RULES AND REGULATIONS OF

PLUMBERS AND PIPEFITTERS LOCAL 430
HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION
(SPD)

EFFECTIVE

SEPTEMBER 1, 2018

PLUMBERS AND PIPEFITTERS LOCAL 430
HEALTH AND WELFARE FUND
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TULSA, OK 74115
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TO ALL ELIGIBLE INDIVIDUALS:

We are pleased to provide you with this new Booklet, which describes the current benefits provided by the Fund.

Since the last Booklet was printed, quite a few changes have been made. Therefore, we urge you to read your new Booklet carefully so you will understand the benefits available to you and your eligible Dependents. You should also keep the Booklet in a safe place for future reference. While it is hoped that everyone will enjoy good health at all times, we believe that you will feel, as we do, that the Fund benefits provide financial security in times of need.

If you have any questions about your benefits, eligibility, claim procedures, etc., please contact the Fund Office.

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

Sincerely,

BOARD OF TRUSTEES

PLEASE REMEMBER
YOU MUST NOTIFY THE FUND OFFICE WHEN:

- **You have a change of address.**

- **You get married.**

  (You will need to provide the Fund Office a certified copy of the marriage license. In the event there is not a formal marriage license, you will need to complete and sign a form, which is available from the Fund Office).

- **You acquire an eligible dependent child through marriage, birth, placement for adoption, etc.**

  (You will need to provide the Fund Office a certified copy of the birth certificate and, if applicable, the adoption, guardianship, or foster care court decree.)

- **You and your spouse divorce or become legally separated.**

  (You will need to provide the Fund Office with court-approved legal separation papers.)

- **Your eligible dependent child ceases to qualify as a covered dependent**.

- **You wish to change your Beneficiary.**

- **You have a death in your family.**

  (You will need to provide the Fund Office a certified copy of the death certificate.)

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SCHEDULE OF BENEFITS

BENEFITS FOR EMPLOYEES ONLY	
Death Benefit	$5,000
Accidental Death & Dismemberment Benefit	
Loss of: life, both hands, both feet, both eyes, one hand and one foot, one hand and one eye, or one foot and one eye	$10,000 (Full Benefit)
Loss of: one hand, one foot, or one eye	$5,000 (One-half of Full Benefit)
(Note: Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint, and loss of an eye means the entire and permanent loss of sight in that eye.)	

BENEFITS FOR ELIGIBLE EMPLOYEES & DEPENDENTS	
MEDICAL BENEFITS	
Deductibles	
Calendar Year Deductible - PPO Providers	$1,000 per person
Calendar Year Deductible - Non-PPO Providers	$1,000 per person
All services and supplies are subject to the calendar year deductible except dental, prescription drugs and covered in-network preventive services. Balance-billed charges and excluded services do not count toward the calendar year deductible. In addition, penalties for failure to obtain pre-authorization and coinsurance paid toward mandatory outpatient surgeries performed on an inpatient basis will not count toward your deductible.	
Prescription Drug Deductible	$100 per person per calendar year
Coinsurance (except as otherwise indicated)	
PPO Provider	Plan pays 75% of Covered Charges
Non-PPO Provider	Plan pays 55% Covered Charges
Provider Outside PPO Service Area	Plan pays 75% of Covered Charges
Out-of-Pocket Limits	
PPO Provider	Medical: $5,000 per person; $10,000 per family; includes the calendar year deductible amount. Prescription Drug: $1,600 per person; $3,200 per family; includes the prescription drug deductible amount.
Non-PPO Provider	No out-of-pocket limits

BENEFITS FOR ELIGIBLE EMPLOYEES & DEPENDENTS	
Balance-billed charges and excluded services do not count toward the out-of-pocket limits. In addition, penalties for failure to obtain pre-authorization will not count toward your out-of-pocket limits.	
Calendar Year Maximums	
Spinal (Chiropractic) Treatment	20 visits per person
X-rays in Connection with Spinal Treatment	$140 per person
Lifetime Maximums	
Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome	$2,000 per person
Note: Second surgical opinion is required to confirm Medical Necessity of TMJ treatment	
Voluntary Vasectomy	$500 per person
Bereavement Counseling	$200 per person
Surgical Treatment of Morbid Obesity	$15,000 per person
Alternative Medical Treatment	$20,000 per person
Other Maximums	
Organ/Tissue Transplants	$100,000 per organ/tissue transplant
Vasectomies	$500 per surgery
Covered Ambulance Transportation	$1,500 per occurrence per person
Hospital Room and Board	
Semi-Private Room	Hospital's average semi-private room rate
Private Room	Hospital's average semi-private room rate (or 90% of private room charge if no semi-private room available)

UTILIZATION REVIEW REQUIREMENTS

- You must obtain pre-admission certification prior to all non-emergency/non-maternity Hospital admissions by contacting the Utilization Management Company Blue Cross at the number on the back of your identification card. The current UMC is Blue Cross and Blue Shield the toll-free phone number is (800)635-1928. Failure to do so will result in a $500 reduction in benefits.
- If the Hospital admission is due to a Medical Emergency, you must obtain admission certification by the end of the second business day following admission by contacting the UMC at the number on the back of your identification card. The current UMC is Blue Cross and Blue Shield and the number is (800)635-1928. Failure to do so will result in a $500 reduction in benefits.
- No benefits are payable for Hospital services and supplies while you remain in the Hospital beyond the number of days certified as Medically Necessary for the condition causing the hospitalization.
- Benefit reductions for non-compliance will not count toward your out-of-pocket limits.

Spinal Treatment/Physical Therapy	
Visits 1–10 per calendar year	Covered Charges limited to $50 per visit

BENEFITS FOR ELIGIBLE EMPLOYEES & DEPENDENTS	
Visits 11–20 per calendar year	Covered Charges limited to $40 per visit
Prescription Drugs	
Generic Drugs	Plan pays 90% of Covered Charges
Brand-Name Drugs	Plan pays 75% of Covered Charges
Emergency Room Treatment	Plan pays 75% of Covered Charges for both PPO Providers and Non-PPO Providers
Surgical Treatment of Morbid Obesity	Plan pays 50% of Covered Charges
Alternative Medical Treatment	Plan pays 50% of Covered Charges
In-Network Preventive Services	Plan pays 100% of Covered Charges, not subject to the deductible. See "Preventive Services Benefits" beginning on page 48
Out-of-Network Preventive Services	Plan pays 55% of Covered Charges, subject the deductible.

DENTAL BENEFITS	
Calendar Year Deductibles	
Class I Services	None
Class II and III Services (Combined)	$50 per person. Maximum of 3 calendar year deductibles per family.
Class IV Services	None
Coinsurance	
Class I Services	Plan pays 100% of Covered Charges
Class II Services	Plan pays 80% of Covered Charges
Class III Services	Plan pays 50% of Covered Charges
Class IV Services	Plan pays 50% of Covered Charges
Calendar Year Maximums	
Class I, II, and III Services (Combined)	$1,200 per person; not applicable to pediatric dental for individuals under age 19
Class IV	None
Lifetime Maximums	
Class I, II, and III Services	None
Class IV Services	$1,000 per person; not applicable to pediatric dental for individuals under age 19

BENEFITS FOR ELIGIBLE EMPLOYEES & DEPENDENTS	
VISION BENEFITS	
Calendar Year Deductible	None
Coinsurance	Plan pays 100% of Covered Charges
Calendar Year Maximum	$400 per person for all services and supplies combined; not applicable to pediatric dental for individuals under age 19

Benefits described in this Schedule of Benefits are subject to all the terms, exclusions, and limitations of the Plan.

DEFINITIONS

ALLOWABLE CHARGE

"Allowable Charge" means the amount this Plan allows as payment for Covered Charges. The Allowable Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

- With respect to a PPO provider, the negotiated fee/rate set forth in the agreement between the PPO network and the Plan; or
- With respect to a Non-PPO provider, the amount set forth by the PPO network, which is based on Medicare allowable amounts; or
- The Physician or other health care practitioner's actual billed charge.

The Plan's Allowable Charge list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

Any amount in excess of the "Allowable Charge" amount does not count toward the Plan's Out-of-Pocket Limits.

ALTERNATE RECIPIENT

"Alternate Recipient" means any child of an Employee who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Plan as the Employee's Dependent.

AMBULANCE

"Ambulance" means a vehicle, helicopter, airplane, or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

AMBULATORY SURGICAL FACILITY

"Ambulatory Surgical Facility" means a specialized facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures, and is part of a Hospital or is licensed as an Ambulatory Surgical Facility by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located, or if licensing is not required, meets certain Plan requirements.

BOARD OF TRUSTEES OR TRUSTEES

The terms “Board of Trustees” and “Trustees” mean the persons appointed pursuant to the Trust Agreement to serve as the Union Trustees and Employer Trustees for the Fund, and their successors.

COMPETITIVE EMPLOYMENT

“Competitive Employment” means work (including self-employment, supervisory, estimation, or pipe detailing work) as a plumber, steamfitter, or pipefitter for any employer, contractor or other business entity who is not a signatory party to a collective bargaining agreement or Participation Agreement by and between the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada or a United Association Local Union and said employer, whose business performs work:

- within the trade autonomy of the plumbing, steamfitting, pipefitting, heating, or air conditioning industries covered by the Plan; or

- in the geographical jurisdiction of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local Union Number 430, AFL-CIO.

Work performed by an Employee who has been designated as an organizer by the Union and engages in protected activity at the direction of the Union will not be considered Competitive Employment.

CONTRIBUTING EMPLOYER

“Contributing Employer” means any employer who:

- has a collective bargaining agreement with the Union or Participation Agreement with the Trustees requiring periodic contributions to be made to the Fund;

- signs a copy of the Trust Agreement or a Participation Agreement; and

- is accepted for participation in the Plan by the Trustees or is a party to the Trust Agreement.

“Contributing Employer” also includes the Plan and the Union to the extent either entity:

- becomes obligated, pursuant to a Participation Agreement with the Trustees, to contribute to the Plan on behalf of its Employees on substantially the same basis upon which other Contributing Employers are contributing to the Plan;

- is accepted for participation in the Plan by the Trustees; and

- makes contributions to the Plan as required by the Participation Agreement.

COSMETIC SURGERY

"Cosmetic Surgery" means any surgical procedure or medical treatment performed primarily to improve, preserve, or restore physical appearance, but not physical function. Cosmetic Surgery includes, but is not limited to, removal of tattoos, breast augmentation, "tummy tucks," and "face lifts."

COVERED CHARGE

"Covered Charge" means a charge, incurred by an Eligible Individual while covered by the Plan, for a covered service or supply, to the extent that:

- the service or supply is ordered or prescribed by a Physician;
- the service or supply is Medically Necessary, as defined below;
- the charge does not exceed the Allowable Charge, as defined above;
- the service or supply is not Experimental and/or Investigational, as defined below;
- the charge is not for a service or supply that is excluded;
- the charge is not in excess of any calendar year, lifetime, or other maximums shown in the Schedule of Benefits;
- the service or supply is for the diagnosis or treatment of an Injury or Illness (except where wellness/preventive services are payable by the Plan); and
- the charge is not resulting from a third-party liability claim that has been paid.

A charge is incurred on the date the service or supply for which the charge is made is rendered or obtained.

COVERED EMPLOYMENT

"Covered Employment" means employment for which a Contributing Employer is obligated to contribute to the Fund on behalf of an Employee for participation in the Plan.

CUSTODIAL CARE

"Custodial Care" means any care and services given mainly for personal hygiene or to perform the activities of daily living, regardless of where the care is given or who

recommends, provides, or directs the care. Some examples of Custodial Care are helping a patient get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medicines that can be self-administered.

DENTIST

"Dentist" means a person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered, and who is acting within the scope of his or her license. A Dentist does not include a person who lives with you or the patient, or is part of your or the patient's family (e.g., a spouse, a child, brother, sister or parent).

DEPENDENT

"Dependent" means:

1. Your lawful spouse, provided the spouse is recognized as such under federal tax laws.

2. Your children under the age of 26, including:

    - your natural-born child;
    - your legally adopted child;
    - a child placed with you for adoption;
    - your stepchild; and
    - a child placed with you by an authorized placement agency or by a judgment, decree or other order.

3. Your unmarried children who satisfy the above requirements in (2), except for the age requirement, and who are incapable of self-sustaining employment by reason of a mental or physical handicap. The handicap must have arisen prior to the age at which eligibility as a Dependent child would otherwise have terminated and while the child was covered under the Plan. Adequate proof of the child's handicap and dependence on you must be provided to the Plan no later than 31 days after the child attains the limiting age and would otherwise lose coverage, and thereafter as the Trustees require. Eligibility for such child will continue for as long as your coverage remains in force, and the child's handicap and dependence on you continues.

4. An Alternate Recipient under a Qualified Medical Child Support Order (QMCSO).

Acceptable forms of proof of a Dependent's eligible status that may be required by the Plan include, but are not limited to, certified copies of:

- Birth certificates.
- Marriage licenses, divorce decrees, or court-approved legal separation papers.
- Adoption, guardianship, or foster care court decrees.
- Death certificates.
- Physician statements attesting to the incapacity of a dependent child.
- Qualified Medical Child Support Orders (QMCSOs).
- Tax returns or other legal papers confirming dependent status.

If you are covered by the Plan as both an Employee and a Dependent, any benefit payments on your behalf will be administered in accordance with the Coordination of Benefits provisions beginning on page 65. In no event will benefit payments exceed 100% of Covered Charges.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means any medical equipment that:

- can withstand repeated use;
- is primarily and customarily used for a medical purpose;
- is not generally useful in the absence of an Injury or Illness;
- is not disposable or non-durable; and
- is appropriate for the patient's home.

Durable Medical Equipment includes, but is not limited to, sleep apnea monitors, blood sugar monitors, electric hospital beds with safety rails, wheelchairs, nebulizers, oximeters, oxygen and supplies for its administration, and ventilators.

ELECTIVE ABORTION

"Elective Abortion" means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

ELIGIBLE INDIVIDUAL

"Eligible Individual" means each Employee and each of his or her Dependents, if any, when covered by the Plan.

EMPLOYEE

"Employee" means:

- An employee who is covered by a collective bargaining agreement between the Union and his or her Contributing Employer, that requires the Contributing Employer to make periodic contributions to the Fund on behalf of his or her Covered Employment; and

- An employee who is covered by a Participation Agreement between his or her Contributing Employer and the Trustees, that requires the Contributing Employer to make periodic contributions to the Fund on behalf of his or her Covered Employment.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974 and any regulations promulgated thereunder, as amended.

EXPERIMENTAL AND/OR INVESTIGATIONAL

"Experimental and/or Investigational" means a service or supply that meets any of the following conditions:

1. The service or supply is described as an alternative to more conventional therapies in the medical treatment plan that is under investigation or in the consent form signed by or on behalf of the patient;

2. The prescribed service or supply may be given only with the approval of an Institutional Review Board, as defined by federal law;

3. There is an absence of authoritative medical, dental, or scientific literature on the subject, or else there is a preponderance of such literature published in the United States, which shows that recognized experts classify the service or supply as experimental and/or investigational, or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully

marketed and it has not been granted at the time the service or supply is prescribed or provided or a current investigational new drug or new device application has been submitted and filed with the FDA. A drug will not be considered Experimental and/or Investigational if it is FDA-approved as an investigational new drug for treatment use, or classified by the National Cancer Institute as a Group C cancer drug for treatment of a life threatening disease, or FDA-approved for cancer treatment and is prescribed for treatment of a type of cancer for which the drug is not approved for general use and the FDA has not determined that it should not be prescribed.

5. The prescribed service or supply is available to the Eligible Individual only through participation in Phase I or Phase II clinical trials, or Phase III experimental or research clinical trials, or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

FUND

"Fund" means the Plumbers and Pipefitters Local 430 Health and Welfare Fund.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto, as amended.

HOSPICE

"Hospice" means an agency or organization that administers a program of palliative and supportive health care services for terminally ill persons assessed to have a life expectancy of six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting, with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must be approved by Medicare, or licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located, or if licensing is not required, meet certain Plan requirements.

HOSPICE CARE

"Hospice Care" means care that:

- is furnished or arranged by a Hospice;

- is provided as a part of a coordinated plan of home and inpatient care designed to meet the special needs of the terminally ill patient and the family unit due to the terminal illness; and

- may include medical care, palliative care (care that is rendered to relieve the symptoms or effects of an Illness without curing the Illness), respite care (care that is furnished to a terminally ill patient so that the family unit may have relief from the stress of caring for the terminally ill patient), and medical social services (counseling furnished to the terminally ill patient or to the family unit to assist each in coping with the dying process of the terminally ill patient) for the terminally ill patient.

A "terminally ill patient" means an Eligible Individual whose Physician has certified that the person is terminally ill and expected to live six (6) months or less. "Family unit" means each member of the terminally ill patient's family who is an Eligible Individual.

HOSPITAL

"Hospital" means a public or private facility or institution, licensed and operating according to law, that:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and

- is approved by Medicare as a Hospital; and

- provides care and treatment by Physicians and nurses on a 24-hour basis.

ILLNESS

"Illness" means any bodily sickness or disease, as diagnosed by a Physician, including any congenital abnormality, and including pregnancy of a covered Employee or covered Employee's spouse.

INJURY

"Injury" means an accidental bodily Injury that requires treatment by a Physician. It must result in loss independently of Illness and other causes.

MEDICAL EMERGENCY

"Medical Emergency" means the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such 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 placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In the event of a Mental Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

MEDICALLY NECESSARY

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

- necessary in terms of generally accepted American medical and dental standards; and
- consistent with the symptoms or diagnosis and treatment of an Illness or Injury; and
- not provided solely for the convenience of the patient, Physician, Dentist, or Hospital; and
- "Appropriate" given the patient's circumstances and condition; and
- "Cost-efficient," safe, and effective for the Illness or Injury for which it is used.

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

MEDICARE

"Medicare" means the benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

MENTAL DISORDER

"Mental Disorder" means 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). "Mental Disorder" does not include psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications.

NON-PREFERRED PROVIDER ORGANIZATION OR NON-PPO

"Non-Preferred Provider Organization" or "Non-PPO" means a Hospital, Physician, or other provider of health care services that is not part of a Preferred Provider Organization (PPO) with whom the Fund has a contractual agreement.

OCCUPATIONAL INJURY OR ILLNESS

"Occupational Injury or Illness" means any Injury or Illness arising from or sustained in the course of any occupation or employment, including self-employment.

PARTICIPATION AGREEMENT

"Participation Agreement" means a written agreement between a Contributing Employer and the Trustees, which obligates the Contributing Employer to make contributions to the Fund on behalf of Employees covered by the agreement.

PHYSICIAN

"Physician" means any of the following licensed practitioners who are acting within the scope of their licenses and performing services that would be payable under the Plan if performed by a doctor of medicine (MD):

- A doctor of medicine (MD), doctor of osteopathy (DO), doctor of surgical chiropody (DSC), doctor of podiatry (DP), or doctor of chiropractic (DC).
- A certified registered nurse anesthesiologist (CRNA), or advanced nurse practitioner (ANP).
- A Physician Assistant.
- A licensed clinical psychologist.
- Where required by law, any other licensed practitioners who are acting within the scope of their licenses and performing services that would be payable under the Plan if performed by an M.D.

A Physician does not include a person who lives with you or the patient or is part of your or the patient's family (the Employee, the patient or a spouse, child, brother, sister or parent of the Employee or patient).

The Plan will not discriminate with respect to participation under the Plan against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

PHYSICIAN ASSISTANT (PA)

"Physician Assistant (PA)" means a person legally licensed as a physician assistant, who acts under the supervision of a Physician and performs services within the scope of his or her license. A Physician Assistant does not include a person who lives with you or the patient or is part of your or the patient's family (the Employee, the patient or a spouse, child, brother, sister or parent of the Employee or patient).

PLAN

"Plan" means the Rules and Regulations of the Plumbers and Pipefitters Local 430 Health and Welfare Fund, initially adopted effective June 1, 1970, as amended and restated.

PREFERRED PROVIDER ORGANIZATION OR PPO

"Preferred Provider Organization" or "PPO" means a Hospital, Physician, or other provider of health care services that is part of a Preferred Provider Organization (PPO) with whom the Fund has a contractual agreement.

PRESCRIPTION DRUGS

"Prescription Drugs" means any of the following:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

- Drugs that require a prescription under state law but not under federal law.

- Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

"Qualified Medical Child Support Order" or "QMCSO" means a medical child support order or a National Medical Support Notice that qualifies as a QMCSO, as determined by the Trustees. A "QMCSO" creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Eligible Individual is eligible under the Plan.

In order to qualify as a QMCSO, the medical child support order must clearly specify the following information:

- The name and last known mailing address, if any, of the participant and the name and mailing address of each Alternate Recipient covered by the order;

- A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient or the manner in which such type of coverage is to be determined;

- The period of coverage to which the order applies; and

- The name of this Plan.

In addition, the medical child support order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of a state law relating to medical child support orders for Medicaid eligible children as described in Section 1908 of the Social Security Act.

TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION OR SYNDROME

"Temporomandibular Joint (TMJ) Dysfunction or Syndrome" means symptoms of the TMJ including, but not limited to, masticatory muscle disorders producing severe pain in and about the TMJ, pain in the muscles of the face, headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus and/or hearing impairment.

TOTAL DISABILITY

"Total Disability" means:

- an Employee's complete and continuous inability to perform the material and substantial duties of his or her regular occupation and not engaging in any work for profit; or

- a Dependent's inability to perform the normal activities of a person of the same age and sex.

TRUST AGREEMENT OR TRUST

The terms "Trust Agreement" and "Trust" mean the Agreement and Declaration of Trust initially establishing the Plumbers and Pipefitters Local 430 Health and Welfare Fund effective June 1, 1970 as Pipefitters Local 430 Health and Welfare Fund (formerly Local Number 205), as amended and supplemented from time to time.

UNION

"Union" means the Plumbers and Pipefitters Local 430, and any other labor organization that is or becomes a party to the Trust Agreement and has a collective bargaining agreement with a Contributing Employer requiring periodic contributions to the Fund, provided such other labor organization is accepted by the Trustees for participation in the Fund.

UTILIZATION MANAGEMENT (UM)

"Utilization Management" or "UM" means a managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review may include, but is not limited to, precertification, admission

certification, continued stay review, discharge planning, retrospective review, case management, and physician fee negotiation.

UTILIZATION MANAGEMENT COMPANY OR UMC

"Utilization Management Company" or "UMC" means an independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Management services.

ELIGIBILITY FOR BENEFITS

ELIGIBILITY RULES FOR COLLECTIVELY BARGAINED EMPLOYEES

The following eligibility rules apply to Employees who are subject to a collective bargaining agreement between their Contributing Employer and the Union.

Initial Eligibility

You will initially become eligible for benefits on the first day of the second month following a period of up to six consecutive months during which you have worked at least 400 hours of Covered Employment. All hours you work in Covered Employment will be accumulated in an Hour Bank account established by the Plan on your behalf. For the first month of eligibility, 140 hours will be deducted from your Hour Bank.

Maintenance of Eligibility

After you initially become eligible, 140 hours of Covered Employment will be deducted from your Hour Bank account for each month of coverage. You must have at least 140 hours of Covered Employment accumulated in your Hour Bank account at the beginning of each month in order to be covered for that month. There is a one (1) month lag between the time you work and the time the corresponding hours are credited to your Hour Bank account.

You will be allowed to accumulate a maximum of 3,600 hours in your Hour Bank account after the withdrawal for coverage for the current month. For each month of coverage, 140 hours will be subtracted from the accumulated hours that have been credited to your Hour Bank. You will continue to be covered for subsequent months as long as you have 140 hours of credit in your Hour Bank account.

Any hours previously credited to your Hour Bank account will be pro-rated based upon any newly adopted collectively bargained Employer hourly contribution rate and adjusted as follows:

$$\text{New Hour Bank Account Hours} = \frac{\text{Prior Hourly Contribution Rate}}{\text{Newly Adopted Hourly Contribution Rate}} \times \text{Prior Hour Bank Account Hours}$$

Termination of Eligibility

Your eligibility will terminate on the earliest of the date of your death, the last day of the month in which you take a military service leave of absence, the date the Plan or Trust is terminated or amended to exclude coverage for you, or the last day of the month in which the contribution hours in your Hour Bank account are less than 140 hours for the next month's coverage.

In the event the contribution hours in your Hour Bank account are less than 140 hours and no contribution hours are credited to your Hour Bank account for 12 consecutive calendar months, your Hour Bank account will be reduced to zero. To again become eligible for benefits in the future, you will be required to fulfill all of the initial eligibility requirements described above.

In the event you engage in Competitive Employment, your eligibility will terminate and you will forfeit all work hours previously credited to your Hour Bank as of the last day of the month following your acceptance of work in Competitive Employment. To again become eligible for benefits in the future, you will be required to cease Competitive Employment and fulfill all of the initial eligibility requirements described above.

An Employee's accumulation of Hour Bank "hours" may be forfeited if the Employee's Contributing Employer withdraws from participation in the Fund and the Employee continues in employment with the withdrawing Contributing Employer.

ELIGIBILITY RULES FOR NEWLY RECRUITED EMPLOYEES

Definition of Newly Recruited Employee

"Newly Recruited Employee" means an Employee who is newly employed by a Contributing Employer that is a signatory to a collective bargaining agreement with the Union during the term of the last negotiated collective bargaining between Local Union No. 430 and the contractor association.

Initial Coverage

You will become eligible for one month of coverage under the Plan beginning on the first day of the month following the receipt by the Plan of a lump-sum payment equivalent to the current hourly contribution rate multiplied by 400. Such lump-sum payment will be made by Local Union No. 430 and/or your Contributing Employer.

Additional Eligibility Rules

Except as stated above for initial coverage, all eligibility rules for collectively bargained Employees apply to Newly Recruited Employees, including the rules under Maintenance of Eligibility and Hour Bank, Termination of Eligibility, and Eligibility Rules for Dependents.

Reinstatement of Eligibility

In the event your coverage terminates because you are not credited with the minimum number of hours of Covered Employment required for continuing eligibility (after taking into account any accumulated hours in your Hour Bank), you may be reinstated to eligibility on the first day of the second month following the month in which you are credited with a total of at least 140 hours of Covered Employment. In order to be reinstated, you must be credited with a total of at least 140 hours of Covered Employment within the 12-consecutive month period immediately following your termination. If you are not credited

with a total of at least 140 hours of Covered Employment within the 12-month period immediately following your termination, any accumulated hours in your Hour Bank will be forfeited. In order to again become eligible for coverage under the Plan, you will be required to fulfill all of the initial eligibility requirements described above.

Other Credited Hours of Employment – Reciprocity

In the event you leave the jurisdiction of the Fund to perform work for an employer who makes contributions on your behalf to another welfare fund covering members of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, provided such fund is signatory to a Reciprocal Agreement with this Fund, the Trustees will accept contributions made on your behalf as directed by you in writing, consistent with the terms of its Reciprocal Agreement. For eligibility purposes, this Fund will credit your Hour Bank upon receipt of contributions from the other reciprocating welfare fund on a pro-rata basis using this Fund's Employer contribution rate. If you perform work outside the jurisdiction of this Fund and wish to have contributions transferred to or from the Fund, you may obtain, upon request, additional information regarding the existence of a Reciprocal Agreement pertaining to such employment.

ELIGIBILITY RULES FOR NON-BARGAINING UNIT EMPLOYEES

Coverage for full- and part-time Employees working a minimum of 173 hours per month who are not otherwise covered by a collective bargaining agreement with Local Union No. 430 will become eligible to participate in the Plan on the first day of the calendar month following the month in which his or her Contributing Employer makes the first contribution to the Fund on his or her behalf in accordance with the Participation Agreement. Your initial period of coverage will be three months, for which your Employer must contribute three times the applicable monthly contribution amount on your behalf.

Your coverage will continue each month, provided that in the prior month your Contributing Employer makes the required contribution to the Fund on your behalf in accordance with the Participation Agreement.

Your coverage under the Plan will terminate on the earliest of the following dates to occur: (1) the end of the month in which your employment terminates; (2) the date of your death; (3) the last day of the month in which you take a military service leave of absence; or (4) the date the Plan or Fund is terminated or amended to exclude you from coverage.

Non-collectively bargained Employees are not eligible for an Hour Bank account, but all other provisions of the Plan are applicable for the non-collectively bargained Employees.

In the event a non-collectively bargained Employee, who has been employed by a Contributing Employer for 12 or more consecutive months and has maintained at least 12 months of continuous Plan eligibility, becomes enrolled in the Joint Apprenticeship Training Fund as an indentured apprentice, such individual will be granted up to four (4) months of eligibility under the Plan while he or she is working as an indentured apprentice

and is dispatched to a Contributing Employer as a collectively bargained Employee, beginning with the first of the month that his or her coverage as a non-collectively bargained Employee terminates. Thereafter, he or she will be entitled to accumulate hours in an Hour Bank and be subject to the eligibility provisions for collectively bargained Employees.

ELIGIBILITY RULES FOR EMPLOYEES OF NEW CONTRIBUTING EMPLOYERS

Employees of a newly organized Employer that enters into a collective bargaining agreement with a participating local Union will be eligible under the following terms and conditions:

Initial Eligibility

You will initially become eligible for one month of coverage under the Plan beginning on the first day of the month following the execution of a collective bargaining agreement, provided all required information is received by the Fund Office prior to the proposed effective date of coverage.

The Fund will establish a "negative" Hour Bank account for each Employee, and each Employee will be credited with 400 negative hours.

Maintenance of Eligibility

To maintain eligibility, you are required to work a minimum of 140 hours per month in Covered Employment and Employer contributions must be paid by the newly Contributing Employer. There is a one (1) month lag between the time you work and the time the corresponding hours are applied toward your continuing eligibility requirements. Thus, hours worked in Covered Employment during the month prior to your initial eligibility month will be used to satisfy the eligibility requirements for your second month of coverage. Any hours of Covered Employment in excess of 140 hours in a given month will be applied to your negative Hour Bank account until the negative Hour Bank reaches zero.

Until the negative Hour Bank reaches zero, if you work less than the required 140 hours in any given month, you will be considered to have a COBRA qualifying event, as described beginning on page 26. An exception to this rule will be granted, but only with respect to hours worked in Covered Employment during the month prior to the initial eligibility month. If you do not work the required 140 hours in Covered Employment during the month prior to your initial eligibility month, you may continue coverage for one month beyond the initial eligibility month, but you will incur additional negative hours, up to a maximum of 140 hours, toward your negative Hour Bank account. The number of additional hours credited your negative Hour Bank account will be the difference between the number of hours worked and the required 140 hours. For example, if you work 100 hours in the month prior to your initial eligibility month, you may only continue coverage beyond the initial eligibility month by incurring an additional 40 negative hours, for a total of 440 negative hours. Thereafter, you will not be permitted to incur additional negative hours.

Extended Coverage/Coverage During Total Disability

Extended coverage or coverage during a Total Disability will only be available once your negative Hour Bank reaches zero.

Reinstatement of Eligibility

Except as otherwise indicated in "Maintenance of Eligibility," above, if you fail to maintain the required 140 hours within a monthly period, fail to elect self-payment coverage (COBRA), and have not reached zero in your negative hour bank, you will only regain coverage through the initial eligibility rules for collectively bargained employees (or non-collectively bargained employees, as applicable).

Newly Hired Employee

Employees hired by the newly Contributing Employer subsequent to the effective date of collective bargaining agreement will be subject to the normal initial eligibility rules for collectively bargained employees, as previously described.

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

LEAVE OF ABSENCE FOR MILITARY SERVICE

If you, the Employee, take a leave of absence for qualified military service (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard), your coverage and your Dependents' coverage under the Plan will generally terminate on the last day of the month in which the qualified military service begins unless you elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To ensure protection of your rights under USERRA, you are obligated to notify the Plan as soon as you are called up for military service.

Under USERRA, you can elect to continue medical, dental, and vision coverage for yourself and your Dependents for the period of your leave, up to a maximum of 24 months. If the leave does not exceed 31 days, there is no cost to continue your coverage. If the leave exceeds 31 days, the Plan will require you to pay for continued coverage. This right to continue coverage will generally be subject to the Plan's payment, notification, cancellation, and other administrative procedures, time frames and rules for COBRA coverage.

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

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

- if the period of service was 31 days or more but less than 180 days, your eligibility will be reinstated on the day you make application to return to work with an Employer, provided that you make application 14 days from the date of discharge; or

- if the period of service was more than 180 days, your eligibility will be reinstated on the day you make application to return to work with an Employer, provided you make application within 90 days from the date of discharge.

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

If you do not return to work in Covered Employment or do not seek re-employment in Covered Employment within these time periods, you will forfeit your credited hours of Covered Employment and contributions.

FAMILY AND MEDICAL LEAVE (FMLA)

If you are eligible for benefits under the Plan and eligible for leave under the Family and Medical Leave Act of 1993 (FMLA) and the Plan's FMLA policies and procedures, you can elect to continue medical, dental, and vision coverage for yourself and your Dependents during the period of FMLA leave, provided you satisfy the following conditions:

- Your Employer must certify that the Employer is subject to the FMLA requirements and that you are eligible for FMLA leave;

- Your Employer must timely notify the Fund of the type and duration of FMLA leave that has been requested, and must timely furnish the necessary information to support your eligibility for FMLA leave; and

- Your Employer must submit contributions to the Fund for the duration of the FMLA leave to continue your coverage.

You will not be required to use your Hour Bank to continue your coverage during the FMLA leave. When you return to Covered Employment at the end of your FMLA leave, your eligibility will continue just as if your Covered Employment had continued without interruption.

ELIGIBILITY RULES FOR DEPENDENTS

Eligibility Rules for Dependents

An Employee's Dependent spouse and Dependent children are eligible for coverage under the Plan without cost to the Employees provided they qualify as Dependents, as previously defined.

In order for your Dependents to be covered under the Plan, you must be covered, in which event the coverage for your eligible Dependents will become effective on the latest of the following dates:

- the date your coverage becomes effective, if the person is a Dependent on that date;
- the date an individual becomes a Dependent through birth or is newly acquired, if on that day you are eligible for coverage; or
- if applicable, the date specified in a Qualified Medical Child Support Order.

Termination of Eligibility

Dependent coverage will terminate on the earliest of the following dates:

- the date your coverage terminates;
- the date the dependent no longer qualifies as a Dependent (however, if the dependent no longer qualifies as a Dependent due to attaining age 26, coverage will terminate on the last day of the month in which the Dependent turns 26);
- the last day of the month in which you take a military service leave of absence unless you continue coverage for the Dependent under USERRA; or
- the date the Plan is terminated or amended to eliminate coverage for the Dependent.

SPECIAL ENROLLMENT PERIODS

Dependents Losing Other Coverage

If your Dependent is eligible, but not enrolled, for coverage under the Plan, such Dependent may enroll in the Plan through a mid-year benefit election if each of the following conditions is met:

- The Dependent was covered under other group health coverage at the time coverage under this Plan was previously offered to the Dependent;

- The Dependent's other coverage was under a COBRA continuation provision and that COBRA coverage is exhausted, or the other coverage was maintained by an employer and the other coverage terminated as a result of loss of eligibility or because the Employer stopped contributing toward the other coverage (but not because of a failure to make a required payment or for cause).

- You enroll such Dependent for coverage under this Plan no later than 30 days after the other coverage terminates.

New Dependents

If you acquire a Dependent through marriage, birth, adoption or placement for adoption, you may enroll the new Dependent and, in the case of birth, adoption or placement for adoption, your Dependent spouse who is not then enrolled within 30 days after the date of the marriage, birth, adoption or placement for adoption.

Effective Dates

Coverage for Dependents added because of marriage is effective as of the date all of the necessary paperwork to enroll the Dependents is received, provided it is received within the 30 days following the marriage. Coverage for Dependents added because of birth, adoption or placement for adoption is effective retroactive to the date of the birth, adoption, or placement for adoption provided all of the necessary paperwork to enroll the Dependents is received within 30 days following the birth, adoption, or placement for adoption.

COBRA SELF-PAYMENT PROVISIONS FOR EMPLOYEES AND DEPENDENTS

The federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) gives covered Employees and Dependents the right to continue their health care coverage under the Plan, on a self-payment basis, when it would otherwise end because of a "qualifying event."

ELIGIBILITY FOR COBRA COVERAGE (QUALIFYING EVENTS)

A covered Employee who would otherwise lose health care coverage under the Plan due to one of the following qualifying events will be entitled to elect COBRA coverage:

- Failure to work or be credited with the required number of hours of Covered Employment to maintain coverage under the Plan; or

- Termination of employment for any reason other than gross misconduct.

A covered Dependent who would otherwise lose health care coverage under the Plan due to one of the following qualifying events will be entitled to elect COBRA coverage:

- The Employee fails to work or be credited with the required number of hours of Covered Employment to maintain coverage under the Plan;

- The Employee terminates employment for any reason other than gross misconduct;

- The Employee dies, divorces or becomes legally separated, or becomes entitled to Medicare (which is the date the Employee actually becomes covered under Medicare); or

- A Dependent child ceases to qualify as an eligible Dependent under the Plan.

QUALIFIED BENEFICIARIES

After a qualifying event, COBRA coverage is available to each person who is a "qualified beneficiary." A "qualified beneficiary" is any Employee or Dependent who, on the day before the qualifying event, has health coverage under the Plan and would otherwise lose that coverage due to the qualifying event. In addition, any Dependent child who is born to or placed for adoption with a covered Employee during a period of COBRA coverage is also a qualified beneficiary.

If a qualified beneficiary with COBRA coverage acquires a family member who could be enrolled in the Plan as a Dependent if the qualified beneficiary was an active Employee, the qualified beneficiary may add the family member to his or her COBRA coverage for the remainder of the COBRA coverage period; however, the family member is not a qualified

beneficiary with independent COBRA rights. In addition, if a qualified beneficiary with COBRA coverage has a Dependent who: (1) was eligible but did not enroll in the Plan at the time of the qualified beneficiary's initial enrollment because the Dependent had other group health coverage; and (2) lost the other coverage due to exhaustion of COBRA, loss of eligibility or termination of employer contributions (but not due to the Dependent's failure to pay timely any required premium or self-payment or termination of coverage for cause), the qualified beneficiary may add that Dependent to his or her COBRA coverage for the remainder of the coverage period, within 30 days after termination of the Dependent's other coverage. If COBRA coverage ceases for a qualified beneficiary, it will end for any family members of the qualified beneficiary who are also enrolled but are not qualified beneficiaries in their own right.

NOTICE

The Fund Office will notify all Employees and Dependent spouses of their COBRA rights when they first become covered under the Plan. The Fund Office will also notify (at his or her last known address) an Employee and his or her Dependent(s) whenever their coverage would otherwise end due to an Employee's death, termination of employment, insufficient hours or, if applicable, Medicare entitlement. The Fund Office must notify the affected Employee and/or Dependent(s) of their COBRA coverage rights within 30 days of the date coverage will otherwise terminate due to such qualifying event.

You are required to provide the Fund Office with timely notice of the following events in order to protect your rights to elect COBRA coverage:

- divorce or legal separation of the Employee;
- the death of an Employee after his or her termination of employment;
- the eligibility for Medicare by an Employee who is continuing coverage under COBRA (at a time when he or she is no longer employed by a Contributing Employer);
- the failure of a Dependent child to meet the definition of Dependent;
- when an individual entitled to COBRA coverage for a maximum of 18 months is determined by the Social Security Administration to be disabled; and
- when the Social Security Administration determines that a disabled individual receiving COBRA coverage is no longer disabled.

In order to give notice of the above events, you must send a letter to the Fund Office containing the following information:

- the covered Employee's name;

- the qualified beneficiary's name;
- the type of event for which notice is being provided;
- the date of the event;
- for a divorce or legal separation, a copy of the divorce or legal separation decree; and
- for a Social Security Administration disability determination, a copy of the determination.

For the required notice of a divorce or legal separation, a Dependent ceasing to qualify for Dependent status or a second qualifying event, the notice must be postmarked or hand delivered no later than 60 days after the later of: (a) the date on which the relevant qualifying event occurs; or (b) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination that an individual is disabled, notice must be postmarked or hand delivered to the Fund Office prior to the end of the first 18 months of COBRA coverage and no later than 60 days after the latest of:

- the date of the disability determination by the Social Security Administration;
- the date on which the qualifying event occurs; or
- the date on which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event.

You must notify the Fund Office within 30 days of the date the disabled individual is determined to no longer be disabled.

If you do not timely notify the Fund Office, in writing, of the occurrence of any of the events listed above for which you are required to give Notice, you may forfeit your right to elect continuation of coverage under COBRA. Notice may be provided by the Employee, a Dependent, or representative acting on behalf of the Employee or Dependent. Notice from one individual will satisfy the requirements for all individuals affected by the same qualifying event. If an individual provides notice to the Fund Office relating to the qualifying event but is not entitled to COBRA coverage, the Plan will send written notice to the individual explaining why he or she is not entitled to COBRA coverage within the same time period required for sending a COBRA election notice if the individual was entitled to COBRA coverage.

How to Elect COBRA Coverage

Within 30 days after receiving timely notice of a qualifying event from an Eligible Individual, or within 30 days after you lose coverage due to the Employee's death, termination of employment, insufficient hours worked or Medicare entitlement, the Fund Office will furnish the affected Employee and/or Dependent(s) with specific information on when and how to elect COBRA coverage, including the amount of the required self-payment. Notice given to an Employee or Dependent spouse will be deemed to be notice to all affected Dependent children living with the Employee or Dependent spouse. The Employee and Dependent(s) will then have 60 days after the later of (1) the date coverage would otherwise end due to the qualifying event, or (2) the date of notification of the right to continue coverage, in which to elect to continue coverage under COBRA.

Each qualified beneficiary will have an independent right to elect COBRA coverage. COBRA coverage may be elected by some qualified beneficiaries and not others and regardless of whether the Employee elects it. An Employee may elect COBRA coverage on behalf of the Dependent spouse, and a parent may elect COBRA coverage on behalf of Dependent children living with him or her. If you waive COBRA coverage during the 60-day election period, you may revoke the waiver and elect COBRA coverage at any time during the 60-day election period; however, COBRA coverage may be provided only from the date of revocation and not retroactive to the date coverage terminated.

Unless otherwise specified in an election, any election by an Employee or his or her Dependent spouse will be deemed also to be an election on behalf of all other Dependents who would lose coverage due to the qualifying event.

Type of Coverage under COBRA

The health care coverage available under the Plan during the COBRA coverage period is the same medical, dental, and vision coverage provided to Eligible Individuals with respect to whom a COBRA qualifying event has not occurred. If there is a change in the health care coverage provided by the Plan to Eligible Individuals not covered under COBRA, that same change will be made to the COBRA coverage.

Self-Payment Amounts

Qualified beneficiaries who elect COBRA coverage must pay the amount of the required self-payment on an after-tax basis. The amount of the monthly self-payment(s) required for COBRA coverage will be established by the Board of Trustees. The COBRA self-payment amounts will be periodically reviewed and may be changed by the Trustees at their discretion, provided the self-payment amount remains constant for a 12-month period to the extent required by COBRA. In no event will the monthly self-payment amount exceed 102% of the applicable premium, except in the case of an individual whose self-pay eligibility period is increased from 18 to 29 months due to a disability, in which case the self-payment amount will be no more than 150% of the applicable premium for any month beginning after the 18th month of coverage and continuing through the 29th month

unless the disability ends at an earlier date. The Fund Office will notify you of the cost of COBRA coverage at the time notice of entitlement to COBRA coverage is distributed.

DURATION OF COBRA COVERAGE

COBRA coverage is available to a qualified beneficiary until the first of the following events to occur:

- the Plan ceases providing any benefits to any Eligible Individual;
- the last day of the last month for which the required self-payment was made timely (taking into account the applicable grace period);
- the date, after the COBRA election, on which the individual first becomes covered under Medicare or another group health plan that does not have a limitation or exclusion for any pre-existing condition that affects the individual (or if it does, the first day on which the limitation or exclusion no longer affects the individual);
- for the loss of coverage due to insufficient hours or termination of employment (unless due to gross misconduct), 18 months have passed since the loss of coverage.
- for loss of coverage due to an Employee's death, divorce, legal separation, or entitlement to Medicare, or to a Dependent's loss of status as an eligible Dependent under the Plan, 36 months have passed since the loss of coverage. In the case of multiple qualifying events, coverage will in no event be extended for more than 36 months from the date of initial loss of coverage.
- if an individual is extending COBRA coverage from 18 to 29 months due to disability, the last day of the month that includes the 30th day following a Social Security Administration determination that the individual is no longer disabled; or
- failure to follow the Plan's policies and procedures and taking action that would result in termination of coverage for cause for a similarly situated active Employee or Dependent (such as submission of false claims to the Plan).

If you are entitled to COBRA coverage for 18 months, that period can be extended for up to 11 additional months (29 months total) if one of the qualified beneficiaries with COBRA coverage is determined by the Social Security Administration to be totally disabled before or during the first 60 days of COBRA coverage, and notifies the Fund Office of that determination before the end of the initial 18-month COBRA period and, if earlier, within 60 days after the later of:

- the date of the determination;
- the date of the initial qualifying event; and

- the date on which coverage would otherwise be lost due to the initial qualifying event.

If one qualified beneficiary is disabled, the entire family receiving COBRA coverage is entitled to receive the additional 11 months of COBRA coverage.

If an Employee experiences a termination of employment or insufficient hours qualifying event less than 18 months after he or she first becomes entitled to Medicare (enrollment in Medicare Part A or Part B), the period of COBRA coverage available to his or her Dependents will last until 36 months after the date the Employee first becomes entitled to Medicare.

If COBRA coverage terminates early before the applicable 18, 29 or 36 month period, the Plan will send written notice to the affected individual(s) as soon as practicable after the Plan determines that such coverage will terminate, setting forth the reason for termination, the date of termination and your right, if any, to alternative coverage.

DUE DATES FOR SELF-PAYMENTS

The initial self-payment must cover the cost of coverage from the date it would otherwise terminate through the end of the month in which the initial self-payment is made. There is an initial grace period of 45 days, measured from the date COBRA coverage is elected, in which to make the first required self-payment. If the initial self-payment is not made by the end of this grace period, COBRA coverage will not take effect.

Each subsequent self-payment is payable on a monthly basis and due on the first day of the month for which coverage is intended. There is a 30-day grace period, measured from the first day of the month, in which to make the required self-payment. If a self-payment is received at the Fund Office later than 30 days after the due date, it will not be accepted. Coverage will terminate as of the end of the last month for which payment was made timely, and the qualified beneficiary will forfeit all rights to receive COBRA coverage. **There will be no waivers granted.**

SELF-PAY ELIGIBLES AFFECTED BY MULTIPLE EVENTS

No person may enjoy any one continuous COBRA coverage period under the Plan beyond 36 months from the date of the initial loss of coverage.

NAME OF PLAN & NAME, ADDRESS AND TELEPHONE NUMBER OF THE PARTY RESPONSIBLE FOR COBRA ADMINISTRATION

Plumbers and Pipefitters Local 430 Health and Welfare Fund
2908 N Harvard Ave.
Tulsa, OK 74115
918-836-0430

WHEN A CONTRIBUTING EMPLOYER WITHDRAWS FROM THE FUND

If an Employee's Contributing Employer withdraws from participation in the Fund and the Employee continues in employment with the withdrawing Contributing Employer, the Employee's rights to self-pay and/or elect COBRA coverage may be forfeited.

UNAVAILABILITY OF COVERAGE

Where you or your dependents have provided notice to the Fund Office of a divorce or legal separation, beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but you are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund is required to provide an election notice.

KEEP THE FUND INFORMED OF ADDRESS CHANGES

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

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

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

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.
To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE?

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

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

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

SELF-PAYMENT PROVISIONS FOR SURVIVING DEPENDENTS

Dependents of a deceased Employee may elect to continue coverage through self-payment under COBRA, or in lieu of COBRA coverage may make self-payments to the Plan to continue coverage, provided they were covered Dependents at the time of the Employee's date of death.

If you elect to maintain eligibility for benefits by making self-payments, your coverage will continue for as long as the required self-payments are made unless and until the surviving spouse remarries or, with respect to a Dependent child, until the child ceases to qualify as a Dependent. No additional persons will be eligible under this provision except for a child of an Employee born subsequent to the Employee's date of death.

If your coverage terminates because the required self-payment is not made, coverage may not be reinstated.

The benefits for Dependents of deceased Employees are the same as benefits for Dependents of living Employees, except that dental benefits and vision benefits are not provided.

The amount of self-payment will be determined by the Trustees and will be based on the Plan's operating expense factor as well as the cost for the benefits in effect at that time.

COMPREHENSIVE MEDICAL BENEFITS

CALENDAR YEAR DEDUCTIBLE

The calendar year deductible, as shown in the Schedule of Benefits, is the amount of Covered Charges you must incur and pay each calendar year before your Covered Charges incurred during the calendar year are payable under the Plan. A separate calendar year deductible applies to each person each calendar year.

All services and supplies are subject to the calendar year deductible except dental, prescription drugs and covered preventive services. Balance-billed charges and excluded services do not count toward the calendar year deductible. In addition, penalties for failure to obtain pre-authorization and coinsurance paid toward mandatory outpatient surgeries performed on an inpatient basis will not count toward your deductible.

COMMON ACCIDENT CALENDAR YEAR DEDUCTIBLE LIMIT

When two (2) or more Eligible Individuals, who are members of the same family unit, are injured in the same accident, only one (1) calendar year deductible will be applied to the Covered Charges incurred by such family members as a result of the accident, during the calendar year in which the accident occurs.

PRESCRIPTION DRUG DEDUCTIBLE

The prescription drug deductible, as shown in the Schedule of Benefits, is the amount of prescription drug Covered Charges you must incur and pay each calendar year before your prescription drug Covered Charges incurred during the calendar year are payable under the Plan. A separate calendar year deductible applies to each person each calendar year.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Trustees have contracted with a Preferred Provider Organization (PPO) to provide a network of doctors, hospitals, and other medical service providers who agree to charge you discounted fees. Services may still be obtained from a non-PPO provider, which is a provider that does not belong to the PPO; however, the charges will not be discounted. A listing of PPO providers will be provided to you without charge. For a list of PPO providers, see www.bcbsil.com or call 1-800-810-2583.

COINSURANCE

The coinsurance percentages, as shown in the Schedule of Benefits, are the percentages of Covered Charges payable under the Plan after satisfaction of the calendar year deductible, subject to any maximum limitations. The coinsurance percentages for services

rendered by PPO providers are generally higher than the coinsurance percentages for services rendered by Non-PPO providers.

If you incur Covered Charges for services rendered by a Non-PPO provider, and you reside 25 or more miles outside the PPO service area, such Covered Charges will be payable at the coinsurance percentage shown in the Schedule of Benefits under "Provider Outside PPO Service Area."

OUT-OF-POCKET LIMITS

The out-of-pocket limits for PPO providers, as shown in the Schedule of Benefits, are the maximum amounts you are responsible for paying each calendar year for PPO providers before the Plan begins to pay 100% of Covered Charges for PPO providers incurred by that individual for the remainder of that calendar year.

Expenses incurred for medical services or supplies that are not covered by the Plan and charges in excess of the Allowable Charge will not be applied towards satisfaction of the out-of-pocket limit. In addition, balance-billed charges and penalties for failure to obtain pre-authorization will not count toward your out-of-pocket limits.

INPATIENT CERTIFICATION AND CONTINUED REVIEW PROGRAM

You must comply with the Plan's inpatient certification and continued review program in order to be eligible for the full level of benefits payable under the Plan. The Plan has appointed a Utilization Management Company to manage these certification requirements. Failure to comply with the requirements of this program will result in a reduction of benefits to the extent described below and/or in the Schedule of Benefits.

You must obtain inpatient certification prior to a non-emergency Hospital admission. The UMC will evaluate the request, and if it determines that the proposed admission is Medically Necessary and that the Hospital is the most appropriate setting for the treatment, it will pre-certify a specific number of days for an inpatient stay. If you fail to obtain an inpatient certification, the benefits otherwise payable will be reduced by the amount described in the Schedule of Benefits.

If the Hospital admission is due to a Medical Emergency, inpatient certification must be obtained by the end of the second business day following the admission. Upon receipt of the required information, the UMC will evaluate whether the admission was Medically Necessary, if continued inpatient care is needed, and whether the admitting Hospital is the most appropriate setting for such continued care. If it is, the UMC will certify an initial number of days of inpatient care and, if appropriate, pre-certify an additional number of days for continued inpatient care. If you fail to obtain an inpatient certification, the benefits otherwise payable will be reduced by the amount described in the Schedule of Benefits.

Once you are admitted to a Hospital, the UMC will monitor the inpatient stay for continued Medical Necessity and appropriateness. If additional days of inpatient care are needed

beyond the number certified, you must notify the UMC and provide the necessary information as soon as possible and prior to the end of the certified stay. Upon receipt of this information, the UMC will evaluate whether the additional inpatient care is Medically Necessary and whether the Hospital is the most appropriate setting for the additional care; if it is, the UMC will pre-certify an additional number of days of continued inpatient care.

If at any time the UMC determines that fewer days of inpatient care are needed and that care can safely and effectively be delivered in another setting, the UMC may change its precertification or certification. Notice of any change will be provided to you or your medical provider prior to its effective date. If you remain hospitalized as an inpatient beyond the number of days pre-certified or certified as Medically Necessary and appropriate for the condition causing the hospitalization, no benefits will be payable.

If you incur a reduction or loss of benefits due to non-compliance with the inpatient certification and continued review program requirements, such amounts will not count towards your out-of-pocket limit.

There will be no restriction or reduction in medical benefits payable under the Plan, to or for a covered mother or newborn child, with respect to a Hospital admission and inpatient stay for childbirth for up to 48 hours for a normal vaginal delivery or up to 96 hours for a caesarian section. If additional day(s) of inpatient care are needed for the mother or newborn child beyond this 48 or 96-hour period, the Eligible Individual or medical provider must contact the Plan for certification of the additional stay.

ALTERNATIVE MEDICAL TREATMENT BENEFITS

Under certain circumstances, the Plan may provide benefits for “alternative medical treatment” in accordance with an alternative medical treatment plan. An “alternative medical treatment plan” is a medical treatment plan developed between an Eligible Individual, the attending Physician and any other licensed health care providers, and approved by the Plan, with the goal of providing the most appropriate care in a timely, efficient, and cost-effective manner. If an alternative medical treatment plan is approved, benefits will be paid for expenses incurred in connection with an alternative medical treatment plan, regardless of whether they qualify as Covered Charges under the Plan’s comprehensive medical benefits, subject to the maximum amount indicated in the Schedule of Benefits.

The Board of Trustees expressly reserves the right, in its sole discretion at any time, to discontinue providing benefits for alternative medical treatment to the extent such treatment is not covered under the Plan’s comprehensive medical benefits and regardless of whether the alternative medical treatment plan was previously approved.

COVERED CHARGES

Medical benefits are payable for Covered Charges incurred by an Eligible Individual for the following services and supplies, subject to the applicable deductible, coinsurance and benefit limitations shown below and/or in the Schedule of Benefits:

1. Hospital room and board facility fees with general nursing services, including laboratory, x-ray, diagnostic, and related ancillary services and supplies.

2. Hospital specialty care unit facility fees (e.g., intensive care unit, cardiac care unit, neonatal care unit), including laboratory, x-ray, diagnostic, and related ancillary services and supplies.

3. Hospital outpatient services.

4. Services for medical care provided by a Physician or other covered health care practitioner in an office, Hospital, emergency room, or other covered health care facility location, including but not limited to surgical procedures or the repair of a dislocation or fracture, but not including the services of an assisting surgeon or the services of a person who lives with the Employee or patient or is part of the Employee's or patient's family.

5. Administration of anesthesia by persons not employed by the Hospital.

6. Services of a Registered Nurse (R.N.) for private duty nursing care and services of a licensed physiotherapist.

7. Surgical procedures listed in Appendix A when performed on an outpatient basis (such as in an Ambulatory Surgical Facility, a Physician's office or clinic, or the outpatient department of a Hospital).

   If you undergo any of the surgical procedures listed in Appendix A on an inpatient basis, the coinsurance percentage will be reduced to 50% for all covered Hospital, medical and surgical services received as a result of that surgical procedure.

   The benefit reduction for covered outpatient surgery performed on an inpatient basis will not apply when an inpatient Hospital confinement is Medically Necessary as a result of:

   - your medical condition, which requires prolonged post-operative observation by a nurse or other skilled medical staff;

   - your anesthesia status;

   - technical problems shown by your admission notes or operative report; or

- the performance of a second surgical procedure that requires Hospital confinement, at the same time as or shortly following the first procedure (such as, for example, a mastectomy following a breast biopsy).

8. Outpatient laboratory and radiology (X-ray) services and examinations, including technical and professional fees associated with diagnostic and curative laboratory and X-ray services. Includes mammograms, Pap smears and prostate examinations.

9. Use of a Hospital emergency room (ER) and any ancillary services (such as laboratory or X-ray services) performed during the ER visit for the treatment of a Medical Emergency.

10. Maternity related services incurred by an Employee or Employee's Dependent spouse. Benefits will not be payable for maternity/pregnancy expenses incurred by a Dependent child, except as required under the Affordable Care Act (ACA).

    Benefits will not be payable for Elective Abortions or for drugs or devices used to terminate pregnancy and/or cause an abortion. However, benefits will be payable for Covered Charges incurred for any complications that are the result of an Elective Abortion.

    This Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Nor will the Plan require a health care provider to obtain pre-admission certification or admission certification from the Plan (or its Utilization Management Company) for a length of stay not in excess of these periods.

11. Professional Ambulance services, including:

    - Local professional ground Ambulance services; and

    - Transportation to the United States from another country by professional non-air Ambulance or on a regularly scheduled flight on a commercial airline when: (i) the transportation is required as a result of a Medical Emergency that occurred while you were traveling outside of the United States; (ii) special and unique covered Hospital services are required which are not provided by a local Hospital; and (iii) transportation is Medically Necessary.

    Benefits for all Ambulance transportation are limited to the amounts shown in the Schedule of Benefits. In addition, covered transportation to the United States from another country is subject to the section "Medical Treatment Rendered Outside of the United States."

12. Office visits and X-rays related to spinal (chiropractic) treatment, up to the limits shown in the Schedule of Benefits.

13. Surgical treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome performed by a Physician or Dentist and including:

    - inpatient Hospital expenses, provided surgery is performed; and

    - surgical expenses up to the lifetime maximum amount shown in the Schedule of Benefits.

    Before benefits are payable, a second opinion, which confirms the Medical Necessity of the treatment to be received, must be obtained.

14. Treatment of Mental Disorders during a Hospital confinement, a Residential Treatment Center confinement, partial hospitalization, intensive outpatient treatment or an office visit.

15. Services related to an Eligible Individual's receipt of an organ or tissue transplant, including but not limited to patient screening, organ/tissue procurement, transportation of the organ/tissue, transportation and surgery for the patient and donor, follow-up care in the home or a Hospital, and immuno-suppressant drugs. Benefits for organ or tissue transplants are subject to the maximum amount shown in the Schedule of Benefits.

    Organ/tissue transplant services must be performed at a transplant center program in a major medical center, which is approved by either the federal government or the appropriate state agency of the state in which the center is located.

16. Prescription Drugs (including smoking cessation drugs) and medicines requiring a Physician's written prescription.

    Prescription Drugs for the treatment of erectile dysfunction (e.g., Viagra, Cialis and, Levitra), are limited to a maximum of 15 pills per month and covered only if the dysfunction is determined to be of an organic nature.

17. Rehabilitative physical therapy provided by a licensed physiotherapist. Benefits will not be payable for services provided by a person who lives with the Employee or patient or who is a part of the Employee's or patient's family.

18. Blood and blood products and equipment for its administration.

19. Durable Medical Equipment. Coverage for rental of hospital beds and wheelchairs are limited to the purchase price of such equipment.

20. Corrective appliances, including casts, splints, braces, trusses, and crutches.

21. Initial placement of artificial limbs and eyes to replace natural limbs and eyes.

22. Initial placement of contact lenses required because of cataract surgery.

23. Dental services rendered by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural Teeth (including the initial replacement of the injured teeth and any necessary dental X-rays). Treatment must begin within 90 days of the Injury and be completed within one year after the Injury.

    "Dental Injury" means an Injury to Sound, Natural Teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

    "Sound Natural Teeth" means teeth that are whole or properly restored, without impairment or periodontal disease, and not in need of the provided treatment for reasons other than Dental Injury.

24. Screenings for heavy metal and benzene for Employees.

    These screenings are not subject to the calendar year deductible.

25. Mastectomy and related reconstructive breast surgery including:

    - All stages of reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    - Prostheses; and
    - Treatment of physical complications of mastectomy, including lymphedemas.

    Benefits for reconstructive breast surgery will be provided as required by the Women's Health and Cancer Rights Act of 1998 and in a manner determined in consultation with the attending provider and the patient.

26. One routine physical examination every two (2) calendar years for Eligible Individuals ages 18 through 40 and one routine physical examination every calendar year for Eligible Individuals over the age of 40, including laboratory expenses.

27. The following Hospice Care services provided to a terminally ill patient, including bereavement counseling for the terminally ill patient's family unit. A "terminally ill patient" means an Eligible Individual whose Physician has certified that the

person is terminally ill and expected to live six (6) months or less. "Family unit" means each member of the terminally ill patient's family who is an Eligible Individual.

- Confinement of a terminally ill patient as an inpatient. The Plan will not pay for more than a total of eight (8) days of inpatient respite care.

- Home health care furnished to the terminally ill patient in the patient's home, including services of a home health aide, professional services of a nurse, physical therapy or other therapy, nutrition counseling and special meals, and medical support.

- Counseling furnished to the terminally ill patient or to the family unit to assist each in coping with the dying process of the terminally ill patient. The counseling may be furnished by a social worker or a pastoral counselor but only if such person is licensed and practicing within the scope of his or her license.

- Bereavement counseling furnished to the family unit by a licensed or certified social worker or licensed pastoral counselor. Bereavement counseling is only covered during the 12-month period that begins on the date of the death of the terminally ill patient.

28. Gastric restrictive procedures or gastric or intestinal bypass for the surgical treatment of morbid obesity. In order for benefits to be payable, the surgery must be considered Medically Necessary, as determined by the Plan, and must meet all medical criteria established by the Utilization Management Company.

    The coinsurance rate for the surgical treatment of morbid obesity will not increase to 100%, even after the out-of-pocket limit is reached as a result of other Covered Charges.

29. Orthopedic or corrective shoes and other supportive appliances for the feet (e.g., customized foot orthotics), but only when ordered by a Physician for Employees and Employees' Dependent spouses, not for Employees' Dependent children.

30. Vasectomies up to the maximum shown in the Schedule of Benefits. Reversals of vasectomies are not covered.

31. Out-of-network well-child care for Dependent children through the age of 12, including routine physical examinations, school examinations (sports examinations are excluded), active immunizations, checkups and office visits to a Physician. Covered immunizations include, but are not limited to the following: hepatitis B vaccine (HBV); diphtheria, tetanus and pertussis vaccine (DTaP); haemophilus influenza type B vaccine (Hib); inactivated polio virus vaccine (IPV); pneumococcal conjugate vaccine (PCV); measles, mumps and rubella (MMR);

chicken pox (varicella); and tetanus booster (Td). For information on in-network well-child care, refer to the Preventive Services Benefits section beginning on page 48.

32. The following out-of-network vaccinations and office visits at which the vaccinations are administered: hepatitis A and hepatitis B vaccinations; pneumonia vaccinations for Eligible Individuals age 45 and over; HPV vaccinations in accordance with Centers for Disease Control (CDC) guidelines (limited to $400 for vaccination series); and herpes zoster (shingles) vaccinations for Eligible Individuals age 60 and older. These vaccinations and the office visits at which the vaccinations are administered are not subject to the calendar year deductible. For information on in-network vaccinations and office visits, refer to the Preventive Services Benefits section beginning on page 48.

33. Participation in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition.

    The Plan will:

    - Not deny you participation in the trial;
    - Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items and services otherwise covered by the Plan that are furnished in connection with participation in the trial; and
    - Not discriminate against you because of your participation in the trial.

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

    - Your health care provider is a participating provider in this Plan and that provider has concluded that your participation in the trial would be medically appropriate; or
    - You provide medical and scientific information establishing that your participation would be medically appropriate.

    Routine patient costs do not include the following:

    - The investigational item, device, or service, itself;
    - Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

COMPREHENSIVE MEDICAL BENEFITS - EXCLUSIONS

No medical benefits will be payable for any of the following, even if they are deemed to be Medically Necessary:

1. Any treatment, service, or supply unless it is specifically identified as covered.

2. Contact lenses, eye refractions, and the fitting or cost of visual aids, except as specifically identified as covered.

3. The cost of hearing aids and the fitting thereof.

4. Alcohol, drug, or substance abuse treatment.

5. Expenses for services or supplies not Medically Necessary or not recommended by a Physician, Dentist, optometrist, ophthalmologist or any other health care provider recognized by the Plan as appropriate.

6. Expenses or charges in connection with dental work or dental surgery unless specifically covered under another section, including, but not limited to:

    - treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or

    - surgery or splinting to adjust dental occlusion.

7. Expenses for treatment of Temporomandibular Joint (TMJ) Dysfunction or Syndrome, except as specifically covered under another section.

8. Medical services and supplies rendered outside the United States except for:

- treatment of a Medical Emergency that occurred while the Eligible Individual was traveling outside of the United States; and

- transportation to the United States from another country to the extent specifically covered,

both of which are subject to the provisions of the section “Medical Treatment Rendered Outside of the United States.”

9. Expenses for the medical termination of an established pregnancy including, but not limited to, expenses for:

   - Elective Abortions; and

   - Abortifacients (i.e., drugs or devices used to terminate pregnancy and/or cause an abortion), including but not limited to oxytocin, hyperosmotic solutions, prostaglandins (e.g., Misoprostol and Cytotec), antiprogesterones (e.g., Mifepristone or RU-486 and Mifeprex), progesterone production blockers (e.g., Epostane), and folic acid antagonists (e.g., Methotrexate).

   Although benefits are not payable for Elective Abortions, benefits are payable for complications that result from an Elective Abortion.

10. Expenses for Custodial Care.

11. Expenses for or in connection with the treatment of obesity or appetite control, including, but not limited to, drug therapy, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, skin reduction procedures, and any complications thereof, even if those procedures are performed to treat a comorbid or underlying health condition, except as provided by the Plan with respect to morbid obesity or with respect to covered preventive services required under the Affordable Care Act (ACA).

12. Expenses for or in connection with sex transformations.

13. Treatment related to sexual dysfunction, except for Prescription Drugs for the treatment of erectile dysfunction to the extent specifically identified as covered.

14. Expenses for the promotion of fertility, including, but not limited to:

   - fertility tests;

   - reversal of surgical sterilization; and

- attempts to cause pregnancy by hormonal therapy, artificial insemination, in-vitro fertilization and embryo transfer or any similar treatment or method.

15. Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.

16. Any services or supplies excluded under the "General Exclusions and Limitations."

MULTIPLE SURGICAL PROCEDURES LIMITATION

When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowable Charge will be allowed as the Plan's benefit (subject to the calendar year deductible and coinsurance):

The allowances for multiple surgeries through the same incision or operational field:

- Primary procedure – 100% of the Allowable Charge.

- Secondary and additional procedures – 50% of the Allowable Charge per procedure.

The allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

- First site primary procedure – 100% of the Allowable Charge.

- First site secondary and additional procedures – 50% of the Allowable Charge per procedure.

- Second site primary and additional procedures – 50% of the Allowable Charge per procedure.

WEEKEND HOSPITAL ADMISSIONS LIMITATION

If you are admitted as a resident patient in a Hospital on a Friday or Saturday, benefits, to the extent otherwise payable, will be payable for the Covered Charges incurred on that Friday, Saturday, and/or Sunday only if the admission is for a Medical Emergency or for surgery that is scheduled to be performed within 24 hours of the admission.

MEDICAL TREATMENT RENDERED OUTSIDE OF THE UNITED STATES

In the event you receive medical care or treatment outside of the United States, the Plan will provide benefits for Covered Charges only if the medical care or treatment is

Medically Necessary and is required as a result of a Medical Emergency that occurred while you were traveling outside the United States.

In order for the Plan to reimburse such Covered Charges, you must submit a claim and itemized bill that satisfies each of the following:

- The itemized bill must either be in English or fully translated into English.

- The itemized bill must either include both CPT-4 procedure code/s and ICD-9 diagnosis code/s or must include a full description of the procedures, medical services, procedures and/or supplies furnished and the diagnosis for each date of service.

- The itemized bill must clearly identify the provider's credentials and show that the provider is a registered or certified health care practitioner.

- The charges must be in U. S. currency and the value of the currency must have been determined as of the time the claim was incurred.

The Plan will determine the Allowable Charge based on the general level of charges made by providers rendering comparable services in the geographical area of the Fund Office.

EXTENDED BENEFITS

If you are Totally Disabled by Injury or Illness on the date coverage ends, and you do not elect to continue coverage through the Plan under COBRA, the Plan will pay for Covered Charges incurred as a result of such Injury or Illness as if coverage had not ended, until the earliest of:

- 90 days from the date coverage ended.

- The date the Total Disability ends.

Benefits payable are those in effect on the date coverage ends, and are subject to all applicable deductible, coinsurance, and benefit limitations.

IN-NETWORK PREVENTIVE SERVICES BENEFITS

PREVENTIVE SERVICES BENEFIT OVERVIEW

This Plan provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,

- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and

- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost sharing. This means that the service will be covered at 100% of the Plan's Allowable Charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this preventive services benefit.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Plan will determine whether a particular benefit is covered under this preventive services benefit.

Dependent children will be provided the full range of covered preventive services applicable to them (e.g., for their age group) without cost sharing and subject to reasonable medical management techniques.

OFFICE VISIT COVERAGE

Preventive services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the preventive services benefit. The following conditions apply to payment for in-network office visits under the preventive services benefit. Non-network office visits are not covered under the preventive services benefit under any condition.

- If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if a person has a cholesterol-screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol-screening test, the Plan will require a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as preventive services and paid at 100%. Well woman visits are also treated as preventive services and paid at 100%.

PREVENTIVE SERVICES COVERAGE LIMITATIONS AND EXCLUSIONS

- Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable benefit, not the preventive services benefit.

- Services covered under the preventive services benefit are not also payable under other portions of the Plan.

- The Plan will use reasonable medical management techniques to control costs of the preventive services benefit. Specifically, the Plan will only cover the most cost-effective test methodology that is medically appropriate for the patient for all preventive tests and services on this list. The Plan will also establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.

- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

- Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

  - When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

  - When related to judicial or administrative proceedings;

  - When related to medical research or trials, except to the extent the Plan is required by law to cover the examination, screening, test, item, or service; or

  - When required to maintain employment or a license of any kind.

- Services related to male reproductive capacity, such as condoms, are not covered.

DENTAL BENEFITS

COVERED DENTAL CHARGES

"Covered Dental Charges" are the Allowable Charges incurred by an Eligible Individual while covered under the Plan, for any Covered Class I, II, III or IV Dental Services described below, unless otherwise excluded from coverage.

DENTAL CALENDAR YEAR DEDUCTIBLE

The dental calendar year deductible, as shown in the Schedule of Benefits, is the amount of Covered Dental Charges you must incur and pay each calendar year before your Covered Dental Charges incurred during a calendar year are payable under the Plan. A separate calendar year deductible applies to each person each calendar year. However, a maximum of three dental calendar year deductibles must be satisfied per family in a calendar year.

The dental calendar year deductible applies only to Class II and Class III Dental Services combined. No deductible applies to Class I or Class IV Dental Services.

DENTAL COINSURANCE

The coinsurance percentages, as shown in the Schedule of Benefits, are the percentages of Covered Dental Charges payable under the Plan after satisfaction of the Dental calendar year deductible, if applicable, subject to any maximum limitations.

DENTAL CALENDAR YEAR MAXIMUM

The amount paid on your behalf as dental benefits during a calendar year is limited to the dental calendar year maximum amount, as shown in the Schedule of Benefits. The dental calendar year maximum applies only to Class I, Class II, and Class III Dental Services combined. No dental calendar year maximum applies to Class IV services. Once you reach the dental calendar year maximum for a calendar year, no further benefits will be payable on your behalf for Class I, Class II, or Class III Dental Services incurred during the calendar year.

The dental calendar year maximum is not applicable to pediatric dental services for individuals under age 19.

DENTAL LIFETIME MAXIMUM

The amount paid on your behalf as dental benefits during your lifetime is limited to the dental lifetime maximum amount, as shown in the Schedule of Benefits. The dental lifetime maximum applies only to Class IV Dental Services. No dental lifetime maximum applies to Class I, Class II, or Class III Dental Services. Once you reach the dental lifetime

maximum, no further dental benefits will be payable on your behalf for Class IV Dental Services under the Plan.

The dental lifetime maximum is not applicable to pediatric dental services for individuals under age 19.

COVERED DENTAL CHARGES

Dental benefits are payable for Covered Dental Charges incurred by an Eligible Individual for the following dental services, subject to the dental calendar year maximum (applicable to Class I, II and III Dental Services combined), the dental calendar year deductible (applicable to Class II and III Dental Services combined), the dental lifetime maximum (applicable to Class IV Dental Services), and applicable coinsurance, as shown in the Schedule of Benefits.

COVERED CLASS I DENTAL SERVICES

1. Diagnostic dental procedures employed by Dentists in evaluating existing conditions to determine the required dental treatment, including oral examinations, mouth X-rays, and emergency palliative treatment. Diagnostic services are subject to the following limitations.

    - Dental Benefits for full-mouth X-rays are provided no more than once in a 36-consecutive-month period, unless necessary for the diagnosis and treatment of a specific disease or Injury.

    - A panoramic film is considered the same as a full-mouth X-ray series and is paid as such.

    - A panoramic film in conjunction with a complete intra-oral survey is not a separate benefit.

2. Preventive dental procedures employed by Dentists to prevent the occurrence of disease, including routine prophylaxis (cleaning), topical application of fluoride, and space maintainers for eligible Dependent children. Preventive services are subject to the following limitations.

    - Dental benefits for prophylaxis, oral examinations, and bitewing X-rays are provided no more than twice in any 12-consecutive-month period.

    - Dental benefits for topical applications of fluoride are provided only for Eligible Individuals through age 18 and are provided no more than once in any 12-consecutive-month period.

- Dental benefits for space maintainers are provided when used to replace prematurely lost or extracted teeth for Eligible Individuals through 15 years of age and not for orthodontic purposes.

COVERED CLASS II DENTAL SERVICES

1. Restorative services used by Dentists in the treatment of carious lesions, including amalgam and composite restorations (fillings), stainless steel crowns, and sealants for eligible Dependent children through age 13. Restorative services are subject to the following limitations.

    - Posterior composite restorations are considered cosmetic in nature, and Dental Benefits for such restorations are limited to the allowance made for amalgam restorations.

    - Dental benefits for a single tooth surface repair are provided no more than once per tooth in any 12-consecutive-month period, regardless of the number of combinations or restorations placed.

    - Benefits for stainless steel crowns are provided no more than once per tooth in any 60-consecutive-month period for eligible Dependent children 12 years of age and over.

    - Dental benefits for porcelain crowns, porcelain-fused-to-metal crowns, or plastic-processed metal type crowns are provided only for eligible Dependent children under 12 years of age.

    - Dental benefits for crowns on the same tooth are provided no more than once in a 60-consecutive-month period.

    - Dental Benefits for sealants are provided no more than once per tooth in any 60-consecutive-month period for eligible Dependent children through age 13. Benefits are limited to sealants for the first and second molar teeth, provided such teeth are free of caries and restorations on the occlusal surfaces.

2. Oral surgery, including procedures for extractions, routine post-operative care for extractions, and other oral surgery. Oral surgery services are subject to the following limitations.

    - Dental benefits are provided for general anesthesia and/or intravenous sedation only when administered in conjunction with multiple extractions in two or more quadrants in one appointment or when deemed Medically Necessary.

    - Dental benefits are not provided for services to correct a cleft palate.

- Dental benefits are not provided for oral surgery services reimbursed under the comprehensive medical benefits.

3. Endodontic services used by Dentists for the treatment of non-vital teeth, including such services as pulpal therapy and root canal filling.

4. Periodontic services used by Dentists for the treatment of diseases of the gums and supporting structures of the teeth. Periodontic services are subject to the following limitations.

    - Certain periodontic procedures are covered only when performed in conjunction with other and related periodontic services. Pre-determination is recommended before beginning treatment.

    - Dental benefits are not provided for services rendered in connection with increasing the vertical dimension of the teeth or restoring tooth structure.

    - Dental benefits are not provided for services rendered in connection with rebuilding or maintaining occlusal surfaces or for stabilizing the teeth, including but not limited to, equilibration or occlusal adjustment and periodontal splinting.

COVERED CLASS III DENTAL SERVICES

1. Major restorative services, including onlays and permanent crown restorations (other than stainless steel) for the treatment of carious lesions when teeth cannot be restored with another filling material. Major restorative services are subject to the following limitations.

    - Dental benefits are provided for porcelain/ceramic onlays to the same tooth no more than once in any 84-consecutive-month period.

    - Dental benefits are provided for crowns on the same tooth no more than once in any 60-consecutive-month period.

2. Prosthodontic services, including construction of fixed bridges, partial dentures, and complete dentures, including adjustment or repair of an existing prosthodontic device. Prosthodontic services are subject to the following limitations.

    - Dental benefits are provided for fixed bridges and removable partials only for Eligible Individuals age 16 or over.

    - Dental benefits are provided for an upper or lower denture no more than once in any 60-consecutive-month period.

- Dental benefits are provided for reline and rebase no more than once in any 36-consecutive-month period for any one appliance.

- Dental benefits are provided for a temporary denture only if it is an immediate temporary denture, which cannot be made permanent and is replaced by a permanent denture within 12 months from the date of the initial installation of the temporary denture.

- Dental benefits are provided for partial dentures, fixed bridges, or removable bridges no more often than once in any five-year period, except where the loss of additional teeth requires the contributions of a new appliance.

- For purposes of this Plan, the 36, 60 or 84-consecutive-month periods are to be measured from the date on which the prosthetic appliance was last supplied or repaired.

- Dental benefits are provided for replacement or addition of teeth to an existing denture or bridgework only when extraction of one or more natural teeth is required.

- Dental benefits are not provided for charges for replacement of lost, missing, or stolen appliances.

- Dental benefits are not provided for any type of anesthesia or IV sedation, except where specifically mentioned.

Optional Treatment

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment based on the applicable percentage of the Allowable Charge for such procedure will be made toward a more elaborate or precision appliance that you and the Dentist may choose to use. The balance of the cost remains your responsibility. If implantology techniques are utilized, the Plan will allow the cost of a standard complete or partial denture towards the cost of any appliances constructed in association therewith.

COVERED CLASS IV DENTAL SERVICES

Orthodontic services for an Eligible Individual through age 17, limited to payment of monthly or other periodic charges through the completion of treatments or attainment of age 19 or to the date coverage terminates, whichever occurs first. Orthodontic services include the necessary treatment and procedures required for the correction of malposed teeth by a Dentist. Such treatment may consist of interceptive therapy, functional/myofunctional therapy when in conjunction with full-banded comprehensive therapy and when performed by the same Dentist. Orthodontic services are subject to the following limitations.

- Dental Benefits for orthodontic services are provided only for eligible Dependent children who have not yet attained age 19.

- If the treatment plan is terminated before completion of the case for any reason, the Plan's obligation ceases as of the date of termination.

- If the treatment is terminated by the Dentist by written notification to the Plan and to the Eligible Individual for lack of patient interest and cooperation, the Plan's obligation for payment of benefits terminates on the last day of the month in which the Eligible Individual was last treated or, if earlier, the date his or her coverage under the Plan terminates.

- Dental Benefits are not provided for any charge for the replacement or repair of an orthodontic appliance.

DENTAL BENEFIT LIMITATIONS

In addition to all other provisions, the dental benefits payable are subject to the following limitations:

- Payment of benefits terminates on the last day of the month in which you become ineligible for the dental benefits under this Plan.

- Termination of care due to death will be paid in full, to the maximum allowable, for services completed or in progress.

- When services in progress are interrupted and completed later by another Dentist, the Plan will review the claim and determine the payment to be made to each Dentist.

DENTAL BENEFIT EXCLUSIONS

Unless specifically stated otherwise, dental benefits will not be provided for any of the following:

- Charges for any dental services or supplies for which benefits are provided under the comprehensive medical benefits of the Plan.

- Charges for prescription drugs and pre-medications, hospitalization or additional fees charged for Hospital treatment or preventive control programs, sterilization, management fees, tests and laboratory examination, bleaching of discolored teeth, and house calls, Hospital calls and office visits.

- Services provided for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment rendered or planned (cosmetic dentistry).

VISION BENEFITS

Vision benefits are payable for expenses incurred by an Eligible Individual while covered under the Plan, for the following services and supplies, with no deductible but subject to the calendar year maximum for vision benefits per Eligible Individual as shown in the Schedule of Benefits:

- Visual acuity examination;
- Eyeglass lenses;
- Eyeglass frames;
- In lieu of eyeglass lenses and frames, the Plan will provide benefits for prescription contact lenses or corrective procedures, such as LASIK, Radial Keratotomy (RK), and Photoradial Keratotomy (PRK).

GENERAL EXCLUSIONS AND LIMITATIONS

Comprehensive medical, preventive services, dental, and vision benefits will not be payable for the following:

1. Injury or Illness arising from or sustained in the course of any occupation or employment, including self-employment, for compensation, profit, or gain.

2. Expenses incurred before coverage begins or after coverage ends (except as specifically provided under any extended benefits provisions in the Plan).

3. Expenses resulting from the Eligible Individual's participation in a riot or in the commission of a felony (not to include an act of domestic violence).

4. Charges for services or supplies for which no charge is made that the Eligible Individual is legally obligated to pay or for which no charge would be made in the absence of coverage.

5. Charges for missed or broken appointments.

6. Charges for the completion of forms and/or submission of supportive documentation required for a benefit determination.

7. Expenses for Cosmetic Surgery.

8. Expenses for services or supplies that are:

   - not provided in accordance with generally accepted professional medical standards;

   - Experimental and/or Investigational; or

   - not proven safe and effective.

9. Expenses for services or supplies which are chiefly for instruction, education or training.

10. Expenses incurred for acupuncture treatment (except when used as an anesthetic agent for covered surgery).

11. Unless otherwise required by law, expenses or charges for services or supplies that are provided or paid for by the federal government or its agencies, except for:

    - the Veterans Administration when services are provided to a veteran for a disability which is not service connected;

- a military Hospital or facility when services are provided by the armed services; or

- a group health plan established by a government for its own civilian Employees and their Dependents.

12. Expenses that result from an act of declared or undeclared war or armed aggression unless otherwise required by law.

13. Unless otherwise required by law, losses, expenses or charges:

    - which are incurred while the Eligible Individual is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and

    - for which any governmental body or its agencies are liable.

14. Expenses associated with Injury or Illness caused by suicide, attempted suicide or self-inflicted Injury, or as a result of or incidental to the Eligible Individual being under the influence of alcohol, a narcotic, a chemical or a drug other than narcotics, chemicals, and drugs that are prescribed by a Physician and used strictly as prescribed and under prescribed conditions. This exclusion does not apply to any Injury or Illness that resulted from an act of domestic violence or a physical or mental medical condition.

15. Charges for services and supplies for the care and treatment of bodily Injuries or Illnesses to the extent they exceed the Allowable Charges or the charges that would have been made for such care and treatment in the absence of the benefits provided by the Plan.

16. Expenses for habilitation services. Habilitation services are health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

17. Charges for long-term care services. Long-term care services include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing.

18. Expenses for weight loss programs, except as required under the Affordable Care Act (ACA)

LIFE INSURANCE BENEFITS

LIFE INSURANCE BENEFITS

If an Employee dies while covered for life insurance benefits, benefits, in the amount shown in the Schedule of Benefits, will be paid in one lump sum to his or her surviving Beneficiary upon submission of satisfactory proof of death to the Plan.

BENEFICIARY

The "beneficiary" is the person(s) or entity validly designated in writing by the Employee or, in the absence of a valid designation, determined in accordance with the terms of the Plan or applicable law, as being entitled to receive the life insurance benefits payable under the Plan because of the Employee's death.

The Employee may designate any person or entity as his or her beneficiary and may change the beneficiary designation at any time without the consent of the then named beneficiary. The Plan will not be held liable for a payment made to a beneficiary determined at the time of payment and prior to receiving an Employee's written request to change the beneficiary designation.

MORE THAN ONE BENEFICIARY

If there is more than one beneficiary, the life insurance benefit will be paid in equal shares to the Employee's beneficiaries, unless otherwise stated in the Employee's beneficiary designation. The share of a beneficiary who does not survive the Employee will pass equally to those who survive unless otherwise stated in the beneficiary designation.

BENEFICIARY NOT DESIGNATED

If an Employee does not designate a beneficiary, or if no beneficiary survives the Employee, then the life insurance benefit will be paid to the first surviving class of the following classes of beneficiaries:

- the Employee's surviving spouse;
- the Employee's surviving children;
- the Employee's surviving parents;
- the Employee's surviving siblings; or if none
- the Employee's estate.

POLICY/CERTIFICATE OF INSURANCE

The life insurance benefit, and Employees' obligations and rights related thereto, are subject to the terms and conditions of the insurance policy purchased by the Trustees on behalf of the Plan to provide the life insurance benefit, and related certificate of insurance, as in effect at the date of death. The insurance policy and certificate of insurance are incorporated herein by reference and made a part of the Plan and will override any conflicting provisions of the Plan with respect to eligibility for and payment of the life insurance benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (EMPLOYEES ONLY)

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

Accidental death and dismemberment (AD&D) benefits, in the amounts shown in the Schedule of Benefits, will be provided upon an Employee's death or covered loss due to an Injury sustained in an accident that occurs while the Employee is covered for the AD&D benefits.

The AD&D benefit for a covered death or loss is the full benefit or one-half of full benefit, as shown in the Schedule of Benefits and in effect at the date of the accident or loss. The Plan will not pay more than the Full Benefit for all covered losses (including death) from one accident.

COVERED LOSS

A "covered loss," for purposes of the AD&D benefit, is a loss that:

- is shown in the Schedule of Benefits;
- results, directly or independently of all other causes, from an Injury sustained in an accident that occurs while you are covered under the Plan;
- occurs within 90 days from the date of the accident; and
- is not excluded under the AD&D benefit exclusions listed below.

PAYMENT OF BENEFITS

The AD&D benefit for loss of life will be paid to your beneficiary as described and determined under Life Insurance Benefits - Beneficiary. All other AD&D benefits will be paid to you.

AD&D EXCLUSIONS

No AD&D benefit will be paid for a loss that is caused or contributed to by any:

1. Disease;
2. Drug, chemical, poison, or inhalation of gas;
3. Injury that is sustained:

a. in the course of any medical or dental diagnosis or treatment, including the therapeutic use of nuclear energy;

b. while you are in or upon any aircraft, unless you are a fare-paying passenger on a regularly scheduled flight;

4. Injury that is intentionally self-inflicted while sane or that is self-inflicted while insane;

5. Injury or disease that results from:

a. any act of war;

b. the covered person's commission or attempted commission of a crime; or

c. non-therapeutic release of nuclear energy.

POLICY/CERTIFICATE OF INSURANCE

The AD&D benefit, and Employees' obligations and rights related thereto, are subject to the terms and conditions of the insurance policy purchased by the Trustees on behalf of the Plan to provide the AD&D benefit and related certificate of insurance, as in effect at the date of the accident or loss. The insurance policy and certificate of insurance are incorporated herein by reference and made a part of the Plan and will override any conflicting provisions of the Plan with respect to eligibility for and payment of the AD&D benefit.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

The medical, dental, and vision benefits provided under the Plan will be coordinated with any medical, dental, and vision benefits provided to an Employee or Dependent by any Other Plan. It is the obligation of the Employee or Dependent to inform the Plan of the existence of such benefits from Other Plans.

Failure to notify the Fund Office of coverage or benefits from any Other Plan or Plans may result in an overpayment, which may be subject to recovery against the Employee or Dependent and may be determined to be insurance fraud.

DEFINITIONS

Other Plan

"Other Plan" means any plan providing benefits or services for or by reason of medical, dental or vision care or treatment, which benefits or services are provided by:

- group, blanket or franchise insurance coverage, whether on an insured or self-insured basis (except student accident insurance);
- group Blue Cross and/or Blue Shield and other pre-payment coverage on a group basis, including Health Maintenance Organizations (HMOs);
- coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- group or individual automobile no fault coverage;
- any coverage under governmental programs, and any coverage required or provided by any statute, including Title XVIII of the Social Security Act of 1965 as amended, Medicare Part A and Part B or Part C as amended, (if entitled) whether or not you have registered for Part A or enrolled for Part B or Part C of Medicare **(this means that Medicare's allowances will be considered when the Plan calculates the benefit payments of Medicare-eligible Eligible Individuals regardless of whether or not you have registered for Part A or enrolled for Part B or Part C), but not a state plan for medical assistance provided under Title XIX of the Social Security Act (Medicaid) or as otherwise prohibited by law;**
- other arrangements of insured or self-insured group coverage.

Other Plans include, but are not limited to, coverage provided under employer-sponsored health care coverage resulting from your spouse's employment, Medicare coverage as a result of your or your Dependent's disability, automobile insurance, including no-fault coverage, and other work-related health care plans.

Allowable Expense

"Allowable Expense" means any necessary and reasonable expense (including deductibles and coinsurance) for medical, dental, or vision services, treatment or supplies, part or all of which is covered under any Other Plan. However, any expense that is not payable by the primary plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, pre-admission testing, pre-admission review of Hospital confinement, mandatory outpatient surgery, etc.) will not be considered an Allowable Expense by the secondary plan.

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

EFFECT ON BENEFITS

When a claim involving an Allowable Expense is made under this Plan, these coordination of benefits provisions apply in determining the benefit due an Eligible Individual under the Plan for any Allowable Expense. When the claim is made, the order of benefit determination rules set forth below will be applied to determine which plan is the primary plan and which plan(s) are the secondary plan(s). The primary plan will pay its benefits without regard to the secondary plans(s). The secondary plan(s) will then adjust their benefits so that the total benefits from all plans do not exceed the Allowable Expense. No plan pays more than it would without the coordination of benefit provisions.

Benefits payable under another plan include the benefits that would have been payable had claim been duly made for them, and, in the case of benefits payable under Parts A, B and C of Medicare, the benefits that would have been payable had the Eligible Individual enrolled for coverage under the plan.

Order of Benefit Determination

A plan without a coordinating provision is always the primary plan.

If two or more plans have a coordinating provision, the rules establishing the order of benefit determination will be as follows:

1. Non-Dependent/Dependent: The plan that covers the person as an employee will be primary, and the plan that covers the person as a dependent will be secondary.

2. Active, Laid-Off or Retired Employee: The plan that covers the person as an active (not laid-off or retired) employee or as that employee's dependent will be primary, and the plan that covers the person as a laid-off or retired employee or as that laid-off or retired employee's dependent will be secondary. 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 under the Non-Dependent/Dependent rule.

3. Dependent Child Covered Under More Than One Plan of Parent: If the parents are married and the child is covered under both parents' plans, the plan of the parent whose birthday (month and day only) occurs earlier during a calendar year will be primary for the child, and the plan of the parent whose birthday (month and day only) occurs later in the calendar year will be secondary for the child. If both parents have the same birthday, the plan that has been in effect longer will be the primary plan.

   However, in the event the parents are legally separated or divorced, the following rules apply:

   - If a court order places financial responsibility for the child's health care on one of the parents, the plan covering that parent will be the primary plan;
   - If there is no such court order, the plan covering the parent with custody of the child is primary;
   - The plan of the spouse of the custodial parent (if any) pays next;
   - The plan of the non-custodial parent pays next;
   - The plan of the spouse of the non-custodial parent (if any) pays next; and
   - If there is a Qualified Medical Child Support Order ("QMCSO") mandating coverage of the child as an Alternate Recipient, the plan subject to the QMCSO will be the primary plan.

4. When the Plan and an Other Plan cover a Dependent child for whom claim has been made and the Other Plan does not contain the birthday rule as set forth above, but uses a benefit determination provision that is based on the parent's sex, then the Plan will also use that sex-based benefit determination provision when applicable.

5. If an individual whose coverage is provided under a right of continuation under federal or state law or under any Other Plan continuation of coverage rules is also covered under the Plan, the plan covering the person as an employee, retiree, or dependent thereof will be the primary plan, and the plan providing continuation coverage will be the secondary plan. If the Other Plan with which the Plan is

coordinating does not have the rule described above and, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

6. Longer/Shorter Length of Coverage: When the previous rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time will be the primary plan, and the plan that has covered such person the shorter period of time will be secondary.

When the Other Plan is Medicare, this Plan will be considered the primary plan, and Medicare the secondary plan, for any Employee (or the Employee's Dependent) who is covered under this Plan by reason of current employment status with an Employer, for as long as the employment status continues.

For purposes of coordinating with Medicaid, this Plan will assume primary payer status for any covered person or Alternate Recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to an Eligible Individual or Alternate Recipient will be made in accordance with any assignment of rights made by or on behalf of such Eligible Individual or Alternate Recipient as required by Medicaid. If this Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquire the rights of the Eligible Individual or Alternate Recipient for payment of such benefits.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of, and implementing the terms of, these coordination of benefit provisions, the Plan may release to or obtain from any other organization or person, any information that the Plan deems to be necessary for such purposes. Any Eligible Individual claiming benefits under the Plan must furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

The Plan reserves the right to pay over to any organization or Other Plan any amounts it determines to be warranted in order to satisfy the intent of its coordination of benefits provisions, and any amount so paid will fully discharge the Plan and Fund, to the extent of such payment, from further liability under the Plan.

RIGHT OF RECOVERY

Whenever overpayments have been made by the Plan, the Plan has the right to recover the overpayments from:

- Any person to or for or with respect to whom such payments were made.

- Insurance companies, providers, plans or other organizations to or for or with respect to whom such payments were made.

In the event the overpayment is due to your failure to submit a claim for benefits to any Other Plan that would have otherwise considered the expenses as covered, whether in whole or in part, the Plan will reduce any payment of future benefits for claims incurred by you or your Dependents until full recoupment of the overpayment has been made.

The Plan will presume that the level of health care coverage provided by the Other Plan(s) is equivalent to the Plan's level of coverage and calculate the amount of the payment that should have otherwise been made by the Plan. You must cooperate fully with the Plan and Trust by providing documentation and taking whatever action is reasonably required by the Plan to assist with recovery of overpayment.

SUBROGATION

In the event of any payment under the Plan for any Injury or Illness for which a third party is or may be held responsible, the Plan will be subrogated, on a first dollar basis, to all the rights of recovery of an Eligible Individual against any person or entity (including the Eligible Individual's insurer) because of the alleged negligent conduct of a third party, for the amount of benefits paid or provided by the Plan. You must execute and deliver to the Plan everything necessary to secure such rights as requested by the Plan. You must not do anything after a loss to prejudice the Plan's subrogation and reimbursement rights and must cooperate fully with the Plan.

If requested in writing by the Trustees, you must take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages or payment of medical expenses from any person or entity potentially liable to you. In their sole discretion, the Trustees reserve the right to prosecute an action in your name against any third parties potentially liable to you in an effort to recover monies paid by the Plan.

In addition, any benefits paid by the Plan with respect to an Injury or Illness for which a third party is or may be held responsible will be made on the condition that the Plan will be reimbursed, and you agree to reimburse the Plan, out of the first proceeds of any recovery, settlement or judgment payable by the responsible third party, whether by way of litigation, settlement or otherwise, and regardless of how the proceeds are characterized. The Plan must be reimbursed an amount of money equal to all sums paid by the Plan on behalf of the injured Eligible Individual and all expenses, costs and attorneys' fees incurred by the Plan in connection with the prosecution and collection of the Plan's subrogation or reimbursement interest.

Amounts recovered in excess of the amount owed to the Plan for reimbursement of benefits and costs will be paid to you, but such excess will apply as a credit against liability of the Plan for further payment to you or on your behalf, which has arisen or may arise from the Injury(ies) or Illness that form the basis of the claim asserted by you or on your behalf.

CLAIMS AND APPEAL PROCEDURE

DEFINITIONS

Adverse Benefit Determination

"Adverse Benefit Determination" means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan, including "rescissions" of coverage, regardless of whether there is an adverse effect on any particular benefit at the time of the claim. A "rescission" is generally a cancellation or discontinuance of coverage with a retroactive effect for reasons other than a failure by the claimant to timely pay premium. In the event a Preferred Provider Organization (or PPO) Physician or Hospital declines to render services to you unless you pay the entire cost, and the provider exercises no discretion on behalf of the Plan, such a decision is not considered an Adverse Benefit Determination.

Claim

"Claim" means a request for a benefit made by a claimant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of Plan are not considered Claims, nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, in the event a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination will be considered a Claim.

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

Concurrent Claim

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

Disability Claim

"Disability Claim" means a Claim that requires a finding of total disability as a condition of eligibility. This includes claims for the 90-day extension of benefits provided to an Eligible Individual who is Totally Disabled by Injury or Illness on the date his or her coverage terminates.

Post-Service Claim

"Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Concurrent, or Urgent Claim.

Pre-Service Claim

"Pre-Service Claim" means a Claim for a benefit for which the Plan requires approval before medical care is obtained.

Relevant Documents

"Relevant Documents" means documents pertaining to a Claim provided they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the minimum requirements under ERISA for benefit claims and appeal procedures, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the rules of the Plan have been appropriately applied to a Claim.

Urgent Claim

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

CLAIMS PROCEDURES

Pre-Service Claims

In order to submit a Pre-Service Claim, you must contact the UMC prior to the admission or provision of medical care and provide the UMC with the name, address, and social security number of the claimant, the date and reason for the proposed admission or medical care, and whatever additional information is requested by the UMC.

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

In the event an extension is required because additional information is needed from the claimant, the claimant will be notified, before the end of the initial 15-day period, of the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline will be suspended from the date of the extension notice until either 45 days or the date the claimant responds to the request (whichever is earlier). The UMC will then have 15 days to make a decision on the Claim and notify the claimant of the determination.

In the event a claimant improperly files a Pre-Service Claim, the claimant will be notified as soon as possible but not later than five (5) days after receipt of the claim, of the proper procedures to be followed in filing a Pre-Service Claim. The claimant will only receive notice of an improperly filed Pre-Service Claim in the event the claimant communicates with a person customarily responsible for handling Plan benefit matters about a potential Pre-Service Claim, and the Claim includes: (i) the patient's name; (2) the patient's specific medical condition or symptom; and (3) the patient's specific treatment, service, or product for which approval is requested.

Unless the potential Pre-Service claim is refiled properly, it will not constitute a Claim.

Urgent Claims

Urgent Claims must be submitted by calling the UMC for the Plan and providing any information needed to make a determination.

The UMC will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, in the event a Physician with knowledge of the medical condition of the patient determines that the Claim is an Urgent Claim, and notifies the UMC of such, it will be treated as an Urgent Claim.

For properly filed Urgent Claims, the UMC will respond to the claimant with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Urgent Claim by the UMC. The determination will also be confirmed in writing.

In the event an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the UMC will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to make a determination. The claimant must provide the specified information within 48 hours. In the event the information is not provided to the UMC within that time, the Claim will be denied.

Notice of the decision will be provided no later than 48 hours after the UMC receives the requested information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.

In the event a claimant improperly files a potential Urgent Claim, the UMC will notify the claimant as soon as possible but not later than 24 hours after receipt of the information, of the proper procedures to be followed in filing a Claim. Unless the potential Claim is refiled properly, it will not constitute a Claim.

With respect to an Urgent Care Claim, a health care professional with knowledge of the medical condition of the Eligible Individual will be permitted to act as an authorized representative.

Concurrent Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by the UMC for the Plan as soon as possible. In any event, the Eligible Individual will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend an approved Urgent Claim will be acted upon by the UMC within 24 hours of receipt of the request, provided the request and information needed to make a determination is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend previously approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable to the type of Claim involved.

Post-Service Claims

In order to submit a Post-Service Claim, a claim form in or on a form acceptable to the Plan must be completed on behalf of the person for whom the claim is being made and submitted to the Fund Office with the itemized bill/s.

The itemized bill/s must include the following information:

- the name of the patient;
- the date of service;
- the type of service or procedure code;
- the diagnosis or diagnosis code;
- the billed charges;

- the Federal Taxpayer Identification Number (TIN) of the provider; and

- the billing name and address of the provider.

Specifically for prescription drugs, a receipt or computer generated printout from the pharmacy must be submitted that includes the full name of the patient, the name of the physician, the name of the prescription drug, the pharmacy's prescription number, the date purchased and the cost of the prescription before taxes.

The claim must be submitted to the Fund Office (unless otherwise designated by the Plan) within 90 days from the date that the expense was incurred, unless it is shown by the Eligible Individual not to have been reasonably possible to give notice within such time limit, in which case it must submitted as soon as it is reasonably possible to do so and within one year from the date the expense was incurred. In no event will benefits be allowed if notice of claim is made beyond one year from the date on which expenses was incurred.

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

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

In the event the Plan determines that additional information is required from the claimant, the Plan may issue a combined request for additional information and notice of Adverse Benefit Determination. The notice of Adverse Benefit Determination would only be applicable in the event the claimant fails to provide any information within 45 days. In this case, the Plan would not issue a separate notice of Adverse Benefit Determination in the event the claimant failed to submit any information within 45 days. The combined notice will clearly state that the Claim will be denied in the event the claimant fails to submit any information in response to the Plan's request, and will satisfy the content requirements of both the request for additional information and the notice of Adverse Benefit Determination. When the combined notice is used, the time

frame for appealing the Adverse Benefit Determination will begin to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

Disability Claims

Disability Claims must be submitted to the Plan at its Fund Office (unless otherwise designated by the Plan) in writing, using the appropriate application form, or in a form acceptable to the Plan and with adequate proof of loss, within 90 days after the claimant first becomes disabled. An application form may be obtained by contacting the Fund Office. The failure to submit a Disability Claim within this 90-day period will not invalidate or reduce the Claim if it was not reasonably possible to do so, provided the Disability Claim is submitted as soon as reasonably possible and within one year after the claimant first becomes disabled.

The Plan will make a decision on the Disability Claim and notify the claimant of the decision within 45 days from the Plan's receipt of the Claim. In the event the Plan requires an extension of time due to matters beyond its control, the 45-day period may be extended for up to 30 days provided the claimant is notified of the reason for the delay and the new response deadline. This notification will occur before the expiration of the 45-day period. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

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

Life Insurance Benefits and Accidental Death and Dismemberment Benefits

Claims for Life Insurance Benefits and Accidental Death and Dismemberment Benefits must be submitted to the Fund Office (unless otherwise designated by the Plan) within 90 days from the date of loss, unless it is shown by the Eligible Individual not to have been reasonably possible to give notice within such time limit, in which case it must submitted as soon as it is reasonably possible to do so and within one year from the date of loss. In no event will benefits be allowed if notice of claim is made beyond one year from the date of loss.

For properly filed Life Insurance and Accidental Death and Dismemberment Claims, claimants will be notified of the Plan's decision on the Claim within 90 days from the Plan's receipt of the Claim. This period may be extended one time by the Plan for up to 90 days provided the extension is necessary due to matters beyond the control of the Plan. In the event an extension is necessary, the claimant will be notified, before the end of the initial 90-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

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

Time Limit on Filing of Claims

Benefits will be paid by the Plan only if notice of Claim is given to the Plan within 90 days from the date on which expenses with respect to which claim is made were incurred unless it is shown by the Employee or other Eligible Individual, if appropriate, not to have been reasonably possible to give notice within such time limit, in which case notice of Claim must be given to the Plan as soon as reasonably possible and within one year after the date the expense was incurred. In no event will benefits be allowed if notice of Claim is given to the Plan beyond one year from the date on which expenses were incurred.

Authorized Representatives

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

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

Notice of Initial Benefit Determination

For all Claims properly and initially filed under the Plan, the claimant will be provided with written notice of the initial benefit determination. In the event the determination is an Adverse Benefit Determination, the notice will include:

- Sufficient information to identify the claim involved, including the date of service, name of health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. The Plan will provide, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason/s for the determination, including the denial code and its corresponding meaning, and, if any, a description of the standard used in denying the claim. This description also will include a discussion of the decision;

- Reference to the specific Plan provision/s on which the determination is based;

- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

- A description of all available internal appeals and external review processes, including information about how to initiate an appeal and the time limits applicable to the procedures;

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

- In the event an internal rule, guideline or protocol is relied upon in deciding the Claim, a statement that it was relied upon and that a copy is available upon request at no charge;

- In the event the determination is based on the absence of medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination will be available upon request at no charge;

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

- Disclosure of the availability of, and contact information for, any office or ombudsman available to assist individuals with internal claims and appeal and external review processes;

- Confirmation that the Plan shall continue to provide coverage to the claimant pending the outcome of his/her internal review and appeal. This means that the Plan will not reduce or terminate coverage for an ongoing course of treatment without an opportunity for advance review. For Urgent Care Claims, the Plan shall allow individuals under treatment to go forward with an expedited external review at the same time as the internal appeals process; and

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relied upon in making the Adverse Benefit Determination.

The claimant shall be provided, free of charge and before an Adverse Benefit Determination is issued, with (a) any new or additional evidence considered, generated or used by the Plan with regard to the claim, and (b) any new or additional rationale on which the Adverse Benefit Determination will be based. The new or additional evidence or rationale will be provided as soon as possible, and sufficiently before an Adverse Benefit Determination is due, in order to give the claimant a reasonable opportunity to respond to the new information before the Adverse Benefit Determination is issued.

APPEAL PROCEDURE

Appealing an Adverse Benefit Determination

In the event a Claim is denied in whole or in part, or in the event the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision and receive a full and fair review by complying with the Appeal Procedure set forth in this section. If the claimant does not appeal the initial decision in accordance with this Appeal Procedure, the initial decision on the Claim will be final.

Post-Service Claims, Disability Claims and Rescissions of Coverage. Appeals of Adverse Benefit Determinations regarding Post-Service Claims, Disability Claims and rescissions of coverage must be submitted in writing to the Fund Office (unless otherwise designated by the Plan) within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

- the name and address of the patient;

- the name and address of the covered Employee if different;

- the date of the Adverse Benefit Determination; and

- the basis of the appeal, i.e., the reason/s why the Claim should not be denied.

Urgent Claims and Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims and Pre-Service Claims may be made orally within 180 days

after receipt of the notice of Adverse Benefit Determination by calling the UMC for the Plan.

Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims may be made orally by calling the UMC for the Plan. For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set time frame for appeal; however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim regarding an extension of care, the appeal time frame will be the time frame for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to the appeal.

Life Insurance and Accidental Death and Dismemberment Claims. For appeals of claims involving Life Insurance Benefits and Accidental Death and Dismemberment Benefits, the claimant must file with the Plan a written request for review within 60 days following receipt of the notice of Adverse Benefit Determination.

The Appeal Process

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

An appropriate fiduciary for the Plan, who did not make and is not a subordinate of the person who made, the initial Adverse Benefit Determination on the Claim, will review and decide the appeal. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

In the event the Claim was initially denied on the basis of a medical judgment (such as a determination that the treatment or service is not Medically Necessary or is Experimental and Investigational), a health care professional who was not consulted and is not a subordinate of any health care professional who was consulted in connection with the initial determination and who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on his or her Claim, without regard to whether the advice was relied upon in deciding the Claim.

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention) will not be made on the basis of whether that person is likely to support a denial of benefits.

Time Frames for Notices of Appeal Determinations

The reviewer will make a determination within a reasonable period of time following receipt of a properly filed appeal, without regard to whether all of the necessary information accompanies the filing, and within the following time frames depending on the nature of the Claim on appeal:

Pre-Service Claims. Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by the UMC for the Plan.

Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the UMC for the Plan.

Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent by the UMC for the Plan before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent by the UMC for the Plan and will be based on the time frames for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to the appeal.

Post-Service Claims and Rescissions of Coverage. Decisions on appeals involving Post-Service Claims and rescissions of coverage will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, in the event the request is received within 30 days of the next regularly scheduled meeting, a decision will be made no later than the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing prior to the extension, of the special circumstances and date by which a determination will be made. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than five (5) days after the decision is reached.

Disability Claims. Notice of the appeal determination for Disability Claims will be made in the same manner as for Post-Service Claims.

Life Insurance and Accidental Death and Dismemberment Claims. Notice of the appeal determination for Life Insurance and Accidental Death and Dismemberment Claims will be made in the same manner as for Post-Service Claims.

Content of Appeal Determination Notices

The determination of an appeal will be provided to the claimant in writing. The notice of an Adverse Benefit Determination will include:

- Sufficient information to identify the claim involved, including the date of service, name of health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its

corresponding meaning, and the treatment code and its corresponding meaning. The Plan will provide, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason/s for the determination, including the denial code and its corresponding meaning, and, if any, a description of the standard used in denying the claim. This description also will include a discussion of the decision;

- Reference to the specific Plan provision/s on which the determination is based;

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

- A description of all available internal appeals and external review processes, including information about how to initiate an appeal and the time limits applicable to the procedures;

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

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

- In the event the determination is based on Medical Necessity, or because the treatment is determined to be Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination will be available upon request at no charge;

- Disclosure of the availability of, and contact information for, any office or ombudsman available to assist individuals with internal claims and appeal and external review processes;

- Confirmation that the Plan shall continue to provide coverage to the claimant pending the outcome of his/her internal review and appeal. This means that the Plan will not reduce or terminate coverage for an ongoing course of treatment without an opportunity for advance review. For Urgent Care Claims, the Plan shall allow individuals under treatment to go forward with an expedited external review at the same time as the internal appeals process; and

- The following statement or a similar disclosure to the extent required by ERISA: “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.”

The claimant shall be provided, free of charge and before an Adverse Benefit Determination is issued, with (i) any new or additional evidence considered, generated or used by the Plan with regard to the claim, and (ii) any new or additional rationale on which the Adverse Benefit Determination will be based. The new or additional evidence or rationale will be provided as soon as possible, and sufficiently before an Adverse Benefit Determination is due, in order to give the claimant a reasonable opportunity to respond to the new information before the Adverse Benefit Determination is issued.

Decision Final and Binding

A decision on appeal of any Claim made under the Plan in accordance with the Appeal Procedure will be final and binding on all persons, except as otherwise described in "External Appeal Procedures," below.

When a Lawsuit may be Started

No Employee, Dependent, beneficiary or other person or entity will have any right or claim to benefits from the Plan other than as specified in the Plan. Any dispute as to eligibility, type, amount, or duration of benefits under the Plan will be resolved pursuant to the Plan and Trust Agreement.

In no event may legal action be brought by or on behalf of any individual to receive benefits under the Plan unless the individual or his or her legal representative has first fully complied with and timely exhausted all of the requirements of the Claims and Appeal Procedures under the Plan and received a final determination on appeal, and in no event may legal action be brought later than one year following a final determination of a Claim under the Plan.

EXTERNAL APPEAL PROCEDURES

External review is only available for Adverse Benefit Determinations that involve medical judgment (for example, a determination that a service is not Medically Necessary) or rescissions of coverage. The Plan's internal appeals procedures generally must be exhausted before external review is available. If a claim is denied due to failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

If the Plan fails to strictly adhere to the internal claims and appeals procedures, the Participant will be permitted to immediately initiate external review or seek remedies available under ERISA and applicable state law, as if they had exhausted all required internal appeals. This rule does not apply if failure to strictly adhere to the claims and appeals procedures:

- was "de minimis";
- was non-prejudicial to the claimant's right to external review;

- was attributable to good cause or matters beyond the Plan's control;
- is not reflective of a pattern or practice of non-compliance by the Plan; and
- was in the context of an ongoing good-faith exchange of information.

External Review of Standard Claims

Request for External Review. A claimant may file a written request for an external review of a standard (non-urgent) claim with the Plan within four months after the date of receipt of a notice of an Adverse Benefit Determination or notice of the denial of an appeal. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

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

- the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the Adverse Benefit Determination or the denial of an appeal does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- the claimant has exhausted the Plan's internal appeal process (except, in limited, exceptional circumstances); and
- the claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete, and the Plan shall allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Review By Independent Review Organization. If the request is complete and eligible, the Plan shall assign the request to an Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally recognized accrediting organization to conduct the external review. The Plan

shall refer the claim to one of the IROs with whom the Plan has contracted for such assignments, and shall rotate claims assignments among them. The IROs with whom the Plan has contracted are not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO will utilize legal experts, where appropriate, to make coverage determinations under the Plan.

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO shall consider when conducting the external review.

Within five business days after the date of assignment of the IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or denial on appeal. Failure by the Plan to timely provide the documents and information shall not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or denial on appeal. Within one (1) business day after making the decision, the IRO shall notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the assigned IRO shall, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or denial on appeal that is the subject of the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or denial on appeal and provide coverage or payment. Within one (1) business day after making such a decision, the Plan shall provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall then terminate the external review upon receipt of such notice from the Plan.

The IRO shall review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim "de novo" (as if it is new) and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process, as applicable. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- the claimant's medical records;

- the attending health care professional's recommendation;

- reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;

- the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

- appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

- any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- the opinion of the IRO's clinical reviewer(s).

The assigned IRO shall provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO shall deliver the notice of final external review decision to the claimant and the Plan.

The assigned IRO's decision notice shall contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, 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 overage provisions and evidence-based standards, considered in reaching its decision;

- a discussion of the principal reason or 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 either the Plan or to the claimant;

- a statement that judicial review may be available to the claimant; and

- current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six (6) years. An IRO shall make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or denial on appeal, the Plan immediately shall provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review of Claims

The Plan shall allow a claimant to make a request for an expedited review with the Plan at the time the claimant receives:

- an Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

- a denial on appeal, if the claimant has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the denial on appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements set forth above for Standard External Review. The Plan shall immediately send a notice that meets the requirements set forth above for Standard External Review to the claimant of its eligibility determination.

Review By Independent Review Organization. Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan shall assign an IRO pursuant to the requirements set forth above for Standard Review. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or denial on appeal to the assigned IRO

electronically, by telephone, facsimile, electronic means or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for Standard Review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Decision. The IRO shall provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO shall provide written confirmation of the decision to the claimant and the Plan.

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the claimant is dissatisfied with the external review determination, the claimant may seek judicial review as permitted under ERISA Section 502(a).

PRIVACY AND SECURITY RULES

The law known as HIPAA resulted in federal privacy and security rules that require health plans, such as this Plan, to protect the confidentiality of your protected health information, also referred to as "PHI." PHI is defined under HIPAA and generally includes individually identifiable health information created or received by the Plan. A complete description of your privacy rights can be found in the Plan's Privacy Notice, which was distributed to you upon enrollment. You may also request a copy of the Privacy Notice at any time by contacting the Fund Office.

Your PHI will not be used or disclosed by the Plan or Plan Sponsor except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you. We have required all of our business associates, such as the Plan's consultants, that may create or receive PHI on our behalf to observe the privacy and security rules with respect to such PHI. We will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. If someone other than you, even a friend or relative, contacts us, and wants to discuss a claim or matter involving your PHI, your authorization will first be required unless the discussion is otherwise permitted under HIPAA.

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and to amend the information in certain circumstances. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Your rights are explained in greater detail in the Privacy Notice.

If you have questions about the privacy or security of your health information or wish to file a complaint under HIPAA, please contact the Fund Office. The Administrative Manager at the Fund Office serves as the Plan's Privacy and Security Officer.

PLAN INFORMATION

PLAN NAME AND TRUST FUND NAME

The Plan is known as the Plumbers and Pipefitters Local 430 Health and Welfare Fund Rules and Regulations. The Trust Fund through which the Plan's benefits are provided is known as the Plumbers and Pipefitters Local 430 Health and Welfare Fund. It is a jointly administered trust fund, initially established effective June 1, 1970, by the Unions and certain Employers pursuant to a collective bargaining agreement.

TYPE OF PLAN

This Plan is a group health plan maintained for the purpose of providing medical benefits, dental benefits, vision benefits, death benefits, and accidental death and dismemberment benefits.

PLAN SPONSOR

The Plan is sponsored and administered by a joint Board of Trustees consisting of Union representatives and Employer representatives. The address and telephone number that you may use to contact the Board of Trustees is:

Board of Trustees
Plumbers and Pipefitters Local 430
Health and Welfare Fund
2908 N. HARVARD AVE.
TULSA, OK 74115
(918) 836-0430

TRUSTEES OF THE PLAN

Union Trustees	Employer Trustees
Mike Skinner, Secretary Plumbers & Pipe Fitters Local 430 2908 N. Harvard Avenue Tulsa, OK 74115	Bobby York York Plumbing P.O. Box 471886 Tulsa, OK 74147
Mike Kubala Plumbers & Pipe Fitters Local 430 2908 N. Harvard Avenue Tulsa, OK 74115	Daniel Owens McIntosh Services, Inc. 8141 E. 48th Street Tulsa, OK 74145
Joe Washington Plumbers & Pipe Fitters Local 430 2908 N. Harvard Avenue Tulsa, OK 74115	Richard Shoemaker, Jr., Chairman Shoemaker Heating & Air Conditioning 1623 N. 71 E. Avenue Tulsa, OK 74115-4625
Landon Varnell Plumbers & Pipe Fitters Local 430 2908 N. Harvard Avenue Tulsa, OK 74115	Scott Soder, Vice Chairman Soder Mechanical Inc. 9526 East 54th Street Tulsa, OK 74145

You may obtain a complete list of the individual Employers and Employee organizations participating in the Plan by written request to the Fund Office. You may examine the list at the Fund Office upon ten days' written notice. ERISA allows the Plan to charge a reasonable fee for the copying costs. You may want to ask the amount of the fee before requesting copies.

PLAN ADMINISTRATION

The Plan is administered by the Board of Trustees, which can be contacted as follows:

Board of Trustees
Plumbers and Pipefitters Local 430 Health & Welfare
2908 N. Harvard Ave.
Tulsa, OK 74115
(918) 836-0430

The Board of Trustees has the full and exclusive authority and discretion to determine all matters arising under the Plan, including but not limited to questions of eligibility, the amount of benefits payable, all methods of providing and arranging for benefits, and the interpretation and construction of the provisions of the Plan and Trust Agreement for the Fund. Any determination, interpretation, or construction adopted by the Trustees is

binding on all persons. No officer, agent, or employee of the Union or Employer is authorized to speak for or on behalf of the Board on any matter relating to the Plan.

The Board of Trustees has delegated certain responsibilities for the Plan's day-to-day operations to an Administrative Manager. The Administrative Manager is:

Judy Hill
2908 N. Harvard Ave.
Tulsa, OK74115
(918) 388-6598

AGENT FOR SERVICE OF LEGAL PROCESS

The Board of Trustees has been designated as agent for service of legal process. Legal process may be served on the Board of Trustees or upon any member of the Board of Trustees at the address listed above.

EMPLOYER IDENTIFICATION NUMBER (EIN) AND PLAN NUMBER

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 73-0776131. The Plan Number assigned by the Board of Trustees to the Plan is 501.

PLAN YEAR

The records of the Plan are kept on the basis of a Plan Year, which begins on January 1 and ends on the following December 31. For purposes of maintaining the Plan's fiscal records, the end of the Plan year is December 31.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to various collective bargaining agreements requiring the signatory Employers to make contributions to the Fund at fixed rates. You may examine these collective bargaining agreements at the Fund Office upon ten days' advance written request. In addition, you may obtain copies of any such agreements, for a reasonable charge, upon written request to the Fund Office.

CONTRIBUTION SOURCE

Contributions to the Plan are made primarily by Employers in accordance with collective bargaining agreements. The collective bargaining agreements require contributions to the Plan at a fixed rate per hour.

Employees and their Dependents are not allowed to contribute to the Plan except for the following circumstances for which continuation of coverage on a self-payment basis is permitted by the Plan: (1) eligible surviving Dependents of a deceased Employee may

self-pay to continue coverage, except that dental and vision coverage is not provided; (2) eligible Employees and Dependents may self-pay to continue coverage under COBRA; and (3) eligible Employees who take a qualified military leave of absence exceeding 31 days may self-pay to continue coverage under USERRA. In all such cases, the Board of Trustees will determine the amount of the required self-payments based upon the cost of providing the coverage and any additional amounts for related administrative costs permitted by law.

You may obtain, upon written request to the Fund Office, information as to whether a particular employer or employee organization participates in the Plan and, if so, their address.

PLAN ASSETS

The Plan's assets and reserves are held in the custody of the Bank of Oklahoma, N.A. and invested by the Board of Trustees under an investment management contract.

FUNDING MEDIUM

Benefits are provided from the Plan's assets, which are accumulated in the Fund pursuant to contributions made by contributing Employers and self-payments made by eligible individuals to continue coverage when authorized by the Plan, as well as investment earnings related thereto. These assets are held by the Trustees in trust for the purpose of providing benefits to Eligible Individuals and defraying reasonable administrative expenses of the Plan. The Plan's assets include any insurance policies purchased by the Trustees to provide life insurance benefits and accidental death and dismemberment benefits under the Plan. None of the medical, dental or vision benefits are insured by a contract of insurance. There is no liability on the part of the Trustees or any other individual or entity to provide payment over and above the amounts in the Fund collected and available to pay benefits.

INSURANCE COMPANY

The Plan's life insurance benefits and accidental death and dismemberment benefits are provided under a group insurance policy issued to the Fund by:

Symetra Life Insurance
777 108th Ave NE
Suite 1200
Bellevue, WA 98004

SELECTION OF PHYSICIANS AND FACILITIES

The Plan pays benefits for certain health care expenses, but the Plan does not provide hospital or medical services. Accordingly, the Plan is not responsible for any acts or

omissions by hospitals or other facilities, or by Physicians, other medical professionals, or any facility staff member or employee thereof.

NON-ASSIGNMENT OF BENEFITS

Benefits under the Plan are not subject to anticipation, assignment, alienation, sale, transfer, or pledge. The rights, benefits and causes of action stemming from a denial of benefits under this Plan are not assignable either before or after benefits are provided.

FACILITY OF PAYMENT

It is important that you keep the Fund Office informed of your current address at all times. If benefits are payable to you but the Fund cannot make such payment because you have not provided it with your current address and cannot be located, or you are incompetent or unable to execute a valid receipt and no guardian has been appointed for you, the Fund may, at its discretion, pay any amount otherwise payable to you to a spouse, relative or other person or institution as it determines to be equitable. The Fund will be fully discharged of its legal obligations under the Plan to the extent of such payment.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Upon written request to the Fund Office, you may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

PROCEDURE FOR OBTAINING ADDITIONAL PLAN DOCUMENTS

If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Fund Office at the address or phone number listed above. You may be charged a reasonable fee to cover the cost of any materials you wish to receive.

AMENDMENT AND TERMINATION OF THE PLAN

The Board of Trustees reserves the right, in its sole discretion, at any time and from time to time, to:

- Amend or terminate either the amount or condition with respect to the payment of any benefit, regardless of employment or retirement status, or illness, injury, condition or disability suffered prior to the effective date of amendment or termination; or

- Alter or postpone the method of payment of any benefit; or

- Amend or terminate the right to continue coverage on a self-payment basis; or

- Amend or terminate any other provisions of the Plan for any class of Employees or Dependents.

In no event, however, may any amendment or termination cause any part of the Fund to revert to an Employer.

In the event of a Plan termination, only claims and expenses incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used. In no event will the Board of Trustees or any individual Trustee, Employer, Union or other individual or entity be liable to provide the payment of benefits over and beyond the Plan assets in the Fund available for such purpose.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE PLAN. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR SOLE DISCRETION, CONDITIONS SO WARRANT.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

This statement of your rights under ERISA is required by federal law and regulation.

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Fund 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 Fund Office, 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 Fund Office may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to:

- Continue health care coverage for yourself or your Dependent spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against

you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of 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 to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan by following the Claims and Appeal Procedure described in this booklet before you may file suit in any court. You will then have one year in which to start a lawsuit, as described on page 83. In no event may you bring legal action in a court later than this one-year period.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should: 1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or 2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or 3) visit the EBSA website at www.dol.gov/ebsa; or 4) write to the EBSA’s Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

APPENDIX A

SURGICAL PROCEDURES TO BE PERFORMED ON AN OUTPATIENT BASIS

Arthroscopy (internal examination of joint)

Bronchoscopy (internal examination of lung), adult, with or without biopsy

Cataract removal

Cystourethrosocopy (internal examinations of urinary bladder and urethra)

Digestive tract endoscopy (internal examination of esophagus, stomach, colon and rectum)

Dilation and curettage (D&C) of uterus

Excision of pilonidal cyst, simple

Laparoscopy (internal examination of abdomen), with or without tubal ligation (female sterilization)

Laryngoscopy and tracheoscopy (internal examination of larynx and windpipe)

Morton's neuroma (of foot)

Myringotomy (puncture of membrane in ear), with or without insertion of tubes

Prostate biopsy

Reduction of nasal fracture, open or closed

Release of carpal tunnel (in wrist)

Vasectomy (male sterilization)

Tubal ligation (female sterilization)