

A Guide To Your Welfare Plan

Summary Plan Description and Plan Document

Effective January 1, 2016

United Association Local No. 7

Welfare Plan A

For Building Trade and HVAC Members

The Trustees believe that the plan providing health coverage described in this Summary Plan Description (“SPD”) is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act)

United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members

18 Avis Drive, Latham, NY 12110

Telephone: 518-785-3440

January 1, 2016

Dear Participant:

This booklet is a description of the United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members as it is in effect on January 1, 2016.

The Plan is governed by a Board of Trustees of which half represent the Union and half represent the participating Employers. Our role, as Trustees of the Welfare Plan, includes the responsibility for collecting contributions (which are required by an agreement between your Employer and Local 7 or between your Employer and the Trustees).

The Board of Trustees has the ultimate responsibility for the management of Plan assets. In addition, the Board of Trustees has the sole power to amend the Plan. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an auditor, an attorney and one or more investment managers.

The daily operation of the Plan is maintained by the Fund Administrator, Robert W. Valenty. Mr. Valenty and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

If, after going through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the fund office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Fund Administrator or to the Trustees, in writing.

Sincerely,

Board of Trustees
United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members

Important Notice

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. The Trustees have endeavored to make this booklet as accurate as possible. However, the terms of the insurance policies shall override the provisions of this booklet in the case of any conflict between this booklet and the provisions of the insurance policies. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever in their sole and absolute judgment conditions so warrant. This booklet describes the Plan as it exists on January 1, 2016.

Caution

This booklet, together with booklets prepared by Capital District Physicians' Health Plan (CDPHP) and OptumRx which are incorporated herein by reference, and the personnel at the fund office and the Fund Administrator are authorized sources of Plan information for you. The Trustees of the Plan have not empowered any one else to speak for them with regard to the Welfare Plan. No Employer, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority.

Communications

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Fund Administrator or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

No Guarantee Of Income Tax Consequences

Neither the Board of Trustees, Fund Administrator, nor the fund office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the fund office if the Participant has reason to believe that any such payment is not so excludable.

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Important Aspects

- ◆ Familiarize yourself with the whole booklet.
- ◆ Application must be made for all benefits before you may be entitled to benefits.
- ◆ Make sure that the fund office is aware of all your dependents and your current address.
- ◆ Make sure your death benefit beneficiary designation is up to date.
- ◆ All claim forms must be completely filled in; incomplete forms will be returned.

Plan Change Or Termination

The Trustees reserve the right to change or discontinue 1) the types and amounts of benefits under the Plan, and 2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility or account balances have already been accumulated.

Benefits provided by the Plan:

- ◆ are not guaranteed;
- ◆ are not intended or considered to be deferred income;
- ◆ are not vested at any time;
- ◆ are subject to the rules and regulations adopted by the Trustees; and
- ◆ may be modified or discontinued and such right to modify or terminate is not contingent on financial necessity.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

Upon any termination or liquidation of the Trust under which Plan assets are held, the Trustees shall turn over any surplus Fund moneys to any future Trust Fund or Welfare Fund that may be created consistent with the terms of the Trust associated with this Plan. If no such new Fund is created, then and in that event, the Trustees shall turn over any surplus Fund moneys to the **then existing eligible Employees on a pro rata basis in accordance** with the ratio his or her contributions bear to the entire contributions for the twelve (12) month period immediately preceding the termination date of the Trust.

Modification Of Benefits & Eligibility Rules

For All Participants, Including Employees, Pensioners And Dependents.

This Summary Plan Description includes information concerning the benefits provided by the Trustees to Participants, including Employees, pensioners and dependents. It also outlines the circumstances that can result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that an Employee, pensioner or dependent might otherwise reasonably expect a plan to provide.

The benefits and eligibility rules applicable to Employees, pensioners and dependents have been established by the Trustees as part of an overall benefit plan for Participants. The right to amend or modify the eligibility rules and plan of benefits for Employees, pensioners and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for Employees, pensioners and dependents and the eligibility rules relating to qualification are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

In accordance with the rules and regulations of the Plan and the Agreement and Declaration of Trust, no Employee, pensioner or dependent has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of Employees and/or pensioners and/or dependents at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for Employees and/or pensioners and/or dependents and there shall not be any vested right by any Employee, pensioner or dependent or beneficiary nor contractual rights after the disposition of Plan assets in connection with the termination of this Plan. The provisions for Employees, pensioners and dependents' coverage shall be reviewed periodically by the Trustees.

Section I. Overview Of Plan

The United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members is a "Personal Account" Plan. Employer Welfare contributions are made to the Personal Account Plan for your covered work. The Trustees will determine the portion of such contributions which will be credited to your Personal Account. This determination may change from time to time depending upon the financial requirements of the whole Plan.

Once you have a Personal Account, you will be a Participant in the Plan.

Your account will grow with all the contributions that are credited to it in the future and through special allocations called financial activity allocations. When the Plan's financial activity permits, the Trustees may declare a bonus to be credited to eligible accounts. This will happen no more than once a year. In determining whether or not to declare this bonus, and the amount and form of the bonus, the Trustees will take into consideration the investment results on the Plan's assets, the expenses of administration of the Plan and reserve requirements for the future.

Your account will be decreased by any benefit distribution made from it, or administration charges levied against each Participant's account on an equitable basis, if, for instance, the investment yield on the Plan reserves is not sufficient to offset the costs of administration of the Plan. Accounts which have had no activity of any kind in the preceding 12-month period are assessed a charge of \$10 per month.

You will continue as a Participant until your account is reduced to zero; at that time your participation stops. If you are self-paying to the Plan for your Insurance Benefit coverage or your Insurance Benefit coverage has otherwise been extended, you are still a Participant.

If you should die while there is still a balance in your account, your surviving spouse and your dependent children may use it for their health care expenses. If you have no spouse or dependent children when you pass away, your account will be forfeited.

In the following sections you will see what is required to become eligible for the benefits that exist in the Plan for you once you are a Participant.

Section II. Eligibility Requirements

This section describes the eligibility requirements for benefits that exist in the Plan.

A. ACTIVE EMPLOYEES

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirements in your current period of Plan participation. In order to do this, you must work at least 840 hours in covered employment in 12 or fewer consecutive calendar months.

Apprentices enrolled in the U.A. Local No. 7 apprenticeship program may satisfy the general eligibility requirements by working 420 hours in covered employment in 6 or fewer consecutive calendar months. However, in order to be eligible for life insurance, accidental death and dismemberment, disability income, and extended coverage, 840 hours must be worked in a period of 12 or fewer calendar months.

If contributions are made to the Plan on your behalf before you have satisfied the general eligibility requirements and such contributions cannot be used to satisfy the general eligibility requirements (because they were made more than 12 months before you became eligible), such contributions will be forfeited and used for Plan administrative costs.

If you have once satisfied the general eligibility requirements for this Plan and your participation stops, in order to satisfy them for a future period of Plan participation, you must once again satisfy the general eligibility requirements to be entitled to any benefits.

B. PENSIONERS

If you are a pensioner under the United Association Local No. 7 Pension Plan (Local 7 Pension Plan), you will continue to be covered under this Plan for as long as your account lasts. Furthermore, when your account runs out, you and your eligible dependents may be eligible to continue coverage under the Insurance Benefit. To be eligible, you must satisfy each of the following requirements:

1. When you retire with a Normal or Early Pension under the Local 7 Pension Plan, you must have been eligible for coverage (other than COBRA) under the Insurance Benefit on the day immediately preceding the start of your pension. If you retire on a Disability Pension, you must have been eligible for coverage (including COBRA) under the Insurance Benefit on the day immediately preceding the start of your pension.
2. You must have been continuously eligible for coverage under the Insurance Benefit during the five-year period immediately preceding the start of your pension under the Local 7 Pension Plan.
3. You must make the required monthly payment on time.
4. You and your spouse must enroll in Medicare Parts A & B as soon as you are eligible to do so. If you enroll in Medicare Part D, you will become ineligible for this Plan's prescription drug benefit.

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The cost of pensioner benefits is shared between the Welfare Plan and the eligible pensioners. Monthly payments are required for all pensioner coverage. The amount of the monthly payment will be determined by the Trustees.

If you return to covered employment, your retiree welfare coverage will continue with no interruption as long as your required premium is paid. You will not be covered as an active Employee, and you will not receive personal account allocations for hours worked.

C. DEPENDENTS

A dependent is any one of the following persons:

1. Covered Employee's Spouse

The term "spouse" shall mean the person recognized as the covered Employee's legal spouse under the laws of the state where the marriage was performed, regardless of the spouse's gender. The Fund Administrator may require documentation proving a legal marital relationship as recognized under applicable State law.

2. Covered Employees Child(ren)

Children are covered from birth up to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the child's birthday.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Employee.

If both mother and father are Employees, their children will be covered as dependents of the mother or father, but not of both. The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Fund Administrator.

A covered child who reaches the limiting age and is totally disabled will continue to be considered a dependent as long as they are: incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and are unmarried. The Fund Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

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After such two-year period, the Fund Administrator may require subsequent proof not more than once each year. The Fund Administrator reserves the right to have such dependent examined by a Physician or other Medical Doctor of the Fund Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

3. Excluded Dependents

Other individuals living in the covered Employee's home, but who are not eligible as defined; divorced former spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

4. Eligibility Requirements for Dependent Coverage

A family member of an Employee will become eligible for dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for dependent coverage.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this Plan.

Marriage certificates and birth certificates are required in order to enroll spouses and dependents.

In the event of divorce or when a dependent is no longer eligible for coverage, it is your responsibility to notify the fund office immediately. If you fail to notify the fund office, you will be responsible for all claims paid for your ineligible spouse and or ineligible dependent.

If a person covered under this Plan changes status from Employee to dependent or dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

5. Termination of Dependent Coverage

A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- a. The date the Plan or dependent coverage under the Plan is terminated.
- b. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- c. The date a covered spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

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- d. On the first date that a dependent child ceases to be a dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

D. EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be the lesser of:
 - a. The 24 month period beginning on the date on which the person's absence begins; or
 - b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
2. A person who elects to continue health plan coverage is required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

E. EMPLOYEES ON FAMILY LEAVE

Under The Family Medical Leave Act you may be eligible for up to twelve weeks of unpaid leave from your employment for any of the following reasons:

1. you need to care for your newly-born or newly-adopted child,
2. you need to care for your spouse, child or parent who has a serious health problem, or
3. you have a serious health problem which prevents you from performing your job.

If you qualify for such a leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your work in covered employment had not stopped, unless your Employer fails to make the required contributions for you. If you do not return to work at the end of your leave, you may be responsible for repaying the Employer contributions made during the leave. You should contact your Employer for further information about your eligibility for such a leave.

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F. TERMINATION OF BENEFITS

1. Actives

If you become unavailable for Covered Employment for a reason other than your total disability or becoming a pensioner under the United Association Local 7 Pension Plan, your entitlement to the Insurance Benefit will stop at the end of the month that you become unavailable for Covered Employment. You will not be eligible for the Insurance Benefit until you satisfy the general eligibility requirements again.

2. Retirees

Welfare coverage will be permanently terminated for non-payment of required premium. Once retiree coverage is terminated, retiree coverage may not be reinstated for any reason at a later date.

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Section III. Overview Of Benefits

This section is intended to give you a quick reference to the benefits available under the United Association Local No. 7 Welfare Plan. All benefits are self-insured. CDPHP is the administrator of the medical benefits, OptumRx is the administrator of the prescription drug benefit, and Delta Dental is the administrator of the dental benefits. All other benefits are administered by the fund office. A detailed description of each benefit follows the table.

Type of Benefit	Persons Covered	Benefit
<u><i>Insurance Benefits</i></u>		
Medical	Active members, pensioners & dependents	Administered by CDPHP
Prescription Drug	Active members, pensioners & dependents	Administered by OptumRx
Dental	Active members and their dependents, optional for pensioners and their dependents	Basic and preventive services, administered by Delta Dental
Vision	Active members, pensioners & dependents	Up to \$300 per Plan Year for one pair of prescription eyeglasses, or contact lens package and examination. Covered persons under age 18 are not subject to the \$300 limitation.
Hearing	Active members, pensioners & dependents	Up to \$2,000 every five (5) years for hearing aid(s) and evaluation.
Asbestos Screening	Active members & pensioners	Periodic Asbestosis Screening
<u><i>Pooled Benefits</i></u>		
Life Insurance	Active members & pensioners	\$5,000 per member, \$2,500 per pensioner
Accidental Death and Dismemberment	Active members & pensioners	By schedule
Disability Income	Active members	By schedule, up to 40 weeks
Medicare Part B Premium Reimbursement	Pensioners	Reimbursement for Medicare Part B insurance premiums by the Fund
<u><i>Personal Account Plan Benefits</i></u>		
Health Expense Benefit	Active members, pensioners & dependents	Reimbursement from your account for certain health care expenses

The medical, dental and prescription drug benefits are available to you (as an eligible Participant), your eligible spouse and your eligible dependent children. The remaining benefits have differing coverage or possibly no coverage for retirees, spouses and/or dependents. The details regarding the different coverages under the Insurance Benefit are described in this section.

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As long as you remain available for covered employment, each month charges for certain insurance coverages will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. If your account runs out, you will be permitted to self-pay your health care insurance charges under COBRA.

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Section IV. Medical Benefits

The Medical Benefits are self-insured and are currently administered by CDPHP. The following is the schedule of Medical Benefits. All benefits described in this schedule are subject to the exclusions and limitations described more fully herein, including, but not limited to, the Fund Administrator's determination that: care and treatment is or is not Medically Necessary; that services, supplies and care are or are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Schedule of Medical Benefits Plumbers & Steamfitters Local 7 Welfare Plan		
	Participating Providers	Non-Participating Providers
Maximum Lifetime Benefit Amount	Unlimited	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating providers.		
Deductible, Per Calendar Year		
Per Covered Person		\$250
Per Family Unit		\$500
The Calendar Year deductible is waived for the following Covered Charges:		
<ul style="list-style-type: none"> - Ambulance - Emergency Room - Urgent Care 		
Co-Insurance And Copayments		
Hospital services	\$250	As shown below
Physician visits	\$20	As shown below
Outpatient services	Varies by service	As shown below
Emergency room	\$100	As shown below
The Emergency room co-insurance payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 24 hours of the admission, even if the patient is discharged within 24 hours of the admission.		
Maximum Out-Of-Pocket Amount, Per Calendar Year		
Per Covered Person		\$2,500
Per Family Unit		\$5,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		

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	Participating Providers	Non-Participating Providers
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over fee schedule allowance Member responsibility		
Hospital Services		
Room and Board	\$250 copay, reimbursed at the semiprivate room rate	\$250 ded., 20% coinsurance after deductible semiprivate room rate
Intensive Care Unit	\$250 copay, same as semiprivate room rate	\$250 ded., 20% coinsurance after deductible semiprivate room rate
Skilled Nursing Facility	\$250 copay, reimbursed at the facility's semiprivate room rate 120 days per Calendar Year maximum	\$250 ded., 20% coinsurance after deductible The facility's semiprivate room rate 120 days per Calendar Year maximum
Physician Services		
Inpatient visits	100% fee schedule	\$250 ded., 20% coinsurance after deductible.
Office visits	\$20 copay	\$250 ded., 20% coinsurance after deductible.
Surgery – office	\$20 copay	\$250 ded., 20% coinsurance after deductible.
Allergy testing	\$20 copay	\$250 ded., 20% coinsurance after deductible.
Allergy serum and injections	100% fee schedule	\$250 ded., 20% coinsurance after deductible.
Home Health Care	\$10 copay 200 days - including home infusion therapy- per Calendar Year maximum	\$250 ded., 20% coinsurance after deductible. 200 days - including home infusion therapy- per Calendar Year maximum
Ambulatory Surgery	\$50 copay	\$250 ded., 20% coinsurance after deductible
Hospice Care	\$10 copay. After copayment 210 days inpatient and outpatient lifetime maximum.	\$250 ded., 20% coinsurance after deductible. 210 days inpatient and outpatient lifetime maximum
Bereavement Counseling	\$10 copay. After copayment 5 visits Lifetime maximum	\$250 ded., 20% coinsurance after deductible. 5 visits Lifetime maximum
Emergency Room	\$100 copay – copay waived if admitted	\$100 copay – copay waived if admitted
Ambulance Service	\$50 copay	\$50 copay

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	Participating Providers	Non-Participating Providers
Urgent Care Center	\$35 copay	\$35 copay
Chemotherapy	\$20 copay	\$250 ded., 20% coins. after deductible
Hemodialysis	\$20 copay	\$250 ded., 20% coins. after deductible
Radiation Therapy	\$20 copay	\$250 ded., 20% coins. after deductible
Radiology Services	100% fee schedule	\$250 ded., 20% coins. after deductible
Laboratory Services	100% fee schedule	\$250 ded., 20% coins. after deductible
Occupational Therapy	\$10 copay 60 visits agg. with physical therapy per Calendar Year maximum	\$250 copay, 20% coins. after deductible 60 visits agg. with physical therapy per Calendar Year maximum
Physical Therapy	\$10 copay 60 visits agg. with occupational therapy Calendar Year maximum	\$250 ded., 20% coins. after deductible 60 visits agg. with occupational therapy Calendar Year maximum
Inhalation / Respiratory Therapy	\$10 copay 30 visits agg. therapy per Calendar Year maximum	\$250 copay, 20% coins. after deductible 30 visits agg. Therapy per Calendar Year maximum
Durable Medical Equipment	20% copay	\$250 ded., 20% coins. after deductible
Prosthetics	20% copay	\$250 ded., 20% coins. after deductible
Orthotics	20% copay	\$250 ded., 20% coins. after deductible
Spinal Manipulation Chiropractic	\$10 copay	\$250 ded., 20% coins. after deductible
Mental Disorders		
Inpatient	\$250 copay	\$250 ded., 20% coins. after deductible
Outpatient	\$5 copay	\$250 ded., 20% coins. after deductible
Substance Abuse		
Inpatient	\$250 copay	\$250 ded., 20% coins. after deductible
Outpatient	\$10 copay	\$250 ded., 20% coins. after deductible

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	Participating Providers	Non-Participating Providers
Preventive Care		
Routine Well Adult Care	100% fee schedule	\$250 ded., 20% coins. after deductible
Includes: routine physical examination or gynecological exam, pap smear, mammogram, prostate screening, laboratory blood tests, and bone density.		
Flu Vaccination	100% fee schedule	\$250 ded., 20% coins. after deductible
Routine Well Child Care	100% fee schedule	\$250 ded., 20% coins. after deductible
Includes: routine physical examination, laboratory blood tests, hearing tests, and immunizations to age 19.		
Organ Transplants	\$250 copay	\$250 ded., 20% coins. after deductible
Infertility Benefits	Benefit varies by service	\$250 ded., 20% coins. after deductible
Includes: Diagnostic testing to determine infertility and treatment -- covered for ages 21-44; actual in vitro fertilization, embryo transfer, sperm processing and cloning are not covered.		

A. DESCRIPTION OF MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

The Plan is a plan which contains a Participating Provider Organization. This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher Participating payment will be made for certain Non-Participating services:

If a Covered Person has no choice of Participating Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Participating Provider at an In-Participating facility.

Additional information about this option, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, and updated as needed.

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Note: The following services must be pre-certified or reimbursement from the Plan may be reduced or unavailable.

(However, the attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.)

- Inpatient Admission
- Skilled Nursing Facility stays
- MRI/CAT scans
- Durable Medical Equipment

Please see the Cost Management Section for details.

B. DEDUCTIBLES

Deductibles and/or Co-insurance payments are dollar amounts that the Covered Person must pay before the Plan pays.

The deductible amount is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. A deductible is paid once a Calendar Year per Covered Person. Each January 1st, a new deductible amount is required.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

C. BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

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D. OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% of the allowed amount (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% of the allowed amount (except for the charges excluded) for the rest of the Calendar Year.

E. MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

Reimbursement for covered charges is based on the agreed upon or allowed amount for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. Hospital Care

The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

2. Skilled Nursing Facility Care

The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- a. the patient is confined as a bed patient in the facility; and
- b. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- c. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

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3. Physician Care

The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

- a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the fee schedule that is allowed for the primary procedures; 50% of the fee schedule will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the fee schedule allowance for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the fee schedule allowed for that procedure; and
- c. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's fee schedule allowance.

4. Private Duty Nursing Care

The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- a. Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- b. Outpatient Nursing Care. Outpatient private duty nursing care is not covered.

5. Home Health Care Services and Supplies

Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

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6. Hospice Care Services and Supplies

Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered spouse and/or covered dependent children). Bereavement services must be furnished within six months after the patient's death.

7. Other Medical Services and Supplies.

These services and supplies not otherwise included in the items above are covered as follows:

- a. Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- b. Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- c. Cardiac rehabilitation as deemed Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- d. Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
- e. Initial contact lenses or glasses required following cataract surgery.
- f. Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator or Fund Administrator.
- g. Medically Necessary diagnostic testing for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome.

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- h. Laboratory studies.
- i. Treatment of Mental Disorders and Substance Abuse. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- j. Injury to or care of mouth, teeth, and gums. Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- k. Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- l. Organ transplant limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

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transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- m. The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
- n. Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
- o. Routine Preventive Care. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- p. The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts.
- q. Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- i. reconstruction of the breast on which a mastectomy has been performed,
- ii. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- iii. coverage of prostheses and physical complications during all stages of mastectomy, including lymph edemas,

in a manner determined in consultation with the attending Physician and the patient.

- r. Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C.
- s. Sterilization procedures.
- t. Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.
- u. Coverage of Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

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This coverage is only provided if the newborn child is an eligible dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Charges for Routine Physician Care. The benefit is limited to Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- v. Diagnostic x-rays.

F. COST MANAGEMENT SERVICES

The patient or family member may call CDPHP to receive certification of certain Cost Management Services.

1. Utilization Review

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- a. Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- Hospitalizations
- MRI/CAT scans
- Substance Abuse/Mental Disorder treatments
- Skilled Nursing Facility stays
- Durable Medical Equipment

- b. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- c. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- d. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

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

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

- a. Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement, if such certification is appropriate. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator **before** services are scheduled to be rendered with the following information:

- i. The name of the patient and relationship to the covered Employee
- ii. The name, Social Security number, and address of the covered Employee
- iii. The name of the Employer
- iv. The name and telephone number of the attending Physician
- v. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- vi. The diagnosis and/or type of surgery
- vii. The proposed rendering of listed medical services

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact us immediately after the admission.

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The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. Failure to follow this procedure may reduce or eliminate reimbursement received from the Plan.

- b. Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

G. SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

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H. PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. performed on an outpatient basis within seven days before a Hospital confinement;
2. related to the condition which causes the confinement; and
3. performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 100% for In-Network services and subject to a \$250 ded., 20% coins. for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

I. CASE MANAGEMENT

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family, and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. personal support to the patient;
2. contacting the family to offer assistance and support;
3. monitoring Hospital or Skilled Nursing Facility;
4. determining alternative care options; and
5. assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan or Fund Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan or Fund Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

J. EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

1. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
2. Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
3. Educational or vocational testing. Services for educational or vocational testing or training.
4. Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the agreed upon or allowed amount.
5. Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
6. Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary.
7. Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. However, refer to the Vision Benefit described in Section VII.
8. Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
9. Foreign travel. Care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
10. Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
11. Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

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12. Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan. However, refer to (Hearing Benefit) in Section VII.
13. Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
14. Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
15. Impotence. Care, treatment, services, or supplies in connection with treatment for impotence.
16. Infertility. Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation, prescription drugs for treatment of infertility and charges for surgical correction of physiological abnormalities.
17. Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.
18. No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.
19. Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
20. Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
21. No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.
22. No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
23. Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
24. Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass,

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and lap band surgery, including reversals. Medically Necessary non-surgical charges for Morbid Obesity will be covered.

25. Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
26. Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
27. Plan design exclusions. Charges excluded by the Plan design as mentioned in this document.
28. Prescription drugs. Charges for prescription drugs are covered under the Prescription Drug Benefit.
29. Private duty nursing. Charges in connection with care, treatment or services of a private duty nurse.
30. Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
31. Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
32. Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
33. Self-Inflicted. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
34. Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
35. Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
36. Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.
37. Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary.

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38. Speech therapy. Charges in connection with speech therapy unless the condition was a result of an accident or sickness.
39. Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization.
40. Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
41. War. Any loss that is due to a declared or undeclared act of war.

K. COORDINATION OF BENEFITS

1. When You Have Other Health Benefits. It is not unusual to find yourself covered by two or more health insurance contracts, plans or policies ("policy or policies") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service which would be covered by all the policies, we will coordinate benefit payments with any payment made under the other policies. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:
 - a. Any group remittance, group, or blanket insurance policy; including HMO and other prepaid group coverage; except that blanket school accident coverages or such policies offered to substantially similar groups (e.g., Boy Scouts, Youth Groups) shall not be considered health insurance policy.
 - b. Any self-insured or non-insured plan, or any other plan arranged through any Employer; trustee; union; Employer organization or employee benefit organization.
 - c. Any CDPHP or other service type group plan or group remittance subscriber contract.
 - d. Any coverage under governmental programs, or any coverage required or provided by statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; or
 - e. Medical benefits coverage in group and individual mandatory automobile traditional "fault" type contracts.
2. Rules to Determine Payment. In order to determine which policy is primary certain rules have been established. The first of the rules listed below which applies shall determine which policy shall be primary:
 - a. If the other policy does not have a provision similar to this one, then it will be primary.
 - b. If you are covered under one policy as an Employee and you are only covered as a dependent under the other policy, the policy which covers you as an Employee will be primary.

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- c. Subject to the provisions in Paragraphs "i" and "ii" below, if you are covered as a child under both policies, the policy of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the policy which covered the parent longer is primary.
- i. If the other policy does not have the rules described immediately above, but instead has a rule based on gender of a parent and, as a result, the policies do not agree on which shall be primary, the policy under which you are the dependent of a male will be primary.
- ii. There are special rules for a child of separated or divorced parents. If your parents are separated or divorced, benefits are determined in this order:
- (1) first, the policy of the parent with custody of the child;
 - (2) then, the policy of the spouse of the parent with custody of the child;
 - (3) finally, the policy of the parent not having custody of the child.
- However, if the terms of a court decree state the order of responsibility and the entity obligated to pay or provide the benefits of the policy of that parent has actual knowledge of the court decree, that policy shall be primary.
- d. If you are covered under one of the policies as an active Employee, neither laid-off nor retired, or as the dependent of such an active Employee, and you are covered as a laid-off or retired Employee or a laid-off or retired Employee's dependent under the other policy, the policy covering you as an active Employee will be primary. However, if the other policy does not have this rule in its coordination of benefits provision, and as a result this Plan and the other policy do not agree on which shall be primary, this rule shall be ignored.
- e. If none of the above applies, then the policy which has covered you for the longest time will be primary.

The above rules apply whether or not you actually make claim under both policies.

3. **Payment of the Benefits When This Plan is Secondary.** When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other policy and under this Plan do not exceed the amount we would have paid if we were primary.
4. **Right To Receive and Release Necessary Information.** We have the right to release or obtain information, which we believe necessary to carry out the purpose of this section. We will not notify you or obtain your consent before releasing or obtaining information except as required by applicable Federal and State laws and regulations. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.
5. **Payments to Others.** We may make payment, in our sole discretion, to any other person, insurance company or organization the amount which it paid for your covered services and which we decide we should have paid. These payments are the same as benefits paid and they satisfy our obligation to you under this Plan.

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6. Our Right to Recover Overpayment. In some cases, we may have made payment to you even though you had coverage under another policy. Under these circumstances, it will be necessary for you to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits program if we have not already received payment from that other program. You must sign any document which we feel is needed to help us recover any overpayment.

Section V. Prescription Drug Benefits

Your prescription drug benefit is self-insured. It is currently administered by OptumRx.

Special Covered Expenses

In addition to prescription drugs, your prescription drug benefit covers the following:

- ◆ Insulin on prescription,
- ◆ Needles and syringes on prescription,
- ◆ Imitrex (including the auto-injector),
- ◆ Bee sting kits,
- ◆ Certain diabetic supplies on prescription,
- ◆ Pre-Natal vitamins, fluoride vitamins (pediatric), and
- ◆ Oral contraceptives and contraceptive devices.

Exclusions

Your Plan excludes the following:

- ◆ Fertility drugs,
- ◆ Anorexiant,
- ◆ Smoking cessations,
- ◆ Federal legend vitamins (except for Pre-Natal),
- ◆ Allergy serums, and
- ◆ Retin A, except with FDA approved diagnosis for members and dependents up to age 26.

A. HAVING YOUR PRESCRIPTION FILLED AT A PHARMACY

You may use your identification card at any OptumRx participating pharmacy. If you have any questions regarding whether your pharmacy participates, please contact OptumRx Customer Service Department toll free at 1-866-863-1408.

Once the pharmacist has dispensed your medication you will be asked to pay the required co-insurance for each new or refill prescription received.

A Direct Reimbursement Claim Form is required when you purchase a prescription from a non-participating pharmacy. Simply request a Direct Reimbursement Claim Form from the fund office or member services at 1-866-863-1408. Use one claim form for each new or refill prescription. Complete the Direct Reimbursement Claim Form and submit directly to OptumRx. Reimbursement will be made directly to you.

Your co-insurance per 30-day prescription is 20% for generic drugs and formulary brand name drugs and 30% for non-formulary brand name drugs. A 34-day supply is available for new and refill prescriptions from your local OptumRx participating pharmacy.

If you are taking a maintenance medication, you must use OptumRx Home Delivery beginning with the 4th fill of the prescription. If you continue to fill your maintenance medication at a retail pharmacy,

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then your co-insurance per 30-day prescription is 35% for generic drugs and formulary brand name drugs and 45% for non-formulary brand name drugs.

B. HAVING YOUR PRESCRIPTION FILLED THROUGH OPTUMRX HOME DELIVERY

The OptumRx Home Delivery program allows members to receive large quantities of maintenance medication (such as: heart medication, blood pressure medication, diabetic medication, etc.) at a discounted rate.

You can obtain a 90-day supply of your prescription through the OptumRx Home Delivery program. The co-insurance per prescription is 20% for generic drugs and formulary brand name drugs and 30% for non-formulary brand name drugs.

Contact the fund office if you are interested in using the OptumRx Home Delivery program.

Section VI. Dental Benefits

The dental benefit is provided as a part of active members comprehensive health care benefits. This benefit applies when covered dental charges are incurred by a person while covered under this Plan. Retired members may elect dental coverage at an additional monthly cost, by completing a Retiree Dental Election Form.

This election will be available only at the time of retirement. If a retiree opts out of the dental program, he or she will forfeit his or her dental coverage permanently.

Calendar Year deductible, per person	\$50
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The deductible applies to these Classes of Service:

Class B Services - Basic

Class C Services - Major

Dental Percentage Payable

Class A Services - Preventive & Diagnostic	80%
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Class B Services - Basic	80%
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Class C Services - Major	50%
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Maximum Benefit Amount

Class C -Major Per person per Calendar Year	\$1,000
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A. DEDUCTIBLE

This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

B. BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental

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Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

C. MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

D. DENTAL CHARGES

Dental charges are the allowed amount made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

E. CLASS A SERVICES: PREVENTIVE AND DIAGNOSTIC DENTAL PROCEDURES

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each year.
2. One bitewing x-ray series every 6 months.
3. One full mouth x-ray every 36 months.
4. One fluoride treatment for covered dependent children under age 19 each Calendar Year.
5. Emergency palliative treatment for pain.
6. Sealants on the occlusal surface of a permanent posterior tooth for dependent children under age 16, once per tooth in any 36 months.

F. CLASS B SERVICES: BASIC DENTAL PROCEDURES

1. Amalgam restorations on primary or permanent teeth.
2. Oral surgery. Routine extractions, soft tissue impaction, partial bony impaction, complete bony impaction, and fractures.
3. Repair of dentures and bridges.
4. Rebasing or relining of removable dentures.
5. Endodontics (root canals).

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6. Extractions. This service includes local anesthesia and routine post-operative care.
7. Recementing bridges, crowns or inlays.
8. Fillings, other than gold.
9. General anesthetics, upon demonstration of Medical Necessity.

G. CLASS C SERVICES: MAJOR DENTAL PROCEDURES

1. Installation of crowns, not part of a bridge. Not more than once every 5 years.
2. Installation of removable or fixed bridges to replace one or more natural teeth. Not more than once every 5 years.
3. Installation of full or partial dentures. Not more than once every 5 years.
4. Periodontics (gum treatments).

H. PREDETERMINATION OF BENEFITS

Before starting a dental treatment for Class C - Major Dental Procedures, a predetermination of benefits form must be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Delta Dental Of New York
One Delta Drive
Mechanicsburg, PA 17055

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

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I. ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the allowed amount for an amalgam filling. The patient will pay the difference in cost.

J. EXCLUSIONS

A charge for the following is not covered:

1. Administrative costs. Administrative costs of completing claim forms or reports or for providing dental records.
2. Broken appointments. Charges for broken or missed dental appointments.
3. Crowns. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
4. Excluded under Medical. Services that are excluded under Medical Plan Exclusions.
5. Hygiene. Oral hygiene, plaque control programs or dietary instructions.
6. Implants. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
7. Medical services. Services that, to any extent, are payable under any medical expense benefits of the Plan.
8. No listing. Services which are not included in the list of covered dental services.
9. Orthodontia. Orthodontic treatment and orthognathic surgery.
10. Personalization. Personalization of dentures.
11. Replacement. Replacement of lost or stolen appliances.
12. Splinting. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

Section VII. Other Benefits

The benefits described in this section are self-funded by the Plumbers and Steamfitters Local No. 7 Welfare Plan.

A. VISION BENEFIT

Under the Vision Benefit, you will be entitled to reimbursement for the cost of an eye exam, and one pair of prescription eyeglasses or contact lens package every year. The maximum amount of this Benefit is \$300 every Plan Year per covered person over the age of 18. Covered Persons under age 18 will not be subject to the \$300 vision benefit reimbursement limitation.

B. HEARING BENEFIT

Under the Hearing Benefit, you will be entitled to reimbursement of up to \$2,000 in any consecutive five (5) year period for expenses pertaining to preliminary tests and purchase of a hearing aid(s). There is no reimbursement for expenses related to loss, theft, repairs, service or batteries.

C. ASBESTOS SCREENING BENEFIT

Active members and pensioners who wish to have the asbestos screening physical must obtain an exam voucher from the fund office which must be presented to the Plan's designated examination provider at the time of the exam.

The examination provider uses the following guidelines set forth by OSHA which are based on the age of the worker and the length of exposure to asbestos:

1. Workers who are under 35 years with less than 10 years of service; test every 5 years;
2. Workers who are 35 – 44 years with 10 years or more of service; test every 2 years; and
3. Workers who are 45 years and older regardless of the length of service; test annually.

D. POOLED BENEFITS

1. Life Insurance Benefit

The Life Insurance Benefit provides a Death Benefit to your designated beneficiary if you die while a Participant in this Plan. The amount is \$5,000 for active members and \$2,500 for pensioners.

2. Accidental Death & Dismemberment Benefit

This provides coverage for loss of a member as a result of an accident and such loss occurs within 90 days of the accident. A member means a hand, a foot, or loss of sight in one eye. The Accidental Death and Dismemberment Benefit pays in accordance with the following schedule:

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Loss	Active Member Benefit	Pensioner Benefit
Life	\$5,000	\$2,500
One member	\$2,500	\$1,250
Two members	\$5,000	\$2,500

No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

- a. bodily or mental illness or disease of any kind;
 - b. medical or surgical treatment of an illness or disease;
 - c. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
 - d. suicide or attempted suicide;
 - e. intentional self-inflicted injury;
 - f. participation in, or the result of participation in a felony, or a riot;
 - g. war or act of war, declared or undeclared; or any act related to war, or insurrection;
 - h. service in the armed forces of any country while such country is engaged in war; or
 - i. police duty performed during service in the Armed Forces or units auxiliary thereto.
3. Disability Income Benefit

If you are unable to perform Covered Employment because of an injury, illness, or pregnancy, you will be eligible to apply for a weekly Disability Income Benefit. To be eligible for this Benefit, you must be under the care of a physician for such injury, illness or pregnancy, you must not be receiving a Disability Pension from the United Association Local No. 7 Pension Plan or any other pension plan, you must not be entitled to a Social Security Disability Pension Benefit, and you must file your claim within 30 days after you become disabled. If you file late, you will not be paid for any disability period more than two weeks before the claim is filed. Late filing may be excused at the discretion of the Plan Administrator only if it is shown that it was not reasonably possible to file earlier. No benefits will be paid if you file more than 26 weeks after your disability begins. The amount of the weekly Disability Benefit is the lesser of 50% of your average weekly salary or \$250 per week for the first 26 weeks, and the lesser of 60% of your average weekly salary or \$350 per week for the remaining 14 weeks.

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No more than 40 weekly Disability Benefit payments will be made for any one period of disability. Successive periods of disability due to the same or related cause(s) not separated by return to full time active employment for two (2) full weeks will be considered one period of disability.

Payments start with the first workday of your disability if your disability is due to an accident, and after seven days if due to illness or inability to work because of pregnancy.

4. Medicare Part B Premium Reimbursement

Covered Pensioners are eligible to be reimbursed for all or part of their Medicare Part B insurance premiums. Each year the Fund will reimburse covered pensioners for the Medicare Part B premiums paid on their behalf during the prior Plan Year. Spouses, widows and dependents are not eligible for this reimbursement. The amount of reimbursement is at the discretion of the Trustees.

Example: Suppose you pay \$1,156.80 in Part B insurance premiums on yourself for the year ending December 2015. Then in 2016 you may apply for reimbursement. In order to be reimbursed you must submit a copy of your 2015 Form SSA-1099 as proof of payment. Your reimbursement check will be processed as soon as we receive your Form SSA-1099.

5. Metabolic Formulas & Special Foods

This benefit applies to dependent children only up to age 12. Coverage will end on the child's 12th birthday. If your dependent child has been diagnosed with a metabolic disorder requiring special formula and/or special foods the Fund will reimburse up to \$5,000 per calendar year of the cost you incurred for special formula and/or food prescribed by a physician.

E. PERSONAL ACCOUNT PLAN BENEFITS

The Personal Account Plan Benefits are designed to help you pay for certain medical costs not covered by this or any other health care or insurance plan. The following Benefit may be reimbursed from your Personal Account:

1. *Health Expense Benefit*

If you incur health care expenses while you are a Participant in the Plan, for yourself, your spouse, or your dependent child, and these expenses are not covered under the Medical Benefit of the Insurance Benefit or any other insurance program, you may apply for a distribution of a portion of your account to pay for the uncovered bills.

These expenses may include, but are not limited to the following:

- a. dental expenses,
- b. eye care expenses,
- c. hearing aids,
- d. physical exams,
- e. Insurance Benefit deductibles, co-insurance and co-payments, and
- f. Prescription Drug deductibles, co-insurance and co-payments.

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However, you are not allowed to reduce the balance in your account below the amount equal to eight (8) months of the monthly premium for family coverage.

Claims under this Benefit may be submitted only if they total at least \$200. You may add several bills together in order to reach the \$200. In any event, regardless of the amount of your covered bills, in the months of March and November you may submit such bills to the Plan. Such submissions are not permitted in any other month.

Finally, claims for reimbursement under this Benefit must be made within twelve (12) months from the date the expense was paid.

F. BENEFIT LIMITATIONS

Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

Reimbursable expenses are not allowed to be withdrawn from your account if your account would be reduced below the amount of annual premium required for family coverage. This provision is necessary to provide a reserve for you for the most vital benefits of a Welfare Plan.

Total reimbursements for the Health Expense Benefit may not exceed \$10,000 in any one Plan Year.

Section VIII. Coverage Options

As long as you remain available for covered Employment, each month charges for certain insurance coverages will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. If your account runs out or you become unavailable for covered Employment, you will be permitted to self-pay your health care insurance charges under COBRA.

A. SINGLE COVERAGE

If your spouse and children are already covered under your spouse's employer's health care plan, you may elect to be covered for "single" health care insurance only.

B. EXEMPTION OF COVERAGE

If you are covered under your spouse's employer's health care plan or some other employer health care plan, you may elect to not be covered under the Medical Benefit of the Insurance Benefit. However, to forego coverage for your dependents or yourself, you must show the Trustees that the coverage of your dependents and/or you under the spouse's employer's (or other employer's) health care plan meets certain standards. These standards are determined by the Trustees and the Plan Administrator will let you know what these standards are if you contact him.

If you forego coverage for yourself and your dependents, you will still qualify for the following four (4) Pooled Benefit coverages, if you are an active member. If you are a pensioner and forego coverage you are only entitled to Asbestos Screening.

1. Disability Income,
2. Life Insurance,
3. Accidental Death and Dismemberment, and
4. Asbestos Screening.

Further, if the other health care coverage stops, the Plan's Insurance Benefit's Medical Benefit must begin effective no later than the first day of the month after 60 days from the date the other coverage stops (except for COBRA).

You will be allowed to "opt out" of your Personal Account Plan Benefits. If you "opt out" of your Personal Account Plan Benefits you will forfeit any monies in your account as of the date you "opt out". You will be allowed to "opt out" of your Personal Account Plan Benefits on the first day of any month. You are not required to waive or "opt out" of plan coverage for yourself or your dependents. It is your choice to decide on the medical coverage arrangements that are best for you and your family.

C. QUALIFYING STATUS CHANGE

A Qualifying status change is a specific event or change that allows you to make changes to your benefit elections. You are prohibited from dropping, adding, or changing health plan coverage during the Plan Year unless a qualifying status change occurs. When a qualifying status change occurs typically notification must be received by the fund office within 31 days of the status change to alter your coverage. In the case of enrolling a newborn child notification must be received by

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the fund office within 60 days of birth. You must provide supporting documentation such as a marriage certificate to enroll a new spouse or a birth certificate or adoption papers to enroll a new child.

If the notification is received more than 60 days after the birth of a child or 31 days after any other event, the request will be denied and the change cannot be made until the 1st of the month after receipt of a completed application and requested documentation.

HIPAA Special Enrollment Rights

There are two circumstances under which you may qualify for a special 30-day enrollment period and make mid-year election changes:

Loss of Coverage

If you decline enrollment for yourself or your dependents because of other health insurance or group health plan coverage, you may add coverage in this plan mid-year if you or your dependents lost eligibility for that other coverage (or if the Employer stops contributing toward your or your dependent's other coverage).

Gaining a Dependent

If you gain a new dependent through marriage, adoption, or placement for adoption, you may add coverage in this plan. If you gain a new dependent through birth you may add coverage in this plan and only in such case will the special enrollment period be extended to 60 days.

Medicaid/CHIP Special Enrollment Rights

Employees who are eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an Employee if the dependent is eligible, but not enrolled, for coverage under such terms) may enroll for coverage under the terms of the plan if either of the following conditions is met:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE.** – The Employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP. – The Employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests coverage under the group health plan not later than 60 days after the date the Employee or dependent is determined to be eligible for such assistance.

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D. EXTENDED COVERAGE

If your account runs out while you are covered by the Insurance Benefit, you may be covered for up to three (3) additional months. To qualify for this special extended coverage you must be available for Covered Employment on the day the extended coverage begins. Also, you must remain available for Covered Employment during each day of the extension, unless you are unable to work due to injury or illness and you are under the care of a physician.

If your account is still insufficient to cover your Insurance Benefit premium at the end of this special extension, you may apply for an additional period of up to three (3) months. You may qualify for up to a maximum of three (3) extensions, or 9 months of coverage. The application must be made to the Trustees in writing.

E. COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

1. Qualifying Events

For individuals covered by the Plan as Employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the Employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

2. Spousal Eligibility for COBRA Coverage

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

- a. Your death.
- b. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.
- c. Divorce or judicial order of legal separation.
- d. Your enrollment in Part A or Part B of Medicare.

3. Dependent Eligibility for COBRA Coverage

Your dependent children may elect COBRA continuation coverage upon the occurrence of any of the following events:

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- a. Your death.
- b. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.
- c. Divorce or judicial order of legal separation of the child's parents.
- d. Your enrollment in Part A or Part B of Medicare.
- e. The child ceases to qualify as an "eligible dependent".

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the fund office immediately of such a change.

4. Notifications to the Fund Office

Your Employer has the obligation to notify the fund office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because Employees frequently work for more than one Employer making contributions to the Plan, and because of the difficulty which this causes Employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Plan Administrator in case of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent or the birth or adoption of a dependent. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Plan Administrator within the time limits may result in your ineligibility for COBRA continuation coverage.

5. Notification of COBRA Rights

After the Plan Administrator receives notice of the occurrence of one of the above qualifying events, the Plan Administrator will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Plan Administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated.

6. Election of COBRA Coverage

The Employee, spouse and dependent children each has independent election rights. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have at least 60 days from the date he or she would lose coverage because

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of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Plan Administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form is received by the Plan Administrator on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the Plan Administrator.

7. Benefits Provided Under COBRA Coverage

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance or disability income benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

8. Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you eliminate or reduce such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

9. Termination of COBRA Coverage (How Long Coverage Lasts)

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If you are the disabled person, your spouse and your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

- a. The plan sponsor no longer provides group health coverage.

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- b. Failure to pay the monthly premium on time.
- c. The individual becomes covered under another group health plan (other than one sponsored by the plan sponsor) except for any period the other group health plan limits coverage of your pre-existing conditions.
- d. The individual enrolls in Part A or Part B of Medicare.
- e. Circumstances are such that the individual's participation could be canceled if the individual were an active Employee.

If any of these events occur, the fund office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the Employee, spouse or dependent child may have under the Plan to elect alternate coverage.

10. Cost of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the fund office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per Participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled Participants are at a monthly charge based on one and one-half times the average annual per Participant cost incurred by the Plan. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay Participants described in the section on Continuation Coverage for Retirees.

11. Additional Information About COBRA Coverage

COBRA continuation coverage is described in greater detail in a letter sent out by the fund office to each Participant when the Participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

F. COBRA EXTENSION

A Participant covered under COBRA can apply for a special COBRA extension if the Participant's COBRA coverage is about to expire while the Participant is currently working in covered employment for the purpose of satisfying the Plan's general eligibility requirements of 840 hours again. To be eligible to apply for this special extension, the Participant must be

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working in Covered Employment on the last workday preceding the date his/her COBRA coverage expires. The special COBRA extension will end on the earlier of:

1. the date the individual is no longer available for covered employment,
2. six months after the special COBRA extension began, and
3. the day after a monthly premium is due but not received by the fund office.

Applications for this special extension must be made before the Plan's COBRA continuation coverage period ends and there must be no interruption in timely premium payments. Premiums during this extension period will be the same as the normal COBRA premiums.

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Section IX. Claim & Appeal Procedure

A. CLAIM PROCEDURE

Self-Insured Medical Benefits: Claims for Self-Insured Medical Benefits administered by CDPHP, the third-party administrator (TPA), are to be sent to:

Capital District Physicians' Health Plan, Inc.,
P.O. Box 66602,
Albany, NY 12206-6602.
Telephone: (518) 641-3140
Toll free: (877) 269-2134
Website: www.cdphp.com

Most providers will submit the claims for you based on the information on your identification card. If you need to file a claim directly, claim forms can be obtained from the fund office:

UA Local 7 Welfare Fund
18 Avis Drive
Latham, NY 12110
Telephone: (518) 785-3440
Website: www.ualocal7.org

Self-Insured Pharmacy Benefits Administered By OptumRx: You may obtain prescriptions at participating pharmacies by presenting your identification card and paying coinsurance, without submitting a paper claim. If it is necessary to purchase a prescription because you do not have your identification card or because the pharmacy where your prescription is filled is a non-participating pharmacy, you may submit your claim for reimbursement to the prescription benefits manager (PBM):

OptumRx
PO Box 509075
San Diego, CA 92150-9075
Telephone: (866) 863-1408
Website: www.optumrx.com

This form must be accompanied by a copy of the Prescription Drug Program Direct Reimbursement Form and either a full pharmacy printout or the original attached receipt(s).

Self-Funded Self-Administered Vision, Hearing, Life Insurance, AD&D, Disability Income, Asbestos Screening, and Medicare Part B Reimbursement Benefits: Applications for these self administered benefits must be made in writing on forms that may be obtained from the fund office.

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B. CLAIM DENIAL AND APPEAL

Initial Decisions

Time Frames

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations 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, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

The only possible Pre-Service, Urgent Care, or Concurrent Claims are claims for Medical, Prescription Drug and Dental Benefits. Note that all other claims are all Post-Service Claims.

Pre-Service Claims

The receipt of some medical benefits (Health Care and Prescription Drug Benefits) may be conditioned on advance approval from the third-party administrator or prescription benefits manager (PBM). Claims for such benefits are considered Pre-service Claims, as defined above. For Pre-service Claims, the following rules apply. Generally, you will be notified of the third party administrator's or prescription benefits manager's determination (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the third-party administrator's or prescription benefits manager's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator's or prescription benefits manager expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. If the claim is improperly filed, the third-party administrator or prescription benefits manager will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the third-party administrator regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information or to follow filing procedures. You will be notified of the failure as soon as possible, but not later than 24 hours after receipt of

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the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the third-party administrator's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination by CDPHP (the third-party administrator for Self-Insured Medical and Dental Benefits) or the Plan (for all other benefits) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the third-party administrator or the Plan (as applicable) notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;
2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;
5. In a case of an adverse determination involving a claim for urgent care, a description of the expedited review process applicable to such claims;

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6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and
7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the determination. To appeal an adverse determination of a Pre-Service, Urgent Care Medical or Dental, or Post-Service Medical or Dental Claim, you must appeal to the TPA, CDPHP or Delta Dental or to the PBM, OptumRx within 180 days after you receive the initial adverse benefit determination. To appeal an adverse determination of any other benefit you must write to the Trustees within 180 days after you receive the initial adverse benefit determination. Notwithstanding anything in this paragraph to the contrary, for Concurrent Care Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded only a reasonable period of time to appeal.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20__." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

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In addition, in regard to all appeals other than those involving the Life Insurance and Accidental Death and Dismemberment Benefits: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims

If urgent care claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the plan's benefit determination on review, shall be transmitted between you and the third-party administrator by telephone, facsimile, or other similarly expeditious method.

Determinations on Appeal

Time Frames

Pre-Service Claims: The third-party administrator will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review (except that if there are two (2) levels of appeal, the decision has to be made within 15 days at each level).

Urgent Care Claims: The third-party administrator will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Major Medical Benefits: The third-party administrator will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) days after receipt of the request for review except that if there are two (2) levels of appeal, the decision has to be made within 30 days at each level).

Life Insurance, Accidental Death and Dismemberment, and Disability Claims: Appeals of adverse Disability Benefit claims must be decided by the Trustees within 45 days (plus a possible 45-day extension, if necessary). Appeals of adverse Life Insurance and Accidental Death and Dismemberment claims must be decided by the Trustees within 60 days (plus a possible 60-day extension, if necessary).

All Other Claims: The Trustees, at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

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Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;
2. Reference to specific plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits;
4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA");
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

C. FUND OFFICE CLAIM PAYMENT POLICIES

It is the general policy of the United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members to issue payments for all claims that are administered by the fund office within a period of 30 days from the date of receipt of the claim by the fund office, but there are exceptions.

For all claims, the following will be required:

1. Obtain an appropriate claim form(s) from the fund office.
2. Complete your portion of the form(s). Be sure that the Participant's signature and the Participant's social security number are in the proper spaces.
3. Upon completion of the claim form(s), attach all itemized bills, insurance information, and proof of payment and return it to the fund office.

An expense is considered to be incurred on the date the service or treatment is performed or a purchase is made, rather than on the date the bill is received.

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D. INCOMPETENCE

In the event it is determined that a claimant is unable to care for his affairs because of illness, accident, or incapacity, either mental or physical, payments due may be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion (unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representative).

E. COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case and they may from time to time adopt such formulas, methods and procedures as they consider advisable.

F. CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted, as well as any benefit payments made in error.

G. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all Employees (and pensioners) and their covered spouses and dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Employees, pensioners, covered spouses and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this Plan pays benefits in such situations.

These rules have two (2) purposes. First, the rules ensure that your benefits will be paid. However, where there is a question of third party liability, many months may pass before the third party actually pays and a recent United States Supreme court case places the Plan at risk it pays your covered expenses before your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant benefits it may have advanced to you or a service provider on your behalf as soon as practicable, and no later than out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

1. Rights Of Subrogation And Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to advise the Plan of that fact. By law and under the express provisions of this Plan, the Plan

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automatically acquires any and all right, which you may have against the third party. The Plan shall be entitled to subrogation or reimbursement to all rights of recovery of you, your representatives, guardians, beneficiaries, spouses, dependents, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trust, or any other agents, persons or entities that may receive a benefit on behalf of any such person or entity (collectively an "Eligible Individual") to the extent of any amounts which the Plan has paid or may become obligated to pay on account of any claim against any person, organization, or other entity in connection with the injury, illness, sickness, accident or condition to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverages and any Employer of the Eligible Individual under the provisions of a Workers' Compensation or Occupational Disease Law.

In addition to its subrogation right, the Plan has the right to be reimbursed for any payments made on your behalf under these circumstances from any Source. The Plan must be paid or reimbursed from any settlement, judgment or other payment that you obtain, or another Eligible Individual obtains, from the liable third party, whether or not designated as payment for medical expenses, before you receive anything from said settlement, judgment or other payment and before any other expenses, including attorneys' fees and court costs, are taken out of the settlement, judgment or other payment.

The Trustees may, in their sole discretion, delay paying any Plan benefits relating to expenses incurred for which a third party may be liable and/or recover any such Plan benefits already paid and/or require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you or a service provider any benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement.

The Plan's subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement, judgment or otherwise, whether there is a partial or full recovery and regardless of whether you or another Eligible Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as for medical expenses or as amounts for other than medical expenses and regardless of whether liability is admitted or contested by the Source. **YOU AND ALL OTHER ELIGIBLE INDIVIDUALS, AS A CONDITION OF PLAN PARTICIPATION, AGREE THAT THE PLAN SHALL RECEIVE IN FULL ALL MEDICAL EXPENSES IT HAS PAID OR IS OBLIGATED TO PAY AND ALL OF ITS ATTORNEYS' FEES, AUDIT FEES, COURT COSTS AND OTHER EXPENSES RELATING TO SUCH A CLAIM FOR WHICH A THIRD PARTY HAS LIABILITY OR MAKES A PAYMENT BEFORE YOU, ANOTHER ELIGIBLE INDIVIDUAL OR AN ATTORNEY OR OTHER REPRESENTATIVE OF YOU OR THE OTHER ELIGIBLE INDIVIDUAL RECEIVES ANYTHING FROM ANY SOURCE.** Once the Plan makes or is obligated to make any payment on behalf of you or another Eligible Individual on account of a claim, the Plan is granted, and you and all other Eligible Individuals consent to, an equitable lien by agreement and a constructive trust on the proceeds of any

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payment, settlement or judgment received, or to be received, by you or another Eligible Individual from any Source. **THE PLAN SPECIFICALLY DISAVOWS ANY CLAIMS THAT YOU OR ANOTHER ELIGIBLE INDIVIDUAL MAY MAKE UNDER ANY FEDERAL OR STATE COMMON LAW DEFENSE, INCLUDING, BUT NOT LIMITED TO, THE COMMON FUND DOCTRINE, THE DOUBLE-RECOVERY RULE, THE MAKE-WHOLE DOCTRINE, OR ANY SIMILAR DOCTRINE OR THEORY, INCLUDING THE CONTRACTUAL DEFENSE OF UNJUST ENRICHMENT. ACCORDINGLY, THE PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS APPLY ON A PRIORITY, FIRST-DOLLAR BASIS TO ANY RECOVERY OF YOU OR ANOTHER ELIGIBLE INDIVIDUAL FROM ANY SOURCE WITHOUT REGARD TO LEGAL FEES AND EXPENSES OF YOU OR THE OTHER ELIGIBLE INDIVIDUAL AND YOU AND THE OTHER ELIGIBLE INDIVIDUAL WILL BE RESPONSIBLE FOR PAYING ALL LEGAL FEES AND EXPENSES.**

2. Assignment Of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, including, without limit, court costs, audit fees, and attorneys' fees, then the excess will be paid to you and/or your attorney, as the Plan Trustees deem appropriate.

3. Failure To Disclose And/Or Cooperate

If you fail, or another Eligible Individual fails, to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and/or fail to cooperate with the Fund's subsequent recovery efforts); if you fail to sign and require any attorney you retain to sign the Plan's lien forms; if you, another Eligible Individual, and/or your attorneys fail to pay and/or reimburse this Plan out of any recovery or payment you obtain, or another Eligible Individual obtains, from the third party; and/or if you fail, or another Eligible Individual fails, to fully pay and/or reimburse the Plan (out of any judgment or settlement you receive, or otherwise, even if this Plan reduces the amount of its lien or otherwise limits its rights); then you are, and any other Eligible Individual is, personally liable to this Plan for the payment and/or reimbursement owed to this Plan by or from the third party. This Plan may offset the amount you owe, or another Eligible Individual owes from any future benefit claims, or, if necessary, take legal action against you or another Eligible Individual. The Plan may take any appropriate legal action, asserting all appropriate legal and/or equitable remedies, including, but not limited to, suits under ERISA Section 502(a)(3), including, without limit, injunctive action to ensure any claim payment amounts are preserved and not disbursed, and/or suits under any other applicable federal or state law; the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies received from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal and/or equitable relief, take priority over the interest and right of any other person or entity. You and any other Eligible Individual will owe the Plan all court costs and the Plan's other expenses, including, without limit, its attorneys' fees and audit fees in any legal action the Plan takes against you and/or another Eligible Individual for any such failure.

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H. THE TRUSTEES' DECISION IS FINAL AND BINDING

The Trustees' final decision with respect to their review of your appeal will be final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction. The Trustees have exclusive and absolute authority and discretion to determine all questions of eligibility and entitlement to benefits under the Plan as well as to make all interpretations of Plan provisions. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Section X. Your Rights Under ERISA

As a Participant in this Plan you are entitled to certain rights and protection under ERISA. ERISA provides that all Plan Participants shall be entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the fund administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the fund administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

B. CONTINUE GROUP HEALTH PLAN COVERAGE

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

No group health plan will be permitted to impose a pre-existing condition limitation for plan years starting January 1, 2014; therefore, this plan will not provide certificates for separations after December 31, 2014.

C. 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

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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.

D. 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 fund administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, 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.

E. ASSISTANCE WITH YOUR QUESTIONS.

If you have any questions about your Plan, you should contact the fund administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor at:

JFK Federal Building
Room 3575
Boston, MA 02203
(607)565-9600

or

The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration,
U.S. Department of Labor at:

200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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F. MOTHERS AND NEWBORNS

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

G. CHARGES RELATED TO A MASTECTOMY

Your benefit coverage includes charges incurred by you or your beneficiary in connection with a mastectomy covered by the Plan or insurance issuer, in a manner determined in consultation with the attending physician and you or your beneficiary, for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas, provided you/your beneficiary elect breast reconstruction in connection with such mastectomy.

Section XI. Protected Health Information

This Section describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. Protected health information (or “PHI”) is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your Employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your protected health information.

A. PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how we are most likely to use and/or disclose your protected health information.

1. Payment and Health Care Options

We have the right to use and disclose your protected health information for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule).

2. Payment

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

3. Health Care Operations

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

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4. Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management.

5. Other Covered Entities

We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

6. Plan Sponsor

We may disclose your protected health information to the plan sponsor or the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

B. POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

C. OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1. Required by Law

We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

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2. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government that is collaborating with the public health authority.

3. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

4. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

5. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

6. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

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7. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donations and transplantation.

8. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

9. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

10. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

11. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

12. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

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13. Others Involved in Your Health Care

Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

D. REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following is a description of disclosures that we are required by law to make:

1. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with the HIPAA Privacy Rule.

2. Disclosures to You

We are required to disclose to you most of your protected health information in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

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E. OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

F. YOUR RIGHTS

The following is a description of your rights with respect to your protected health information:

1. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by calling us at the number/writing to: *Robert W. Valenty, Fund Administrator, Plumbers & Steamfitters Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440.*

It is important that you direct your request for restriction to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the number/address indicated might delay processing the request. We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

2. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by calling/writing: *Robert W. Valenty, Fund Administrator, Plumbers & Steamfitters Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440.* It is important that you direct your request for confidential communications to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

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We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, “reasonableness” will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan Participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan Participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, “EOB”). Therefore, it is extremely important that you contact us **as soon as** you determine that you need to restrict disclosures of your protected health information.

If you terminate your request for confidential communications, the restriction will be removed for all your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

3. Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a “designated record set”. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

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We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

4. Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling/writing to *Robert W. Valenty, Fund Administrator, U.A. Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440*. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

5. Right of an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations, and therefore, will not be subject to your right to an accounting. There also are other exceptions to this right. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to *Robert W. Valenty, Fund Administrator, Plumbers & Steamfitters Local No. 7 Welfare Plan, 18 Avis Drive, Latham, NY 12110 (518) 785-3440*. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2004. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

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6. Right to a Paper Copy of the Notice of Privacy Practices

You have a right to a paper copy of such Notice, even if you have agreed to accept such Notice electronically.

G. COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us. A copy of the complaint form is available from this contact office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Section XII. Defined Terms

The following terms have special meanings and when used in this Plan will be capitalized.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Employer or **Employer** is an Employer participating in the Plan by virtue of being signatory to the Trust agreement.

Covered Person is an Employee or dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of

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Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home. Effective July 1, 2016 breast pumps will be considered durable medical equipment under this plan.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Enrollment Date is the first day of coverage.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan or Fund Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan or Fund Administrator shall be guided by a reasonable interpretation of Plan provisions, but shall have sole and absolute discretion in making these evaluations. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan or Fund Administrator will be final and binding on the Plan and on you. The Plan or Fund Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary

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to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they, without limit, are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as dependents under the Plan.

Fund Administrator maintains the daily operation of the Plan. Please refer to the Technical Details section for contact information.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of the following requirements: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet all the following requirements: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

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Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes, without limit, Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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For Building Trade & HVAC Members

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan or Fund Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means United Association Local No. 7 Welfare Plan, which is a benefits plan for certain qualified Employees of Board of Trustees of United Association Local No. 7 Welfare Plan A, For Building Trade & HVAC Members and is described in this document.

Participant is any Employee or dependent who is covered under this Plan.

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Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of the following requirements:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

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Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Trustees means the Trustees designated in the Agreement and Declaration of Trust, together with their successor or successors, designated in the manner provided therein.

Union shall mean United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada Local No. 7.

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Section XIII. Technical Details

(As required by the Employee Retirement Income Security Act of 1974, as amended)

PLAN NAME: United Association Local No. 7 Welfare Plan.

EDITION DATE: This Summary Plan Description is produced as of January 1, 2016.

PLAN SPONSOR: Board of Trustees of United Association Local No. 7 Welfare Plan.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 14-6029930

PLAN NUMBER: 501 (assigned by federal government)

TYPE OF PLAN: Welfare Benefit Plan

PLAN YEAR ENDS: May 31.

PLAN ADMINISTRATOR: Board of Trustees of United Association Local No. 7 Welfare Plan, 18 Avis Drive, Latham, New York, 12110, Phone # (518) 785-3440.

FUND ADMINISTRATOR: Robert W. Valenty, 18 Avis Drive, Latham, NY 12110.

AGENT FOR THE SERVICE OF LEGAL PROCESS: Mr. Robert Valenty, Fund Administrator, United Association Local No. 7 Welfare Plan, 18 Avis Drive, Latham, New York, 12110, Phone # (518) 785-3440.

In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Plan Trustee.

TYPE OF PLAN ADMINISTRATION: Direct by employees of the Board of Trustees.

TYPE OF FUNDING: Benefits are self-insured.

SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the United Association Local No. 7 Welfare Plan, certain benefit funds with whom this Plan has reciprocal agreements, and, in certain circumstances, Participants.

COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with a collective bargaining agreement. A copy of this agreement may be obtained by you upon written request to the Fund Administrator and is available for examination by you at the fund office.

PARTICIPATING EMPLOYERS: You may receive from the Fund Administrator, upon written request, information as to whether a particular Employer participates in the sponsorship of the Plan. If so, you may also request the Employer's address.

PLAN BENEFITS PROVIDED BY: The United Association Local No. 7 Welfare Plan, CDPHP, OptumRx, and Delta Dental.

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NO INSURANCE UNDER THE PBGC: Since this Plan is not a defined-benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the United Association Local No. 7 Welfare Plan. The following are the individual Trustees that make up the Board as of January 1, 2016:

Employer

Peter Campito
c/o Campito Plumbing & Heating
P.O. Box 550
Latham, NY 12110

Robert Snyder
c/o F.P.I. Mechanical, Inc.
11 Green Mountain Drive
Cohoes, NY 12047

Dan Keating
BPI Piping
P O Box 311
Waterford, NY 12188

Union

Timothy J. Carter
9 Carrolls Grove Road
Troy, NY 12180

Paul Fredericks
17 Barrows St.
Albany, NY 12209

Edward Nadeau, Business Manager
Plumbers & Steamfitters Local 7
18 Avis Drive
Latham, NY 12110