Plan Document and Summary Plan Description of the Utah Pipe Trades Welfare Trust Fund

Effective August 1, 2016

To All Participants:

This is the Plan Document and Summary Plan Description of the Utah Pipe Trades Welfare Trust Fund. This Plan describes benefits funded by the Trust: medical, prescription drug, and weekly disability benefits, and benefits under the Employee Assistance Program (EAP). It also summarizes insured benefits: life and accidental death and dismemberment insurance. You may ask the Administrative Office for a copy of insurance contracts, where your insured benefits are described in full. In the event of ambiguity or conflict between an insurance contract and the Plan or other documents, the insurance contract controls.

The Plan was adopted for the exclusive benefit of Participants (and their Covered Dependents) who are employed by certain Employers in the pipe trades industry. Costs are funded by contributions from these Employers. Plan benefits are designed to help cover some of your expenses when you become sick, are injured, or die. This written version of the Plan describes benefits for claims incurred on or after August 1, 2016.

Here are some important tips on using your benefits:

- The Plan has a network of Preferred Providers, also called "PPO"s. Using the Preferred Providers will result in a substantial savings to you and the Plan. Please contact the Administrative Office for a list of PPO providers near you.
- Inform the Administrative Office of any address changes to ensure that you receive updated Plan and self-pay information.
- Inform the Administrative Office of any changes in your Eligible Dependents.
- Note that capitalized terms in this document have very specific meanings. Please refer to the definitions section in Article XII.

As your Trustees, we make every effort to administer the Trust carefully and make changes to your Plan as the Trust's financial condition changes. Eligibility provisions and benefits may be increased or decreased from time to time. You will be notified if there are changes.

Important addresses and telephone numbers are listed on the Quick Reference Chart located in the front of this document.

Sincerely,

Board of Trustees

The Board of Trustees has the sole, exclusive, and discretionary authority to make any and all determinations under the Plan, including eligibility for benefits, amount of benefits payable, and the meaning of Plan language. The Plan Administrative Office is the only party authorized by the Board of Trustees to answer questions about the Trust and the Plan. No Trustee, Employer, Employer Association, or Labor Organization, nor any of their employees or representatives, has any authority in this regard. The Board of Trustees reserves the sole and exclusive right to amend or terminate the Plan, change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

Table of Contents

I. Quick Reference Chart, Summary of Benefits and Quick Answers

The Quick Reference Chart below contains important contact information for each of your benefits. That chart is followed by the Summary of Benefits, highlighting the main features of each of the Plan's benefits. See the Definitions section, which begins on page 79, and other applicable sections as noted for details.

QUICK REFERENCE CHART

Information/Action Needed	Whom to Contact
Administrative Office /Medical Plan Claims Administrator • Eligibility for Coverage • ID cards • Medical Claims and Appeals • Claim Forms (Medical) • Prescription Drug Program Appeals • Plan Benefit Information • Weekly Disability Claims and Appeals • Summary of Benefits and overage (SBC) • HIPAA Notice of Privacy Practices	**BeneSys Administrators** Physical Address: 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 Mailing Address: P.O. Box 1975 San Ramon, California 94583 Phone 925.398.7041 Toll Free 877.416.8181 Facsimile 925.462.0108 www.utpipetradesbenefits.org staff@utpipetradesbenefits.org
Medical PPO Network (Inside Utah) • Medical Network Provider Directory • Additions/Deletions of Providers	**Wise Provider Networks** (801) 649-6501 or (866) 485-5205 www.wiseprovider.net
Medical PPO Network (Outside Utah) • Medical Network Provider Directory • Additions/Deletions of Providers	**First Health Network** (888) 685-7774 www.myfirsthealth.com
Case Management and Precertification Manager • Case Management/Medical Management • Precertification (explained in Article IV.)	**American Health Group (AHG)** 2152 S. Vineyard, Suite 103 Mesa, AZ 85210 (602) 265-3800 or 1-800-847-7605 http://www.amhealthgroup.com/

QUICK REFERENCE CHART

Information/Action Needed	Whom to Contact
Prescription Drug Program/Pharmacy Benefit Manager (PBM) • Retail PPO Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Preauthorization of Certain Drugs • Specialty Drug Program • Prescription Drug Program Claims • Direct Member Reimbursement (for Non-network retail pharmacy use)	**CVS Caremark** (PBM) • Retail Pharmacy Customer Service: 1-877-819-9364 www.caremark.com • Caremark Mail Order Pharmacy P.O. Box 659541 San Antonio, TX 78265 (877) 889-3402 • Caremark Specialty Pharmacy (800) 237-2767
Employee Assistance Program (EAP) • 24-7 assistance with mental health and/or substance abuse issues, at no cost to you (See Article V.) • Referrals to providers in your area • Short-term counseling	**Blomquist Hale Consulting** Telephone numbers: • Ogden: 801-392-6833 • Brigham City: 435-723-1610 • Orem: 801-225-9222 • Logan: 435-752-3241 • Salt Lake City: 801-262-9619 • Other Utah locations, and nationally: 800-926-9619 www.blomquisthale.com
COBRA Administrator • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Notification of Qualifying Event	**BeneSys Administrators** Physical Address: 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 Mailing Address: P.O. Box 1975 San Ramon, California 94583 Phone 925.398.7041 Toll Free 877.416.8181 Facsimile 925.462.0108 www.utpipetradesbenefits.org staff@utpipetradesbenefits.org

QUICK REFERENCE CHART

Information/Action Needed	Whom to Contact
Life and Accidental Death and Dismemberment (AD&D) Insurance • Information About Coverage • Claims and Appeals • Beneficiary Designations	**ULLICO*** c/o Administrative Office – BeneSys Administrators. See contact information above. Or, you may contact ULLICO directly at: Claims Administrator The Union Labor Life Insurance Company 8403 Colesville Road, Stop 709 Silver Spring, MD 20910-6331 Phone: 1-866-795-0680 ** Insured benefit; entity listed is the insurer.*
HIPAA Privacy & Security Officers	**BeneSys Administrators** See contact information above.

SUMMARY OF BENEFITS

Below are brief summaries of some of the key benefits provided by the Plan. Further explanation of these and other benefits may be found later in this document. Read this document carefully, and all subsequent Summaries of Material Modifications provided to you, to determine the conditions under which benefits are payable.

Summary of Medical Benefits	
BENEFIT DESCRIPTION	**BENEFIT MAXIMUMS PER COVERED INDIVIDUAL**
Lifetime Maximum	
Weight Management Surgery (includes complications)	Once per lifetime
Calendar Year Maximums	
Skilled Nursing Facility	60 days
Inpatient Rehabilitation Facility	60 days (No limit for Mental or Nervous Disorders, or Substance Abuse)
Rehabilitative therapies	60 days
Chiropractic Care	30 visits

Summary of Medical Benefits	
DESCRIPTION	**CALENDAR YEAR DEDUCTIBLE PER COVERED INDIVIDUAL**
Services and Supplies delivered by a PPO Provider and outside a PPO coverage area	$450
Services and Supplies delivered by a non-PPO Provider	$900
Preventive Care and Outpatient Prescription Drugs	No deductible

Summary of Medical Benefits		
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	**CALENDAR YEAR OUT-OF-POCKET COINSURANCE MAXIMUMS PER COVERED INDIVIDUAL**	
	PPO Provider and Provider Outside of PPO coverage area	**Non-PPO Provider in PPO coverage area**
Out-of-Pocket Coinsurance Maximum • Each Calendar Year, you must pay your deductible and then you and the Plan share the cost of Covered Medical Expenses up to your maximum out-of-pocket coinsurance amount. Thereafter the Plan pays 100% of most Covered Medical Expenses. • Note that certain expenses do not accumulate to the Out-of-Pocket Coinsurance Maximum and are expenses that you must always pay, including: deductibles, copays, outpatient prescription drug expenses, expenses not covered by the medical plan, expenses in excess of the plan's Allowed Charge and any other expense in excess of a Plan limit.	$2,000	$4,000

	2016 Out-of-Pocket Limits * Cost-Sharing for Medical and Outpatient Drug Benefits On a Calendar Year Basis		
	Medical	**Outpatient Drugs**	**Annual Total**
Per Person	$4,000	$2,600	$6,600
Family	$8,000	$5,200	$13,200

* These out-of-pocket limits have the following restrictions:

- Once you reach the out-of-pocket limit for medical expenses, you owe no further deductible, copay, or coinsurance for medical expenses from PPOs that are for Covered Medical Expenses, for the remainder of the calendar year.
- The medical out-of-pocket limit applies only to Covered Medical Expenses incurred at PPO providers (or that the Plan pays as if incurred at a PPO Provider).

- Once you reach the out-of-pocket limit for outpatient prescription drugs, you owe no further copay or coinsurance for covered prescription drugs received from a participating pharmacy, for the remainder of the calendar year.
- The outpatient drugs out-of-pocket limit applies only to the extent a drug or supply is covered under the Plan's Outpatient Prescription Drug Program and is filled at a participating pharmacy
- The limits do not apply to expenses incurred for services or supplies in excess of another Plan limit, such as a visit limit, or in excess of an Allowed Charge.
- The limits apply only to Covered Medical Expenses and costs of covered prescription drugs incurred for the family members you have properly enrolled for coverage under the Plan.
- The limits renew each calendar year. That is, your cost sharing for expenses incurred in 2015 will not apply toward the out-of-pocket limits in 2016.
- The out-of-pocket limit amounts may be adjusted annually by the Trustees, in accordance with law.
- Even if you reach an out-of-pocket limit for a year, the Plan's other limits and exclusions continue to apply – for example, the requirement that a service be Medically Necessary and visit limits.

Summary of Medical Benefits

Certain services require precertification as described in Article IV.

BENEFIT DESCRIPTION	AMOUNTS YOU PAY: YOUR COINSURANCE, COPAY AND DEDUCTIBLE	
	PPO Provider and Non-PPO Provider Outside of PPO coverage area	**Non-PPO Provider in PPO coverage area**
Office Visits	$35 Copay per visit, 20% Coinsurance after deductible is met	$35 Copay per visit, 40% Coinsurance after deductible is met
Office Visits for prenatal and post-natal care	No charge	40% Coinsurance after deductible is met
Physician Services (non-office visit services including Anesthesia)	20% Coinsurance after deductible is met	40% Coinsurance after deductible is met
Chemotherapy • (one $35 Copay in any 30-day period)	20% Coinsurance after deductible is met	40% Coinsurance after deductible is met
Home Health Care, Durable Medical Equipment, Hospice, Outpatient Laboratory and Outpatient Radiology Services	20% Coinsurance after deductible is met	40% Coinsurance after deductible is met
Urgent Care	$40 Copay per visit, 20% Coinsurance after deductible is met	$40 Copay per visit, 40% Coinsurance after deductible is met

Summary of Medical Benefits

Certain services require precertification as described in Article IV.

BENEFIT DESCRIPTION	AMOUNTS YOU PAY: YOUR COINSURANCE, COPAY AND DEDUCTIBLE	
	PPO Provider and Non-PPO Provider Outside of PPO coverage area	**Non-PPO Provider in PPO coverage area**
Emergency Room (ER)	$250 Copay per visit, 20% Coinsurance after deductible is met	$250 Copay per visit, 20% Coinsurance after deductible is met
Ambulance	20% Coinsurance after deductible is met	40% Coinsurance after deductible is met
Inpatient Hospital	$250 Copay per admission, 20% Coinsurance after deductible is met	$500 Copay per admission, 40% Coinsurance after deductible is met
Skilled Nursing Facility, Inpatient Rehabilitation Facility (Non-Hospital), and Residential Treatment Facility	$250 Copay per admission, 20% Coinsurance after deductible is met. No coverage for any Non-PPO Providers, regardless of coverage area	Not Covered
Outpatient Hospital and Licensed Ambulatory Surgical Facility for Outpatient Surgery	$35 Copay per visit, 20% Coinsurance after deductible is met	$35 Copay per visit, 40% Coinsurance after deductible is met
Preventive Care	No charge	No coverage
Chiropractic Benefits: • Payable for treatment of spinal maladjustments or subluxation only, up to a maximum of 30 visits per year.	$35 Copay per visit, 20% Coinsurance after deductible is met	$35 Copay per visit, 40% Coinsurance after deductible is met
All other Covered Medical Expenses not listed in this Summary of Medical Benefits	20% Coinsurance after deductible is met	40% Coinsurance after deductible is met

Summary of Outpatient Prescription Drug Benefits

(The out-of-pocket maximum for Outpatient Prescription Drugs is explained at p. 4)

DRUG DESCRIPTION	Amount You Pay for Prescriptions Filled at a PPO Retail Pharmacy (Up to 30-day Supply)	Amount You Pay for Maintenance Drug Prescriptions Filled at a Mail Order Pharmacy (Up to 90-day Supply)	Amount You Pay for Prescriptions Filled at a Non-PPO Pharmacy
Generic Drugs	$8 Copay	$15 Copay	You pay 100%. Plan reimburses no more than it would have if you had used a PPO Pharmacy **
Formulary (Preferred) Brand Drugs	30% Coinsurance	$45 Copay	
Non-Formulary (Non-Preferred) Brand Drugs	50% Coinsurance	$60 Copay	
Preventive Care Drugs	No charge	No charge	No coverage
Specialty Drugs (Up to a 30-day Supply)	50% Coinsurance, up to $60 maximum. Specialty drugs must be filled by calling the Prescription Drug Program Specialty Pharmacy listed in the Quick Reference Chart.		
Compound Drugs	Compound drugs that cost $300 or more must be precertified before the drug is filled, by contacting the PBM listed in the Quick Reference Chart.		

**You must file a Direct Member Reimbursement (DMR) form to ask for reimbursement (form available from the PBM listed on the Quick Reference Chart in the front of this document).

Summary of Life and AD&D Insurance

Life and AD&D benefits are fully insured. For the name of the insurance company, see the Quick Reference Chart. The Insurer's contract, booklet, and certificate describe your Life and AD&D insurance coverage.

Participant Life Insurance	
Employee	$10,000
Retiree	$2,000
Participant AD&D Insurance	
Employee	$10,000
Retiree	No Benefits
Covered Dependent Life Insurance	
Spouse	$1,000
Child under 14 days	No Benefit
Child age 14 days but under 6 months	$250
Child age 6 months but under 26 years	$1,000

Summary of Employee Assistance Program (EAP) Benefits

EAP benefits are provided at no cost to Participants and their Covered Dependents. Call the EAP any time, day or night, for help and short-term counseling. See also Article V for more information.

Summary of Weekly Disability Benefits for Active Employees	
Benefit Description	
Weekly Benefit	$444 subject to FICA taxes
Benefit duration per disability	13 weeks
Benefit Commencement	1st day of Injury 8th day of Illness

QUICK ANSWERS

Here are some quick answers to a few commonly asked questions. However, these quick answers don't explain all of the Plan's rules and limits. To know the Plan's rules and limits, you must read the rest of this booklet.

When will I first be covered by the Plan?

If you work for the Union or affiliated training fund or under a collective bargaining agreement, your Employer reports and the Administrative Office tracks your Covered Hours. This is called the hour bank system. If you have 300 Covered Hours in no more than 5 consecutive months, you will participate in the Plan the following month. 300 Covered Hours is required to begin coverage, and 140 Covered Hours is required in each month to continue coverage. Amounts over that remain in your hour bank, up to 420 hours.

Example: John begins working in February. He works as follows:

February:	70 hours
March:	150 hours
April:	140 hours
Total:	360 hours

At the end of April John satisfies the initial eligibility requirements (300 hours). His coverage begins on May 1 and will continue through June. His hour bank is left with 80 hours (=360 less 280 (140 x 2 for May and June coverage).

What do I have to do to continue coverage?

After initial eligibility, you must have at least 140 Covered Hours in your hour bank to get coverage two months later. Covered Hours are credited to your hour bank the month you work the hours.

Example: In the above example, assume John works 150 Covered Hours in May. He has 230 Covered Hours in his bank (80 left over from April plus 150 for work in May). John has coverage in July and 90 hours left in his bank.

If I lose coverage, how do I regain it?

You must accumulate 140 Covered Hours within 4 months of the month in which you lost Plan coverage, to regain coverage two months later. If you don't, you must reestablish initial eligibility by again working 300 hours.

Example: In the above example, John has coverage in July, with 30 hours left in his bank. Assume he **doesn't** work in May or June. With only 30 hours in his bank, John has no coverage in August. But if John works 130 hours in July, he will have 160 hours in his bank—30 left over from work through April, plus another 130 for work in July. That's enough to get him coverage in September.

What if my employer doesn't make timely contributions?

If your employer doesn't pay the proper amount on time to the Trust for your Covered Hours, you will receive no credit. There is one exception: if you can prove you worked (save your pay stubs!), you will receive credit for your Covered Hours, up to 140 hours in each of 2 months in a 12-month period.

What if I am working in another jurisdiction?

If your work is covered by a reciprocity agreement with the Plan, you can arrange for your health contributions for that work to be sent to this Plan. The amount received is divided by this Plan's current hourly contribution rate, to arrive at your Covered Hours of work.

Example: John travels to Las Vegas to work a Union job. John completes reciprocity paperwork in Las Vegas. The Las Vegas plumbers and pipefitters health plan sends this Plan $800. The current contribution rate for this Plan is $6.51 per hour. John earns 123 ($800 ÷ $6.01) Covered Hours toward coverage in this Plan.

Is my Spouse covered? My Dependent children?

Yes, if you enroll them within 60 days of your initial eligibility and if you provide a marriage certificate (spouse) and birth certificates (children). Common law marriages are not recognized by the Plan. The Plan has special rules on coverage of children in Article II.

What is a deductible? What is a copay? What is coinsurance?

You must pay a portion of the cost of your healthcare expenses that are covered by the Plan. These cost-sharing amounts are called deductibles, copays, and coinsurance. Each year you pay for healthcare expenses up to the amount of your deductible, before the Plan covers any expenses. A copay is the fixed amount you pay to the doctor or medical facility each time you receive treatment. Coinsurance is the percentage of expenses you pay for covered charges, after your payment of the deductible and copay. Your doctor or medical facility will bill you for the deductible, copay, and coinsurance. Many of the cost-sharing amounts you pay (deductibles, copays and coinsurance) are capped at an annual out-of-pocket limit, after which the Plan pays 100% of covered services.

How do I get the most value out of the Plan?

- Use PPO providers. They charge less, and you pay less.
- Precertify your surgeries and Hospital visits. Ask your Physician if a generic drug is appropriate for you. You'll pay less for generic than for brand name drugs.
- Use urgent care facilities instead of emergency rooms, if medically appropriate.
- Preventive Care is free when received from PPO Providers.

I'm over 65. Should I enroll in Medicare Part B if I am covered under the Plan as a Retiree?

Yes. Whether or not you enroll in Medicare Parts A and B, the Plan pays benefits as if you did enroll with Medicare, and as if Medicare is reimbursing your medical expenses. For this reason, to save you money, you should enroll in Medicare Parts A and B when first offered the opportunity.

How about Medicare Part D?

You do not have to enroll in Medicare Part D. If you enroll in Medicare Part D and are a Retiree, the Plan won't pay your prescription expenses and you will need to rely on Medicare to help pay outpatient drug expenses.

What do I do to qualify for Retiree coverage?

You must have been covered by the Plan for 60 of the last 120 months, including the month immediately before your retirement, retire from the Utah Pipe Trades Pension Trust Fund, and elect to begin retiree coverage immediately after you retire from the Pension Plan. If you instead elect COBRA, you will forever lose the opportunity to elect retiree coverage under the Plan.

How much does Retiree coverage cost?

The cost of Retiree coverage is established by the Board of Trustees, and adjusted periodically. In making adjustments, the Board may consider the Plan's funding status, costs, anticipated contributions, and other relevant factors.

What if I lose coverage because I'm out of work?

You will be eligible to pay to temporarily continue your health coverage under COBRA, or you can look for an individual insurance policy through the Marketplace (visit www.healthcare.gov).

II. Eligibility

The Trustees establish the required contribution amount, and may reject any contribution that does not comply with an applicable agreement, the Plan or the Trust.

Active Employee Participants

For Employees covered by a Collective Bargaining Agreement, and for Non-Bargaining Employees of the Union or an affiliated training fund, eligibility for Plan benefits is determined under an "hour bank" system, which also lets you build up hours of eligibility for use during periods of slack employment or layoff.

When you begin working for a Contributing Employer, the Plan Administrative Office sets up an hour bank account to track your Covered Hours of employment. Covered Hours are your work hours for which your Employer must contribute to the Trust Fund. Your account is credited with your Covered Hours when the Administrative Office receives contributions for those Hours. If your Employer makes a contribution for your Covered Hours at a rate less than that set by the Trustees, you will receive hour bank credit as follows: hourly rate received divided by the rate set by the Trustees times .75. The Trustees may also reject the contribution altogether and no hours will be credited to your hour bank. Once you establish your Initial Eligibility, 140 Covered Hours per month are deducted from your hour bank account to provide your coverage**.**

Flat-Rate Employee Participants

Non-Bargaining Employees of the Utah Mechanical Contractors Association, or of an Employer (including a self-employed individual) that is signatory to a current Collective Bargaining Agreement, participate in the Plan on a flat-rate basis. If you are a Flat-Rate Employee, your coverage will begin as described below. You will not participate in the hour bank system, and your coverage will continue as long as you continue to qualify and your Employer makes the required contributions on your behalf, until your coverage otherwise ends pursuant to the Plan.

All Non-Bargaining Employees (regardless of whether participating as an Active Employee or a Flat-Rate Employee) and their Employers must satisfy all requirements in this booklet and the Trust Agreement, including application procedures, in order to participate in the Plan. Participation is also subject to the terms of the Employer's Non-Bargaining Participation Agreement with the Board of Trustees. Only those classes of employees described in an Employer's Non-Bargaining Participation Agreement are eligible to participate in the Plan as Non-Bargaining Employees. The Board of Trustees may, in its discretion, approve or reject any Employer's application to enter into a Non-Bargaining Participation Agreement.

Initial Eligibility

Active Employees

To first become eligible, you must work at least 300 Covered Hours within no more than five consecutive months. Your coverage begins on the first day of the first month following your completion of this eligibility requirement.

If you build up 300 hours in less than five months, you'll be eligible sooner. For example, if you earn 300 hours in only three months, your coverage starts on the first day of the fourth month.

Newly-Organized Contributing Employers. In accordance with Trust Rules and Procedures, the Trustees may waive these initial eligibility requirements for the Employees of a newly-organized Contributing Employer. If a waiver is granted to your Employer, they must make an initial contribution to the Trust in an amount equal to 150 hours times the contribution rate then in effect for each Active Employee, plus contributions based on your actual hours worked in the first month the Collective Bargaining Agreement is effective. Those contributions, subject to the lag month, will be used to determine your eligibility in the third month, and so on. To qualify for waiver of the initial eligibility requirements, you must be employed on the date your Employer becomes signatory to a Collective Bargaining Agreement. If your initial eligibility requirements are waived in accordance with the above, you'll become eligible on the first day of the month after your Employer becomes signatory. Such eligibility will continue for two months. After the first two months, your eligibility is determined in accordance with the normal rules (see *Continuing Eligibility* section), with the exception that during your first 12 months of coverage there will be no carryover of hours remaining in your hour bank after deduction for the current month's coverage.

When Hours Are Credited to Your Bank. Covered Hours are credited to your hour bank account for the month you worked the hours. However, Covered Hours will not be credited to your hour bank account until the Plan Administrative Office actually receives your Employer's contributions for them. This can cause you to lose eligibility and coverage even though you worked the necessary hours. If your Employer later makes the required contributions or your contributions are received through reciprocity and the Trust accepts them, your account will be retroactively adjusted. If you have enough Covered Hours, your coverage will be reinstated as if contributions were received on time. Your reported hours will be posted according to the actual work month and your Employer's payment will be applied first to the earliest hours for which payment is owed.

There is one exception. If you can prove that you worked (for example with paystubs), you will receive credit for your Covered Hours, up to 140 hours in each of 2 months in a 12-month period.

Flat-Rate Employees

Contributions. Your Employer must make contributions to the Plan on behalf of all Non-Bargaining Employees who regularly work at least 25 hours per week, except those Non-Bargaining Employees who waive Plan coverage because they have other group healthcare coverage. The monthly contribution is equal to 140 hours times the current bargaining hourly contribution rate. Before your coverage begins your Employer must pre-pay 2 months of contributions for each Non-Bargaining Employee. For each month thereafter, your Employer must pre-pay the monthly contribution on or before the 15th day of the month prior to the month for which coverage is intended. Non-bargaining contributions will be first applied to bargaining contributions owed by your Employer, if your Employer is delinquent on its bargaining contributions.

Eligibility. You will be eligible for coverage on the latest of (1) the effective date for your Employer's non-bargaining participation in the Plan, which is the first day of the month following the date the Administrative Office notifies your Employer that its application to participate has been approved, (2) the date your Employer has paid two months of contributions on your behalf, and (3) the date you are regularly scheduled to work at least 25 hours per week and meet all other eligibility requirements described in your Employer's approved Application and Agreement for Non-Bargaining Participation.

Effective Date. The effective date for your Employer's non-bargaining participation in the Plan is the first day of the month following the date the Administrative Office notifies your Employer that its application to participate has been approved. If you are employed with your Employer at that time, this

is also the date you and your Dependents, excluding your Spouse if he or she has waived or declined coverage, become eligible for coverage under the Plan.

If you are hired after the initial effective date of your Employer's non-bargaining participation, you must complete an application for participation or execute a waiver of coverage card (as discussed below). Your date of coverage will be the later of (1) the first day of the month following your completion of the participation requirements in your employer's approved Application and Agreement for Non-Bargaining Participation, or (2) submission of your application to participate.

Waiver of Coverage and Special Enrollment. If you have other healthcare coverage, you may waive Plan coverage for yourself and/or your Eligible Dependents by completing a waiver card (available from the Administrative Office) and returning it to the Administrative Office within 30 days of your date of hire or, if later, within 30 days of the effective date of your Employer's non-bargaining participation in the Plan. This option also applies to Non-Bargaining Employees of an affiliated training fund.

If you or your Eligible Dependents originally waived Plan coverage, you may later enroll in the Plan during Annual Enrollment for coverage the following year, or if you qualify for special enrollment. Your Eligible Dependents' special enrollment rights are described below, in the section called "Dependents." You qualify for special enrollment as follows:

- If you waived Plan coverage because you had other healthcare coverage, you may enroll yourself and your Eligible Dependents if (a) the other coverage was non-COBRA coverage and you lost the coverage due to divorce or legal separation, termination of employment or reduction in hours, death of an employee, loss of dependent status, exhaustion of the other plan's lifetime limit on all benefits, cessation of employer contributions, or any other reason for which a special enrollment opportunity is required by law, or (b) if the other coverage was COBRA coverage and you lost the coverage due to exhaustion of the COBRA coverage.

- If you (a) lose eligibility under a Medicaid plan or a state child health plan offered under the State Children's Health Insurance Program ("SCHIP"), or (b) become eligible for a premium assistance subsidy through a Medicaid plan or a state child health plan offered under SCHIP, you may enroll yourself.

- If your Eligible Dependent has a special enrollment right, you also qualify for special enrollment. (See the Section below called "Dependents" for details.)

To enroll, you must submit a completed application and enrollment form to the Administrative Office within 60 days of the event giving rise to the special enrollment opportunity. If approved by the Administrative Office, coverage will be effective retroactive to the date of the event that entitled you to special enrollment. The application and enrollment form is available from the Administrative Office.

Continuing Eligibility

Active Employees

After you become eligible for the first time, your coverage will continue so long as you have at least 140 Covered Hours credited to your hour bank account. After your first month of coverage, there is a one-month lag between your work month and Plan coverage month. That is, the number of Covered Hours already in your bank plus those that you work and are credited in a month (month 1) determine

whether you have Plan coverage two months later (month 3). The lag month is necessary for the Administrative Office to receive and process reported hours.

Building Up Hours for Future Eligibility. For months when you work more than 140 Covered Hours, the extra hours build up in your account. You may use these hours to continue your coverage during months when you earn less than 140 hours. For example, let's say you work only 100 hours one month but you've built up a balance of 200 hours in your hour bank, so you have 300 total hours available — more than enough for a month's coverage. 140 hours are deducted from your total hour bank for a month's coverage, leaving a balance of 160 hours in your account. Even if you do not work any hours next month, you have more than enough hours for another month of eligibility.

The maximum number of hours you can have in your hour bank account at any time — after deducting hours for the current month — is 420 (enough for three months of eligibility).

The right to continued coverage and eligibility under the Plan based on your hour bank is not vested or accrued. The Board of Trustees has the authority to modify or cancel your Plan coverage and eligibility, and hours in your hour bank account. If your Employer's Bargaining Unit ceases participation in the Plan, or you work for an employer that has no obligation to contribute to the Plan or any reciprocal plan for your work that, regardless of geographic region, is in the same industry, trade, or craft covered by a Collective Bargaining Agreement or a Non-Bargaining Participation Agreement, you will lose eligibility and all accumulated hours in your hour bank account.

If your hour bank account is below 140 hours for 6 months, it is eliminated. See below, **Restoring Lost Coverage**, for more information.

Flat-Rate Employees

After you become eligible for the first time, your coverage will continue until it ends for one of the reasons described below in the section entitled "When Coverage Ends".

Dependents

Eligible Dependents may receive coverage under the Plan's Medical, Outpatient Prescription Drug and Employee Assistance Program benefits, as well as the Plan's life insurance benefit. Dependents are not eligible for coverage under the accidental death and dismemberment insurance or weekly disability benefits.

If you have stepchildren, see the "Coordination of Benefits" section.

Eligible Dependents are:

- Your Spouse, as defined by the Plan.
- Your biological and/or adopted children. "Adopted children" for this purpose includes children who are placed with you for adoption.
- Your stepchildren**.** A stepchild ceases to be an eligible dependent if your marriage with the biological parent terminates or you Legally Separate from your spouse.

The Plan will cover your biological and adopted children and stepchildren through the following ages:

- The end of the month in which he or she turns age 26, or
- After age 25 if your unmarried child is incapable of self-sustaining employment due to a mental or physical disability, provided you are covered by the Plan, apply to continue Dependent coverage at age 25 and 11 months, the incapacity began before your Dependent child's coverage would

otherwise terminate, and your child is dependent on you for support and maintenance. The incapacity must not result from the commission or attempted commission of a felony, or engagement in an illegal occupation, whether or not charges are filed or a conviction results. You must submit proof of incapacity and dependency within 31 days after the child's coverage would otherwise terminate. The Trustees may require subsequent proof from time to time.

The Plan also provides coverage to the biological or adopted child of a Participant if required by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Such coverage begins within a reasonable period after the Plan receives the QMCSO or, if later, the date specified in the QMCSO. Contact the Plan Administrative Office for more information.

When Dependent Coverage Begins

Coverage of your Eligible Dependents generally begins on the same date as your coverage, so long as you complete the Plan's dependent enrollment form (available from the Administrative Office) and return it, along with required legal documentation, to the Administrative Office within 60 days of when you are first eligible for coverage. If you do not complete and return the form on time, your Dependents will have no coverage for the remainder of that calendar year. You'll have another chance to enroll your Eligible Dependents for coverage for the next year by completing a dependent enrollment form during the Plan's Annual Enrollment period (generally in November).

Special Enrollment. You cannot enroll your Eligible Dependents mid-year unless they qualify for special enrollment, as follows:

- If you acquire a new Eligible Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll the new Dependent and your Spouse.

- If you previously did not enroll your Eligible Dependent because he or she had other healthcare coverage, you may enroll the Dependent if (a) the other coverage was non-COBRA coverage and the Dependent lost the coverage due to divorce or legal separation, termination of employment or reduction in hours, death of an employee, loss of dependent status, exhaustion of the other plan's lifetime limit on all benefits, cessation of employer contributions, or any other reason for which a special enrollment opportunity is required by law, or (b) if the other coverage was COBRA coverage and the Dependent lost the coverage due to exhaustion of the COBRA coverage.

- If your Eligible Dependent (a) loses eligibility under a Medicaid plan or a state child health plan offered under the State Children's Health Insurance Program ("SCHIP"), or (b) becomes eligible for a premium assistance subsidy through a Medicaid plan or a state child health plan offered under SCHIP, you may enroll the Dependent.

To enroll your Eligible Dependent, you must complete the Plan's dependent enrollment form and return it to the Administrative Office within 60 days of the event giving rise to the special enrollment opportunity. If approved by the Administrative Office, coverage will be effective retroactive to that date. For example, if you enroll your new Spouse within 60 days of the date of marriage, your Spouse's coverage will begin as of the date of marriage. If you fail to enroll your Eligible Dependent during the 60 day special enrollment period, you must wait and enroll your Eligible Dependent for coverage for the next year by completing a dependent enrollment form during the Plan's Annual Enrollment period (generally in November).

If you are a Non-Bargained Employee who originally waived Plan coverage, and your Eligible Dependent qualifies for special enrollment, you also qualify for special enrollment. The Plan will not provide dependent coverage unless you are also covered. Therefore, you must timely enroll yourself along with your Eligible Dependent in order for the Dependent to receive Plan coverage.

When Coverage Ends

All Participants

Coverage for you will end on the *earliest* of the following:

- The effective date of your retirement from the Pension Plan and/or this Plan;
- The date the Plan is terminated or modified to eliminate your eligibility or coverage;
- Your or your Employer's noncompliance with material terms of the Plan, Trust, a Collective Bargaining Agreement, or a Non-Bargaining Participation Agreement (including payment requirements);
- Fraud/intentional misrepresentation of fact by you, your Dependent, or your Employer,
- The date of your death;
- The date you enter full-time active duty in the United States armed forces, except as otherwise provided by law; or
- The last day of the month in which your Employer's Bargaining Unit ceases participation in the Plan, or you work for an employer that has no obligation to contribute to the Plan for your work that is in the same industry, trade, or craft covered by a Collective Bargaining Agreement or a Non-Bargaining Participation Agreement.

Active Employees

If you are an Active Employee, coverage for you will *also* end on the *earliest* of the following:

- The first day of the month in which your hour bank account balance has fewer than 140 Covered Hours; or
- If you became covered under the Plan due to a Collective Bargaining Agreement, when your Employer fails to employ Employees covered by a Collective Bargaining Agreement.

Flat-Rate Employees

If you are a Flat-Rate Employee, coverage will *also* end on the *earliest* of the following:

- Your Employer's right to participate in the Plan under a Collective Bargaining Agreement or applicable Non-Bargaining Participation Agreement terminates;
- The last day of the month following the month your employment ends or you fail to satisfy the participation requirements of your Employer's Non-Bargaining Participation Agreement; or
- If your Employer is signatory to a current Collective Bargaining Agreement with the Union: December 31st of any calendar year, following the expiration of the 2 year period beginning with the effective date of the Non-Bargaining Participation Agreement, in which your Employer fails to report and make contributions for at least 1,000 hours for at least 1 employee performing work under a current Collective Bargaining Agreement.

Dependents

Your Dependents lose eligibility when you lose eligibility for any of the reasons stated above. In addition, your Dependents' eligibility and coverage will end on the last day of the month in which:

- Your Covered Dependent ceases to be an Eligible Dependent; or
- Your Covered Dependent enters the armed forces of the United States, except as otherwise provided by law.

In addition, your Dependent's coverage will end if you do not, within the time period requested, return an enrollment form or confirmation or proof of eligibility (such as a birth or marriage certificate), as requested by the Administrative Office from time to time. At Annual Enrollment you will be asked to review an enrollment form or confirmation to continue coverage for your Dependents the following calendar year. If you are asked to return the form and you do not, coverage for your Dependents will end, and they will have no options to continue coverage under the Plan.

Coverage for Dependents of a deceased Active Employee will remain in effect until the Active Employee's hour bank falls below 140 hours.

***Notification*.** You are responsible to notify the Administrative Office of any dependent(s) change in status. If you fail to properly notify the Plan when your dependent no longer qualifies as a Covered Dependent and payments are made for services Incurred after your dependent's coverage ends, you will be held financially responsible to reimburse the Plan for any and all overpayments.

Restoring Lost Coverage

Active Employees

If you lose coverage because you have less than 140 Covered Hours in your hour bank, you will become eligible again if you work 140 Covered Hours within six consecutive months after your hour bank dropped below 140 Covered Hours. A lag month will then apply; coverage is reinstated on the first day of the second month following the month in which you have 140 Covered Hours in your hour bank. If you are unable to build up 140 Covered Hours within six consecutive months after your hour bank dropped below 140 Covered Hours, any remaining balance in your hour bank account will be forfeited. You must re-establish Initial Eligibility again to restore coverage.

Example: John was laid off the end of December. He had enough hours in his bank to give him coverage through March. He had 90 hours left in his bank after March coverage.

John must work at least 50 Covered Hours by September for Plan coverage to reinstate 2 months after the month for which the 50 or more Covered Hours are reported. If he does not, his hour bank account goes to zero and he must re-establish initial eligibility by again working 300 Covered Hours within 5 months.
90 bank hours + 50 Covered Hours in May = 140 bank hours to reinstate coverage for July or

90 bank hours + 50 Covered Hours in September = 140 bank hours to reinstate coverage for

Non-Bargaining Employees

If your Plan coverage terminates, you and/or your Employer must re-apply. Coverage will again become effective when a new Non-Bargaining Participation Agreement is approved by the Board of

Trustees (if your Employer's participation terminated) or when you reestablish initial eligibility (if your participation terminated).

Reciprocal Coverage for Work Outside of Utah

The Board of Trustees has entered into reciprocity agreements with other health funds. Under these agreements, your eligibility under the Plan may continue while you are working outside of the jurisdiction of the Plan, so long as contributions from your new employer are timely paid into the Trust Fund in accordance with the reciprocity agreement, and they are sufficient to earn you coverage under the Plan. The Plan divides reciprocal contributions by the current hourly contribution rate to the Plan, to arrive at your Covered Hours. Contact the Administrative Office for more information.

If You Take a Leave of Absence

Generally, coverage ends whenever you do not have enough hours in your hour bank or your Employer hasn't made payment for you. However, under certain circumstances described below, you may retain coverage for a period of time while you are away from work.

Family and Medical Leave Act (FMLA)

Participants are entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993 ("FMLA"), as it may be amended. The determination as to whether a leave of absence is a FMLA leave is made by your Employer, not the Plan, and the Plan provides coverage during a FMLA leave only to the extent it receives the appropriate Contributions from your Employer.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If an Active Participant leaves employment to perform "service in the uniformed services" as defined by USERRA (hereafter "Uniformed Service") for a period of up to thirty (30) days, his/her coverage will continue during such period. If an Active Participant leaves employment to perform Uniformed Service for a period of more than thirty (30) days, the Active Participant and his/her Covered Dependents may continue coverage in accordance with USERRA for up to twenty-four (24) months measured from the date the Active Participant's absence begins. The requirements and procedure to elect continuation coverage under USERRA; the terms and conditions of such coverage; the applicable payment options; and the rules for reinstatement of Plan coverage on reemployment following Uniformed Service are described in the Plan's USERRA Procedures. Continuation coverage under USERRA runs concurrently with continuation coverage under COBRA. If there is any conflict between this section or the Plan's USERRA Procedures and the requirements of USERRA, the requirements of USERRA shall control.

Plan benefits will not be paid for any Illness or Injury determined by the Secretary of Veteran's Affairs to have been Incurred or aggravated during service in the uniformed service.

If You Are Disabled

If you are an Active Employee and are Totally Disabled for more than 30 consecutive days, no deduction will be made from your hour bank from the first day of the month in which your disability began. You must notify the Administrative Office of your Total Disability within 30 days of when you would otherwise lose coverage. You and your Covered Dependents will remain eligible for all benefits under the Plan, and your hour bank will be "frozen." This extended coverage will continue until the earliest of: (1) the first day of the month in which your disability ends, or (2) the first day of the 7th

month following your disability. These extended benefits run concurrently with extended benefits under FMLA.

This extension of benefits will not apply if the disabling condition arises out of any employment, occupation, or work or activity for wages, compensation or profit; or is covered (or would have been covered if workers' compensation premiums had been paid) by workers' compensation; or results from the commission or attempted commission of a felony, or engagement in an illegal occupation, whether or not charges are filed or a conviction results.

If You Die While Covered by the Plan

If you are an Active Employee and you die while covered by the Plan, coverage for your Covered Dependents will continue until your hour bank falls below 140 hours. If you are a Flat-Rate Employee, coverage for your Covered Dependents will continue until the end of the month in which you die. Thereafter, your Covered Dependents may elect to temporarily continue coverage under the COBRA provisions of Article III.

If you qualified for the Retiree Self-Pay Option and you are married at the time of your death, your surviving Covered Spouse may elect to continue coverage for himself or herself (and for your Covered Dependent children through age 26) under the Retiree Self-Pay Option as long as he or she does not remarry.

III. Self-Pay Options for Continuing Your Coverage

If, after becoming a Participant, your coverage ends due to insufficient hours in your hour bank account, reduction in hours or termination of employment, you may continue your coverage if you qualify to make self-payments. A Participant who wishes to self-pay must make timely payments in accordance with the rules of COBRA or Lifetime Self-Pay (both described below) so that no interruption of coverage takes place. That is, coverage must be continuous. Self-payment is the Participant's responsibility. Any break in coverage while on self-pay requires a re-establishment of coverage as described under "Restoring Lost Coverage" in Article II. You may have other options available to you when you lose coverage under the Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Self-pay rules and rates for health benefits are determined by the Trustees. The rules are changed by the Trustees from time to time. Rates are subject to change, and the Trustees may subsidize the rates from time to time in their discretion.

Though not part of COBRA's requirements, you may be able to continue your Life and AD&D benefit. Contact the Administrative Office for more information.

If you wish to change your Self-Pay payment amount because of a change in status by reason of divorce, Legal Separation, death of a Spouse, marriage, retirement or other insurance coverage eligibility, you must notify the Plan Administrative Office no later than the 20th of the month prior to the month of implementation. No retroactive adjustments will be made to credit status changes occurring in previous months.

Please contact the Plan Administrative Office if you have any questions concerning self-pay benefits, costs, payment time periods, etc.

Self-Payment Under COBRA

This Notice is intended to inform you and your Covered Dependents of COBRA Self-Pay rights and obligations. Both you and your family should take the time to read it carefully.

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Participants and their Covered Dependents may Self-Pay to continue their group health coverage in certain situations called Qualifying Events where their coverage would otherwise terminate. Once you lose coverage under the Plan, you may not continue your Weekly Disability Benefits.

COBRA continuation coverage is a temporary continuation of coverage, the length of which depends on the nature of the Qualifying Event. Subject to the conditions described below, COBRA coverage is available to persons who are Qualified Beneficiaries. Qualified Beneficiaries who elect COBRA continuation coverage must pay for that coverage.

Any Qualified Beneficiary who does not elect COBRA within the specified periods and according to the procedures described below will lose his or her right to elect COBRA coverage.

Qualifying Events

If you are an Employee covered under the Plan, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of either of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are a Covered Spouse of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse is an Employee, and your Spouse's hours of employment are reduced;
- Your Spouse is an Employee, and your Spouse's employment ends for any reason other than gross misconduct; or
- You become divorced or legally separated from your Spouse.

If you are a Covered Dependent child of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your parent is an Employee, and his or her employment ends for any reason other than gross misconduct;
- Your parent is an Employee, and his or her hours of employment are reduced;
- The Participant, who is your parent, dies;
- The Participant, who is your parent, divorces or legally separates; or
- You cease to be eligible for coverage under the Plan as a Covered Dependent child.

Under the above rules, a loss of hour bank eligibility may result in a Qualifying Event that is a reduction in the hours of the Employee's employment or the Employee's termination of employment (for reasons other than gross misconduct),

Length of COBRA Coverage

When the Qualifying Event is the end of your employment or a reduction of your hours of employment, coverage may be continued for up to 18 months. When the Qualifying Event is your death, your divorce or legal separation, or a child losing eligibility as a Covered Dependent child, a Covered Dependent's coverage may continue for up to 36 months.

The period of continuation coverage may be extended past these time limits in the following circumstances: if you become eligible for Medicare, you or a Covered Dependent is determined to be disabled by the Social Security Administration, or you or a Covered Dependent has a second Qualifying Event.

Medicare Eligibility Extension. When the Qualifying Event is the end of employment or a reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than you may last for up to 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your Covered Spouse and Dependent children may last for 36 months after

the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Disability Extension. If after you experienced a Qualifying Event because of a reduction in hours or a termination of employment, you or any Covered Dependent is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage, and if you give timely notice (described below) of the disability determination to the COBRA Administrator, you and your entire family (if covered under the Plan) can receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension. If the Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event Extension. If you or your Covered Spouse or Dependent children experience a second Qualifying Event while receiving 18 months of COBRA coverage, your Covered Spouse and children may purchase up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if you give timely notice (described below) of the second Qualifying Event to the COBRA Administrator. This extension is available to your Covered Spouse and Dependent children if you die, get divorced, or obtain a legal separation. It is also available to a Covered Dependent child when he or she stops being eligible under the Plan as a Dependent child. 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.

Special Second Election Period for Certain Eligible Individuals under the Federal Trade Act of 2002. Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit under Section 201 of the Federal Trade Act of 2002. These individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second period beginning on the first day of the month in which the employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the employee's group health plan coverage ended. If you believe you may qualify for the health coverage tax credit, contact the COBRA Administrator at the address or phone number shown below in "How To Give Notice To Elect COBRA", below, for more information.

When You Must Provide COBRA Notification

The Plan will offer COBRA coverage to Qualified Beneficiaries only if the Administrative Office receives timely and proper notice that one of the following Qualifying Events has occurred. If the Qualifying Event is your divorce or legal separation from your Covered Spouse, a Covered Dependent child losing eligibility for coverage as a Dependent, or a determination of disability by the Social Security Administration, **you or another Qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the later of the Qualifying Event or the loss of coverage, using the notice procedures described below. If these notice procedures are not followed, or if notice is not provided to the COBRA Administrator during the 60-day notice period, the Qualified Beneficiaries will lose their right to elect COBRA.**

You must, in writing, tell the COBRA Administrator that you divorced, or that your child aged out or is no longer a Covered Dependent, within 60 days of that event. Otherwise, no COBRA coverage will be provided.

If the Qualifying Event is the end of employment, a reduction of hours of employment, or the death of the Employee, you do not need to give notice of these Qualifying Events. If you are the Spouse or Dependent child of a Retiree Participant, you must give notice of the Retired Participant's death.

How to Give Notice to Elect COBRA

Your notice must be in writing. Verbal notice, including notice by telephone, notice by fax, or notice by email are not acceptable. You must mail or deliver your written notice to the COBRA Administrator at the address listed on the Quick Reference Chart.

You must include the name and address of the Participant and the name(s) and address(es) of the Qualified Beneficiaries. Your notice must also state the type of Qualifying Event and the date it occurred. You should include a copy of the divorce decree or legal separation agreement, if applicable. For a Social Security extension of COBRA, you must include a copy of the Social Security Administration's determination of disability.

If you use the mail, your envelope must be postmarked by no later than the last day of the 60-day deadline specified above. If you hand deliver your notice and documentation, it must be received by an authorized individual at the above address by no later than the last day of the 60-day deadline.

Once the COBRA Administrator is properly and timely notified that a Qualifying Event has occurred, the COBRA Administrator will notify each Qualified Beneficiary of his or her right to elect COBRA coverage. You will have 60 days to elect COBRA coverage beginning on the later of the date coverage ends due to the Qualifying Event, or the date the COBRA Administrator provides you notice of your right to elect COBRA coverage. Each Qualified Beneficiary may elect COBRA coverage for himself or herself, even if other Qualified Beneficiaries do not. Qualified Beneficiaries on COBRA have the same right to enroll family members under the Plan's special enrollment rules as if the Qualified Beneficiary were a Participant. Participants may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA on behalf of their dependent children.

Health Coverage Eligible for Continuation

You are eligible to continue only those health benefits for which you were previously covered.
Though not part of COBRA's requirements, you may be able to continue your Life and AD&D benefit. Contact the Administrative Office for more information.

Election and Payment Procedures

Upon receipt of notice of a Qualifying Event, the COBRA Administrator will mail you a COBRA election form. The Qualified Beneficiaries who want to purchase COBRA coverage must complete and return the election form within 60 days from the later of termination of coverage under the Plan or receipt of the form. You should mail the completed form to the COBRA Administrator at the address noted on the election form, postmarked within the 60-day period.

If you do not timely return the election form, no COBRA coverage will be provided.

You will have 45 days from the date you elect COBRA to make your initial Self-Payment. The payment amount is established by the Board of Trustees, and is adjusted from time-to-time. This initial Self-Payment must include the COBRA payments due from the date you lost coverage through the end of the last full month before you pay. (This could mean payment for more than one month of coverage is due at one time.) Before the end of the grace period, which is the 30th of the month in

which you pay, you must submit payment for that month. Subsequent payments are due on the first day of the coverage month. All payments must be made by check timely sent to the COBRA Administrator at the address listed on the Quick Reference Chart.

COBRA coverage will be cancelled if the COBRA Administrator does not receive your payment within the grace period, which is 30 days after each payment due date. If mailed, your payment is considered made on the date your envelope is postmarked. If your check bounces, you have not made payment.

You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator at the phone number shown on the Quick Reference Chart to confirm the correct amount of your first payment.

When COBRA Coverage Begins

For each Qualified Beneficiary who elects it, COBRA coverage will begin on the date that health coverage under the Plan would otherwise have been lost. However, if you waive your right to COBRA, and within the 60-day election period decide to revoke your waiver, COBRA coverage will begin on the date the revocation of the waiver is postmarked. There will be no coverage for the period between the date you elect to waive COBRA and the date this election was revoked.

When COBRA Coverage Ends

COBRA coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation period under any one of the following circumstances:

- Payment is not made in full and on time (taking into account the grace period);
- The date a Qualified Beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;
- The date a Qualified Beneficiary becomes entitled to Medicare;
- The date the Trust no longer provides group health coverage;
- The first day of the month that is 30 days after the date of a determination by the Social Security Administration that a Qualified Beneficiary on extended disability coverage is no longer disabled. This applies to the extended disability coverage of all Qualified Beneficiaries, but only to the 19th through the 29th month of extended disability coverage; and
- The first day of the month that follows the date the Participant's former Contributing Employer stops maintaining this Plan and starts maintaining another group health plan that covers the same class of employees as the Participant when the Participant worked for the Employer.

If You Have Questions

If you have any questions about COBRA coverage, please contact the COBRA Administrator at the phone number and address shown above. For more information about your rights under ERISA, including COBRA, see "Enforce Your Rights" at the end of this booklet.

Keep Your Plan Informed of Any Address Changes

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

Retiree Self-Pay Option

Employees are eligible to make a one-time election for self-payment Retiree coverage under the Plan. If at the time or after an Employee retires from the Pension Plan the Employee elects COBRA continuation coverage, that Employee will forever lose the opportunity to elect Retiree Self-Pay coverage. Employees are otherwise eligible to elect Retiree Self-Pay coverage as follows:

- *Active Employee*. You must retire under the Pension Plan, be a member in good standing with the Union, and have been an Active Employee continuously covered under this Plan for 60 of the 120 months immediately preceding retirement, including the month immediately preceding retirement. Your hour bank will be reduced to zero on the date you retire. A Participant who has a retirement date under the Pension Plan and does not elect Retiree Self-Pay coverage effective as of the Pension retirement date may not later elect the Retiree Self-Pay Option.
- *Flat-Rate Employee*. You must have been continuously covered under this Plan for 60 of the last 120 months, including the 12 months immediately preceding retirement, and are receiving a monthly Social Security retirement benefit.

If you are still enrolled as a Retiree in the Plan when you (or your Covered Dependents) become eligible for Medicare, to maximize your coverage you should elect and pay for Medicare Parts A and B, but not Part D.

When electing Retiree coverage, Retirees may enroll their Dependents. If married, a Retiree must enroll his or her Spouse when electing Retiree coverage. Retirees may not enroll their Dependents late, unless the Dependent qualifies for special enrollment, as follows: A Retiree Participant who later acquires a new Dependent due to marriage, birth, adoption or placement for adoption may enroll the new Dependent as well as the Retiree's Spouse. To enroll, the Retiree must complete the Plan's dependent enrollment form and submit it to the Administrative Office within 60 days of the event giving rise to the special enrollment opportunity, and coverage will be effective retroactive to the date of the event.

Covered Dependents of a Deceased Retiree. If you die while receiving Retiree coverage, your surviving Covered Dependents may continue coverage under the Plan by continuing the self-payments. If your surviving Spouse remarries, coverage under this Plan will end for your surviving Spouse and Dependent children. Coverage will stop for Dependent children when they would have otherwise lost coverage as a child under the Plan (generally, age 26).

Premiums. Self-payment premium rates are established annually by the Board of Trustees and are subject to change at their discretion.

Duration. Your participation in the Plan as a self-pay Retiree will begin on your retirement from the Pension Plan (or for Flat-Rate Employees, retirement and receipt of Social Security retirement benefits). Your eligibility for self-payment Retiree coverage will end on the *earliest* of the following:

1. The first day of the month for which you failed to timely pay your self-payment premium.
2. The last day of the month in which you are no longer receiving a pension benefit from the Utah Pipe Trades Pension Trust Fund or, if you are a Retiree who retired as a Flat-Rate

Employee, the last day of the month in which you are no longer receiving a monthly Social Security pension benefit.

3. If you are a Retiree who retired as an Active Employee, the last day of the month in which you are no longer a member in good standing with the Union.

4. On the last day of the month following the month you begin to work for an employer that has no obligation to contribute to the Plan for your work, and your work is in the industry, trade, or craft covered by a Collective Bargaining Agreement or a Non-Bargaining Participation Agreement that requires contributions to this Plan.

5. If you are a Retiree who retired as a Flat-Rate Employee, the first day of the month in which you become covered by any group health plan that is primary to Medicare.

Once your eligibility for Self-Pay Retiree coverage has terminated, you may not again participate in the Plan as a Retiree. However, Self-Pay retirees who made the special election to opt out of Plan coverage for 2016 in order to obtain coverage under Medicare or Health Care Reform's Health Insurance Marketplace, may re-enroll for Retiree Self-Pay coverage to begin January 1, 2017 if they can provide proof of continued health insurance coverage through 2016.

If you earn Covered Hours after electing Retiree coverage, the Plan will apply Employer Contributions toward your Retiree Self-Payments owed.

The premium amount, timing, eligibility, and other rules relating to payment for Retiree self-pay coverage are established by the Board of Trustees and are subject to change from time to time. Retiree coverage is not guaranteed and is not vested.

IV. Medical Benefits

Plan medical benefits are designed to help you pay the cost of Covered Medical Expenses for you and your Covered Dependents. In most cases, you will pay a portion of the cost of covered medical services and supplies you receive. Because not all services and supplies are Covered Medical Expenses, it's important to read this Plan carefully and understand your benefits before you receive services, whenever possible.

How the Plan Works

The Plan pays a percentage ("coinsurance") of the cost of Covered Medical Expenses after you pay an annual deductible and any applicable copayment. The Plan may pay Covered Medical Expenses directly to the medical service provider, or reimburse you for expenses you have already paid.

Please see the Summary of Benefits at the front of this booklet for your Medical Benefit highlights. These benefits are described in more detail below.

Important Medical Benefit Provisions

Calendar Year Maximums

Some individual benefits have calendar year maximums. See the Summary of Medical Benefits at the beginning of this booklet for the amount of your Calendar Year Maximum for specific benefits.

Precertification Review (Pre-approval of Certain Services)

Precertification assures that health care services meet or exceed accepted standards of care and are Medically Necessary. **The following services must be precertified (pre-approved) BEFORE the services are provided:**

- **All Transplant services** (and you will be assisted with the location of a plan-approved PPO facility for your transplant)
- **In-patient admissions**: All Hospital admissions for medical, surgical or behavioral health care, in addition to inpatient admissions to a hospice facility, a Skilled Nursing Facility (SNF), inpatient Rehabilitation Facility, and a Residential Treatment Facility for mental health and/or substance abuse treatment. (Note: for pregnant women, precertification is required only for Hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section).
- **Outpatient surgical procedures** performed in a free-standing or Hospital-based outpatient surgery center/unit
- These Diagnostic tests: **MRI scan, CT scan**

To precertify a service, you or your Physician must contact the Case Management and Precertification Manager (contact information is shown in the Quick Reference Chart in the front of this document). If the service or supply is not precertified you will be notified in writing. You may appeal an adverse precertification decision by following the process outlined in Article XI.

NOTE: Precertification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

Concurrent Review

When you are receiving medical services in a Hospital or other inpatient non-Hospital health care facility (for example, a Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility), the Case Management and Precertification Manager will monitor your stay by contacting your Physician or other Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Physician or other Health Care Providers of various options and alternatives for your medical care available under this Plan.

If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Physician will be notified. This does not mean that you must leave the Hospital/facility or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your admission or services were not Medically Necessary, no benefits will be paid.

Case Management

Case management is a voluntary process, administered by the Case Management and Precertification Manager whose name and phone number are listed on the Quick Reference Chart in the front of this booklet. Its medical professionals work with the patient, family, caregivers, Health Care Providers and Claims Administrator to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Any Plan Participant or Covered Dependent, Physician or other Health Care Provider or facility can request case management services by calling the Case Management and Precertification Manager. However, in most cases, the Case Management and Precertification Manager will be actively searching for those cases where the patient could benefit from case management services, and it will initiate case management services automatically.

The case manager can work directly with your Physician, Hospital, and/or other Health Care Provider or facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the case manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services. You, your family, or your Physician may call the case manager at to ask questions, make suggestions, or offer information.

The Plan, on the recommendation of the case manager, may authorize coverage of specific services, supplies, or treatments that would not ordinarily be covered, but only on clear and convincing proof that this alternative care will reduce costs.

For more information or questions on individual case management, please contact the Administrative Office.

Preferred Provider Organization (PPO)

The Plan's Preferred Provider Organizations (PPOs) are networks of Hospitals, Physicians, laboratories and other Health Care Providers and facilities who are located within given service areas and who have agreed to provide health care services and supplies for discounted fees. You pay less when you receive medically necessary services or supplies from a PPO provider. PPO providers have agreed to accept the Plan's payment plus any applicable deductible, copayment and coinsurance costs that you are responsible for paying as payment in full for Covered Medical Expenses.

In the following limited situations, the Plan will pay for Covered Medical Expenses Incurred at a non-PPO health care provider as if they were Incurred in-network:

1. If, due to circumstances beyond your control, you were treated by a non-PPO provider while at a PPO facility (for example, if you visit a PPO Hospital and your lab work is sent to a non-PPO provider for processing, or

2. If there is no PPO provider available to be used for the service or supply.

In these situations, your copay, coinsurance and deductible will be determined at the in-network level, and the Plan will pay the remainder of the Allowed Charge. All other Plan limits (such as Medical Necessity limits) continue to apply.

Health Care Providers who participate in the Plan's PPO Networks are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the PPO Network by calling the Administrative Office or PPO Networks at their telephone numbers or websites shown on the Quick Reference Chart in the front of this document. Provider directories are available at no cost, on the PPO Network website listed on the Quick Reference Chart, or a paper copy may be obtained by contacting the Administrative Office.

Deductible

The deductible is the amount of Covered Medical Expenses you must pay each calendar year before the Plan begins to pay for those expenses. Your deductible payments do not count toward your required copay or coinsurance amounts. Similarly, your required copay or coinsurance payments do not accumulate to meet your deductible amount. Deductible amounts are not interchangeable, meaning that payments of a PPO deductible amount may not be applied to meet a non-PPO deductible and vice versa. The deductible applies separately to each covered individual, and the amount applied to the deductible is the lesser of the billed charges or the amount of the Allowed Charges. See the Summary of Medical Benefits at the beginning of this booklet for the amount of your deductible.

Copayment (copay)

You must pay a charge for certain Health Care Provider services. This charge is a set dollar amount and is called your "copayment" or "copay." The amount of your copayment depends on the type of service and whether the provider is a member of the PPO Network. Your copayments do not accumulate to meet your deductible amount or your coinsurance amount. See the Summary of Medical Benefits at the beginning of this booklet for the copayments applicable to specific services.

Coinsurance

After you have paid the applicable copayment and deductible, the Plan will pay a percentage of Covered Medical Expenses and you are responsible for paying the rest. The part you pay is called your

coinsurance amount. See the Summary of Medical Benefits at the beginning of this booklet for the amount of your coinsurance for specific benefits. Note that if, because of an Emergency, you receive services from a non-PPO provider, the Plan pays Covered Medical Expenses at the PPO coinsurance percentages.

Coinsurance Maximum

Once your coinsurance payments for the year have reached your coinsurance maximum indicated in the Summary of Medical Benefits at the beginning of this booklet, you will owe no further coinsurance for Covered Medical Expenses for that year.

Out-of-Pocket Limit

The sum of applicable deductibles, copays and coinsurance you pay for Covered Medical Expenses are called your "out-of-pocket" costs. There is an annual limit to the out-of-pocket amounts you pay for Covered Medical Expenses, listed in the Summary of Medical Benefits at the beginning of this booklet. Once you reach your out-of-pocket limit for Covered Medical Expenses, you owe no further deductible, copay or coinsurance for Covered Medical Expenses for the remainder of the calendar year. The annual out-of-pocket limit on Covered Medical Expenses applies to amounts you pay toward your in-network deductible, copayments and coinsurance for covered expenses.

Covered Medical Expenses

Covered Medical Expenses include Preventive Care. **Preventive Care** means those services designated as "preventive care" in published guidelines under Health Care Reform and which the Plan is required by law to provide. Preventive Care services and supplies are payable without cost sharing when obtained from in-network PPO providers. The Plan pays nothing for Preventive Care obtained from a non-PPO provider. The Plan uses reasonable medical management techniques (such as age, frequency, location, method) to determine whether a service or supply is Preventive Care and covered by the Plan. Preventive Care is also subject to the Plan's maximum Allowed Charges.

Health Care Reform requires coverage as explained in the following web links:
http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html, and
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

CDC recommended immunizations for children and adults (see http://www.cdc.gov/vaccines/schedules/index.html).

Preventive Care services are those services performed for screening purposes when the individual does not have active signs or symptoms of an Illness or Injury condition. Preventive Care services do not include diagnostic and/or therapeutic tests or services performed because the individual has a condition or an active symptom of a condition.

Preventive Care services provided by the Plan currently include:

- Up to 8 visits through 12 months of age, up to 3 visits 13 months through 24 months of age,
- Annual physical exam 25 months of age and older,
- Annual prostatic specific antigen (PSA) lab test and digital rectal exam for men age 50 and older,
- Annual screening mammogram for women for women starting at age 40,
- Annual fecal occult blood test,

- Screening colonoscopy every 5 years for adults over age 50,
- Physician recommended behavioral interventions for obese individuals with a body mass index of 30 kg/m2.

Certain Preventive Care expenses are payable at no cost for all covered females (as listed on the following two government websites at http://www.hrsa.gov/womensguidelines/ and http://www.healthcare.gov/law/about/provisions/services/lists.html) when obtained from in-network PPO providers, including:

- 100% in-network. Generic FDA-approved contraceptives for females when prescribed by a physician and obtained at a network pharmacy and that are Preventive Care may be covered under the *Outpatient Prescription Drug Benefit* as described in Section VI. For all covered women, birth control devices and services that are Preventive Care are covered.
- Certain over the counter (OTC) drugs as mandated under Health Care Reform as Preventive Services when prescribed and obtained at a network pharmacy, such as aspirin for adults with certain health conditions, tobacco cessation drugs required under Preventive Care and iron supplements for certain children.
- For women, HPV testing beginning at age 30, screening for HIV, and counseling for interpersonal and domestic violence.
- For women, sterilization.
- Prenatal visits. Normal Plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. When a provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal visit expenses, and normal cost-sharing to 60% of the charges representing the remaining expenses.

When both Preventive Care services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the Preventive Care services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply.

When Health Care Reform's Preventive Care rules change, the Plan's coverage of Preventive Care will change accordingly.

Covered Medical Expenses also means the Allowed Charges for the following services and supplies, when Medically Necessary to treat an Illness or Injury and ordered by a Physician or other Health Care Provider. The same Covered Medical Expenses will not be recognized under more than one of the benefits described below. Amounts excluded under Article VIII are not Covered Medical Expenses. Covered Medical Expenses are subject to the annual deductible (unless otherwise noted), copayments, coinsurance and other Plan limits on benefits. Refer to the Summary of Medical Benefits chart at the beginning of this booklet for information on what you pay for Covered Medical Expenses.

- **Ambulance services** for:
  - Immediate, direct transport from the site of an accident to the Hospital where first treated.
  - Transportation between health care facilities where other transportation options would result in loss of life or limb.

- No coverage is provided for Ambulance services used only because the patient must be positioned in a wheelchair or stretcher.

- **Anesthesia,** including supplies and administration by an anesthesiologist or anesthetist during a covered surgical procedure.
- **Chiropractic treatment** by a licensed chiropractor to diagnose and correct structural imbalance, distortion, misalignment, or subluxation of or in the vertebral column and resulting nerve interference. The maximum number of visits per person will be thirty (30) per calendar year, including the initial office visit.
- **Diagnostic imaging, radiology, and lab tests** for charges incurred for imaging (including x-rays, MRIs and CT scans) and laboratory examinations for diagnosis of a bodily Injury or Illness (including allergy testing, basal metabolism determination, and electrocardiograms). *Note that an MRI scan and CT scan requires precertification.*
- **Dialysis services**.
- **Durable medical equipment.** Rental of a wheelchair, hospital bed, oxygen and the equipment for the administration of oxygen, and other similar durable medical equipment when purchase of durable medical equipment would be less expensive than the rental thereof, or if such equipment is not available for rental. Replacement of purchased durable medical equipment is covered once every 5 years, or sooner if there is a change in the covered person's physical condition making the device unusable even with modification or if the device cannot be satisfactorily repaired. Repair of durable medical equipment is covered once every 5 years, except as otherwise required by law. See below under maternity expenses for rental or purchase of breastfeeding equipment.
- **Genetic Testing** services and supplies, as follows:

a) state-mandated newborn screening tests for genetic disorders;
b) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis for Participants and Spouses;
c) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
d) genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
e) genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service in accordance with Health Reform regulations (covered as a preventive service at no cost when in-network provider is used).
f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered persons if all the following conditions are met:
   - the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
   - the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
   - the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual.

- **Genetic Counseling** is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by the Plan.

- **Home Health Care** benefits will be provided when medically necessary and such care is rendered for part-time or intermittent nursing care by a registered Nurse (R.N.), licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (LVN.). Home Health Care will include charges made by a Home Health Care Agency. Home Health Care or Home Health Care Agency benefits include only the following:
  - home health aide services (part-time or intermittently) under the supervision of a registered Nurse (R.N.) or a medical social worker. Home health aide services must be solely for the care of the patient;
  - physical therapy, respiratory therapy, or speech therapy;
  - medical supplies, drugs and medication prescribed by a Physician and necessary laboratory services;
  - nutritional counseling by a registered dietitian; and
  - evaluation of the need for a development of a plan for home care by a registered Nurse (R.N.), physician extender or medical social worker when requested or approved by the attending Physician.

  Home Health Care benefits will not be provided for the following services:
  - a masseur, physical culturist or physical education instructor;
  - routine housekeeping chores or similar services;
  - any services rendered to the patient which could have been provided by any other properly trained person of the household without endangering the individual's life or seriously impairing his/her condition; and
  - services performed by household member, family, or friends.
  - psychiatric care for family members.
- **Hospice Care** (home hospice and inpatient hospice facility) benefits will be paid by the Plan for services and supplies during any Hospice Benefit Period if a Physician certifies that a covered individual is a Terminally Ill Patient. Hospice Care covered charges include only the following:
  - up to 8 days of inpatient confinement for Respite Care; and
  - home Hospice Care furnished to the covered individual in a private residence (not necessarily the residence of the individual). Plan benefits for home Hospice Care include only the following:
    - services of a home health aide,
    - professional services of a registered Nurse (R.N.),
    - physical therapy and respiratory therapy,
    - nutrition counseling and special meals, and
    - services of a licensed or certified social worker for medical social-services rendered during a Hospice Benefit Period not to exceed a maximum of six (6) visits.

  Except for Physicians, all providers must be employees of a Hospice Agency and their services must be billed by a Hospice Agency.

  The following are excluded from the Hospice Care benefit:

- Homemaker or housekeeping services.
- Supportive environmental materials such as hand rails and wheelchair ramps.
- Services performed by household members, family, or friends.
- Psychiatric care, bereavement counseling, and other services for family members.
- Service of volunteers.
- Food, clothing, or housing (other than room and board at a hospice facility).
- Financial or legal counseling.
- Any service or supply not included in the written treatment plan or not specifically mentioned as covered.
- Spiritual counseling.

- **Hospital** charges for the following services. *Note that hospital admissions require precertification.*
  - the Hospital's charge for its daily average semi-private room rate. Unless otherwise excluded, Hospital room and board benefits are payable for 365 days during any one (1) calendar year. A private room charge is payable when Medically Necessary or the Hospital only has private rooms;
  - charges for routine nursery care of a covered newborn child (no deductible applies to the newborn child's admission);
  - miscellaneous charges for
    - services and supplies provided during confinements of the patient as a registered inpatient, at a time when the Hospital room and board benefits are payable, excluding charges for private duty nursing,
    - confinement in an intensive care unit or coronary care unit which exceeds the Hospital daily room and board benefit,
    - customary charges for anesthesia during performance of a procedure,
    - whole blood or blood plasma and the cost of its administration, and
    - autologous blood donation for use by the donor in the event of a planned surgery.
    - when confined as a registered inpatient at a Hospital for the treatment of Mental or Nervous Disorders and/or Substance Abuse. There is no coverage for recovery houses that provide an alcohol or drug-free residential setting, alcohol or drug information, educational materials or programs, referral services or school programs, except as required by law.

      Benefits will be payable for inpatient treatment of Mental or Nervous Disorders, including anorexia or bulimia, and/or Substance Abuse while Hospital confined.

- **Maternity benefits** are covered for a female, as follows. Certain prenatal care expenses are payable for all females as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/. These Preventive Care benefits include routine prenatal obstetrical office visits, screening for gestational diabetes, rental of breastfeeding equipment and supplies necessary to operate the equipment, and lactation support and counseling. Preventive Care maternity benefits are covered only when obtained from in-network providers, and there is no deductible, copay or coinsurance owed.

All other pregnancy, maternity, and delivery services and supplies are covered only for Plan Participants and Spouses. The Plan does not cover other pregnancy, maternity and delivery expenses for a dependent child but does cover complications of pregnancy.

Normal plan cost-sharing applies to all other maternity related services including ultrasounds and delivery fees.

- **Medical supplies** prescribed by a Physician are covered. Covered medical supplies include but are not limited to the following:
  - Diabetic blood sugar (glucose) testing devices and supplies.
  - Ostomy supplies.
  - Oxygen and oxygen supplies.
  - Blood transfusions, including cost of blood and blood plasma if not available free from a blood bank or voluntary donor.
- **Medical/Physician services** are covered as follows:
  - Daily Physician visits when confined in a Hospital, Rehabilitation Facility or Skilled Nursing Facility as a registered inpatient. Benefits are payable at a time when room and board benefit are payable;
  - Office visits and consultations;
  - Physician's visits at a place other than a Hospital or Physician's office;
  - Treatment of Mental or Nervous Disorders, and Substance Abuse;
  - Newborn circumcision;
  - Services for or in connection with alleviation of chronic pain by a pain control center or under a pain control program.
  - The medical plan does not require the selection or designation of a primary care provider (PCP). Participants have the ability to visit any network or Non-Network (Non-PPO) health care provider; however, payment by the Plan may be less for the use of a Non-Network provider. Participants also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Reference Chart.
- **Nursing and Physician Assistant services** by a Nurse, Nurse Practitioner or Physician Assistant.
- **Organ/Tissue Transplants**. Transplants must be performed at a PPO facility that is also designated as a Medicare Transplant Center of Excellence (COE). *Note that all transplant services require precertification* through the Case Management and Precertification Manager (see the Quick Reference Chart at the front of this document for contact information), and they will assist you in locating a plan-approved PPO facility for your transplant. Otherwise, the Plan pays no benefits. Reasonable and necessary donor expenses, including organ/tissue procurement expenses, are

covered only to the extent the organ/tissue recipient is a Participant or Covered Dependent and the donor expenses are not covered by the donor's own insurance or health plan. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted, and transportation fees to deliver the organ/tissue to the patient/recipient. The Plan does not cover experimental transplants or non-human (Xenografted) transplants or implants, except for non-human heart valves.

- **Orthotic devices** that support a weakened body part such as casts, splints, binders, leg/knee/cervical neck braces and crutches. However, foot orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are payable, when custom-made, only once every 12 months for adults and once in a period of 6 months for children under age 19 when replacement is required due to growth.
- **Outpatient Hospital benefits** are payable for Hospital charges for medical services or supplies provided during outpatient care of a covered individual for bodily Injury or Illness. Charges for medical services and supplies provided during outpatient surgery will be considered covered Hospital charges if the charges are made by a Licensed Ambulatory Surgical Facility. *Note that outpatient surgical procedures performed in a free-standing or Hospital-based outpatient surgery center/unit require precertification.*
- **Prescription drugs** that can be obtained only by a Physician's written prescription, including insulin, while you are an inpatient at a Hospital, Skilled Nursing Facility, Rehabilitation Facility, Residential Treatment Facility, or other inpatient treatment facility. Outpatient prescription drugs are covered under the Outpatient Prescription Drug Program, as described below in Article VI**.**
- **Prosthetic devices** are covered. Replacement of the device is payable once every 5 years, or sooner if there is a change in the covered person's physical condition making the device unusable or if the device cannot be satisfactorily repaired.
- **Radiation Therapy – Chemotherapy** benefits are payable for charges Incurred for therapy, including the use of x-ray, radium, cobalt and other radioactive substances. "Chemotherapy" means drug therapy administered as treatment for malignant conditions and diseases of certain body systems. Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.
- **Reconstructive breast surgery** and associated procedures after a Medically Necessary mastectomy (regardless of when the mastectomy was performed) determined in consultation with the patient and attending physician is covered for:
  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

  Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.
- **Rehabilitation Facility**. Plan benefits for room and board and miscellaneous services are payable for charges Incurred by a covered individual as a result of confinement in a Rehabilitation Facility. A 60 day per calendar year limit applies where confinement is due to receipt of Rehabilitative therapies; no limit applies where confinement is related to treatment of Mental or Nervous Disorders, or Substance Abuse. To be covered by the Plan, the Rehabilitation Facility must be an in-Network PPO facility. *Note that admission to a Rehabilitation Facility requires precertification.*

- **Rehabilitative therapies**. Rehabilitative (outpatient and/or inpatient) occupational therapy, physical therapy and speech therapy services prescribed by a Physician are payable for up to 60 days per calendar year when significant improvement can be obtained. The Plan covers additional outpatient therapy if the attending Physician certifies such therapy is Medically Necessary and reasonable.

  The following types of therapy are covered:

  - **Occupational therapy** performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA);
  - **Physical therapy** performed by a Physician or a registered physical therapist; and
  - **Speech therapy** when performed by a qualified therapist.

  Benefits are not payable for Habilitative therapy, or for therapy to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. Physical therapy and occupational therapies which are prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) are not covered by the Plan.

- **Residential Treatment Facility.** Plan benefits for room and board and miscellaneous services are payable for charges incurred by a covered individual as a result of confinement in a Residential Treatment Facility for treatment of Mental or Nervous Disorders, or Substance Abuse. To be covered by the Plan, the Residential Treatment Facility must be an in-Network PPO facility. *Note that admission to a Residential Treatment Facility requires precertification.*

- **Skilled Nursing Facility** (SNF) room and board accommodations and miscellaneous services and supplies are covered up to a maximum of 60 days per calendar year. Services at the Facility must be in lieu of hospitalization. Custodial Care is not covered. To be covered by the Plan, the SNF must be an in-Network PPO facility. *Note that admission to a Skilled Nursing Facility requires precertification.*

- **Surgery.** Charges for the following surgical services are covered:

  - professional surgical services rendered by the operating Physician (surgeon) in the performance of a surgical procedure;
  - professional surgical services rendered by an assistant surgeon (when such services are necessary according to Medicare guidelines) in the performance of a surgical procedure, not to exceed 20% of the operating surgeon's benefit allowed by the Plan;
  - professional surgical service rendered by a legally licensed and qualified Physician's Assistant, registered Nurse (R.N.), or surgical assistant who is acting as an assistant surgeon as part of the surgical team, not to exceed 20% of the operating surgeon's Allowed Charge;
  - when multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session, through the same incision, the total amount payable shall be for the major procedure, plus 50% of the lesser procedures. When multiple procedures are carried out through separate incisions or on separate sites, the total shall be the value of the major procedure plus 50% of the lesser procedure; and
  - professional services rendered by an anesthesiologist during performance of a surgical operation.

  The maximum surgical amount payable shall include the surgery and the follow-up care for the period indicated in the Plan's Allowed Charges schedule.

When an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, simple lysis of adhesions, simple repair of hiatal hernia, puncture of ovarian cyst, etc.) is performed through the same incision, the amount payable, if any, will be as indicated in the Plan's Allowed Charges schedule.

Surgical benefits for a procedure not listed in the Plan's Allowed Charges schedule and not otherwise herein excluded is paid in an amount equal to that shown in the Plan's Allowed Charges schedule for a listed procedure of comparable gravity and severity.

- **Weight management surgery (bariatric surgery)** is covered once per lifetime for individuals diagnosed with "morbid obesity" and includes the following weight management services only: surgical intervention such as gastrointestinal bypass and any complications thereof. "Morbid obesity" means a body mass index (BMI) exceeding 40, or BMI greater than 35 in conjunction with any of the following severe co-morbidities:
  - coronary heart disease; or
  - type 2 diabetes mellitus; or
  - clinically significant obstructive sleep apnea; or
  - high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic); or
  - pulmonary hypertension

  BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared:

  $$BMI = \frac{\text{(weight in kilograms)}}{\text{(height in meters) times (height in meters)}}$$

  or compute using the Obesity Education Initiative website: http://www.nhlbisupport.com/bmi/. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Exclusions

See General Exclusions and Limitations under Article VIII for services and supplies not covered under the Plan. Some services and supplies are not covered by the Plan, even if they are Medically Necessary.

V. Employee Assistance Program

The Employee Assistance Program (EAP) is a resource designed to help you and Covered Dependents deal with many personal or relationship issues that may be causing distress, such as marital difficulties, family problems, stress and anxiety, depression, grief or loss, drug/alcohol addiction, and legal issues. The name and contact information for the EAP administrator can be found in the Quick Reference Chart located at the front of this booklet.

How the EAP Works

To receive EAP assistance, call the EAP administrator at any time (24 hours a day, 7 days a week). Depending on your circumstances, you may be offered short-term counseling services with a licensed mental health professional (for example, a psychologist or family therapist). Counseling may be provided face-to-face or over the telephone. In non-emergency situations, the EAP counselor will offer you an appointment with a licensed mental health professional within 48 hours. In emergency situations, you will receive immediate help. If you are calling concerning a legal issue, you may be offered a consultation with a licensed attorney.

Counseling services and consultations provided by the EAP are confidential except where required by law, although the EAP counselor may help coordinate your care between your other Health Care Providers. You may also authorize the EAP counselor to discuss your care with your family members.

EAP counseling services and consultations are free, with no co-pay, and do not count towards Plan visit limits for Mental or Nervous Disorders or Substance Abuse services. There is no pre-set limit on the number of free EAP counseling sessions offered, although most problems are addressed in just a few sessions over a couple of months. However, if you require lengthier or more specialized services than the EAP is intended to provide (such as help with drug or alcohol addiction), the EAP counselor will refer you to other Health Care Providers within your community. If you decide to seek help from one of these providers, you are responsible for any charges you incur, except to the extent such charges are otherwise covered under the Plan.

VI. Outpatient Prescription Drug Program

The Plan covers outpatient prescription drugs through an independent pharmacy benefit manager (PBM**)** drug card program. The current PBM Outpatient Prescription Drug Program contact information can be located on the Quick Reference Chart in the front of this document. This program features a network of participating PPO retail pharmacies. The list of participating PPO pharmacies can change from time-to-time. For an updated list, contact the PBM. The Medical Plan deductible does not apply to the Outpatient Prescription Drug Program benefits.

Prescription drugs dispensed while you are an inpatient at a Hospital are covered under the Medical Benefits section of the Plan (Article IV).

Generic drugs, including over-the-counter (OTC) drugs, mandated under Health Care Reform as Preventive Care are covered 100% without cost sharing when prescribed and filled at a participating PPO pharmacy or the PBM mail order service.

Copays, Coinsurance and Out-of-Pocket Limit

For some prescriptions you pay a copay or coinsurance amount, as described in the Summary of Outpatient Prescription Drug Benefits in the front of this booklet. These are your out-of-pocket costs for the Outpatient Prescription Drug Program. Once you reach your out-of-pocket limit for covered outpatient prescription drugs, you owe no further copay or coinsurance for covered prescription drugs received from a participating PPO pharmacy for the remainder of the calendar year. See the Summary of Medical Benefits in the front of this booklet for the Outpatient Drug Benefit out-of-pocket limit and additional restrictions.

If You Use a Participating PPO Pharmacy

When you use a PPO pharmacy, simply take your prescription and your drug identification card to the pharmacy and pay the appropriate copayment/coinsurance amount to receive up to a 30-day supply; no claim forms are required. See the Summary of Benefits chart for your copayment/coinsurance.

Also, you may get Preventive Care immunizations (at no cost) at certain participating pharmacies (contact the PBM listed in the Quick Reference Chart for pharmacies in your area which participate in the immunization network).

If you receive a non-formulary brand-name drug when a formulary brand-name drug is available, you will have to pay the higher coinsurance amount. Your participating pharmacy can tell you if a formulary drug is available.

If you choose to purchase a brand name drug when a generic equivalent is available, the plan will only pay the amount it would have paid for the generic drug. So if the brand name drug costs the Plan more, you will have to pay the difference.

Specialty Drugs

Specialty drugs are available on an outpatient basis only when ordered through and managed by the PBM. Specialty drugs are products used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs **require pre-approval** by the clinical staff of the PBM because they often require special handling, are date

sensitive and are usually available only in a 30-day quantity. The list of specialty drugs changes from time to time. Please contact the PBM listed in the Quick Reference Chart located at the front of this document for a current list.

Compound Drugs

A compound medication is one that is made by combining, mixing or altering ingredients in accordance with a prescription, to create a customized medication that is not otherwise commercially available to be purchased. Compound drugs that cost $300 or more must be precertified. Otherwise, the Plan pays no benefits. To precertify a compound drug, you or your Health Care Provider must contact the PBM listed in the Quick Reference Chart at the front of this booklet before the drug is filled. If the precertified compound is not approved you will be notified and provided information on how to appeal that decision. You may request an appeal of an adverse review decision by following the process outlined in Article XI.

NOTE: Precertification does not mean benefits are payable in all cases. Coverage depends on the prescription drugs that are actually provided, your eligibility status at the time the prescription drug is provided, and any benefit limitations.

What do I pay if I use a Non-PPO Pharmacy?

You pay the difference between the Non-PPO pharmacy's charge, and the PBM's maximum rate for the same drug. For example, let's say the PBM's maximum rate for your generic prescription drug is $50, but the cost at your non-PPO pharmacy is $85. At the time of purchase, you must pay your pharmacist the full $85 cost, then, you may file a claim with the Plan's PBM. You are responsible for the $8 generic drug copayment plus the $35 difference between the Non-PPO cost and the PBM's maximum rate for the drug (your total cost is $43). The PBM will reimburse you $42.

If you had instead gotten your prescription filled at a PPO pharmacy, you would have paid $8 at the pharmacy for the same drug.

Maintenance Drugs: Retail or Mail Order

For maintenance drugs — those drugs you use on an ongoing basis to treat chronic conditions such as a thyroid condition, arthritis, diabetes or high blood pressure — if you use a PPO pharmacy or the PBM mail order service you can fill up to a 90-day supply and pay the lower Copayments listed in the Summary of Benefits chart.

In order to ensure the drug will be effective for you, the *first* time you fill a prescription for a maintenance drug, the PBM will authorize only a 30-day supply. After that, you can ask the PBM to authorize refilling your maintenance drugs for a 90 day supply.

90-day supplies of maintenance drugs are only available through a participating retail pharmacy or through the mail order pharmacy listed on the Quick Reference Chart located at the front of this document.

Special Programs

The Trustees may from time to time adopt one or more special prescription drug programs of limited duration that waive all or part of the copayment or coinsurance that would otherwise apply with respect to particular prescription drug purchases in order to promote Plan efficiencies. Any such programs will be communicated in writing.

If You Use a Non-Participating PPO Pharmacy

You must fill specialty drugs and maintenance drugs at a PPO pharmacy or by mail order. If you fill your other prescriptions at a non-PPO pharmacy the same co-payments generally apply, but you must

pay the full cost of the drug up front when you make the purchase. Then, submit a claim form and the receipt to the PBM for reimbursement. Claim forms are available from the Plan Administrative Office or by calling the PBM (see the Quick Reference Chart at the front of this document).

If your non-PPO pharmacy charges more than the PBM's maximum rate for the same drug, you pay the difference.

If You Have other Prescription Drug Coverage

If you or your Covered Dependent have other primary prescription coverage, your prescription drug co-pays may be reimbursed under the medical Plan. See Article IX for more information on coordinating benefits.

Covered Prescription Drugs

Covered prescription drugs include legend drugs, prescription contraceptives, injectables for treatment of allergic reactions such as bee stings, and insulin. Covered prescription drugs will only be those that are Medically Necessary and are dispensed upon the written prescription of a Physician or Dentist. Drugs that have not yet been approved by the FDA are not covered.

Exclusions

In addition to the General Exclusions and Limitations contained in Article VIII, the following are not covered under the Outpatient Prescription Drug Program, except as required by law:

- non-prescription contraceptives for males;
- drugs that do not require a prescription, except insulin;
- over-the-counter (OTC) medications, except that the Plan will cover Prilosec OTC, Claritin OTC and Zyrtec OTC the same as retail generic drugs, as long as the patient presents a written prescription from his or her Physician and the medications are purchased at the retail pharmacy. The Plan will cover drugs—including OTC drugs—mandated by Health Care Reform.
- vitamins, food, legend vitamins and health foods (unless required by Health Care Reform);
- drugs used for diet or obesity;
- smoking/tobacco cessation/deterrents, except when covered as Preventive Care;
- fertility inducing drugs;
- hair growth products such as Rogaine or other topical Minoxidil compounds, or hair loss products;
- medical devices;
- Retin A, except for the treatment of acne. Patients over age twenty (20) require a Physician's letter;
- Desoxyn, Dexedrine and similar central nervous system stimulants are not covered except when prescribed by a physician for the treatment of narcolepsy or hyperactivity associated with attention deficit disorder;
- Drugs to treat erectile dysfunction;
- Drugs not approved for marketing or sale by the FDA;
- Drugs not approved by the FDA for persons with your Illness or Injury;

- Prosthesis (but see Medical Benefits).

INFORMATION ABOUT MEDICARE Part D Prescription Drug Plans FOR INDIVIDUALS WITH Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan benefits. It has been determined that the outpatient prescription drug coverage outlined in this document is "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however, you enroll in a Medicare Part D Prescription Drug Plan, you will lose prescription drug coverage under this Plan. If you enroll in a Medicare Part D Prescription Drug Plan you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan.

Medicare-eligible individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving union group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Medicare Part D Notice of Creditable Coverage (a copy is available from the Administrative Office). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

VII. Dental and Vision Care Benefits

The Plan may from time to time offer dental and/or vision care benefits. You will be notified in writing if these benefits are offered and your ability to opt out of the benefit.

VIII. General Exclusions and Limitations

This Article VIII applies to the Medical and Outpatient Prescription Drug Program benefits.

Because the Plan has limited funding, it does not cover all of your medical and prescription needs. If a service or supply is not covered, then it won't apply toward your annual deductible, coinsurance maximum or out-of-pocket limit, even if the treatment is Medically Necessary. Except as required by law, the Plan does not cover services or supplies rendered for or in connection with any treatment directly or indirectly related to the following. The phrase "in connection with" also means any services, treatment, supplies, or accommodations which are a complication of or would not be necessary but for the occurrence of the excluded type of service, treatment, supply, or accommodations.

- Any services or supplies not specifically identified as covered, except as otherwise required by law;
- Any services or supplies for which coverage is available or furnished under any federal, state or other government program, or while incarcerated, except as required by law;
- Unless specifically provided otherwise, no benefits are provided for any charge under more than one (1) coverage;
- If the individual is not obligated to pay, is not billed or would not have been billed, except for the fact that the individual was covered under this Plan;
- Any service or supply that is not Medically Necessary, or is not generally accepted medical practice for the individual's Illness or Injury;
- Charges resulting from, in connection with, contributed to, occurring during the course of or arising out of any employment, occupation, or work or activity for wages, compensation or profit;
- Hearing examinations (audiograms), hearing aids or the fitting thereof;
- Cosmetic surgery, corrective plastic surgery or reconstructive surgery (except plastic, cosmetic or reconstructive surgery due to a condition caused by a malignancy or as specifically described in Article IV), surgery for developmental malformations, or as the result of earlier cosmetic, plastic, or reconstructive surgery, unless the surgery is necessary for the repair or alleviation of damage resulting from a disability caused by bodily injuries or the surgery is necessary because of congenital disease or anomaly of a Dependent child which has resulted in a functional defect;
- Injury or Illness resulting from any military service, act of war or terrorism, armed invasion or aggression, insurrection, rebellion or riot, except as provided by law;
- Injury or Illness resulting from any release of nuclear energy, except when being used solely for medical treatment of a bodily Injury or Illness under direction and prescription of a Physician;
- Injury or Illness resulting from or arising out of the Participant's or Covered Dependent's commission or attempted commission of a felony or engagement in an illegal occupation, whether or not charges are filed or a conviction results;
- Services or supplies for an Illness or Injury arising out of or occurring during incarceration;
- Vocational training or rehabilitation; Habilitative therapy services.

- Custodial care, medical or dental care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home or similar establishment, unless required by law;
- Expenses for learning deficiencies, behavioral problems and special education;
- Infertility and fertility treatment - Services, drugs, supplies, and any natural or artificial means to induce pregnancy or treat or diagnose infertility (male or female), such as artificial insemination, in vitro fertilization, embryo transfer, gamete intrafallopian transfer, embryo implant, and surrogate motherhood;
- Humidifiers (except the Plan does pay for humidifiers for an eligible CPAP machine), air conditioners, exercise equipment, whirlpools, health spa or swimming, heating lamps or pads, lift or contour chairs, vibrating chairs or beds, blood pressure monitors or machines, and the like;
- Charges Incurred, services delivered or supplies dispensed prior to the individual's effective date of coverage or after the individual's coverage terminates under the Plan;
- Charges for personal service such as radio, television, personal convenience, guest trays or hygiene items;
- Any treatments, services, or supplies to diagnose or treat gender dysphoria (or any other gender identity disorder), sexual addictions, sexual or psychosexual identities or dysfunctions, sexual deviations, sexual inadequacies, transsexualism, or any other similar disorders or conditions of a sexual nature, including any complications arising therefrom, regardless of the condition's origin;
- Charges for private duty nursing care, medical or dental care or treatment, performance of surgical procedures, or therapies when those services are rendered by an individual that ordinarily resides in the patient's home or who is a member of the patient's immediate family;
- Acupuncture, acupressure, or services performed by a naturopathic or homeopathic provider including supplies, except as required by law;
- Routine foot care, including but not limited to, callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches (except foot orthotics), flat pronated foot metatarsalgia, or foot strain; except that removing nail roots and routine foot care is payable when prescribed by a licensed Physician treating metabolic or peripheral vascular disease;
- Non-surgical treatment for temporomandibular joint (TMJ) dysfunction/pain syndrome, upper or lower jaw augmentation or reduction procedures (orthognathic surgery) or appliance for restorations necessary to increase actual dimension or restore occlusion, except as otherwise specifically described herein.
- Orthoptics (vision training);
- Dental benefits, except as provided from time-to-time under Section VII.
- Vision services or supplies, except as provided from time-to-time under Section VII. This exclusion includes, but is not limited to, eye examinations, eyewear or the fitting of contacts or glasses, surgical correction of refractive errors, including but not limited to radial keratotomy and laser in-situ keratomileusis (LASIK);
- Biofeedback or hypnotherapy;
- Nutrition services, supplies and counseling, except as required by law;

- Hair loss or restoration or hair removal;
- Charges for educational material, literature, or charges made by a provider to the extent that they are related to scholastic education, learning disabilities, or behavior modification, or for dealing with normal living such as diet, or medication management for Illness such as diabetes;
- Immunizations which do not constitute Preventive Care;
- Charges for motor vehicles, motor vehicle devices such as hand controls, lifts or specialized vehicle alterations, wheelchair ramps, handrails or other specialized construction in or around the home;
- Air filtration units, vaporizers or humidifiers, heating lamps or pads, lift or contour chairs, vibrating chairs or beds, blood pressure monitors or machines;
- Charges for commode, bath bench, or other convenience items for activities of daily living; batteries or routine maintenance of equipment;
- Reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved;
- Charges for Physician's telephone consultations and/or travel time;
- Charges in connection with shipping, handling, postage, interest or finance;
- Charges for examinations, or consultations provided by any public or private school or halfway house, or by employees thereof, or provided solely to satisfy institutional requirements;
- Charges for missed appointments;
- Charges for inpatient care and treatment when such care and treatment could properly be provided on an outpatient basis;
- Any surcharges an individual, the Fund, or its Administrator incurs as a result of state laws (e.g., New York Health Care Reform Act);
- Any charges Incurred through Medicare private contracting arrangements;
- Expenses payable under any type of motor vehicle insurance (including, but not limited to, personal injury protection (PIP), no-fault, or underinsured/uninsured motorist coverage), or under other insurance;
- Massage or massage therapy;
- Claims Incurred outside the United States, except for emergency services;
- Travel, food, or lodging;
- Services performed outside the scope of the provider's license or certification under state law;
- Services or Supplies that exceed the Plan's Allowed Charge or that the Plan otherwise limits;
- Charges submitted to the Plan more than 12 months after the expense for the service or supply is Incurred;
- Experimental or investigative drugs, devices, services or supplies;
- Smoking cessation or nicotine addiction services or supplies other than Preventive Care;
- Expenses for residential schools, group homes, wilderness programs, half-way house or boarding

school;

- Services or supplies received at school;
- Services and supplies, for which benefits are recoverable under motor vehicle or other insurance (except that the Plan may coordinate benefits or advance payment of expenses as described in Section IX);
- Services or supplies an Employer is required to provide under a labor agreement or that are a condition of employment;
- Work-required exams or tests;
- Charges for weight management, except to the extent of Preventive Care or otherwise specifically covered by the Plan;
- Services or supplies received in a Veteran's facility, except as required by law;
- Charges payable under any other program, plan or insurance, or charges for which a third party is responsible for paying (except that the Plan may coordinate benefits or advance payment of expenses as described in Section IX).
- Expenses for services or supplies related to:
  - dyslexia, learning disorders (including tests and related expenses to determine the presence of or degree of a person's dyslexia or learning disorder);
  - vocational disabilities;
  - court-ordered Mental or Nervous Disorders or Substance Abuse services or custody counseling unless such services are Medically Necessary and would be a covered benefit under the Plan;
  - family planning/pregnancy/adoption counseling, marriage/couples counseling, and transsexual/gender reassignment/sex counseling. (Note marital/family counseling is available through the EAP.)
  - financial or legal counseling;
  - autism spectrum disorder, Asperger's syndrome, pervasive developmental disorder, neurodevelopment delay, a learning disability, and delays in a child's language, cognitive, motor, or social skills.

IX. Coordination of Benefits, Plan Recovery for Overpayments and from Third Parties, Miscellaneous

If you are covered by another health plan, let the Administrative Office know. The Plan will then coordinate benefits, which usually results in you paying for less of your health expenses. You can never receive more from your health plans than you are charged by your doctor and other providers.

Many people enroll in more than one health care plan in order to protect themselves against the high costs of medical or dental care. To keep the cost of Plan benefits as low as possible, the Administrative Office coordinates benefit payments with other health care plans, Medicare, and other governmental plans, and in situations where a person has dual coverage under the Plan.

If you or your Dependents are covered under another health plan, Medicare, or other governmental plan, you must submit identical itemized bills to both plans. Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) pays after the primary plan and may reduce the benefits it pays so that the payments from all plans do not exceed 100% of the total allowable expenses. An "allowable expense" is a health care expense covered by one of the plans, including copays, coinsurance and deductibles. Sometimes the combined benefits that are paid will be less than total allowable expenses.

Effect On Plan Benefits

When the Plan is primary, it pays its regular benefits in full. When the other plan is primary, the Plan pays a reduced amount.

If your primary plan reduced benefits because you did not use a primary plan preferred provider or you did not comply with the primary plan's provisions, such as pre-certification requirements, the Plan will not pay those reductions.

In no event will the Plan reimburse an expense that is or should be covered by another plan, government program, insurance, or other source.

If you have dual coverage under the Plan (for example, because you are a Participant and you are married to another Participant), the Plan will coordinate benefits—Participant coverage is primary and Dependent coverage is secondary. If you have otherwise obtained reimbursement for an allowable expense, the Plan will not again reimburse you for that same expense.

To administer coordination of benefits, the Plan has the right to: exchange information with other plans involved in paying claims; require that you, your Physician, or your health care provider furnish information; reimburse any plan that made payments the Plan should have made; and recover overpayments.

Coordination With Other Health Plans

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

The Administrative Office uses the following rules to determine which medical plan is primary. In general, the Plan does not coordinate outpatient prescription drug coverage. However, the Plan will reimburse your copay for a prescription drug paid primarily by another health plan, to the extent explained below. If the first rule does not determine which plan is primary, the next rule is applied, and so on until the order of benefits is determined.

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the Plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee); then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

   1. the parents are married;

   2. the parents are not separated (whether or not they ever have been married); or

   3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same Birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the Plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the Plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the Plan that covers the parent whose Birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care

services or expenses, the order of benefit determination among the Plans of the parents and their Spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the Spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the Spouse of the non-custodial parent pays last.

F. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents coverage and the dependent's self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the Plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

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

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.

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

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the Plan; or
3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the Plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

If You Are Eligible for Medicare

Medicare is a health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD). When you or your Spouse reaches age 65, Medicare Part A (hospital insurance) is generally automatic if you apply for Social Security benefits. Medicare Part B (medical insurance) requires enrollment and monthly premium payments. Medicare Part D (prescription drug insurance) requires enrollment and monthly premium payments. Contact your local Social Security Administration Office for information about enrolling in Medicare.

You need to enroll for both Medicare Part A and Medicare Part B to receive maximum available benefits under this Plan. If you do not enroll in and utilize Medicare Parts A and B when eligible, benefits payable under this Plan will still be reduced by the amount Medicare would have paid under Medicare Parts A and B. If you enroll in Medicare Part D you will lose outpatient prescription drug coverage under the Plan.

To maximize your coverage, enroll in Medicare when you are eligible, and pay for Part B. However, do not enroll in Part D or the Plan won't pay for your outpatient prescription drugs.

Coordination with Medicare

Medicare is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over), and you are *not* a working Participant, or
- You or your Dependent are entitled to Medicare on the basis of a disability, and you are *not* a working Participant, or
- After being entitled to Medicare on the basis of age (65 or over) or disability, you or your Dependent become eligible for Medicare because of end stage renal disease (ESRD), and you are *not* a working Participant. In these circumstances, Medicare will continue to pay benefits as the

primary provider.

This Plan is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over) and you are a working Participant (unless the exemption below applies), or
- You or your Dependent are entitled to Medicare on the basis of a disability, and you are a working Participant, or
- You or your Dependent become eligible for or entitled to Medicare as a result of having end-stage renal disease (ESRD). Medicare acts as the secondary payer for the first 30 months of eligibility or entitlement. After 30 months, Medicare becomes primary.

The Plan may apply for an exemption that allows a working Participant and his or her Dependents who are receiving Medicare benefits on the basis of age to receive Medicare benefits as primary benefits, and for the Plan to be secondary. This exemption is available only if the Participant works for a Contributing Employer with fewer than 20 employees for 20 or more weeks in both the prior calendar year and the current calendar year, and the government grants the Plan's application for the exemption.

If you are eligible for Medicare the Plan pays benefits as if you had elected Parts A and B, whether or not you actually do so.

Coordination With Medicaid, TRICARE & Other Coverage Provided By Law

This Plan is always primary to Medicaid, TRICARE, and any other coverage provided by any other state or federal law that requires the Plan pay primary.

However, if you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related condition, benefits are not payable by the Plan. If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of any Illness or Injury that is *not* a military service-related condition, benefits are payable only to the extent those services are otherwise covered by the Plan.

Notifying the Plan of Other Coverage

It is your responsibility to notify the Administrative Office if you or your Dependents have coverage other than Plan coverage, or if your other coverage terminates. Failure to provide this notice may result in loss of your Plan benefits. In addition, you will be required to fully reimburse the Plan for any claims paid in excess of the amount that should have been paid under the Plan.

By participating in the Plan, you agree that if the Plan pays primary and later determines that it is the secondary plan, the Plan will be subrogated to all the rights you may have against the other plan, and you agree to execute any documents required or requested by the Plan to pursue its claims for reimbursement of the amount advanced.

Plan's Rights to Recovery

Payment is made for claims based upon your representations and those of your Covered Dependents and/or providers concerning the services rendered and is contingent upon benefits being covered under the terms of the Plan.

By accepting benefits, you and your Covered Dependents agree:

- To promptly refund to the Plan any amount that exceeds the amount covered by the Plan or any amount that is subject to the Plan's subrogation or reimbursement rights, discussed in the following section,
- That the Plan may reduce or deny coverage of your claims or the claims of your Covered Dependents as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and
- To reimburse the Plan in full for any benefits from the Plan to which the individual is later found not to be entitled.

The Plan may also recover interest on the amounts paid by the Plan from the time of the payment until the time the Plan is reimbursed.

Furthermore, whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan will be authorized to pay such benefits to the other party. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you. Any Participant or individual who receives (or whose family receives) benefits from the Plan to which he or she is later found not to be entitled will be required to reimburse the Plan in full.

Plan's Subrogation and Reimbursement Rights

The Plan does not cover any health expenses for an Injury or Illness if the expenses are recoverable from someone else (a "third party"). The Plan may refuse to pay any health expenses the Plan believes are or may be the responsibility of a third party. Alternatively, the Plan may advance payment of benefits while you pursue recovery from a third party, subject to the Plan's right to be fully reimbursed out of any payment that a third party makes to you, your family members, your attorney or to anyone else acting on your behalf in connection with the Injury or Illness (a "third-party payment"). Third-party payments are assets of the Plan and cannot be transferred or paid to you or any other person until the Plan has been fully reimbursed. This is called the Plan's *right to reimbursement*.

In addition, the Plan has the right to take your place in recovering payments directly from the third party. The Plan's right to do this is called its *right of subrogation*.

For instance, if you are injured in an automobile accident, the Plan is entitled to both subrogation and reimbursement as follows:

- If your insurance company or the other driver's insurance company is responsible for making a payment to you because of the accident, the Plan has the right to demand that the insurance company pay the Plan directly first for the expenses covered by the Plan, before you get any excess amount.
- If you make a claim or file a lawsuit against the other driver and get any kind of recovery, the Plan again has the right to be paid first, even if you don't agree it should. If you obtain any kind of payment before the Plan gets its share, you must reimburse the Plan immediately.

Under its rights of subrogation, the Plan may make a claim or file a lawsuit for you, or act in your behalf in any claim or legal proceeding, and would be entitled to reimbursement for court costs, expenses, and attorneys fees, in addition to the benefits advanced by the Plan.

The Plan's rights to subrogation and reimbursement also constitute a "constructive trust" or "equitable lien" against any and all third-party payments made now or in the future, regardless of how the

payments are characterized. The Plan's lien is in the full amount of all the health expenses paid by the Plan in connection with the Illness or Injury, regardless of when the expenses are paid or incurred (including, for example, expenses incurred after you receive a third-party payment). In the Plan's sole discretion, the Plan's lien may also include interest on the amounts paid by the Plan from the time of payment until the time the Plan is reimbursed. The Plan is not required to pay any fees to the attorney you hire to pursue a third-party payment, or to reduce its lien for any costs or attorney's fees you incur or for any other reason.

The Plan's rights to third-party payments. The Plan is entitled to *full* reimbursement for all health expenses it pays relating to the Illness or Injury and has a "first dollar" right of reimbursement. That is, the Plan has the right to be reimbursed first from the total amount of any and all third-party payments, without reduction for any attorney's fees or costs that you may incur in pursuit of the recovery. The Plan has the right to be reimbursed even if the third-party payments are not designated as payment for medical or disability expenses. This includes the following payments:

- Any judgment, settlement, or other payment relating to the Illness or Injury, from whatever source.
- Any payment made by your insurance or a third party's insurance, including vehicle insurance, no-fault automobile insurance, uninsured or under insured motorist coverage, business insurance, homeowner's insurance, personal umbrella insurance, or any other type of insurance or insurance-type coverage.
- Payments designated as medical benefits, as disability payments, as compensation for pain and suffering, as attorneys fees, or as other specified or general damages.
- Any partial payment made for any reason, even if you are not "made whole." This means that the Plan has the right to be repaid in full first, even if you do not expect to receive full compensation for your damages from the third party.

Your notification and cooperation are required. By accepting benefits under the Plan, you agree that the Plan has the rights of subrogation and reimbursement, and you agree to promptly provide information requested by the Administrative Office to help the Plan enforce these rights.

You must notify the Administrative Office within 45 days of the date that you have an Injury or Illness that might be the responsibility of a third party and when you or your attorney gives notice to any third party that you intend to investigate or pursue a claim to recover damages.

In addition, the Administrative Office may require that as a condition of the Plan advancing further benefits relating to the Illness or Injury, you or your covered spouse or other family members, as well as any attorney or authorized representative for you or your covered spouse or other family members, sign a reimbursement agreement within 45 days of request by the Administrative Office. This reimbursement agreement may: (1) incorporate any or all of the rules of the Plan regarding the Plan's rights to subrogation and reimbursement, (2) require that your attorney agree to honor the Plan's lien on third-party payments, and/or (3) contain any other terms necessary or appropriate to enforce the Plan's rights or to ensure that the contract will be enforceable in state or federal court, at the Plan's election. Any benefits the Plan advances in absence of a signed reimbursement agreement will nonetheless be fully subject to the Plan's subrogation and reimbursement rights.

If you receive a third-party payment, you must promptly notify the Plan and hold the total amount of the payment in an escrow or trust account acceptable to the Plan (or, if you are represented by an attorney, you must direct your attorney to hold such funds in trust) until the Plan has been fully

reimbursed. A third-party payment constitutes Plan assets under ERISA, to the extent of the Plan's lien. That means that you have a fiduciary responsibility to protect the Plan's lien and reimbursement rights.

If you or your attorney do not timely provide requested information, do not timely sign the Plan's reimbursement agreement, do not timely reimburse the Plan following receipt of a third-party payment, or otherwise fail to cooperate, the Plan will stop advancing benefits related to the Injury or Illness, and any expenses previously advanced by the Plan will be considered an overpayment of Plan benefits. To recoup the overpayment, the Plan may reverse (i.e., deny) payment of such benefits, deny coverage of your other benefit claims or the claims of your covered family members (even if the claims do not relate to the Injury or Illness), and/or take legal action. The Plan's lien continues to apply to a third-party payment regardless of whether the funds have been disbursed or commingled with other funds.

More about subrogation and reimbursement.

- After you have received a third-party payment, the Plan may pay no further expenses relating to the Illness or Injury, regardless of when the expenses are incurred. As a condition of advancing payment of any further expenses, the Plan may require that you continue to hold all or a portion of the total third-party payment in trust for the purpose of reimbursing the Plan.
- The Plan's subrogation and reimbursement rights also apply to your covered spouse and other family members and to your (or their) estates or heirs in the event of death.
- The Plan's subrogation and reimbursement rights apply even if you receive a third-party payment before the Plan has paid any health expenses relating to the Injury or Illness. In that case, you are responsible to use the third-party payment to pay the health expenses.
- Where the Plan advances benefits related to an Illness or Illness, it pays secondary to any other insurance coverage (for example, personal injury protection (PIP), medical payments, specific loss, or homeowner's insurance).
- The Administrative Office's determination of whether a health expense is related to the Illness or Injury controls. For purposes of the Plan's subrogation and reimbursement rights, an "Illness" also includes a disability.
- The Plan is an employee welfare benefit plan governed by ERISA. The Plan's medical benefits are self-funded.
- The Plan's rights of subrogation and reimbursement are not affected in any way by claims that you must be made whole, or that a "common fund" or any other apportionment doctrine applies under any statute or common law. The Plan disclaims all such doctrines and defenses.

By accepting Plan benefits, you agree to these conditions and covenant not to raise any contrary claims in any action by the Plan to enforce its reimbursement or recovery rights.

No Assignment

Health benefits or other rights under the Plan may not be sold, transferred, pledged or assigned, and any attempt to do so will be void. The provision of Plan documents and information or payment of benefits directly to a Health Care Provider, if any, is done as a convenience for you and your covered Dependents and does not constitute an assignment of health benefits under the Plan.

Provider Nondiscrimination

The Plan will comply with applicable law on provider nondiscrimination.

Keeping Information Current

1. It is your responsibility to make sure the Administrative Office has current information regarding you and your Dependents. Advise the Administrative Office promptly of any change in your home address so their records will be kept current.
2. BENEFICIARY DESIGNATION. Contact the Administrative Office to obtain the necessary form in the event you wish to change your beneficiary for your life and AD&D insurance benefits. A new enrollment form will be sent to you when you notify the Administrative Office of a beneficiary or family composition change.
3. FAMILY COMPOSITION. Give prompt, written notice to the Administrative Office about any change in your family such as marriage or divorce, birth of a child, the marriage or loss of Dependent status of any of your children, or the death of any Dependent. A new enrollment form will be sent to you when you notify the Administrative Office of a beneficiary or family composition change.
4. OTHER INSURANCE COVERAGE. Give prompt written notice to the Administrative Office about any other insurance coverage you or your Dependents may have. Also give written notice of changes in employment of Dependent spouse or children.

It is your responsibility to notify the Administrative Office of a change in Dependent status, such as your divorce. If notice is not given and the Fund pays the claims of a person who is not eligible for coverage, you will be responsible to reimburse the Fund. If you do not promptly reimburse the Fund, the Fund will not pay your and your Dependents' future claims, which the Fund would otherwise cover. The Fund may also sue you to recover overpaid amounts.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations provide specific privacy rights relating to your protected health information ("PHI"). The ways in which the Plan can use and disclose your PHI are summarized in the Plan's Notice of Privacy Practices. You can obtain a copy of this Notice by contacting the Administrative Office.

HIPAA also applies to your PHI that the Board of Trustees (as Plan sponsor) creates, receives or maintains on behalf of the Plan. Unless otherwise permitted by law, the Plan may disclose PHI, including electronic PHI, to the Board of Trustees only if the information is exempt information, or if the disclosure is for plan administration functions.

Definitions. For purposes of this section, the following definitions apply:

- **Protected health information ("PHI")** means information that is created or received by the Plan that identifies a living or deceased individual, or for which there is a reasonable basis to believe the information can be used to identify the individual, and which relates to: the past, present, or future physical or mental health or condition of the individual; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual.

- **Electronic PHI** means PHI that is transmitted or maintained in electronic media.
- **Exempt information** means: (a) summary health information, if requested for purposes of obtaining premium bids or modifying amending, or terminating the Plan; (b) information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from health insurance offered by the Plan; and (c) PHI that may be disclosed pursuant to an authorization that satisfies the applicable requirements of 45 C.F.R. § 164.508.
- **Summary health information** means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals provided health benefits under the Plan, and from which information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.
- **Plan administration functions** are administration functions performed by the Board of Trustees on behalf of the Plan (such as quality assurance, claims appeals, auditing and monitoring), and exclude functions performed by the Board of Trustees in connection with any other benefit or benefit plan of the Board of Trustees.
- **Security incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Trustee Certification. With respect to PHI and electronic PHI (other than exempt information, which is not subject to this section) that it creates, receives, maintains or transmits while performing plan administration functions, the Board of Trustees certifies that:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this booklet or required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they provide PHI that was received from the Plan agree to the same obligations to protect PHI as are imposed on the Trustees, and agree to implement reasonable and appropriate security measures to protect any electronic PHI received from the Board of Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Trustees.
- The Trustees will report to the Plan any impermissible use or disclosure of PHI of which they become aware and any security incident of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

- The Trustees will make PHI available to the Plan to permit Participants and Covered Dependents to inspect and copy their PHI contained in a designated record set, in accordance with 45 C.F.R. § 164.524.

- The Trustees will make a Participant's/Covered Dependent's PHI available to the Participant to amend or correct PHI contained in a designated record set that is inaccurate or incomplete, and the Trustees will incorporate any such amendments, in accordance with 45 C.F.R. § 164.526.

- The Trustees will make a Participant's/Covered Dependent's PHI available to permit the Plan to provide an accounting of disclosures, in accordance with 45 C.F.R. § 164.528.

- The Trustees shall ensure that the adequate separation between the Plan and the Trustees (i.e., the "firewall" described below) required by 45 C.F.R. § 164.504(f)(2)(iii) is established, and ensure that such adequate separation is supported by reasonable and appropriate security measures.

- The Trustee will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI.

Firewall. The Trustees, their professional advisors, and the employees of the Administrative Office that assist with plan administration functions will only have access to and use of PHI (other than exempt information, which is not subject to this section) to the extent necessary to perform plan administration functions, or as otherwise permitted by law.

Effective Mechanism for Resolving Issues of Noncompliance. The Trustees will not retaliate against any person for reporting a privacy violation, filing a privacy complaint with the Trustees, or otherwise exercising any privacy rights. A Trustee who has improperly used or disclosed PHI may be barred from receiving further PHI, barred from Trust conferences, and/or reported to the entity which appointed him.

Hybrid entity designation. To the extent the Plan qualifies as a "hybrid entity" under 45 C.F.R. § 164.103, only its health care components are subject to this section. The Plan designates as its "health care components" all benefits provided by the Plan except for weekly disability benefits, life insurance benefits, and accidental death and dismemberment benefits.

X. Weekly Disability Benefits

Weekly disability benefits are only available to Active Employees.

Weekly Benefit

If you become Totally Disabled due to an accidental bodily Injury or Illness, and are under the care of a Physician for the total disability, the Fund will pay you a weekly benefit in the amount of $444, subject to applicable taxes. Benefits are payable for a maximum of 13 weeks.

You must submit a claim to the Administrative Office, along with a certification by your Medical Doctor or Doctor of Osteopathy that you are Totally Disabled. Your benefit will be payable on (1) the 1st day of your total disability caused by Injury, or (2) the 8th day of your total disability caused by Illness.

Successive Periods of Disability. If you have a second period of total disability, separated from the first by less than two weeks of continuous active work or availability for work, you will be considered to have a single period of total disability rather than two. However, if the second disability occurs after you return or are available for work, and it is caused by a non-occupational bodily Injury or Illness that is entirely unrelated to the first disability, it will be considered a new and separate period of total disability.

Limitations. You are **not** eligible for weekly disability benefits if:

a. You are not under the regular care of a Medical Doctor or Doctor of Osteopathy;

b. The disability arises or is sustained in the course of any employment, occupation, or work or activity for wages, compensation or profit; or

c. The disability is a result of your participation in, or is the consequence of, the commission of a felony, misdemeanor, participation in a riot or otherwise being "outside the law" (excluding traffic violations).

XI. How to File a Claim for Benefits

This section describes the procedures for filing a claim for benefits and for appealing a denied claim. A "claim for benefits" means a request for Plan benefits made in accordance with the procedures described in this booklet. This section ("How to File a Claim for Benefits") applies to the Plan's Weekly Disability Benefits and health benefits. See the applicable insurance contracts for claims procedures for the Life and Accidental Death and Dismemberment ("AD&D") benefits. If you or your Dependent or your Beneficiary or your service provider or other agent submits a claim that is fraudulent or knowingly false, you and your Beneficiaries and Dependents will cease to be eligible for Plan benefits, and will lose eligibility for benefits paid that relate to the false or fraudulent claim. In addition, the Plan reserves the right to take all legal and criminal action to recoup and prevent losses related to false and fraudulent claims.

For purposes of this section, the term "Disability Benefits" refers to the Weekly Disability Benefits and the term **"**Medical Benefits" refers to all health benefits, including prescription and, if offered, dental and vision.

General Claims Information

Enrollment form. You **must** complete and submit an enrollment form to the Plan Administrative Office each calendar year before your claims will be processed. You can obtain an enrollment form from the Administrative Office. You must also submit all information requested by the Administrative Office that is reasonably necessary to administer the Plan and pay benefits, such as social security numbers for you and your Dependents, proof of marriage, divorce, death, or birth, other insurance information, and evidence of employment. Claims will not be paid if the enrollment form and information is not timely received by the Administrative Office.

Where to obtain claim forms. In general, you can obtain a claim form for Medical Benefits or Disability Benefits from your Local Union office or from the Administrative Office. However, you may obtain a claim form for Life and AD&D Insurance benefits from the Administrative Office or from ULLICO, which is the insurer for these benefits.

Where to file claim forms and appeals. All claims must be filed with the Claims Administrator (identified below). However, a claim for Life and AD&D Insurance benefits should be submitted to the Administrative Office, which will assist in the filing of your claim with the Claims Administrator. All appeals of denied claims must be filed with the Claims Fiduciary (identified below).

CLAIMS ADMINISTRATOR/CLAIMS FIDUCIARY CHART		
PLAN BENEFITS*	**CLAIMS ADMINISTRATOR**	**CLAIMS FIDUCIARY**
Medical Benefits Post service medical claims	Administrative Office P.O. Box 1975 San Ramon, CA 94583 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 Telephone: 801-908-5781 or Toll Free at 877-416-8181 Fax: 925-416-0108	Post-service claim appeal: Board of Trustees P.O. Box 1975 San Ramon, CA 94583 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 Telephone: 801-908-5781 or Toll Free at 877-416-8181 Fax: 925-416-0108
Urgent, Pre-service and Concurrent medical plan claims	**American Health Group (AHG)** 2152 S. Vineyard, Suite 103 Mesa, AZ 85210 (602) 265-3800 or 1-800-847-7605	Pre-service claim appeal: Board of Trustees (contact information noted above) Urgent and Concurrent claim appeal: American Health Group (contact information noted to the left)
Prescription Drug Program Urgent and Pre-service retail and mail order prescription drug claims Post service direct member reimbursement of retail prescription drug claims	CVS Caremark Toll Free at 800-770-8014 Submit paper claims to: Caremark Claims Dept. P. O. Box 52136 Phoenix, AZ 85072-2136	Board of Trustees (contact information noted above)
Disability Benefits Weekly disability benefit claims	Administrative Office See above	Board of Trustees See above

CLAIMS ADMINISTRATOR/CLAIMS FIDUCIARY CHART		
PLAN BENEFITS*	**CLAIMS ADMINISTRATOR**	**CLAIMS FIDUCIARY**
Life & AD&D Insurance Benefits (appeals process not described in this document, instead contact the Life Insurance Company)	ULLICO c/o Administrative Office See above	ULLICO 8403 Colesville Road Stop 709 Silver Spring, MD 20910-6331

*A pre-service claim is a request for benefits under the Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. This requirement is also known as precertification or pre-approval. A post-service claim involves only the payment or reimbursement of the cost of the care that has already been provided.

Also, a dispute solely as to whether you have met the requirements for enrollment or eligibility under the Plan is subject to the Plan's internal claim and appeal procedures, as if it were a disability claim. The internal appeal procedures need to be exhausted for such disputes before you can bring a civil action under Section 502(a) of ERISA.

How to complete your claim form for Medical Benefits. In order for a medical claim form to be considered complete, you must:

1. Complete the employee portion of the claim form.
2. For claims after service or treatment, attach all itemized bills or provider's statements that describe the services rendered and return the claim form to the Claims Administrator.

Before submitting a claim, check the claim form to be certain that applicable portions of the form are completed and, for claims after service or treatment, that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim form has to be returned to you for information, delays in payment will result.

Claims must show the applicable procedure codes adapted from: (1) the Current Physician Terminology (CPT) Uniform Codes on Medical Procedures; (2) the American Dental Association (ADA) recommended Uniform Codes on Dental Procedures and Nomenclature, and (3) the actual charges to the Participant for all services or procedures. Many Physicians' offices will submit claims for you directly to the Claims Administrator.

Time limit for filing claims for Medical Benefits. Your completed claim form with all itemized bills generally must be received by the Claims Administrator within 90 days after the date your claim was incurred. NO BENEFITS WILL BE PAID IF YOUR CLAIM IS SUBMITTED MORE THAN 1 YEAR AFTER THE DATE IT WAS INCURRED, unless you establish it was not reasonably possible to submit the claim within 1 year of the date it was incurred.

Many PPO Preferred Providers and participating pharmacies will file a claim on your behalf if notified of your coverage. When you visit a Preferred Provider or a participating pharmacy, advise the personnel in the Provider's office or the participating pharmacy that your coverage is through the Utah Pipe Trades Health and Welfare Trust and present your Plan identification card. The Provider's office or participating pharmacy might be willing to file the claim on your behalf. If a provider submits a claim on your behalf, the Plan may, but is not required to, remit payment of Covered Medical Expenses directly to the Preferred Provider or participating pharmacy, as a convenience to you..

How to complete your claim form for Disability Benefits. In order for a Disability Benefits claim form to be considered complete, you must complete the Employee section and your Physician must complete the Physician section of the form. Return the completed form to the Claims Administrator.

Time limit for filing claims for Disability Benefits. All claims for Disability Benefits must be submitted within 1 year of the date of your Illness or Injury.

Life and AD&D Insurance claims. **Contact the Administrative Office to file a claim for Life and AD&D Insurance benefits. Life and AD&D Insurance claims, along with any required proof of loss, should be submitted as soon as possible following the date of death or dismemberment.**

Your "authorized representative" may file a claim or appeal a denied claim on your behalf. Your "authorized representative" means a person you authorize, in writing, to act on your behalf with respect to a claim. It also means a person authorized by court order to submit claims on your own behalf. For a healthcare claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Claims Review Process

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Claims Administrator. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. Please note that what follows are separate claim procedure rules that apply depending on whether your claim is for Medical Benefits, or Disability Benefits. Moreover, if your claim is for Medical Benefits, different claim and appeal procedures apply based on whether your claim is for prior approval of a benefit before the service or treatment is obtained, or is after service or treatment, and your claim may also be eligible for an external review process. In addition, the Claims Fiduciary may, outside of the timelines set forth herein, reconsider an initial claim or appeal determination at any time if facts that were not within the control of the Claims Fiduciary become known subsequent to the initial determination.

General Provisions Applicable to Medical Benefit Claim Determinations

Initial Denial Decisions and Appeal Decisions will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10 percent or more of the population is literate only in the same non-English language as determined by applicable federal guidance.

If the above percentage threshold standard is met, the following three conditions will apply to claimants in such counties: Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals; the Plan will provide upon request a notice in the applicable non-English language; and the Plan will include in the English version of all notices a statement in the applicable non-English language clearly indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons, including medical experts or review organizations, involved in making decisions and no hiring or retention decisions will be based upon the likelihood that the person will support a denial of benefits.

If the Plan fails to adhere to all the requirements of the Claims Review Process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable. A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

MEDICAL BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for Medical Benefits:

Timing of Initial Determination – Precertification Medical Benefits Claims.

The Plan requires that you get prior review or approval before you receive certain covered services or treatments in order to receive higher levels of benefits under the Plan than if prior approval is not obtained. The following rules apply to these claims for prior review or approval required by the Plan. Prior review or approval procedures required by the Plan are referred to in these procedures as "precertification" claims.

Urgent precertification claims. If your precertification claim is determined by the Plan to be a claim involving urgent care (as defined below), notice of the Plan's decision will be provided to you as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of your claim by the Plan. For this purpose, the Plan shall defer to a determination of urgent care by the attending provider. If, however, you do not provide sufficient information to decide your claim, a notice requesting specific additional information will be provided to you within 24 hours of receipt of your claim. The Plan's decision regarding your claim will then be issued no later than 48 hours after the earlier of 1) the Plan's receipt of the requested information or 2) the expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours). Benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within 3 days after the oral notice.

A "claim involving urgent care" is a claim for precertification where application of the normal time periods for deciding your claim 1) could seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought. If a physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the Plan as involving urgent care.

Regular precertification claims. If your precertification claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to you before the end of the initial 15-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Failure to follow precertification procedures. If your communication to the Plan concerning precertification does not comply with the Plan's procedures for filing pre-certification claims, notice of the proper procedures will be provided to you within five days of the communication. If, however, the communication involves urgent care, notice will be provided within 24 hours. Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service or product being requested. Notice may be oral, unless you request written notice.

Timing of Initial Determination – Medical Benefits Claims After Service or Treatment

If your claim for a benefit does not require pre-approval in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Timing of Determination – Concurrent Care Medical Decision – Medical Benefits Claims

Reduction or termination of ongoing course of treatment. If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

Extension of ongoing course of treatment involving urgent care. If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the Plan within 24 hours after its receipt of

the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

Contents of Initial Denial – Medical Benefits Claims

If your claim is denied, in whole or in part, you will be notified in writing by the Plan. The written notice will include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the denial, including to the extent applicable the denial code and its corresponding meaning and a description of the plan's standard, if any, that was used in denying the claim;
- references to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's available internal appeal and external review processes for denied claims, including information regarding how to initiate an appeal and the applicable time limits for submitting your appeal (claims involving urgent care will have a description of expedited appeal procedures);
- a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

Appeal Procedure for Denied Medical Benefits Claims

A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time. If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Claims Fiduciary within 180 days after receiving notice of denial, unless your claim concerns the reduction or termination of a previously approved ongoing course of treatment. In that case, you must file a written appeal within a shorter time period that permits the Claims Fiduciary to issue an appeal decision before the treatment is reduced or terminated. You or your authorized

representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents. In addition:

- the appeal decision will not defer to the initial decision denying your claim and will be made by the Claims Fiduciary, who is not a person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon;
- if your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method;
- you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with the claim, and such information will be provided as soon as possible and sufficiently in advance of the date the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and
- if a final internal appeal decision is based on a new or additional rationale, you will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

The Claims Fiduciary reviews appeals of denied claims and makes final determinations. The Claims Fiduciary has the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement in order to determine benefits under the Plan.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decision – Precertification Medical Benefits Claims

Urgent care precertification claims. A decision on your appeal will be made as soon as possible, but no later than 72 hours after an appeal is received.

Regular precertification claims. A decision on your appeal will be made within a reasonable period of time, but no later than 30 days after an appeal is received.

Timing of Appeal Decision – Medical Benefits Claims After Service or Treatment

If you or your representative would like to appear before the Board of Trustees when they consider your appeal, notify the Administrative Office when you file your appeal. The Administrative Office will notify you of the time and date you may appear.

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Claims Fiduciary after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Appeal Decision – Medical Benefits Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the decision, including to the extent applicable the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim that includes a discussion of the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents;
- an explanation of the Plan's available external review process for denied claims, including information regarding how to initiate the external review and the applicable time limits;
- a statement of your right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and that a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

Standard External Review Process for Denied Claims

If your claim for medical benefits is denied in an Initial Determination or Appeal Decision and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial but only if the denial involves 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer; or 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. The request must be filed with the Claims Fiduciary within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not related to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Plan shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan has contracted with at least IROs for assignments under the Plan and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility and acceptance for external review which will include a statement that you may submit within ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Plan within one business day. Upon receipt of the information, the Plan may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;

- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

Expedited External Review Process for Denied Claims

If your claim is eligible for the external review process, you may request an expedited external review if:

- an Initial Determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal Appeal Decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your

ability to regain maximum function, or the Appeal Decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Plan shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Plan shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Plan.

DISABILITY BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for Disability Benefits.

Timing of Initial Denial - Disability Benefits Claims

A written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan. If matters beyond the control of the Plan require an extension of the time for processing your claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Initial Denial – Disability Benefits Claims

If your claim for a benefit is denied, you will be notified in writing. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review;
- a statement of your right to bring a civil action under Section 502(a) of ERISA, if your claim is denied on appeal;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

Appeal Procedure for Denied Claim – Disability Benefits Claims

If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Claims Fiduciary within 180 days after receipt of written notice of the denial. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

In addition, the following procedures apply:

- the appeal decision will not defer to the initial decision denying your Disability Benefits claim and will be made by the Claims Fiduciary, who is not the person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person; and
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your Disability Benefits claim will be identified upon request, whether or not the advice was relied upon.

The Claims Fiduciary reviews appeals of denied claims and makes final determinations. The Claims Fiduciary has the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement and to determine eligibility for benefits under the Plan.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decision – Disability Benefits Claims

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Claims Fiduciary after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Appeal Decision – Disability Benefits Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents;
- a statement of your right to bring a civil action under Section 502(a) of ERISA.
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request, and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

Relevant Documents

For purposes of this section ("How to File a Claim for Benefits"), "Relevant Document" means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- if the claim was a medical or disability claim, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

Limitations Period for Lawsuits

You must exhaust the Plan's internal claims and appeal process before filing a request for external review or filing a lawsuit. In order to bring a lawsuit in court regarding your claim, you must file suit within 2 years after your appeal is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in a contract for an insured benefit, then that limitations period applies to that benefit.

If You Have Questions

If you have questions about filing your claim or an appealing a denied claim, please do not hesitate to contact the appropriate Claims Administrator. Each Claims Administrator's contact information is listed above in Section I of this booklet.

XII. Definitions

When used in this Plan, certain terms have specific meanings. These terms are defined below:

Active Employee: An employee who meets the hour bank eligibility rules in Article II.

Administrative Office or Plan Administrative Office: The individual, entity, or independent third party designated and engaged by the Board of Trustees to administer the Plan and process benefit claims, as listed in the Quick Reference Chart at the beginning of this booklet.

Allowed Charge or Allowable Charge or Allowed Amount: The **lowest** of:

a. With respect to a PPO Health Care Provider, the fee set forth in the agreement between the PPO Health Care Provider and the PPO**, or**

b. With respect to Self-Pay Participants entitled to Medicare, the maximum amounts allowed by Medicare for participating and non-participating Medicare Physicians; **or**

c. The amount that is less than or equal to the 90th percentile of the charge established for the geographic area by the Plan's third party service; **or**

d. The Health Care Provider's actual charge.

In accordance with federal law, with respect to emergency services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the **greater** of:

1. the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or
2. 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
3. (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

NOTE: These minimum payment standards for emergency services in a Hospital emergency room **do not apply** in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges. See also the definition of **emergency services** in this chapter.

Ambulance, Professional Ambulance Service: A ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is: 1) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and 2) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals.

Annual Enrollment: The period toward the end of each year (generally the month of November) during which Participants must complete and return an enrollment form and/or Dependent verification to the Administrative Office.

Bargaining Unit: A group of Employees working for an Employer and represented by the Union.

Beneficiary: The individual named on the last form provided by the Administrative Office, properly completed and signed by the Participant, and received by the Administrative Office prior to the Participant's death.

Claims Administrator: The Claims Administrator for particular benefits under the Plan as set forth in the "Claims Administrator/Claims Fiduciary" chart in Article IX of this document.

Claims Fiduciary: The Claims Fiduciary for particular benefits under the Plan as set forth in the "Claims Administrator/Claims Fiduciary" chart in Section I of this booklet.

Collective Bargaining Agreement or Collectively Bargained: An arms-length contract between an Employer and the Union that provides the Employer will contribute to the Trust for a Bargaining Unit, and that is accepted by the Trustees in writing.

Concurrent Review: A managed care program designed to assure that hospitalization and other inpatient health care facility admissions and length of stay, surgery and other health care services are Medically Necessary by having the Case Management and Precertification Manager conduct ongoing assessment of the health care as it is being provided.

Contribution: The amount an Employer contributes to the Trust as required by an applicable Collective Bargaining Agreement or accepted Non-Bargaining Participation Agreement.

Covered Dependent: A Spouse or child of a Participant who is eligible for Plan benefits as described in Article II, whose Dependent coverage has begun and not been lost.

Covered Hours: The hours worked by an Employee for which your Employer must contribute (and has contributed) to the Trust Fund, under a Collective Bargaining Agreement or an accepted Non-Bargaining Participation Agreement.

Covered Medical Expenses: Allowed Charges Incurred for Medically Necessary services and supplies that the Plan reimburses.

Covered Spouse: A Spouse whose coverage has begun and not been lost.

Custodial Care: Care that is designed primarily to assist a person in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of Custodial Care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

Dependent/Eligible Dependent: A person eligible for coverage as the Participant's Spouse or child, as described in Article II of the Plan.

Emergency: An unforeseen Injury or Illness that requires immediate medical attention to avoid serious risk to health.

Emergency Services: means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a Hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during

the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

- The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Employee: An employee on behalf of who an Employer is required to contribute to the Trust pursuant to a Collective Bargaining Agreement or an accepted Non-Bargaining Participation Agreement.

Employer/Contributing Employer: A business entity that is required by a Collective Bargaining Agreement or an accepted Non-Bargaining Participation Agreement to make payments into the Trust. The Board of Trustees must accept a Collective Bargaining Agreement or sign a Non-Bargaining Participation Agreement with the Employer before the Plan covers an Employer's Employees.

Essential Health Benefit: A service or supply on which Health Care Reform prohibits the Plan from imposing annual or lifetime dollar limits.

Experimental: A drug, device, medical or dental treatment or procedure is experimental or investigative, as determined by the Board of Trustees or its designee, if:

- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

- the drug, device, medical or dental treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

- All phases of clinical trials shall be considered Experimental (except that expenses for otherwise Covered Medical Expenses that are Incurred by a Participant or Covered Dependent participating in a clinical trial will be covered to the extent legally required); or

- Reliable Evidence shows that the drug, device, medical or dental treatment or procedure is the subject of on-going phase I, II or 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 diagnosis; or

- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical or dental treatment or procedure 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 diagnosis.

Reliable Evidence shall mean only reports and articles published in the United States in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) utilized by other facilities studying substantially the same drug, device,

medical or dental treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical or dental treatment or procedure.

Note that under this Plan, experimental, investigational or unproven does not include routine costs associated with a certain approved clinical trial related to cancer or other life-threatening illnesses, in accordance with applicable law.

Flat-Rate Employee: A Non-Bargaining Employee of the Utah Mechanical Contractors Association or of any Employer (including a self-employed individual) that is signatory to a current Collective Bargaining Agreement with the Union. These Employees do not participate in the hour bank system—instead, flat-rate contributions are made in accordance with Article II of this booklet and the applicable Non-Bargaining Participation Agreement.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays or that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Provider/Provider: A Physician, Dentist, Nurse, Physician Assistant or any of the following to the extent benefits are provided for herein: Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, licensed psychologist, licensed psychiatrist, certified or licensed clinical social worker, practitioner providing counseling and therapy services prescribed by a psychiatrist or psychologist, physical therapists, occupational therapists, speech therapists, inhalation therapists, anesthetists, audiologists, optometrists, and midwives. The Plan covers services by the before mentioned only when the Health Care Provider acts within the lawful scope of his or her license.

Unless required by law, providers whose services are not covered under the Plan include, but are not limited to, massage therapists, hypnotists, acupuncturists, doctors of naturopathy and/or homeopathy, Christian Science or other religion-based practitioners, any therapist not listed in the above paragraph and any practitioner for whom the state in which the individual practices does not require a medical-related license.

Health Care Reform: The Patient Protection and Affordable Care Act of 2010, as amended, and applicable agency regulations.

Home Health Care or Home Health Care Agency: A public or private agency or organization that administers and provides home health care and is certified by Medicare or an appropriate state agency.

Hospice Agency: A public or private agency or organization that administers and provides Hospice Care and is certified by Medicare or an appropriate state agency.

Hospice Benefit Period: The period that begins on the date the Physician certifies that the Covered individual is a Terminally Ill patient and ends six (6) months after it began or on the death of the Covered individual, if sooner. If the Hospice Benefit Period ends before the death of the Covered individual, a new Hospice Benefit Period may begin if the Physician again certifies that the Covered individual is a Terminally Ill patient.

Hospice Care: Palliative and supportive medical, health and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary.

Hospital: means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

1. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and
2. provides diagnosis and treatment on an inpatient basis for compensation; and
3. is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A Hospital may include inpatient acute care facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Illness: A disease or infection and all related symptoms or conditions related to the same Illness.

Incurred: Claims and Expenses are Incurred on the date the covered service is rendered or the supply is obtained.

Initial Eligibility: Establishing eligibility for Plan benefits as provided in the "Initial Eligibility" section of Article II.

Injury: Condition resulting from an external violent force and all related symptoms and conditions resulting from the same force, independent of Illness and all other causes.

Legal Separation: A decree of Legal Separation in lieu of divorce.

Licensed Ambulatory Surgical Facility: A place which maintains and operates facilities for surgery and surgical diagnosis and treatment on an open panel basis by persons licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of pre-school age, infirmary or orphanage, private sanitarium, private office or clinic of licensed health care professionals, maternity home for pre-natal or post-natal care, mental health facilities, home or institutions, or any other facility which exists for the purpose of providing health care services.

Medically Necessary or Medical Necessity: A supply or service is Medically Necessary or meets Medical Necessity, as determined by the Board of Trustees or its designees, if it meets all of the following:

- Must be ordered by a licensed physician. *However, the fact that a physician has performed, prescribed, ordered, recommended, or approved a service does not, in itself, establish Medical Necessity for purposes of the benefit provisions of this Plan.*

- Must be provided in the most appropriate setting and must be provided at the most appropriate level of service and care for the patient's medical condition.

- Must not be Experimental or investigational or provided for medical or other research.

- Must be required to diagnose or treat the patient's condition.

- Must be consistent with the symptoms or diagnosis and treatment.

- Must be appropriate as good medical practice.

- Must be in accordance with accepted medical practices and standards and appropriate in the amount, duration, and frequency for the symptoms, diagnosis, or treatment of a non-occupational Injury or Illness.

- Must not be possible to safely provide the service or supply on an outpatient basis (relevant when determining Medical Necessity of inpatient treatment).

Mental or Nervous Disorders: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Mental or Nervous Disorders include, among other things, depression, schizophrenia, and Substance Abuse and treatment that primarily uses psychotherapy or other psychotherapist methods. Certain Mental or Nervous Disorders, conditions and diseases are specifically excluded from coverage as noted in Articles IV, VIII and XII of this document.

Non-Bargaining Employee: Any employee whose Employer has signed a Non-Bargaining Participation Agreement with the Trustees and who qualifies for participation pursuant to that Agreement and the applicable provisions of Article II. As further described in Article II, a Non-Bargaining Employee participates as either an Active Employee or a Flat-Rate Employee.

Non-Bargaining Participation Agreement: An agreement between an Employer and the Trustees that permits certain Employees not covered by a Collective Bargaining Agreement to participate in the Plan.

Nurse: A Registered Nurse (RN), Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Clinical Specialist Psychiatric Nurse (CSPRN), Certified Nurse Midwife, or Certified Nurse's Assistant (CNA) acting within the lawful scope of his or her license.

Orthodontia or Orthodontics: Correction of malposed teeth, for any reason.

Participant: A person who is currently eligible for and has performed all tasks (including completed all required forms and paid all amounts) required to obtain Plan coverage as a result of his or her own past or current employment as follows:

- **Active Participant:** An Active Employee or a Flat-Rate Employee who is currently entitled to participate in the Plan as provided in Article II of the Plan.
- **Retiree or Retired Participant:** A Retired Employee who is currently entitled to participate in the Plan as provided in the "Retiree Self-Pay Option" in Article III of the Plan.
- **Self-Pay Participant:** A Participant by virtue of COBRA or the "Retiree Self-Pay Option" under Article III of the Plan.

Pension Plan: Utah Pipe Trades Pension Trust Fund.

Physician: A person who is licensed or certified to practice and who is lawfully practicing within the scope of the license or certification as a Doctor of Medicine or a Doctor of Osteopathy.

Physician Assistant (PA): An individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a Physician, is certified and licensed by the state to practice, and who is lawfully practicing within the scope of their certification and license.

Plan: This benefits program as maintained by the Utah Pipe Trades Welfare Trust Fund.

Plan Year: The 12 month period beginning on October 1st of each year.

Preferred Provider/Non-Preferred Provider: A Preferred Provider is any Plan-recognized provider, corporation, organization or entity that has contracted with the Plan to provide covered benefits in accordance with Article IV. A Non-Preferred Provider has not so contracted with the Plan.

Preferred Provider Organization (PPO) or Network: A health care organization composed of physicians, Hospitals, or other providers which provides health care services at a reduced fee.

Preventive Care: Those services and supplies—including Medically Necessary prescription drugs--designated as "preventive care" in published guidelines under Health Care Reform, and which the Plan is required by law to provide.

Prosthetics: Artificial replacement of limbs, eyes and/or associated structures.

Rehabilitation Facility: a facility that is licensed or certified as a rehabilitation facility by the state or jurisdiction where such services are provided, and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or other nationally recognized and reputable accreditation organization.

Residential Treatment Facility: An intermediate non-Hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. Residential Treatment Facilities must be licensed by the state or jurisdiction where such services are provided.

Respite Care: Care that is furnished to a Terminally Ill patient when confined as an inpatient so that the family unit may have relief from the stress of the care of the individual.

Retired Employee or Retiree: Any former Active Employee who is receiving or who is eligible to receive a pension benefit under the Pension Plan, and who is a member in good standing with the local Union. It also means any former Flat-Rate Employee who has been continuously covered under the Plan for a minimum of sixty (60) months out of the last one hundred twenty (120) consecutive months immediately preceding retirement, and he/she must be receiving a monthly Social Security retirement benefit. Such Flat-Rate Employee must have been eligible during the twelve (12) month period immediately preceding retirement. Once an individual becomes a Retired Employee he/she cannot reinstate coverage as an Active Employee or Flat-Rate Employee.

Skilled Nursing Facility: A facility primarily providing skilled nursing care for patients and which has certification from The Joint Commission (TJC).

Spouse: The person to whom a Participant is legally married and who is recognized as a spouse under the Tax Code. For purposes of the Plan, a "Spouse" does not include a spouse by a common law marriage, a spouse from whom the Participant is Legally Separated, or a domestic partner.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs (including the nondependent abuse of drugs) or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Substance Abuse Treatment Facility: See definition of Residential Treatment Center.

Terminally Ill: A patient whose Physician certifies that such patient is terminally ill and is expected to live six (6) months or less.

Totally Disabled: A person who is unable to perform work within his or her job classification at the time the disability begins and he or she is not engaged in any other occupation for compensation, profit or gain.

Trust, Trust Agreement, or Trust Fund: The Agreement and Declaration of Trust establishing the Utah Pipe Trades Welfare Trust Fund, as modified or amended.

Trustees, Board of Trustees, or Board: Those persons designated as Trustees pursuant to the terms of the Trust Agreement, and their successors.

Union: Local Union No. 140 of the United Association of the Plumbing and Pipefitting Industry of the United States and Canada, and any other Union authorized by the Board of Trustees to participate in the Fund, as provided in the Trust Agreement.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

XIII. Important Information

Reciprocity and Transfer of Assets and Liabilities

(a) If the Trustees enter into reciprocity agreements with other employee benefit plans and trusts in which assets are transferred to the Plan and Trust on behalf of an employee whose employer is contributing into the transferor plan and trust, the employee will be credited with the contributions applicable to his employment with the contributing employer for purposes of determining participation eligibility and benefits in the Plan, but only pursuant to the terms of the Plan.

(b) If employer contributions on behalf of an employee into the Plan and Trust are to be transferred pursuant to a reciprocity agreement to another plan and trust, that employee shall not be credited in any way with hours of service or contributions under the terms of the Plan and Trust for any purpose, including but not limited to calculating participation, eligibility and benefits. Nothing in the foregoing, however, is intended to impair the right of the Plan and Trust to enforce delinquent contributions from a contributing employer whose contributions are to be transferred pursuant to a reciprocity agreement.

Administration of the Plan

Governing Law

This Plan is construed in accordance with applicable federal law, ERISA, and to the extent not otherwise preempted, the laws of the State of Utah.

Severability

If any provision of this Plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of Plan, which shall be construed as if such illegal or invalid provision had never been included.

Name of Plan

This Plan is known as the Utah Pipe Trades Welfare Trust Fund.

Plan Administrator and Type of Administration

This Plan is maintained and administered by a joint labor-management Board of Trustees. The Board of Trustees (Plan Sponsor) is the Plan Administrator, except with respect to insured benefits. The Plan Administrator for an insured benefit is the insurer. The Trustees have engaged the independent third party administrator named below to perform the routine administration of the Plan. The Trustees may, from time to time, contract with other third parties. Contact information for the Administrative Office is:

BeneSys Administrators

Physical Address:
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Mailing Address:
P.O. Box 1975
San Ramon, California 94583

Phone 925.398.7041
Toll Free 877.416.8181
Facsimile 925.462.0108

www.utpipetradesbenefits.org
staff@utpipetradesbenefits.org

Communicating with the Plan

Written communication to the Plan, the Administrative Office, the Trustees, or their agents or representatives, must be received before the expiration of any time period expressed in the Plan or in this Document. These parties' records determine whether a communication has been received and the date of such receipt, unless you procure a United States Postal Service return receipt. So the common law "mailbox rule" does not apply to determine receipt by these parties. The common law mailbox rule does apply for all other purposes under the Plan.

Powers of the Plan Administrator

The Plan Administrator is the named fiduciary and exercises sole and exclusive discretionary authority and control over:

- The interpretation of all Plan and Trust documents, booklets, policies, rules or regulations;
- Granting or denying benefit appeals under the Plan, including coverage, eligibility and benefit determinations; and
- The management and disposition of Plan assets.

The Plan Administrator's exercise of discretion and determinations in all matters are final and binding and entitled to the highest deference permitted by law.

The Plan Administrator may delegate its authority and control to persons other than the named fiduciaries to carry out its responsibilities under the Plan to the extent permitted by ERISA. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Identification Numbers

The employer identification number assigned to the Trust by the Internal Revenue Service is 87-6128290. The Plan number is 501.

Type of Plan

This Plan is an Employee Welfare Benefit Plan providing certain health and welfare benefits to Participants and their Dependents as described in this document.

This document serves as both the written Plan document and the Summary Plan Description required under ERISA.

Plan Year

This Plan operates on an October 1 through September 30 plan year.

Board of Trustees

The Plan's current Trustees are listed below. This list may change from time to time—for a current list, contact the Administrative Office. Individual Trustees may be contacted by mailing correspondence care of the Administrative Office, at the address above.

UNION TRUSTEES	EMPLOYER TRUSTEES
John A. Wadlow	Robert G. Bergman
Roy Adams	Jason Bleak
Robert C. Patterson	Gary Sander
Will Nickell (Alternate)	Brett Christiansen (Alternate)

Service of Legal Process

The name and address of the person designated as agent for the service of legal process is:

M. Ellen Mondress
Song Mondress PLLC
720 Third Avenue, #1500
Seattle, WA 98104

Legal process may also be served upon the Administrative Office or any member of the Board of Trustees.

Collective Bargaining Agreements

This Plan is maintained under Collective Bargaining Agreements. These agreements specify the rate at which Employers must contribute to the Trust to provide Plan coverage for their Collectively Bargained Employees.

Participants and Beneficiaries may obtain a copy of relevant Collective Bargaining Agreements by writing to the Trustees. You may also examine these agreements at the Plan Administrative Office or your local Union office upon 10 days advance written request. The Plan may impose a reasonable charge for providing copies. If you wish, you can ask the Plan Administrative Office the cost before requesting copies.

Source of Contributions

This Plan is funded through Employer contributions as specified in Collective Bargaining Agreements and special Non-Bargaining Participation Agreements. Self-payments by Participants are also permitted as described in this document. The amount of self-payments is fixed from time to time by the Board of Trustees.

Funding

All Employer contributions and self-payments are held by the Trust pending the payment of benefits, insurance premiums, and administrative expenses. Plan benefits are uninsured, with the exception of

the following. Life and AD&D insurance is provided through an insured policy. The Trust may also carry stop loss insurance.

Your Rights as a Plan Participant

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan Benefits

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

Continue Group Health Coverage

- Continue health care coverage for yourself, Spouse, or Covered Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Covered 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.

Hospital length of stay for newborns and mothers

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.