if an extension is required). Please call the Fund Office for assistance if you have a claim for an insured benefit.

Notice of Denial of Claim: If your claim for benefits is denied in whole or in part, the Plan will provide you, your dependent, beneficiaries, or authorized or legal representatives, as may be appropriate (hereafter referred to as "you" or "your") with written or electronic notice of adverse benefit determinations within the time

frames previously stated. Notices will include the following information stated in an easily understandable manner:

(a) Information sufficient to identify the claim involved, including date of service; provider; claim amount; denial codes and their respective meanings; description of any standard used in determining the denial; and provision stating that the diagnosis and treatment codes and their corresponding meanings are available upon request.

(b) The specific reason or reasons for the adverse benefit determination.

(c) References to specific Plan provision(s) on which the adverse benefit determination is based.

(d) A description of any additional material or information, if any, necessary for you to perfect your claim and, where appropriate, an explanation of why the material or information is necessary.

(e) A description of the Plan's claim appeal procedure and time limits applicable to such appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review or, for health claims only, pursuant to page 164, to request an external review with an independent review organization after the Plan’s claims procedures have been exhausted.

(f) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such criterion will be provided free of charge to you upon request.

(g) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

(h) If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with your claim, you may request the

identity of the expert, regardless of whether the advice was relied on.

(i) A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you feel that the action taken on your eligibility or claim is incorrect, you immediately should ask the Fund Office to review your claim with you.

In some cases, the Fund Office may request additional information from you which might enable the Fund Office to reevaluate its decision.

If all or part of a claim is denied or if you are otherwise dissatisfied with the determination made by the Plan, or if you have not received the notice of denial of your claim within the applicable time limits after the Plan has received all necessary claim information, you have the right to appeal the decision and request an internal review of the claim. The Plan will provide for a full and fair review of a claim and adverse benefit determination, pursuant to the following:

(a) **You will have 180 days after you receive the notice of an adverse benefit determination of a medical or disability claim to file your appeal in writing to the Fund Office and it must include the specific reasons you feel the denial was improper.**

(b) You will be allowed the opportunity to submit written issues and comments, documents, records, and other information relating to the claim for benefits which may have been requested in the notice of denial or which you may consider desirable or necessary.

(c) You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all designated, pertinent documents, records, and other information relevant to your claim for benefits.

(d) Your review will take into account all comments, documents, records, and other information submitted by you relating to the

claim, whether or not such information was submitted or considered in the initial benefit determination.

(e) The Plan will provide you or your duly authorized representative, free of charge, any new or additional evidence or rationale considered, relied on, or generated in connection with an appeal and allow you to respond. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan’s final adverse benefit determination must be provided.

(f) The Board of Trustees, as an appropriate named fiduciary for the Plan, will be the assigned decision maker on appealed claims, except for claims relating to fully insured benefits. The Plan must ensure that all claims and appeals are adjudicated with the utmost impartiality and avoid conflicts of interest. The claims or appeals adjudicator must be independent from and impartial to the Plan.

(g) The Plan will consult with appropriate health care professionals in deciding appealed claims that are based in whole or in part on medical judgment, including determination of experimental or investigational treatments and medical necessity. Such health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for the appeal of an adverse benefit determination will be someone who was not consulted in the initial adverse benefit determination nor the subordinate of such individual.

(h) If a medical or vocational expert's advice was obtained on behalf of the Plan in connection with your claim, you may request the identity of the expert, regardless of whether the advice was relied on.

(i) The Board of Trustees will review post-service and disability claim appeals at their next regularly scheduled Board of Trustees' meeting (at least quarterly) that follows the receipt of the request for review. However, if the request is filed within 30 days of the date of the meeting, the determination may be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension, the appeal

decision can be pushed back to the third meeting following the appeal request, but the Plan must notify you of this extension and of the special circumstances and the date as of which the determination will be made prior to the extension time. The Plan will provide you with written or electronic notice of an adverse benefit determination as soon as possible but within five days of the decision being made. The notice will include the following information stated in an easily understandable manner:

(1) Information sufficient to identify the claim involved, including date of service; provider; claim amount; denial codes and their respective meanings; description of any standard used in determining the denial; and a provision stating that the diagnosis and treatment codes and their corresponding meanings are available upon request.

(2) The specific reason or reasons for the adverse benefit determination.

(3) A discussion of the decision.

(4) References to specific Plan provision(s) on which the adverse benefit determination is based.

(5) A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(6) A statement of your right to bring a civil action under Section 502(a) of ERISA, or for health claims only, pursuant to this page and page 164, to request an external review with an independent review organization after you have exhausted the Plan's claim appeal procedure.

(7) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such criterion will be provided free of charge to you upon request.

(8) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment of the Plan in applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

(9) A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

You may assign appeal rights to a provider of services or supplies, provided the appropriate authorization agreement is completed.

If the Plan fails to adhere to all claims and claims appeal requirements, you are deemed to have exhausted the claims appeals process and may seek an external review or file a lawsuit, unless the violation was de minimis, non-prejudicial, due to good cause or matters beyond the Plan's control, or in the context of an ongoing, good-faith exchange of information with you, and not reflective of a pattern or practice of non-compliance.

The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner. You will be given maximum opportunity to present your viewpoint on any denied claim. You may not begin any legal action, including proceedings before administrative agencies, until you have followed the procedures and exhausted all levels of the appeal procedure described here. You may, at your own expense, have legal representation at any stage of the appeal procedure. No legal action for any benefits under the Plan may begin later than 12 months after the Plan issues a written adverse benefit determination on appeal. Benefits under this Plan will be paid only if the Board of Trustees (or its Plan Administrator) decides in its discretion that you are entitled to them. The Plan will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Plan Administrator). Such decision will be final and binding on all persons covered by the Plan who are claiming any benefits under the Plan, unless the decision is determined by a court having jurisdiction over the matter to be arbitrary and capricious.

Please remember that no employer or union representative is authorized to interpret the Plan or to act as an agent of the Trustees.

If you have any questions about the claim appeal procedure described here, please contact the Fund Office.

FEDERAL EXTERNAL CLAIMS REVIEW AND APPEAL PROCEDURES

If a health claim is denied on appeal (in whole or in part) or you disagree with the amount of the benefit, you have the right to have the decision on appeal reviewed by requesting an external review from an independent review organization. The Plan offers this right in accordance with and to the extent required by available guidance issued by the Departments of Health and Human Services, and Labor, and the Internal Revenue Service. Requests for review must be in writing and filed with the Fund Office no later than four months after the date you receive the notice of denial on appeal. You may submit copies of evidence supporting the request for review, and state the reasons you disagree with the claim determination. For an external review, the adverse benefit determination or final adverse benefit determination must involve medical judgment or a rescission of coverage. The determination of the decision-maker will be final and binding upon all persons covered by the Plan who are claiming a benefit, unless the decision is determined to be arbitrary and capricious by a court having jurisdiction over such matter.

GENERAL DEFINITIONS

Alumni means persons who once participated in the Plan because of work performed under a collective bargaining agreement requiring contributions to this Fund and who currently perform work which is not covered by such agreement for:

(a) one or more employers that are parties to the collective bargaining agreement requiring contributions to the Fund;

(b) the Fund; or

(c) the Union.

Bargaining Unit Employee means any employee represented by the Union and working for an employer (as defined in the Trust Agreement), and with respect to whose employment an employer is required to make contributions to the Trust Fund.

Bodily Injury means accidental bodily damage, including all related conditions and recurrent symptoms, which require treatment by a physician and which result in loss independently of sickness and all other causes.

Calendar Year means that period commencing at 12:01 a.m. standard time on the date the covered person first becomes eligible and continuing until 12:01 a.m. standard time on the next following January 1st. Each subsequent calendar year will be the period from 12:01 a.m. standard time on January 1st to 12:01 a.m. standard time on the next following January 1st. The time will be that time at the address of the Trustees.

Classes of Coverage means:

Class A - Active Employees

Coverage provided by the Trustees through the Fund to all eligible employees, unless they qualify for other classes of coverage provided by the Trustees through the Fund.

Class C - Retirees or Disabled Employees Who Are Not Medicare Eligible

Coverage provided by the Trustees through the Fund for eligible retired employees who meet either the disability or retirement requirements stated previously and who are **ineligible** for Medicare Benefits.

Class D - Retirees or Disabled Employees Who Are Medicare Eligible

Coverage provided by the Trustees through the Fund for eligible retired employees who meet either the disability or retirement requirements and who are **eligible** for Medicare Benefits.

You are considered disabled, by sickness or accident, if you are prevented from performing all of the usual duties of your occupation or trade. The Trustees will make such determination in a non-discriminatory manner.

As a retiree, once you become eligible for Medicare Benefits, **you must apply for Medicare Benefits**. You cannot turn down Medicare Benefits (other than Medicare Prescription Drug Benefits) and pay a higher self-payment to receive the non-Medicare level of benefits through this Fund. All employees and dependents who are eligible for Medicare Benefits are covered under the Class D Medicare Supplement Benefits. If you do not enroll in Medicare Benefits, Plan benefits are paid as though you are enrolled in Medicare Benefits.

As a retiree, employee, or dependent covered under Class D, you will become ineligible for the Plan's prescription drug benefits if you enroll for Medicare Prescription Drug Benefits. If you do not enroll for Medicare Prescription Drug Benefits, you will continue eligibility for the Plan's prescription drug benefits, provided you are otherwise eligible for Class D benefits. If you lose eligibility for the Plan's prescription drug benefits due to enrollment for Medicare Prescription Drug Benefits, your prescription drug benefits under the Plan will be reinstated if you later drop or terminate coverage for Medicare Prescription Drug Benefits, provided you maintained continuous coverage under the Plan.

Coinsurance/Copayment means the amount to be paid by you for each applicable medical service.

Complications of Pregnancy means:

(a) conditions whose diagnosis are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; puerperal infection, toxemia, eclampsia, and missed abortion;

(b) a nonelective cesarean section surgical procedure;

(c) terminated ectopic pregnancy; or

(d) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

(a) false labor;

(b) occasional spotting;

(c) prescribed rest during the period of pregnancy;

(d) similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy; or

(e) an elective cesarean section.

Confinement means being a resident patient in a hospital for at least 15 consecutive hours per day. Successive confinements are considered one confinement if:

(a) due to the same bodily injury or sickness; and

(b) separated by fewer than 30 consecutive days when you are not confined.

Covered Expense/Charge means expense incurred by you or your covered dependents due to bodily injury or sickness. To receive

benefits, the eligible expense must be incurred while you are covered for that benefit under the Plan.

Covered Person means the employee (active, disabled, or retired) or any of the employee's eligible covered dependents.

Custodial Care means services provided to assist in the activities of daily living which are not likely to improve your condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking, and taking medication. These services are considered custodial care regardless if a qualified practitioner or provider has prescribed, recommended, or performed the services.

Customary, Usual, and Reasonable (or "reasonable expenses") means the usual and customary fee or charge for the covered services rendered and for the covered supplies furnished in the area concerned, provided services and supplies are recommended and approved by a physician or dentist. Reasonableness is determined by comparisons with fees and charges by other providers for similar services and supplies as authorized by the Trustees and may include data obtained from the FAIR Health schedule for relevant zip code areas at the percentile Trustees adopt (currently the 90th percentile) or from guidelines obtained from other sources as well.

Dental Hygienist means any person who is currently licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision of a dentist.

Dentist means any person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry, and who is acting within the usual scope of such practice.

Dependent means a covered employee's:

(a) Legally married spouse, consistent with governing laws.

(b) Natural blood-related child, stepchild, legally adopted child (or child placed for adoption) who is under age 26. Adopted

children and children placed for adoption are subject to all terms and provisions of the Plan.

(c) Child who is named as an alternate payee in a Qualified Medical Child Support Order or National Medical Support Notice with which you and the Plan are obligated to comply to the extent of the terms of such Order.

(d) Grandchild, as long as the employee's covered dependent who is the parent of the grandchild is not yet age 18 and the grandchild receives more than half of his or her annual financial support from the covered employee and has the same principal residence as the covered employee for, more than half the calendar year except for temporary absences.[1]

(e) A dependent grandchild of a covered employee as described in the preceding paragraph (d) must be a citizen or national of the United States or a resident of the United States, Canada, or Mexico. This does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as the covered employee, is a member of the covered employee's household, and the covered employee is a citizen or national of the United States.

Durable Medical Equipment (DME) means equipment that is medically necessary and able to withstand repeated use. It also must be primarily and customarily used to serve a medical purpose and generally not be useful to a person except for the treatment of a bodily injury or sickness.

Emergency means an acute, sudden onset of a bodily injury or sickness which is life threatening or becomes more severe or significantly worsens without immediate medical or surgical treatment.

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[1] A temporary absence can be due to special circumstances such as sickness or education. Children who are away at school are considered to share the covered employee’s principal residence, as long as it is reasonable to assume that they will return to the covered employee’s home when school is not in session.

Employee means you when you are working under the jurisdiction of, are a member of, or are employed by Local 434 Plumbers - Steamfitters - Refrigeration Workers and Service Technicians.

Employer means an employer engaged in the Plumbing, Refrigeration or Piping business who has a collective bargaining agreement in effect with Local 434 Plumbers - Steamfitters - Refrigeration Workers and Service Technicians or a Participation Agreement with the Trustees requiring periodic payments to Local 434 Health & Welfare Fund. This includes currently in force collective bargaining agreements with previously independent Locals 31, 385, 557, and 778 who also are required to make periodic payments to the Local 434 Health & Welfare Fund.

Expense Incurred means the customary, usual, and reasonable charges made for services and supplies needed to treat the condition. The date a supply or service is rendered is the expense incurred date.

Experimental or **Investigational** means a treatment, procedure, facility, equipment, drug, device, or supply which, based on reliable evidence, falls within any one of the following categories on the date rendered, provided, or utilized:

(a) It is not generally recognized among experts in the medical profession in the State of Wisconsin as accepted medical practice for the diagnosis or treatment of a patient's medical condition; or

(b) It is considered by any governmental agency or subdivision, including, but not limited to, the U.S. Food and Drug Administration, the Office of Health Technology Assessment, or HCFA Medicare Coverage Issues manuals to be:

    (1) experimental or investigational;

    (2) not considered reasonable and necessary; or

    (3) any similar findings; or

(c) It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the

treatment, procedure, facility, equipment, drug, device, or supply was rendered, provided, or utilized; or

(d) It is approved by the U.S. Food and Drug Administration under its Treatment Investigational New Drug regulations or is a U.S. Food and Drug Administration approved drug used for unrecognized treatment indications; or

(e) It is the subject of ongoing Phase I or Phase II clinical trials, or is in the research, experimental, study or the investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts in the United States regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device, or supply is experimental or investigative will be determined by the Trustees in their discretion based on reliable evidence. Reliable evidence will mean the HCFA Medicare Coverage Issues manuals, as amended from time to time; published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treatment facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedure; the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure; or any other evidence which the Trustees determine in their discretion, from time to time, to be a reasonable and accurate source.

Notwithstanding the prior, to the extent required under the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial.

Qualified Individuals must use a PPO Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.

"Routine Patient Costs" include items and services typically provided under the Plan for a participant not enrolled in an Approved Clinical Trial. However, such items and services do not include: (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

"Qualified Individual" is a participant who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other Life-Threatening Condition and either: (a) the referring health care professional is a participating provider and has concluded that the participant's participation in the Approved Clinical Trial would be appropriate; or (b) the participant provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

"Approved Clinical Trial" is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is:

(a) Approved or funded by one of the following:

    (1) the National Institute of Health;

    (2) the Centers for Disease Control and Prevention;

    (3) the Agency for Health Care Research and Quality;

    (4) a cooperative group or center of any of the preceding entities or the Departments of Defense or Veterans Affairs;

    (5) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(6) the Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.

(b) Conducted under an investigational new drug application reviewed by the FDA; or

(c) A drug trial that is exempt from having such an investigational new drug application.

"Life-Threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

Family Member means your lawful spouse, child, grandparent, brother or sister, or any person related in the same way to your covered dependent.

Free-Standing Surgical Facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing surgery. It does **not** provide services or accommodations for patients to stay overnight.

Hospital means an institution which:

(a) maintains permanent full-time facilities for bed care of resident patients; and

(b) has a physician and surgeon in regular attendance; and

(c) provides continuous 24-hour-a-day nursing services; and

(d) is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of injured or sick persons; and

(e) is legally operated in the jurisdiction where located; and

(f) has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services; or

(g) is a lawfully operated qualified treatment facility certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does **not** include an institution which principally is a rest home, nursing home, convalescent home or home for the aged, or a place principally for the treatment of alcoholism, chemical dependence, or psychological disorders.

Maintenance Care means any service or activity which seeks to prevent bodily injury or sickness, prolong life, promote health, or prevent deterioration of a covered person who has reached the maximum level of improvement or whose condition is resolved or stable.

Medically Necessary or **Medical Necessity** means the extent of services required to diagnose or treat a bodily injury or sickness which is known to be safe and effective by the majority of physicians who are licensed to diagnose or treat that bodily injury or sickness. A service is not medically necessary merely because it is ordered by a physician. Such services must be:

(a) performed in the least costly setting required by your condition;

(b) not provided primarily for the convenience of the patient or the physician;

(c) appropriate for and consistent with your symptoms or diagnosis of the bodily injury or sickness under treatment;

(d) furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for your symptoms, diagnosis, bodily injury, or sickness; and

(e) substantiated by the records and documentation maintained by the provider of service.

Medicare Benefits means Part A and B of Title XVIII of the Social Security Amendments of 1965, as enacted or amended.

Medicare Prescription Drug Benefits means Medicare Part D, the federal Medicare prescription drug program created by the Medicare Modernization Act of 2003 and effective January 1, 2006.

Military Service or **Military Leave** means service or leave to serve in the United States Armed Forces, the Army National Guard, and the

Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps, or the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Non-Bargaining Unit Employee means a full-time employee who currently performs services for an employer that is party to a collective bargaining agreement requiring contributions to the Fund but who has never participated in the Fund as a collectively bargained employee. A full-time employee is one who is regularly employed by an employer for 25 or more hours per week.

Optician, Optometrist, and **Ophthalmologist** mean any person who is qualified and currently licensed (if licensing is required in the state) to practice each such occupation by the appropriate governmental authority having jurisdiction over the licensure and practice of such occupation, and who is acting within the usual scope of such practice.

Personal Pronoun Usage. Words used in this SPD in the masculine or feminine gender will be considered as the feminine gender or masculine gender respectively, where appropriate.

Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician means a person who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure and who is acting within the usual scope of such practice and includes the services of qualified practitioners such as a doctor of medicine, podiatrist, chiropractor, osteopath, optometrist, and doctor of dental surgery, provided such individual is licensed and acting within the usual scope of such practice.

Plan's Fiscal Year means the 12 months beginning any June 1st and ending the following May 31st.

Pre-Admission Testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a hospital. The tests must be for the same bodily injury or sickness causing the patient to be hospital-confined. The tests must be accepted by the hospital, in lieu of like tests made during confinement. Pre-admission testing does **not** mean tests for a routine physical checkup.

Qualified Medical Child Support Order or **National Medical Support Notice** means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or, any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

(a) provides for child support payments related to health benefits with respect to a child or requires health benefit coverage for such child by the Plan, and is ordered under state domestic relations law; or

(b) enforces a state law relating to medical child support payments with respect to the Plan; and

(c) creates or recognizes the right of a child as an alternate recipient--who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to an eligible employee who is a participant in the Plan; and

(d) includes the name and last known address of the participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

(e) does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

(f) has been determined to be a qualified medical child support order under reasonable procedures adopted and uniformly applied by the Plan. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

Qualified Practitioner means a licensed practitioner providing services within the scope of that license. A qualified practitioner's services are not covered if the practitioner resides in your home or is your family member.

Qualified Treatment Facility means a facility, institution, or clinic duly licensed by the appropriate state agency, and primarily is established and operating within the scope of its license.

Services means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices, or technologies.

Sickness means a disturbance in function or structure of your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of your body.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Total Disability or **Totally Disabled** means, for you or your employed covered spouse, during the first 12 months of disability you or your employed covered spouse are at all times prevented by bodily injury or sickness from performing each and every material duty of your respective job or occupation.

After the first 12 months, total disability or totally disabled means that you or your employed covered spouse are at all times prevented by bodily injury or sickness from engaging in any job or occupation for wage or profit for which you or your employed covered spouse are reasonably qualified by education, training, or experience.

Total disability of an employee or employed spouse is the inability to perform each and every duty pertaining to any occupation.

Total disability of a non-employed spouse or a child is the inability to perform the normal activities of a person of similar age.

Wilson-McShane Corporation means the firm who provides services to the Plan Administrator, as defined in the Plan Supervisor Agreement. Wilson-McShane Corporation is not the Plan Administrator or the Plan Sponsor. Wilson-McShane Corporation is referred to in this Summary Plan Description booklet as the Fund Office and/or Administrative Manager.

You and **Your** means you as the employee (active or retired) and any of your eligible covered dependents, unless otherwise indicated.

Fund Administrative Manager
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Fund Legal Counsel
Reinhart Boerner VanDeuren S.C.
1000 North Water Street, Suite 1700
P.O. Box 2965
Milwaukee, WI 53202

Fund Consultant
Lee Jost and Associates
One Park Plaza
11270 West Park Place, Suite 950
Milwaukee, WI 53224

Fund Certified Public Accountant
Bauman Associates Ltd.
4229 Southtowne Drive
P.O. Box 1225
Eau Claire, WI 54702-1225

Fund Investment Consultant
The Bogdahn Group
4320 Winfield Road, Suite 200
Warrenville, IL 60555

Fund Investment Manager
JB Investment Management, LLC
13890 Bishops Drive, Suite 350
Brookfield, WI 53005

Life and Accidental Death and Dismemberment
Underwritten and Insured by
Anthem Life Insurance Company
Administrative Office
P.O. Box 182361
Columbus, OH 43218-2361

Fund Preferred Provider Network
Anthem Blue Cross and Blue Shield
120 Monument Circle
Indianapolis, IN 46204

Large Case Management
Case Management Specialists, Inc. (CMS)
553 South Industrial Drive
Hartland, WI 53029

Fund Family Assistance Program
Health Systems Management, Inc. (HSM)
2087 Club House Drive
Lillian, AL 36549

Fund Preferred Provider Pharmacy
Catamaran
2441 Warrenville Road, Suite 610
Lisle, IL 60532-3642

Fund Dental Provider
Delta Dental Plan of Wisconsin
P.O. Box 828
Stevens Point, WI 54481-0828

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