INTERNATIONAL ASSOCIATION OF HEAT & FROST INSULATORS LOCAL 17 WELFARE FUND

SUMMARY PLAN DESCRIPTION and PLAN DOCUMENT

Effective January 1, 2015

International Association of Heat & Frost Insulators

Local 17 Welfare Fund

Fund Office
18520 Spring Creek Drive
Tinley Park, Illinois 60477
Telephone: (708) 468-8000
Fax: (708) 468-8018
www.local17fund.com

BOARD OF TRUSTEES
(ADMINISTRATOR AS DEFINED BY LAW)

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Mr. Thomas McGrath	Mr. Jeffrey Corrado

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Johnson & Krol, LLC

CONSULTANT

Milliman

CERTIFIED PUBLIC ACCOUNTANTS

Legacy Professionals LLP

A MESSAGE FROM THE BOARD OF TRUSTEES

Important terms used throughout this booklet are capitalized and defined in the Plan. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Fund Office.

This booklet replaces and supersedes any previous written explanation of the Plan.

IMPORTANT REMINDER

TELL YOUR FAMILY, PARTICULARLY YOUR SPOUSE, ABOUT THIS BOOKLET AND WHERE IT IS LOCATED. PLEASE NOTIFY THE FUND OFFICE PROMPTLY IF YOU CHANGE YOUR ADDRESS. ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE BENEFITS DESCRIBED IN THIS BOOKLET. NO EMPLOYER, THE UNION, NOR ANY REPRESENTATIVE OF ANY EMPLOYER OR UNION, IN SUCH CAPACITY, IS AUTHORIZED TO INTERPRET THIS PLAN, NOR CAN ANY SUCH PERSON ACT AS AGENT OF THE TRUSTEES.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. YOU WILL BE NOTIFIED IN WRITING OF ANY PLAN CHANGES.

PLAN VENDOR INFORMATION AS OF JANUARY 1, 2015

The **Fund Office** is responsible, under the oversight of the Board, for providing various administrative services for the Fund, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and for providing various reports and other services that the Fund requires. At www.local17fund.com, you are able to view the Plan/SPD 24 hours a day, 7 days a week. The site contains additional links and services you will find valuable in understanding and using your coverage effectively. Please take full advantage of this service. Additionally, the Fund Office is available for any questions members may have regarding Plan benefits in general, as well as questions specific to an individual member's eligibility or claims at (708) 468-8000, Monday, Tuesday, Wednesday, Thursday and Friday 7:30am to 4:30pm.

The **Preferred Provider Organization (the "PPO" or "network")** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. ***The Trustees selected Blue Cross and Blue Shield of Illinois ("BCBSIL") as its PPO***. The Blue Cross/Blue Shield ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call the number provided on your ID card or the Fund Office or visit www.bcbsil.com to identify PPO providers.

The **Pre-Certification/Utilization Review Organization ("UR")** helps you and the Plan reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admission and other medical expenses. This process is called the Pre-Certification Program (also known as the Utilization Review Program). ***The Trustees selected Hines & Associates to provide Pre-Certification and UR services to the Plan*** You can contact Hines & Associates for any Pre-Certification questions and/or to request Pre-Certification at **(800) 670-7718**.

The **Pharmacy Benefit Manager ("PBM")** provides access to pharmacies and mail order services offering discounted prices for covered prescription drugs in exchange for the Plan's coverage of such services at a higher level than for non-participating pharmacies or mail order providers. ***The Trustees selected CVS Health to provide the Plan's preferred prescription drug coverage.*** Note that the CVS Health identifying information is included on the front of your BCBSIL ID card so that you are able to use the same card that provides access to medical services in order to access participating pharmacies for the purchase of covered prescription drugs. Call CVS Health at **(877) 411-8167** for active members and retired members.

The **Dental PPO** provides access to dental providers offering discounted fees. ***The Trustees selected Dental Network of America ("DNOA") to provide the Plan's Dental PPO***. Call DNOA at **(866) 522-6758** or visit www.dnoa.com for further information regarding PPO providers. For all other questions, please contact the Fund Office.

The **Employee Assistance Program ("EAP")** provides managed mental health care services to participants and their families. ***The Trustees selected HOPE Assistance Plans as the EAP benefit provider***. The EAP Benefit consists of any benefits established pursuant to the contract between the Plan and the service provider. EAP services are available 24 hours a day, 7 days a week by calling **(708) 594-9714.** Calls are always answered directly by clinical professionals who provide immediate service, even after standard business hours.

The **Death Benefit and the Accidental and Death Dismemberment Benefit (AD&D)** are provided through an insurance carrier and paid in accordance with the terms of the applicable policy. ***The Trustees selected Dearborn National Life Insurance Company to provide the Plan's Death Benefit and AD&D Benefit.*** Call the Fund Office for further information regarding the terms and limitations of these policies.

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SECTION 1: SCHEDULES OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Fund. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice versa.

The following Schedules provide an overview of the benefits available under the Plan.

1.01 Death, Accidental Death & Dismemberment and Short-Term Disability Benefits

Death Benefit	
Active Employees	$50,000
Retirees	$15,000
Accidental Death & Dismemberment Benefit for Active Employees	
For loss of:	
Life	$8,000
Both hands, both feet, or sight of both eyes	$8,000
One hand and one foot, one hand and sight of one eye, or one foot and sight of one eye	$8,000
One hand, one foot or sight of one eye	$4,000
Short-Term Disability Benefit for Active Employees	
Weekly Amount	$500
Maximum number of weeks of benefit	26

1.02 Major Medical Benefit

Major Medical Benefit for Active Employees, Retirees & Dependents		
Calendar Year Deductible (Does not apply to PPO Office Visits, Emergency Services, or Preventive Services)	$200 per person $600 per family	
Out-of-Pocket Maximum per Calendar Year	***PPO Charges***	***Non-PPO Charges***
Once you reach the out-of-pocket maximum, the Plan pays 100% of covered expenses for the calendar year (subject to any other limitations as provided in the Plan). PPO and non-PPO expenses apply toward both the PPO out-of-pocket limits and the non-PPO out-of-pocket limits. *The maximum does not include Non-PPO co-payments (except for emergency room co-payment), Non-PPO Outpatient Surgery Expenses, Pre-Authorization Penalties or Prescription Drug co-payments.	$1,250 per person* $6,250 per family*	$4,000 per person*
Services Requiring Pre-Authorization	***Penalty for Failure to Obtain Pre-Authorization***	
Non-Emergency Inpatient Hospitalizations Home Health Care Skilled Nursing Care Morbid Obesity Organ Transplants PPO Outpatient Surgical Procedures Durable Medical Equipment Hospice	$250 penalty	
Emergency Hospitalizations (required within 1 business day following admission)	$150 penalty	
Non-PPO Outpatient Surgical Procedures	$500 penalty	

Covered Expenses Paid by the Fund up to the Usual and Customary Fees under Major Medical	***PPO Charges***	***Non-PPO Charges***
Office Visit	100% after $15 co-payment	80% after $25 co-payment
Emergency Room Visit	100% after $35 co-payment	100% after $35 co-payment
Preventive Services	100%	Not Covered
Pre-Admission Testing	100%	100%
Hospital/Facility		
Inpatient Treatment	90%	80%
Outpatient Treatment	90%	80%
Morbid Obesity	90%	Not Covered
All Other Covered Medical Expenses	90%	80%
Maximum Benefits Paid under Major Medical		
Chiropractic Care and Naprapathy Services	18 visits per person per calendar year (combined)	
Hearing Care		
Maximum Benefit	80% of Usual and Customary Fees up to $2,000 per ear except for bone anchored hearing aids (osseointegrated auditory implants) for Dependent children under the age of 19	
Frequency Limit	One per ear for any 36 consecutive month period	
Skilled Nursing Care	45 days per person per lifetime	
Infertility Treatment	$50,000 lifetime maximum except for expenses incurred for initial diagnostic tests and procedures done solely to identify the cause or causes of infertility (participant and spouse)	

1.03 Prescription Drug Benefit

Out-of-Pocket Maximum per Calendar Year	$5,350 per person $6,950 per family	
Your Co-Payment Amount (Plan pays100% after Co-Payment)	***Retail (30-day supply)***	***Mail or MChoice (90-day supply)***
Generic	$8 co-payment	$16 co-payment
Brand without generic equivalent	$20 co-payment	$50 co-payment
Brand with generic equivalent	$50 co-payment	$150 co-payment
Specialty	$50 co-payment	
Drugs for Infertility Treatment	$50,000 lifetime maximum (combined with coverage under Major Medical Benefit)	
Out-of-network pharmacy	Plan pays 75% of the cost of the prescription after the applicable co-payment	

1.04 Dental Benefit

Dental Benefit for Active Employees & their Spouse & Dependent Children of Active Employees & Dependent Children of Retirees	
Dental Benefits Other than Orthodontia Care	
Maximum Benefit (excluding Dentures and Orthodontic Care)	$2,000 per person per calendar year except for Diagnostic and Preventive services provided to Dependent children under age 19 $8,000 aggregate per family except for Diagnostic and Preventive services provided to Dependent children under age 19
Calendar Year Deductible	$25 per person for Basic Dental Care and Restorative Services
Diagnostic and Preventive Services	100% up to the Usual and Customary Fees

Basic Dental Care and Restorative Services	80% up to the Usual and Customary Fees after the Calendar Year Deductible
Dentures and Associated Exams and Extractions	80% of the Usual and Customary Fees up to $2,000 per person per calendar year Full denture replacement once every 5 years
Orthodontia Care	
Orthodontia	80% of Usual and Customary Fees up to $4,000 for Dependent children under age 19 per lifetime
Orthodontia for Dependent children under age 19 meeting or exceeding a score of 42 from the modified Salzmann index or Medically Necessary as determined by Utilization Review	80% of Usual and Customary Fees
Dental Benefit for Retirees & their Spouse	
Maximum Benefit (excluding Dentures)	$600 per person per calendar year
Calendar Year Deductible	$25 per person for Basic Dental Care and Restorative Services
Diagnostic and Preventive Services	100% up to the Usual and Customary Fees
Basic Dental Care and Restorative Services	80% up to the Usual and Customary Fees after the Calendar Year Deductible
Dentures and Associated Exams and Extractions	50% of the Usual and Customary Fees up to $1,000 per person per calendar year Full denture replacement once every 5 years

1.05 Vision Benefit

Vision Benefit for Active Employees, Retirees & Dependents	
Maximum Benefit	100% of the Usual and Customary Fees up to $400 per person per calendar year
Professional Exams, Lenses for Corrected Vision and One Pair of Frames Purchased in Conjunction with Newly Prescribed Lenses for Dependent children under age 19	100% of the Usual and Customary Fees up to $400 and 50% of balance over $400

SECTION 2: ELIGIBILITY

2.01 Eligibility for Active Employee Benefits.

A. Eligibility Quarters and Coverage Quarters.

Eligibility Quarters are the time periods during which you accumulate Hours to qualify for Initial and Continued Eligibility for Active Employee Benefits under the Plan. Coverage Quarters are the time periods during which you are eligible for Active Employee Benefits under the Plan.

Eligibility Quarters consist of three (3) consecutive calendar months as follows:

January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31

Coverage Quarters consist of three (3) consecutive calendar months as follows:

May 1 – July 31
August 1 – October 31
November 1 – January 31
February 1 – April 30

B. Initial Eligibility.

You will become eligible for coverage under the Plan on the first day of the Coverage Quarter that corresponds to the first two Eligibility Quarters in which you are credited with at least 800 Hours after you begin working for an Employer as follows:

If you are credited with 800 Hours in the following 2 Eligibility Quarters…	Then you will receive benefits during the following Coverage Quarter
January 1 – June 30	August 1 – October 31
April 1 – September 30	November 1 – January 31
July 1 – December 31	February 1 – April 30
October 1 – March 31	May 1 – July 31

For Example:

Joe begins working for XYZ Company on May 5, 2014. XYZ submits 140 Hours of contributions in May, 180 Hours in June and 160 Hours in July, August and September of 2014 for a total of 800 Hours. As a result, he will be eligible for benefits under the Plan on November 1, 2014 and will continue his eligibility until January 31, 2015 under the Initial Eligibility provisions.

However, if Joe begins working for XYZ Company on May 5, 2014 and XYZ submits 160 Hours on Joe's behalf for the January 1 – June 30 Eligibility Quarters and 480 Hours on his behalf for the April 1 – September 30 Eligibility Quarters, he will be 160 Hours short of the requisite 800 Hours (160+480 = 640) for coverage beginning on November 1, 2014. Accordingly, Joe's coverage will not begin on November 1st, but will instead begin on February 1, 2015 provided that XYZ submits at least 320 total Hours on his behalf for the Eligibility Quarter of October 1 – December 31.

C. Continued Eligibility.

Generally, once you meet the Plan's Initial Eligibility requirements, you will continue your eligibility during each Coverage Quarter as long as you are credited with 350 Hours during the corresponding Eligibility Quarter (the 350 Hour Rule). However, if you are not credited with 350 Hours and you do not voluntarily withdraw from the Union or work in Disqualifying Employment, you may be eligible to continue coverage under the Look Back Rule, the Six-Month Layoff Rule or the Workers' Compensation Disability extension as explained in detail below.

1. 350 Hour Rule.

Once you meet the Initial Eligibility requirements, you will continue to be eligible for subsequent Coverage Quarters if you were credited with at least 350 Hours during the preceding Eligibility Quarter. For purposes of Continued Eligibility, "Hours" includes Vacation Hours, Disability Hours, and hours spent in apprentice classes. The Eligibility Quarters and their related Coverage Quarters are as follows:

Eligibility Quarter	Coverage Quarter
January 1 – March 31	May 1 – July 31
April 1 – June 30	August 1 – October 31
July 1 – September 30	November 1 – January 31
October 1 – December 31	February 1 – April 30

2. Look-Back Rule.

However, if you do not meet the above listed continued eligibility requirements, you may continue your coverage for the applicable Coverage Quarter if you were credited with:

A. 700 Hours in the previous two Eligibility Quarters (6 months);

B. 1,050 Hours in the previous three Eligibility Quarters (9 months); or

C. 1,400 Hours in the previous four Eligibility Quarters (12 months).

3. Six-Month Layoff Rule.

If you are laid off, your coverage under the Plan will be extended for up to six additional months at no cost to you provided that you meet all of the following requirements:

A. You have exhausted your continuing eligibility under (1) and (2) above;

B. You are vested under the Pension Plan;

C. Your Employer notifies the Fund Office of your layoff in writing;

D. You were credited with less than 1,400 Hours during the twelve months immediately preceding the month under review; and

E. You have been covered for at least six of the last twelve months if you previously received extended coverage under this subsection.

If you meet the 350 Hour Rule before exhausting the six months of coverage under this subsection, you may use any unused months for a future layoff.

For Example:

Jeff was laid off from XYZ Company on March 31 and his Employer immediately notified the Fund Office of his layoff. Jeff subsequently exhausts his Continued Eligibility under the Plan effective July 31.

At the time of his layoff, Jeff was vested under the Pension Plan and he was credited with less than 1,400 Hours during the twelve months immediately preceding the month of July. If Jeff had never received coverage under the Six-Month Layoff Rule before his layoff, he will be eligible for benefits under the Plan for up to six additional months or until January 31 of the following year.

4. Workers' Compensation Disability.

Your coverage may also be extended at no cost to you for up to twelve calendar months if you are Disabled and are entitled to benefits under a worker's compensation or occupational disease law provided that the Fund: (1) receives a copy of the Accident report and (2) is notified of your expected return to work date and your actual return to work date.

Coverage under this subsection will continue for up to twelve calendar months from the end of the Coverage Quarter in which your Disability occurs. However, medical expenses related to the Disability for which you are entitled to benefits under this subsection (other than asbestos related diseases) are not covered unless you execute a subrogation and reimbursement agreement with the Fund.

5. Short-Term Disability.

You will be credited with eight hours per day for each day you receive Short-Term Disability Benefits under the Plan (maximum 40 hours per week). Please be aware that no HRA contributions will be made to the Plan while you are receiving Short-Term Disability Benefits.

6. Maintaining Coverage under a Reciprocity Agreement.

In the event that you are working under a reciprocity agreement with a local that reciprocates contributions to the Fund in order to maintain your eligibility under the Plan, and you do not meet the requirements of the above listed Continued Eligibility provisions, you may be eligible to self-pay your contributions to continue your coverage under the Plan.

When the Fund reviews your Hours in the applicable Eligibility Quarter and determines that you do not have enough Hours to continue your eligibility for Active Employee Benefits, you will receive a self-pay option letter. You will have the option to submit the following self-payment contributions:

A. The shortage between the reciprocating local's contribution rate and the Plan's contribution rate for all Hours worked; or

B. The shortage between the reciprocating local's contribution rate multiplied by your Hours worked and the Plan's contribution rate multiplied by the minimum Hours necessary to maintain coverage.

For Example: If the Plan's contribution rate is $10.73 and you are required to work 350 Hours in an Eligibility Quarter to maintain eligibility in the applicable Coverage Quarter, the minimum contribution necessary to continue coverage is $3,755.50. If you work 400 Hours under a reciprocal agreement during the applicable Eligibility Quarter and the contribution rate reciprocated to the Fund is $5.73, you would be required to self-pay $1,463.50 ($3,755.00 - $2,292.00) to maintain your eligibility.

D. When Coverage Ends.

Your coverage for Active Employee Benefits under the Plan will end upon the earliest of the following events:

1. You cease to meet the requirements of the Continued Eligibility provisions;

2. Your death; or

3. The Trustees discontinue the Plan.

E. Reinstatement of Eligibility.

Generally, you must meet the Initial Eligibility requirements if you lose eligibility for four (4) or more consecutive Coverage Quarters.

However, if you lost coverage for less than four consecutive quarters or are vested under the Pension Plan, your coverage under the Plan will be reinstated if you are credited with 350 Hours in the applicable Eligibility Quarter, provided that your loss of eligibility is not a result of work in Disqualifying Employment.

F. Eligibility under the Family Medical Leave Act (FMLA).

When you take leave under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. Your Employer will submit a copy of the approved application to the Trustees so that your rights to health care coverage are protected during your leave.

If you return to work for an Employer within the FMLA guidelines, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

If your coverage terminates, you will then be eligible to purchase COBRA Continuation Coverage. Contact the Fund Office for additional information about your coverage during a FMLA leave or continuing your coverage under COBRA. Your rights under the FMLA are summarized below.

You have the right to take unpaid leave if you meet the following criteria:

1. You worked for the same Employer for at least 12 months;

2. You have worked at least 1,250 Hours during the previous 12 months; and

3. You work at a location where at least 50 Employees are employed by your Employer within a 75-mile radius.

The duration of leave available to you will depend on the reasons for which you are taking the leave:

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.

2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service-member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service-member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26 week leave is the maximum time period allowed and is not in addition to the 12 week leave provided above.

G. Effect of Military Service on Eligibility.

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into active service, your coverage under the Plan will not be affected during the initial 31-day period. Your coverage under the Plan will be suspended at the end of this initial 31-day period under Option 1 below (the default option), unless you elect otherwise.

In order to exercise your options, you must notify the Fund Office in writing when you are called to active service. The Fund Office will send you an election form with three options regarding your Plan benefits as follows:

Option 1: Suspend eligibility and rely on military coverage for you and your Dependents. Active coverage is then reinstated after discharge from the military. This is the **DEFAULT OPTION.**

Option 2: Suspend active coverage and elect COBRA coverage for up to 24 months. Active coverage is then reinstated after discharge from the military.

Option 3: Continue active coverage for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

If your failure to provide advance notice when called to active service is excused under USERRA because of military necessity, then you can make a retroactive election to continue coverage, provided you pay any unpaid amounts that are due.

Option 1

If you elect Option 1 (suspend eligibility and rely on military coverage), your eligibility and Hours will be frozen until you are discharged from active military service. In order to reinstate active eligibility, you must provide the Fund Office with a copy of your discharge papers within the time periods provided under USERRA as described in the chart below.

Length of Active Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

Once you provide the Fund Office with your discharge papers, your Hours, which were suspended when you went into active military service, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund, for the balance of the current Coverage Quarter. Your eligibility for subsequent Coverage Quarters will be determined as of the corresponding determination dates under the Plan's Continued Eligibility Requirements.

Option 2

If you elect Option 2 (suspend active coverage and elect COBRA), your eligibility and Hours will be frozen until you are discharged from active military service. Under this option, you and your Dependents can pay the monthly COBRA premium for up to 24 months of COBRA coverage. The standard election and payment deadlines under COBRA apply.

In order to reinstate active eligibility upon discharge, you must provide the Fund Office with a copy of your discharge papers within the time periods provided under USERRA as described in the above chart.

Once you provide the Fund Office with your discharge papers, your Hours, as of the end of the initial 31-day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund. Your eligibility for subsequent periods will be determined under the Plan's eligibility requirements.

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as your Hours permit. Thereafter you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

Under USERRA, you must provide the Fund Office with a copy of your discharge papers within the time periods provided in the above chart.

If active eligibility has been exhausted under Option 3, then upon discharge you will not qualify for active eligibility until you satisfy the Initial Eligibility Requirements.

In the meantime, you will have the opportunity to pay for COBRA coverage as of the date of discharge, or a later date as agreed to by the Fund. Upon discharge, you can pay for COBRA coverage until the later of (1) the end of six months of payments or (2) the end of the original 24-month period.

2.02 Retired Employee Eligibility for Major Medical, HRA, Prescription Drug, Dental, and Vision Benefits.

Once you retire and are no longer eligible for Active Employee Benefits, this Plan offers Retired Employee Coverage to retirees and their eligible Dependents. Retired Employee Coverage is in lieu of COBRA Continuation Coverage. If you elect Retired Employee Coverage, you will not be eligible to receive COBRA Continuation Coverage once your coverage terminates.

A. Eligibility for Benefits.

Generally, you will be eligible for Retired Employee Coverage if you meet all of the following requirements:

1. You have at least 15 Pension Credit Years and you (i) attained age 55 and completed one hour of service (as defined under the Pension Plan) after your 55th birthday; (ii) attained age 54 and completed 400 hours of service (as defined under the Pension Plan) after your 54th birthday; or (iii) are eligible for a disability pension from the Pension Fund.

2. You were covered under the Plan as an active Employee (including COBRA coverage) at the time of your retirement. If you had a break in health coverage as an active Employee of three consecutive years (twelve consecutive Eligibility Quarters) or more, you must be covered for at least 12 consecutive months immediately prior to your retirement;

3. You enrolled for coverage at your retirement by filling out a retirement application; and

4. You pay the applicable retiree contribution.

B. Retiree Self-Contributions.

If you have a balance in your HRA account at the time you retire, the Fund Office will automatically deduct the amount of the Retiree Contribution from your HRA account each month until your balance is exhausted. Once your HRA account is exhausted, your eligibility for Retired Employee Coverage is conditioned on you authorizing the applicable Retiree Contribution to be deducted from your monthly benefit payable from the Pension Fund. If the amount you receive from the Pension Fund does not cover

the monthly Retiree Contribution amount, you must either pay: (i) the difference or (ii) the full amount of the Retiree Contribution directly to the Fund in order to be eligible for Retired Employee Coverage.

1. When Retiree Contributions Begin.

You must begin making Retiree Contributions with the Coverage Quarter following the quarter in which you have fewer than:

A. 350 Hours in the previous Eligibility Quarter (3 months);

B. 700 Hours in the previous two Eligibility Quarters (6 months);

C. 1,050 Hours in the previous three Eligibility Quarters (9 months); or

D. 1,400 Hours in the previous four Eligibility Quarters (12 months).

If you do not pay the applicable self-contribution, you and your eligible Dependents' eligibility for Retired Employee Coverage will terminate and you will not be allowed to re-enroll at a later date. However, you and/or your Dependents may waive coverage at the time of your retirement and may enroll at a later date if you and/or your Dependents are covered under an employer sponsored health plan and the following conditions are met:

A. There is no gap in coverage;

B. The employer sponsored coverage is lost by reason of termination of employment, termination of plan, death, or divorce; and

C. The application to enroll for benefits is made within 30 days of the termination of the employer sponsored coverage and is accompanied with satisfactory proof of the termination and its effective date.

If coverage terminates because the required contributions are not made, coverage will not be reinstated unless you return to work and again satisfy the requirements for Retired Employee Coverage. Retired Employee Coverage will not be provided concurrently with COBRA Continuation Coverage.

2. Disability Retiree Contributions.

If you are eligible for Retiree Benefits because you are younger than age 55 and are eligible for a disability pension from the Pension Fund, you are not required to submit monthly Retiree Contributions. However, beginning with the month in which you reach age 55, you must pay the applicable contribution as determined under (3) or (4) below.

3. Regular Retiree Contributions.

If you are eligible for Retired Employee Coverage, a timely retiree self-contribution is required to maintain coverage under the Plan. The contribution rates for you and your Dependents are as listed in the chart as follows:

	Contribution Rate
Non-Medicare Eligible Retirees	$330*
Medicare Retirees	$180*
Dependent Children	$250*
Family Maximum	$750*

*The contribution rates as shown above are in effect as of July 1, 2013 and are subject to change at any time, but no more than annually as determined by the Board of Trustees.

4. Reduced Retiree Contributions (Rule of 85).

You may be eligible for lower self-contributions when your age (fixed at initial retirement) and credited service (as defined by the Pension Plan) equal or exceed 85 when added together. This is known as the Rule of 85.

Contributions for you and your Dependents when you meet the requirements under the Rule of 85 are as follows:

	Contribution Rate
Non-Medicare Eligible Retirees	$250*
Medicare Retirees	$100*
Dependent Children	$250*
Family Maximum	$750*

* The contribution rates as shown above are in effect as of July 1, 2013 and are subject to change at any time, but no more than annually as determined by the Board of Trustees.

If you return to work and later re-retire, you will be able to earn additional years of credited service under the Pension Plan under the Rule of 85. However, the age used to determine your eligibility for the Rule of 85 will remain fixed at your initial retirement.

For Example:

At the time of his initial retirement date, Dan was 60 years old and he had 22 years of credited service under the Pension Plan. Under the current Retiree contribution rates, Dan would be required to pay $330 per month because his age and years of credited service when added together do not equal or exceed 85 (60 + 22 = 82).

Dan later returned to work and earned 3 additional years of credited service. When Dan re-retired, he would qualify for the reduced monthly self-contribution rate of $250 because his age at initial

retirement (60) and the total amount of credited service (22 + 3) when added together equals 85 (60 + 25 = 85).

C. When Retired Employee Coverage Ends.

Retiree benefits under this Plan are not vested and will not vest at any time. Accordingly, your Retired Employee Coverage will terminate on the first to occur of the following:

1. The beginning of the month for which you fail to make a required self-contribution;

2. The date on which you return to work;

3. The date of your death; or

4. The date the Trustees terminate Retired Employee Coverage under the Plan.

D. If You Return to Work After Retirement.

Except during a temporary waiver period, your Retired Employee Coverage will terminate the first day of the month following your return to work. However, you may continue your coverage by electing COBRA Continuation Coverage until you become eligible for Active Employee Benefits or for up to 18 months.

A temporary waiver period may be established under a written resolution adopted by the Trustees in consultation with the business manager of the Union for work at certain jobsites for specific periods. If you return to work pursuant to a temporary waiver, you will continue to be eligible to make self-contributions for Retired Employee Coverage until you satisfy the Initial Eligibility requirements for Active Employee Benefits. When your Active Employee Benefits end and you re-retire, you will then resume Retired Employee Coverage.

2.03 Dependent Eligibility.

A. Your Dependents' Initial Eligibility.

Your Dependents will become eligible for benefits on the later of:

1. The date you are eligible for coverage; or

2. The date he or she meets the definition of Dependent under the Plan.

B. When Your Dependents' Coverage Ends.

Your Dependents' coverage will end on the last day of the month on the earliest of the following to occur:

1. Your eligibility ends for reasons other than death;

2. The date he or she no longer meets the definition of a Dependent under the Plan;

3. His or her death;

4. The date the Trustees terminate Dependent benefits under the Plan; or

5. The date your Dependent enters military service.

In the event of your death, your Dependents' coverage will terminate on the last day of the Coverage Quarter in which you are Credited with the requisite hours under the Plan's Continued Eligibility provisions.

C. Family Protection Benefit for Survivors of Deceased Participants.

Your Dependents may also be eligible to continue their coverage under the Plan after your death under the Plan's Family Protection Benefit. Election of this coverage must be made effective immediately following the end of coverage under the Plan's Continued Eligibility provisions. Election at a later date is prohibited and no coverage will be provided unless both of the following conditions are met:

A. Your Dependents were covered under another group health plan provided by your spouse's employer at the time of your death;

B. Your Dependents enroll for coverage immediately upon the termination of coverage under the other plan and supply written documentation from the other group health plan.

Coverage under this subsection is offered in lieu of COBRA Continuation Coverage and once their eligibility terminates under this subsection, they will not be entitled to COBRA Continuation Coverage.

1. Eligibility.

In the event of your death, your Dependents may continue to be covered under the Plan if at the time of your death you:

a. Were eligible for benefits under this Plan;

b. Were vested under the Pension Plan, but you were not yet eligible for retirement; and

c. Your eligibility was not a result of COBRA Continuation Coverage.

2. Survivor Contributions.

A. Dependent Children Coverage.

If you die prior to age 55, your Dependent children are not required to submit contributions to continue coverage under this subsection. Coverage will continue until the earlier of (1) the date they do not meet the Plan's definition of Dependent or (2) their death.

If you die at age 55 or older, coverage for your Dependent children may continue under this subsection provided that they submit the required Survivor Contribution until the earlier of (1) the date they do not meet the Plan's definition of Dependent or (2) their death.

B. Surviving Spouse Coverage.

If you die prior to age 55, your surviving spouse will not be required to submit contributions under this subsection until the earliest of:

1. Five years from the expiration of coverage under the Plan's Continued Eligibility provisions;

2. The date that you would have attained age 55; or

3. Her eligibility for Medicare due to Disability;

If one of the above listed events occurs or you die after age 55, coverage for your surviving spouse may continue under this subsection until the earlier of (1) remarriage; (2) coverage under another group health plan or (3) death provided that he or she submits the required Survivor Contribution.

D. Dependent Coverage Through a Qualified Medical Child Support Order (QMCSO).

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for the participant's children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMSCO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan for the purposes of Coordination of Benefits.

The Fund Office will notify affected participants and alternate recipients if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

2.04 COBRA Continuation Coverage.

A. COBRA Coverage in General.

When you lose coverage because of a Qualifying Event, coverage for you or your eligible Dependents can be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying Events include death, a reduction of hours, loss of employment (except due to gross misconduct), entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan and separation or divorce.

If you elect COBRA coverage, you are entitled to the benefits you were eligible for on the day before the Qualifying Event including Medical, Dental, Vision and Prescription Drug Benefits. However, COBRA coverage does not include the following benefits: Death, AD&D and Short-Term Disability Benefits.

If you elect COBRA coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA coverage is conditioned on timely and uninterrupted payment of premiums.

If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage.

There may be other coverage options for you and your family. Effective for coverage beginning on or after January 1, 2014, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make

a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

B. Eligibility.

1. 18-Month COBRA Continuation Coverage.

You are eligible to elect COBRA coverage when you lose eligibility for benefits because of a Qualifying Event. In such event, you and your eligible Dependents may elect up to 18 months of COBRA coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. An eligible beneficiary generally is an individual covered by the Plan on the day before the Qualifying Event occurs. This includes your spouse and your Dependent child. Also, any child born to or placed for adoption with you during the period of COBRA coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage on the first day of the new Eligibility Period where you did not meet the Continued Eligibility Requirements under the Plan.

2. Disability Extension of 18-Month COBRA Continuation Coverage.

If you or an eligible Dependent is determined by Social Security to be disabled and were disabled during the first 60 days of COBRA coverage, you and all family members previously covered under COBRA may be entitled to receive up to an additional 11 months of COBRA coverage. This means that COBRA Continuation Coverage could continue for a total of 29 months if the required premium is paid and you or an eligible Dependent continues to be disabled. Coverage for the additional 11 months may be at a higher cost.

You must notify the Fund Office of the Social Security Administration's determination of Disability within 60 days of such determination and before the end of the first 18 months of continued coverage. Otherwise, you will not be eligible for the additional 11 months of coverage.

3. 36-Month COBRA Continuation Coverage.

Certain Qualifying Events allow your eligible Dependents to purchase a total of 36 months of COBRA Continuation Coverage. A total of 36 months is allowed if one of the following events occurs during the initial 18-month continuation period or if coverage ends for any of the following reasons:

a. Your death;

b. Your divorce or legal separation;

c. Your reaching eligibility for Medicare; or

d. Your Dependent child no longer qualifies as a Dependent under the terms of the Fund.

You or your Dependent must notify the Fund Office in writing in the event of a legal separation, divorce or a child losing Dependent status within 60 days of the date coverage terminates. If you do not provide the notice to the Fund Office within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA Continuation Coverage.

C. COBRA Premiums, Payments and Due Dates.

The standard COBRA premium is determined by the Trustees and adjusted from time to time.

COBRA premium payments must be made monthly to the Fund Office. The initial COBRA premium payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month, but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA premium payment is not postmarked by the Fund Office within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the first day of the month in which a timely COBRA premium payment was made. Once this coverage is terminate due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

D. The Notification Responsibilities of the Fund Office.

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Fund Office will send the notice within 30 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

In order to protect your Dependents' rights, you should keep the Fund Office informed of any change in your address, in the addresses of Dependents and any change in your family status. Additionally, if your Dependent spouse's qualifying event is due to divorce and you fail to notify the Fund of your divorce in a timely manner, he or she will not be eligible for COBRA Continuation Coverage.

E. Electing Continuation Coverage.

You or your Dependents must complete the COBRA Election Form and send it back to the Fund Office in order to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.

2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.

3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation

Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any other eligible Dependents who were covered by the Plan on the date of the Qualifying Event.

4. The person electing Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.

5. If the COBRA Election Form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

F. When the COBRA Coverage Period Begins.

If you properly elect COBRA Continuation Coverage, the period of COBRA coverage (18, 29 or 36 months) begins on the date your eligibility or your Dependents' eligibility for coverage terminates.

G. When COBRA Coverage Ends.

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group medical, dental or vision plan. However, coverage will continue if you or an eligible Dependent has a health problem for which coverage is excluded or limited under the other group plan;

2. The required premium is not timely paid;

3. The Trust Fund terminates the Welfare Plan;

4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month Continuation Coverage period;

5. Your coverage under the Plan ends and you become entitled to Medicare after you elect COBRA Continuation Coverage. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or

6. Your Dependents become entitled to Medicare after their coverage under the Plan ends.

SECTION 3: HEALTH REIMBURSEMENT ARRANGEMENT

3.01 General Provisions.

The Plan provides for a Health Reimbursement Arrangement (HRA) as approved in the Treasury Department Notice 2002-45 and Revenue Ruling 2002-41. Eligible Employees and eligible Retirees can withdraw amounts from their individual HRA accounts to cover specified expenses that are related to, but not payable under the regular provisions of the Plan.

3.02 HRA Accounts.

A notional HRA account is created on behalf of each Employee who meets the Plan's Initial Eligibility requirements for Active Employee Benefits, except for those Employees working under a collective bargaining agreement on a travel card. You will receive an HRA allocation based on your credited Hours as determined by the Board of Trustees. An HRA allocation will not be made for any amounts received as regular self-contributions, Short-Term Disability contributions or COBRA self-contributions.

If you work under a reciprocal agreement, the contributions made on your behalf will first go to maintain your eligibility for benefits under the Plan. The balance, if any, will be credited to your HRA account.

If the Fund issues a reimbursement check to you for an HRA covered expense, your account balance will be reduced by the amount of such reimbursement. Your account balance will be carried over from year to year except as explained below in Section 3.05.

3.03 Automatic Deduction from an HRA Account to Maintain Coverage Upon Retirement.

If there is a balance in your HRA account upon your retirement, the Fund Office will automatically deduct the amount of the Retiree Contribution from your HRA Account to continue your coverage until your HRA account balance is exhausted. If you do not wish to have your HRA account deducted automatically, you must notify the Fund Office in writing.

3.04 Account Funding, Reimbursement for Expenses and Opt-Out.

A. Account Credits.

Credits are made based on Hours worked and will be credited to your individual account on the 1st of each month following the Fund's receipt of the contribution. Overtime Hours are credited the same rate as regular Hours.

B. Reimbursement for Expenses.

You may submit a claim under your HRA account by submitting a copy of your Explanation of Benefits (EOB) or a copy of your bill to the Fund Office, within 24 months of the date you incurred the expense for which reimbursement is requested (date of service).

Reimbursements are issued weekly. The minimum check amount for an HRA claim will be $25. If the account is not receiving contributions and the balance is less than $25, the minimum claim payment will be the account balance.

If claims submitted total less than $25, the claims will be pended until subsequent claims bring the total unpaid claims to at least $25. An EOB will be sent to you notifying you that the claim is being held until the $25 minimum reimbursement amount is met with additional claim submissions.

If claims in excess of your account balance are submitted, the excess is carried forward until additional contributions during the calendar year are credited to the account. At the end of a calendar year, any unpaid claims exceeding the year-end account balance will not be reimbursed. Claims from one calendar year cannot be reimbursed from contributions in a subsequent calendar year.

C. Opt-Outs.

You may choose to permanently opt-out of your HRA and forfeit your right to reimbursement at any time by notifying the Fund Office in writing. Any balance in your account as of the date the Fund Office receives notice of such opt-out will be permanently forfeited.

3.05 Forfeiture of HRA Account Balance.

The remaining balance in your HRA account will be forfeited when your account has a balance of less than $50 and no contributions have been made into your account or you have made no reimbursement requests for a period of two years.

3.06 HRA Account Reimbursements.

A. Entitlement to Reimbursement.

Your entitlement to reimbursement and the amount of any such reimbursement made by the Fund Office will be based on your account balance at the time the reimbursement check is requested. You may receive reimbursement from your HRA account for the types of covered expenses specified in Paragraph B below.

B. Covered Expenses.

Covered expenses are "qualified medical expenses" under Section 213 of the Internal Revenue Code. The following types of expenses are considered HRA covered expenses:

1. Expenses for dental treatment, including orthodontia;

2. Guide dogs for blind or deaf persons;

3. Travel expenses of the patient when necessary to receive medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment as certified by the patient's Physician;

4. Special telephone or television equipment for hearing-impaired persons;

5. Hearing aids and examinations;

6. Medical expenses not covered by or in excess of benefits provided by another benefit plan, insurer or Medicare;

7. Certain costs of modifying a home or vehicle to accommodate a disabled Dependent;

8. Healthcare insurance premiums not paid by any other source;
9. Special schooling for the mentally impaired or physically disabled;
10. Acupuncture;
11. Vision expenses including surgery or laser treatments to correct vision;
12. Smoking cessation programs;
13. Weight loss programs which are Medically Necessary;
14. Treatment for alcoholism or chemical dependency;
15. Convalescent home charges that are necessary for medical care;
16. Nursing services, including board and meals, that are necessary for medical care;
17. Insulin treatments;
18. Prescription medications; and
19. Orthopedic shoes.

C. Exclusions.

The following expenses are <u>not</u> considered covered expenses under the Plan:

1. Athletic club, health and/or spa or gym memberships;
2. School fees for boarding schools or schools fees not related to a medical necessity;
3. Food, food supplements, non-prescribed vitamins and over-the-counter drugs;
4. Cosmetic surgery, procedures and supplies;
5. Babysitting and childcare;
6. Funeral expenses;
7. Hair transplants;
8. Household help other than that qualifying as long-term care;
9. Personal use items;
10. Teeth whitening; and
11. Expenses not identified as covered expenses above.

3.07 Payment of Benefits Upon Your Death.

If there is a balance in your HRA account on the date of your death, your surviving Dependents may use your balance by submitting claims to the Fund Office for reimbursement of those covered expenses identified in Section 3.06. If you have no surviving Dependents, your account balance may be used to reimburse your estate for outstanding covered expenses. The remaining account balance not used in this manner will be forfeited.

3.08 There is no Vesting of HRA Accounts

HRA accounts are not savings accounts from which you can withdraw at will. You and your Dependents are not vested in your HRA account balances. Amounts accumulated in your HRA account can only be used for HRA account covered expenses, subject to the rules and provisions set forth in this Section.

The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

Benefits payable under the HRA shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

SECTION 4: DEATH BENEFIT

4.01 Death Benefit for Active Employees.

If you are eligible for Active Employee Benefits, the Plan provides for a Death Benefit to be paid to your beneficiary in the event of your death. The amount of the applicable Death Benefit is provided in the Schedule of Benefits.

The Trustees contracted with an insurance carrier to provide this life insurance benefit and benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

4.02 Death Benefit for Retirees.

The Plan will pay a Death Benefit to your beneficiary in the event of your death if you had ten or more years of vesting service (as defined by the Pension Plan) at the time of your death. The amount of the applicable Death Benefit is provided in the Schedule of Benefits.

The Trustees contracted with an insurance carrier to provide this life insurance benefit and benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

4.03 Designating Your Beneficiary.

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

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

1. Your spouse;
2. Your children;
3. Your parents;
4. Your brothers and sisters; or
5. Your estate.

4.04 Conversion of Benefit.

If your life insurance benefit terminates because your eligibility for this benefit ends, or because the group insurance policy terminates, you may be eligible to convert your life insurance benefit to an individual policy under the terms of the life insurer's policy. For more information regarding conversion, please contact the Fund Office.

SECTION 5: ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

5.01 AD&D Benefits for Active Employees Only.

If you are eligible for Active Employee Benefits, your coverage includes the Accidental Death and Dismemberment (AD&D) Benefit. The Trustees contracted with an insurance carrier to provide this AD&D Benefit and this benefit will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

This benefit is payable to you if you sustain one of the losses listed in the Schedule of Benefits as the result of an Accident. The loss must occur within 365 days of the Accident. The benefit amounts are shown in the Schedule of Benefits and are in addition to any other benefits you may receive under the Plan. If you die as a result of an Accident, the benefit is paid to your beneficiary.

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

5.02 Limitations on AD&D Benefits.

The benefits described above do not cover any loss that results from:

A. Disease or infirmity of the mind or body, and any medical or surgical treatment thereof;

B. Infections, except those from an accidental cut or wound;

C. Suicide or attempted suicide, while sane or insane;

D. Intentionally self-inflicted injury;

E. Travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft , or giving or receiving training or instruction in such aircraft;

F. Under the influence of certain drugs, narcotics or hallucinogens unless properly used as prescribed by a physician;

G. Intoxication as defined in the jurisdiction where the Accident occurred;

H. Participation in a riot; or

I. Any of the circumstances listed under the General Plan Exclusions in Section 12.

SECTION 6: SHORT-TERM DISABILITY BENEFITS

6.01 Eligibility for Short-Term Disability Benefits.

If you are eligible for Active Employee Benefits (Dependents are not eligible), your coverage includes the Short-Term Disability Benefit if you meet the following conditions:

A. Your coverage under the Plan is not due to COBRA Continuation Coverage or coverage under the Six-Month Layoff Rule;

B. You are Disabled;

C. You are under the care of a Physician; and

D. Your Physician completes a claim form and it is provided to the Fund upon request, but no more than once every two weeks.

The Trustees reserve the right to require a medical review of your Disability of the Trustees' choosing.

Each Disability is considered a separate and distinct disability period if you return to full-time work for at least two continuous weeks (or for a shorter period of time as determined by the Trustees) between periods of Disability.

6.02 When Your Short-Term Disability Benefits Begin.

The Short-Term Disability Benefits begin on the:

A. First day of Disability due to an Accident;

B. Eighth day of Disability due to a Sickness.

However, if you are hospitalized due to a Sickness, your Short-Term Disability Benefit will begin on the first day of your Disability provided that you did not work on that day.

6.03 Amount of Short-Term Disability Benefits.

The amount payable under this benefit is 1/5 of the weekly benefit amount listed in the Schedule of Benefits for each day (excluding Saturday and Sunday) or the weekly benefit amount listed in the Schedule of Benefits for each full week.

If you are entitled to any weekly benefits under any other group disability plan (including state, local, county and federal government), then your Short-Term Disability Benefit will be reduced by the amount payable under the other group disability plan.

Your Short-Term Disability Benefit is subject to taxes. Social Security taxes will be deducted before you receive your check. You will be responsible for any federal and state income taxes.

6.04 Continuing Your Short-Term Disability Benefits.

Benefits are paid for a maximum of 26 weeks for any one period of Disability. For each week you are paid benefits under this Section, the Fund will credit you with 40 hours to continue your Active Employee Benefits under the Plan.

6.05 When Your Short-Term Disability Benefits End.

The Short-Term Disability Benefits end on the earliest of the following:

A. When you have fewer than 350 Hours in the previous Eligibility Quarter;

B. The date you begin receiving a benefit from the Pension Plan;

C. When you are no longer Disabled; or

D. After 26 weeks of payment for any one period of Disability.

6.06 Limitations on Your Short-Term Disability Benefits.

No Short-Term Disability Benefits will be paid:

A. For any period for which your Disability is not certified by a Physician and you are not under the care of a Physician;

B. For any injury, Sickness, or disease resulting from employment, including self-employment;

C. For any injury or illness resulting from an act of war;

D. For any diagnosis and treatment by a chiropractor or naprapath; or

E. For any Disability when no benefit is payable under the medical coverage.

SECTION 7: MAJOR MEDICAL BENEFIT

7.01 The Deductible.

The deductible is the amount of covered medical expenses that you and each of your eligible Dependents pay each calendar year before benefits begin.

The deductible is listed in the Schedule of Benefits of this booklet.

The deductible applies to each eligible individual in your family every calendar year. Also, once you meet the family deductible, no further deductible will be applied to any eligible member of your family during the remainder of the calendar year.

7.02 Percentage of Benefits Payable.

Once you pay the calendar year deductible, the Fund will pay the percentage of your Covered Expenses listed in the Schedule of Benefits of the Usual and Customary Fees, and up to any Plan maximums.

7.03 Out-of-Pocket Maximum.

After paying your deductible, the maximum amount you pay for covered health care expenses each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Fund pays 100% of all allowable expenses for the rest of the calendar year.

7.04 Maximum Benefit Payable.

For Major Medical, there is no lifetime maximum benefit limitation under the Plan. Other Plan maximums for specific types of benefits are listed in the Schedule of Benefits and are limited to those benefits not considered Essential Health Benefits under the Patient Protection and Affordable Care Act of 2010 (ACA).

7.05 Preferred Provider Organization (PPO).

The Welfare Fund contracts with preferred provider organizations (PPOs) to help control medical costs. A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower as a result of our participation in the PPO.

To minimize your out-of-pocket costs, contact the Fund Office for information about which Hospitals and providers belong to the Plan's PPO. When you use PPO Hospitals and providers rather than non-PPO Hospitals and providers, you can reduce costs for both you and the Fund. The Plan provides for a greater payment percentage (generally 90% instead of 80%) of your Usual and Customary Fees when you use a Hospital or provider in the PPO network. The Fund will provide you with information on PPO providers at your request.

If an out-of-network provider is used, the patient will have larger out-of-pocket expenses, a lower percentage paid and may have to pay the difference between the Usual and Customary Fees and the total billed amount.

7.06 Case Management, Pre-Authorization and Utilization Review.

The Fund has contracted with a provider to perform case management, pre-authorization and utilization review if your claim for benefits involves ongoing treatment. Case management and utilization review are processes in which you as the patient, your family, Physician and/or other health care providers and the Fund Office work together under the guidance of the Fund's independent case management company to coordinate a quality, timely and cost-effective treatment plan that provides Medically Necessary services.

To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact the Fund Office when referring you for services as part of an ongoing treatment plan to determine if such services are subject to case management, pre-authorization and/or utilization review.

A. Pre-Authorization.

If you are expecting to incur expenses for the following types of treatment, you, someone on your behalf or your Physician must contact the utilization review organization to obtain pre-authorization prior to incurring the expense:

1. Emergency Hospitalization.

   If you seek treatment in an Emergency and you are admitted, you must notify the utilization review organization no later than the next business day following admission.

2. Scheduled Hospital and Inpatient Admissions.

3. Home Health Care.

4. Skilled Nursing Facility Care.

5. Morbid Obesity Treatment.

6. Organ Transplants.

7. Durable Medical Equipment.

8. Outpatient Surgical Procedures.

9. Hospice.

Once you have provided the necessary information, the utilization review organization will evaluate the proposed services based on your individual treatment needs and the standards of the community.

B. Penalties.

If you do not contact the utilization review organization, all charges incurred will be subject to a penalty as identified in the Schedule of Benefits. The penalty may not be applied towards your deductible, co-insurance, co-payments or out-of-pocket maximum.

7.07 Covered Expenses and Exclusions.

Under the Major Medical Benefit, certain expenses are Covered Expenses and others are excluded.

A. Covered Expenses.

The Plan covers the Usual and Customary Fees for the following services and supplies provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:

    a. Room and board fees up to:

        i. The Hospital's regular daily semi-private rate;

        ii. The Hospital's regular daily rate for a private room when required for contagious or communicable diseases; or

        iii. Intensive care up to two and one-half times the Hospital's daily semi-private rate.

    b. Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services while hospitalized.

    c. Outpatient Hospital services including fees incurred for:

        i. Outpatient surgical procedures; and

        ii. Emergency treatment for an Accident or Sickness.

    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 Fund or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

2. Medical care and treatment, including surgery, that is listed as a Covered Expense under the Plan and is provided by a legally qualified Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.

3. Pre-admission tests performed on an outpatient basis at a Hospital, an approved independent laboratory, or a Physician's office performed prior to and in connection with Inpatient surgery. The tests must be related to the planned surgery and done within 14 days of hospitalization and the tests must not be repeated after admission to the Hospital.

    Pre-admission tests will not be covered if surgery is not performed within 24 hours of admission to the Hospital, if the surgery is cancelled or postponed (for other than medical reasons), or if the tests are used for diagnosis, research, or surveys.

4. Lung screening test and evaluation and chest x-rays for Participants and their spouses when done as part of an annual exam.

5. Physical examinations for participants for work if requested by the Union as a condition of employment.

6. Charges incurred for childbirth, miscarriage, or any pregnancy or pregnancy-related condition. Prenatal laboratory and radiology charges are covered separately. Hospital expenses for mother and baby are paid as separate claims and are subject to separate deductibles, except in those cases where such expenses are paid under the same per diem charges by the Hospital.

7. Care provided in a Skilled Nursing Care Facility subject to the limitations provided in the Schedule of Benefits when:

    a. Your confinement begins within 14 days after a Hospital admission of at least three days duration;

    b. Your care and treatment are for the Accident or Sickness that caused the Hospital confinement immediately before admission to the Skilled Nursing Care Facility;

    c. A legally qualified Physician must certify that the confinement is necessary for your recuperation from an injury or Sickness and that the confinement is not for the purpose of Custodial Care;

    d. You are under the regular care of a legally qualified Physician; and

    e. The confinement must be in a facility which meets the Plan's definition of a Skilled Nursing Facility.

    The maximum covered expense per day of confinement is 50% of the semi-private room rate expense by the Hospital from which you were discharged. The applicable co-payments for PPO and non-PPO charges will then be applied to the covered expense.

    Successive periods of confinement will count as one confinement unless they are due to unrelated causes or are separated by at least six months during which the patient is not confined in either a Hospital or another Skilled Nursing Care Facility.

8. Transportation services provided by a Hospital or a professionally licensed ambulance service where:

    a. The transportation is from the patient's home, the scene of an Accident or medical emergency;

    b. The transportation is between Hospitals;

    c. The transportation is between a Hospital and a Skilled Nursing Care Facility; or

    d. The transportation is from a Hospital or Skilled Nursing Care Facility to the patient's home.

9. Professional services rendered by a Physician.

10. Hospice care services and supplies provided in accordance with the following rules and requirements:

    a. The attending Physician must certify that the patient's life expectancy does not exceed six months.

    b. Services must be approved in advance by the utilization review organization.

    c. The services must be provided by a facility which meets the Plan's definition of Hospice Organization.

11. Physiotherapy and occupational therapy administered by a provider acting within the scope of his or her license.

12. Speech therapy for treatment of a Sickness or an Accident, or after corrective surgery for a congenital defect.

13. X-ray and laboratory procedures, except for in connection with a routine examination where such services are not Preventive Services.

14. Radiation therapy or treatment.

15. Treatment for Mental and Nervous Disorders and chemical dependency.

16. Blood and blood plasma, if not replaced.

17. Anesthesia, anesthesia services and professional charges for administration. Benefits are not available when used to perform a non-covered service.

18. Dressings, sutures, casts, splints, trusses, braces, crutches, or other necessary medical supplies, with the exception of dental braces.

19. Orthopedic shoes (one pair per lifetime) and lifts.

20. Medical and surgical benefits for mastectomies, as required by federal law under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including the following, when requested by the patient in consultation with her Physician:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications of all stages of mastectomy including lymphedemas.

21. Home health care services and supplies where:

    a. The home health care is provided by a qualified Home Health Care Agency in lieu of Hospital confinement or Skilled Nursing Care Facility confinement;

    b. The home health care services are prescribed in writing by a Physician as a plan of treatment for a condition; and

c. Prior approval is obtained in advance by the utilization review organization.

22. Expenses incurred as a result of an accidental injury to sound natural teeth when treatment plan is submitted or the expense is incurred within 90 days of the Accident.

23. Services rendered by oral or periodontal surgeons for osseous surgery, apicoectomy, and removal of impacted teeth.

24. A glucose meter if certified in writing by the patient's Physician.

25. Two pairs of surgical stockings per year.

26. Electronic heart pacemakers.

27. Chiropractic care and naprapathic services up to the calendar year maximum benefit specified in the Schedule of Benefits.

28. Supplies for colostomy and ostomy care.

29. Treatment or surgery for Morbid Obesity if the covered person:

    a. Has been covered under the Plan for a minimum of five (5) years immediately prior to treatment;

    b. Has been unable to lose significant weight after participating in at least two (2) weight loss programs supervised by a Physician;

    c. Has no specifically correctable cause for Morbid Obesity; and

    d. Is not a Dependent child.

    Treatment must be ordered by a Physician and services must be approved in advance by the utilization review organization.

    Coverage of nutritional supplements is limited to 60 days following surgery.

30. Hearing examinations and hearing aids up to the calendar year maximum benefit specified in the Schedule of Benefits.

31. Two wigs for hair loss resulting from, or the treatment of, a medical condition.

32. Non-experimental organ and bone marrow transplants subject to the following:

    a. If both the donor and recipient are covered under the Plan, each will have their benefits determined separately under the Plan.

    b. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits will be provided for both you and the donor.

    c. If you are the donor of the transplant, you are entitled to benefits under the Plan to the extent benefits are not provided by or available from any other source.

You must contact the utilization review organization before the surgery is scheduled (if medically possible, two weeks' notice should be given). Only expenses incurred no more than five days before the surgery are covered.

The following services are not included:

a. Unrelated medical services;

b. Transportation by air ambulance for a donor or recipient;

c. Travel time and related expenses by a Physician or other provider; or

d. Investigational or experimental drugs.

33. Cardiac rehabilitation if provided immediately following Hospital discharge, but only for Phase I (monitored with individual supervised) and Phase II (monitored with group supervised) rehabilitation.

34. Second surgical opinions (payable at 100% if second opinion is required by the utilization review organization).

35. Preventive Services as required by federal law.

36. Services related to the diagnosis and treatment of infertility for the Participant and his Dependent spouse, including medical expenses of laboratory tests, genetic tests to determine the cause of infertility, prescription drugs, supplies, and surgical procedures (including reversals of voluntary sterilizations), subject to the Plan maximums listed in the Schedules of Benefits.

37. Purchase and/or rental of durable medical equipment, provided advance authorization is obtained from the Fund. The Fund reserves the right to purchase the equipment instead of paying for rental if purchase would cost less than the reasonable and customary rental amount.

    Durable medical equipment means equipment, recognized as such by Medicare Part B, that: (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder, (3) generally is not useful in the absence of illness or injury and (4) is appropriate for use in the home.

    Examples of durable medical equipment include: wheel chairs, Hospital beds and equipment for giving oxygen.

    Coverage for durable medical equipment is not provided for (1) equipment that serves as a comfort or convenience item or (2) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

    Examples of equipment that are not covered include, but are not limited to, the following: exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, whirlpool tubs and portable jacuzzi pumps.

38. Medical services for treatment of Temporomandibular Joint Syndrome (TMJ).

39. Prosthetics and prosthetic devices.

40. Any procedures or services covered under the Plan as listed above that is rendered by a qualified Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.

B. Expenses Not Covered by the Plan.

Certain expenses are excluded from coverage. The Major Medical Benefit does not cover:

1. Food supplements and office supplies for Morbid Obesity.

2. Weight loss programs that are not considered Preventive Services.

3. Custodial Care, maintenance care or medical care treatment, services and/or supplies made by a nursing home, rest home, convalescent home or similar establishment.

4. Dental x-rays and/or dental services performed on or to the teeth, wisdom teeth, nerves within the teeth, gingivae or alveolar process, except as specifically provided under Covered Expenses in Section 7.07(A). Coverage for Inpatient and/or out-patient hospitalization in connection with a covered dental procedure is covered as a Major Medical Expense only when the patient has a medical condition that makes such hospitalization necessary to safeguard the patient's health. This condition must be certified by a Physician.

5. Any losses, expenses or charges for cosmetic surgical procedures and related expenses, except:

    a. For the repair of congenital defects of your Dependent child; or

    b. For conditions resulting from accidental injuries due to Accidents or illnesses, including scars, tumors or diseases that occur.

6. Eye refractions or the fitting or cost of eyeglasses or contact lenses.

7. Infertility services and supplies as follows:

    a. Medical services rendered to a surrogate for purposes of childbirth;

    b. Non-medical costs of an egg or sperm donor;

    c. Costs associated with cryopreservation and storage of sperm, eggs and embryos; and

    d. Selective termination of an embryo.

8. Any expenses or charges for sex transformation or hormones related to treatment for non-organic sexual dysfunction.

9. Marriage counseling.

10. Travel expenses for health care.

11. Nutritional diet supplements and vitamins.

12. Charges for services or supplies which constitute personal comfort or beautification items. Examples of items that are not covered include, but are not limited to, the following: personal hygiene items, items to improve physical appearance, first aid kits, televisions, telephones, exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, saunas, hot tubs, whirlpool tubs and portable jacuzzi pumps.

13. Charges incurred for any Hospital confinement or other medical care or service which an eligible Employee or retiree or other eligible individual would not be legally required to pay.

14. Any expenses or charges for Experimental or Investigative Treatments and Procedures.

15. Any expenses or charges prior to the effective date of coverage under the Plan, or after coverage under the Plan is terminated.

16. Replacement hearing aids if purchased within 36 months after initial purchase. Benefits are not provided for the cost of replacing a lost or damaged hearing aid, or batteries, nor the cost of eyeglass frames which build-in a hearing aid.

17. Charges incurred for hypnosis, acupuncture, acupressure and local anesthesia (when billed separately from the operative procedure performed), auriculotherapy, or continuous epidural or spinal anesthesia when used for chronic pain control, unless Medically Necessary.

18. Abortions after the first two (payable at 50% for second abortion).

19. Charges incurred for Preventive Services provided by a non-PPO provider.

20. Charges incurred for any special education rendered to any individual, regardless of the type of education, purpose of the education, recommendation of the attending Physician, or the qualifications of the individual(s) rendering the special education.

21. Charges incurred for education, training, or room and board while the individual is confined in an institution that is primarily a school or institution of learning or training.

22. Charges related to a routine examination where such services are not Preventive Services.

23. Ambulatory surgical centers that are not in the Plan's PPO Network.

24. Charges for treatment rendered outside the United States.

25. Charges for services that are payable under the Dental, Vision, or Prescription Drug Benefits offered under the Plan.

26. Charges for genetic testing unless specifically listed as a Covered Expense in Section 7.07(A).

27. Charges for any of the circumstances listed under the General Plan Exclusions in Section 12.

SECTION 8: PRESCRIPTION DRUG BENEFITS

8.01 Eligibility of Active Employees and Retired Employees.

You and your Dependents are covered under the Prescription Drug Benefit if you are eligible for medical benefits under the Plan. The benefit amounts are shown in the Schedule of Benefits.

8.02 Covered Prescription Drugs.

Unless otherwise excluded, the program covers Medically Necessary prescriptions by a Physician for the following:

A. All federal legend drugs;

B. State restricted drugs;

C. Compound medications, provided they are pre-authorized by PBM, where required;

D. Contraceptives as required under federal law;

E. Insulin on prescription (including test strips, lancets and all diabetic supplies, for all participants and Dependents who are not eligible for Medicare);

F. Needles and syringes on prescription;

G. Smoking cessation drugs;

H. Aerochambers and similar devices used to maximize the delivery of metered-dose inhaler medications into the lungs;

I. Drugs for the treatment of erectile dysfunction, provided that there is a medical cause for the condition (e.g., prostate cancer, diabetes);

J. Federal legend vitamins and minerals; and

K. Fertility drugs, subject to the Plan maximums listed in the Schedules of Benefits.

8.03 Drugs Not Covered.

This Prescription Drug Benefit does not cover the following:

A. Over-the-counter medications;

B. Investigational or Experimental drugs;

C. Prescription drugs covered under federal, state or local programs, including workers' compensation, for which there is no charge;

D. Amphetamines and/or anorexiants for weight loss;

E. Nutritional supplements, food supplements or substitutes (prescribed or over-the-counter);

F. Retin-A, except for the treatment of acne vulgaris;

G. Any item classified as a device or supply through the prescription card program, unless specifically included in Section 8.02;

H. Drugs or medicines which are not prescribed to treat a mental or physical condition for which the U.S. Food and Drug Administration (FDA) has approved usage of such product, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage;

I. Rogaine or similar drugs and preparations to promote hair growth;

J. Allergy serums;

K. Drugs not included on the Plan's formulary;

L. Drugs for any of the circumstances listed under the General Plan Exclusions in Section 12; and

M. Products indicated for cosmetic use.

8.04 The Pharmacy Benefit Manager, Retail Card Program and Mail Order Program.

A. The Pharmacy Benefit Manager (PBM).

This Fund's Prescription Drug Benefit is administered by a Pharmacy Benefit Manager (PBM). The Fund Office provides the PBM with eligibility data including primary and secondary coverage information. In most cases, the pharmacist has access to this information and will coordinate benefits at the point of purchase. Where the coordination of benefits does not take place at the point of purchase, a claim will need to be submitted directly to the PBM.

Under the Prescription Drug Benefit, you have two programs available to you: (1) the Retail Card Program; and (2) the Mail Order Program.

B. The Retail Card Program.

1. Using a Participating Pharmacy.

The Retail Card Program offers benefits for short-term prescriptions (up to a 30-day supply). When you become eligible for benefits, you will receive the appropriate identification cards for use at any participating pharmacy.

To receive benefits, you must present your ID card and your prescription to your pharmacist. When you use a participating pharmacy, you pay only the co-payment listed in your Schedule of Benefits.

You will receive the quantity prescribed by your Physician, up to the maximums described above, in the Schedule of Benefits and in accordance with clinical quantity limits based on usage considered reasonable, safe and effective. You do not need to submit any forms, receipts or claims. The pharmacist will submit the claim. You simply pay the necessary co-payment when you fill your prescription. The co-payment is not reimbursable under the Major Medical Benefit and does not count toward your Major Medical out-of-pocket maximum.

2. If You Do Not Use A Participating Pharmacy.

You should be able to find a participating pharmacy near your home and wherever you travel. If you choose to fill your prescription at a non-participating pharmacy, you must pay the full cost of the prescription and then you request a claim form for reimbursement from the Fund Office or the PBM. If the claim is covered, you will be reimbursed at 75% of the cost of the prescription minus your co-payment.

C. The Mail Order Program.

You may use the mail to order up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. You are required to use this service for maintenance medications which are medications you or your Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your Physician prescribes a long-term medication that you need right away, ask the Physician to write two prescriptions — a one-month prescription to be filled at a participating pharmacy using the Retail Card Program, and a 90-day prescription to be submitted to the Mail Order Program, which is provided through the PBM. The PBM will not approve more than two 30-day supply fills of any maintenance medication filled at a retail pharmacy.

You will be responsible for paying only the co-payment listed in your Schedule of Benefits for each prescription ordered.

Follow these steps to obtain prescriptions through the mail or by using the PBM website:

1. You or your Physician may request a new patient home delivery form by calling the PBM or the Fund Office;

2. Complete all required information on the form;

3. Enclose the Physician's prescription for a 90-day supply of medication (and up to three refills);

4. Enclose the co-payment, include credit card information on the form, or call the PBM with your credit card information for each prescription, if applicable.

The Mail Order Program will deliver your order to the address you provide. You should send your reorders 30 days before your prescription will run out. You can also phone in your refills or use the website for refills.

If you do not receive your medication within a reasonable amount of time, call the PBM Mail Order Program's customer service department at the number on your Welfare Fund ID card. This number is also on the mail order form and is available from the Fund Office. Alternatively, if you would rather not wait for your maintenance medications to be delivered in the mail, the PBM offers a program for receiving 90-day supply refills of certain maintenance medications at specific retail pharmacies. For more information on this program, please contact the PBM at the number located on the back of your identification card.

8.05 Specialty Drug Benefits.

Specialty drugs are medications created to target and treat complex medical conditions and rare diseases. When treating the following three conditions: (1) rheumatoid arthritis; (2) multiple sclerosis; and (3) infertility, the Plan limits the use of specialty drugs to a preferred list of specific drugs. To receive coverage for specialty drugs, they must be received through the Plan's Specialty Drug Program. If you or your Dependents are prescribed a specialty drug, the medications will be sent directly to your home or work address via safe, temperature controlled and tested packaging at no additional cost.

If you and/or your Dependent are currently taking a non-preferred specialty drug as of January 1, 2015, you will not be required to switch to a preferred specialty drug.

8.06 Pre-Authorization.

Certain compound prescription drugs require prior authorization by the PBM before the prescription may be filled. Pharmaceutical compounding is the combining, mixing or altering of ingredients to create a customized medication that is not otherwise commercially available.

Prior authorization is required for all compound prescriptions with a cost of $300 or more for a 25-day supply. Prior authorization may be requested by you or your Physician before the prescription is presented to the pharmacy. Otherwise, the prior authorization process begins when you present the prescription to the pharmacy. The PBM will contact the Participant's Physician to obtain the necessary documentation and will either approve or deny the request for prior authorization based on the clinical information received.

You should contact the PBM before you have any compound drug prescriptions filled. To contact the PBM, call the phone number on the back of your I.D. card or contact the Fund Office for contact information.

8.07 Medicare Part D

If you are eligible for Medicare, you may choose to enroll in the Medicare Prescription Drug Benefit (Medicare Part D). Persons with prescription benefits under this Plan are unlikely to receive an additional benefit and generally should not sign-up for Medicare Part D. Persons who are not eligible for benefits under this Plan should sign up for Medicare Part D.

The annual enrollment period for Medicare Part D is October 15 through December 7. There is also a special enrollment period if your eligibility for Prescription Drug Benefits under this Plan ends on a date outside of the enrollment period.

Because this Plan provides on average equal or greater prescription benefits than Medicare Part D, the Plan's prescription benefit is considered "creditable coverage." If you are eligible for Medicare, the Plan will send you a Notice of Creditable Coverage before October 15 of each year. This Notice will allow you to avoid payment of a late enrollment penalty if your Prescription Drug Benefit under the Plan ends and you decide to elect Medicare Part D. A late penalty under Part D applies to individuals who go 63 days or longer without Prescription Drug Benefits that are at least as good as Medicare Part D.

If you are eligible for Medicare and are eligible for benefits under this Plan, you may elect Medicare Part D in addition to receiving Prescription Drug Benefits under this Plan. This is known as "dual coverage." **However, the Plan does not coordinate with Medicare Part D. This means that you will not receive any more benefits than you would have received if you were covered solely by the Plan or Medicare Part D. Accordingly, if you are eligible for prescription drugs under the Plan, you should not elect Medicare Part D.**

SECTION 9: DENTAL BENEFIT

9.01 Eligibility for Dental Benefits.

The Dental Benefit applies to you and your Dependents if you are eligible for Active Employee Benefits or Retiree Benefits.

9.02 Predetermination of Dental Benefits.

Although not required, predetermination of whether a treatment is covered provides you with advance notice of which services are covered by the Plan. If you expect a dental treatment to cost $500 or more, the Fund Office strongly urges you to submit a predetermination of benefits claim form that includes:

A. A description of the proposed dental treatment; and

B. The Dentist's estimated charges.

The Fund Office will review the information, estimate the benefits payable under the Plan and return the form to your Dentist. The predetermination is valid for dental work that begins within 90 days of the date the Fund Office returns the predetermination of benefits claim form to your dental provider and before your Eligibility terminates.

9.03 Alternate Course of Dental Treatment.

In determining the amount of benefits payable, the Fund Office may consider alternate courses of treatment appropriate to your condition and capable of accomplishing the desired results. The determination of such an alternative may be based on treatment that is:

A. Customarily used nationwide in the treatment of the condition; and

B. Recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice.

Once you know the exact amount of benefits payable for the treatment, you and your Dentist can discuss the dental treatment that is most appropriate for you. If an alternate course of treatment is suggested, and both you and your Dentist agree to proceed with the original course of treatment, or agree to charges that are higher than the amount allowed by the Fund Office, you will be responsible for paying any excess cost you incur.

9.04 Percentage of Dental Benefits Payable.

The Dental Benefit pays the percentage listed in the Schedule of Benefits. Covered dental expenses are considered to have been incurred on the day the service is rendered. When the complete service is not performed in one day, only the expense for that portion of the completed service will be considered incurred.

9.05 Dental PPO.

The Fund has contracted with a Dental PPO as an additional option with no change in benefits. If you use a provider who is in the Fund's contracted network, the charges may be lower and, as a result, both you and the Fund pay less.

9.06 Covered Dental Expenses.

Covered dental expenses include the following dental services provided by a Dentist or provided under a Dentist's supervision:

A. Diagnostic and Preventive Services:

   a. Routine oral examinations once every six months.

   b. Routine prophylaxis treatments once every six months.

   c. Dental x-ray, when professionally indicated and Medically Necessary. Full-mouth dental x-rays are limited to one per 36-month period and bitewing x-rays are limited to one per calendar year.

   d. One topical application of sodium or stannous fluoride every six months for each Dependent child under the age of 19.

   e. Dental sealants once per lifetime for posterior teeth only for each Dependent child under the age of 19.

B. Basic Care Services:

   a. Emergency treatment for the relief of dental pain;

   b. Amalgam, synthetic porcelain, and plastic fillings;

   c. Treatment of the gums and other supporting structures of the teeth;

   d. Root canals and other endodontic treatment;

   e. Oral surgery, including extractions and pre-operative and post-operative care. Certain oral surgery benefits – osseous surgery (periodontic and impacted tooth extractions) will be covered under the Major Medical Benefit and any unpaid balance will be applied under the Dental Benefit.

C. Restorative Care Services:

   a. Gold fillings when the teeth cannot be restored with another filling material;

   b. Crowns and jackets when the teeth cannot be restored with any filling material (porcelain crowns on anterior teeth only, full cast on posterior);

   c. Bridges, partial dentures, complete dentures and any related exams and extractions. Benefits are not payable if dentures are lost or stolen. In no event will benefits be payable for full denture replacement more than once every five years.

9.07 Orthodontia Care Coverage.

If one of your Dependent children under the age of 19 receives treatment from an orthodontist, the Fund pays the Usual and Customary Charges for certain eligible expenses. Eligible expenses include x-rays, oral examinations, study models, surgery and extractions related to treatment, appliance therapy and functional/myofunctional therapy, pursuant to the Schedule of Benefits.

9.08 Limitations and Exclusions on Payment of Dental Benefits.

The Dental Benefit described above does not cover retired Employees or their Dependent spouses or surviving spouses. In addition, this benefit does not cover the following expenses:

A. Any services payable under workers' compensation or employer's liability laws;

B. Services provided or paid for by any governmental agency or under any governmental program or law, except those services for which the Covered Person is legally required to pay;

C. Services performed for purely cosmetic purposes or to correct congenital conditions;

D. Services performed prior to obtaining eligibility for coverage under the Plan;

E. Temporary procedures;

F. Medications, supplements, and EKGs;

G. Porcelain crown on posterior teeth;

H. Oral hygiene instructions and tissue conditioning;

I. Fluoride mouth wash;

J. Infection control;

K. Temporomandibular Joint (TMJ) surgery;

L. Consultations; or

M. Implants.

SECTION 10: VISION BENEFIT

10.01 Eligibility for Vision Benefits.

The Vision Benefit applies to you and your Dependents if you are eligible for Active Employee Benefits or Retiree Medical Benefits.

10.02 Covered Vision Benefits.

The Vision Benefit includes the following expenses subject to the Schedule of Benefits:

A. Professional examinations by an ophthalmologist or optometrist;

B. Lenses prescribed by either an ophthalmologist or optometrist for corrected vision;

C. Frames purchased in conjunction with lenses newly prescribed by either an ophthalmologist or optometrist;

D. Replacement of broken lenses and/or frames;

E. Contact lenses;

F. Radial keratotomy (RK), photorefractive keratectomy (PRK), and other procedures to reshape the curvature of the cornea in order to correct nearsightedness, farsightedness or astigmatism, subject to the Plan maximums listed in the Schedules of Benefits; and

G. LASIK eye surgery, subject to the Plan maximums listed in the Schedules of Benefits.

10.03 Limitations and Exclusions on Vision Benefits.

This Vision Benefit does not cover vision expenses incurred for the following:

A. Routine yearly examinations required by your Employer and related to your occupation;

B. Job-related Accidents or injuries;

C. Examinations in a Hospital owned or operated by the federal government, or for examinations for which you are not required to pay;

D. Insurance premiums on contact lenses and frames;

E. Medical services; and

F. Contact lens kits.

SECTION 11: THE EMPLOYEE ASSISTANCE PROGRAM

11.01 Eligibility.

You and your Dependents are eligible for the Employee Assistance Program Benefit if you are eligible for Active Employee Benefits.

11.02 The Employee Assistance Program.

The Employee Assistance Program (EAP) provides short-term counseling and assessment-referral services to Employees and their families.

These confidential EAP services were developed to help Employees and their families cope with personal difficulties that can affect their lives both at home and at work. Persons eligible to use the EAP have access to up to three **FREE** counseling sessions per problem, situation or issue.

The EAP assists people with a variety of life problems including alcohol and drug abuse; stress, anxiety, and depression; marital, family, and relationship discord; child and adolescent behavioral problems; child care; elder care; and financial and legal concerns at no cost to the Employee.

All contact with the EAP is confidential. The EAP counselor will not speak with a supervisor, co-worker or family member without permission from the person using the assistance program. Confidentiality is compromised only when a threat to life exists (i.e., suicidal or homicidal risk, stalking or child abuse).

Services may include a comprehensive evaluation, brief counseling and a referral, if necessary. Some services not covered by the Fund's benefits may be provided by the EAP.

SECTION 12: GENERAL PLAN EXCLUSIONS

12.01 Exclusions from Coverage.

The following expenses are not covered under the Plan:

A. Charges for care not expressly specified as a covered expense in this Plan.

B. Accidents, Sicknesses or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law. This exclusion, however, does not apply to the Death or Accidental Death and Dismemberment Benefits.

C. Any expenses or charges for services or supplies that are provided by Hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.

D. Any expenses or charges caused by your voluntary participation in a riot.

E. Any expenses or charges caused by war or any act of war, whether declared or undeclared.

F. Any expenses or charges incurred during the commission of a felony or involvement in a criminal enterprise.

G. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA.

H. Any expenses or charges for which you do not have to pay.

I. Any expenses or charges for services or supplies:

   1. Not provided in accord with generally accepted professional medical standards;
   2. Not Medically Necessary; or
   3. For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.

J. Any expenses or charges for Experimental or Investigative Treatments and Procedures.

K. Any expenses or charges for services and supplies that exceed the Usual and Customary Fees.

L. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.

M. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).

N. Any expenses or charges for third party ordered care, such as a pre-employment physical except as provided herein.

O. Any expenses or charges (1) for failure to keep scheduled visits, (2) for completion of claim forms or (3) for reports or medical requests not requested by the Fund.

P. Charges that would not have been made if this Plan did not exist.

SECTION 13: COORDINATION OF BENEFITS

13.01 Benefits Are Coordinated.

Under the Plan, your medical and dental benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits are coordinated so that no more than 100% of your expenses are paid through the combined coverage of the plans.

13.02 Another Group Plan Defined.

Another group plan or source refers to any plan providing benefits or services and includes:

A. Group blanket or franchise insurance coverage (such as coverage provided to college students);

B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;

C. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;

D. Any coverage under governmental programs;

E. Any coverage required or provided by statute; and

F. The International Association of Heat and Frost Local 17 Welfare Fund when you are covered as:

   1. An Employee and as a Dependent; or

   2. A Dependent child of more than one Employee.

13.03 How Benefits are Paid.

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

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When this Plan is secondary, it will pay the difference between your allowable expenses under this Plan and what your primary plan paid, but not more than the amount this Plan would pay if it were primary.

If the Plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid, as long as the service is covered under this Plan.

If you or a Dependent is covered by another group plan or source in addition to the International Association of Heat and Frost Insulators Local 17 Welfare Fund, the order of benefit payment will be determined according to the Plan's Coordination of Benefits Rules.

13.04 Order of Benefit Payment.

For coordination with other plans the following rules apply:

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

B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent. Additionally, a plan that covers a person as a Dependent spouse is primary and pays benefits before a plan that covers the person as a Dependent child.

C. The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an Employee. However, coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under B above.

D. For claims on behalf of Dependent children whose parents are not divorced or separated or for claims on behalf of Dependent children whose parents share custody or shared custody prior to the child attaining age of majority, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.

E. For claims on behalf of Dependent children whose parents are divorced or separated, the following rules apply:

   1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility or had financial responsibility prior to the child attaining age of majority will be primary.

   2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary. The plan who covers the parent who had custody at the time the child reached age of majority will be primary.

   3. If there is no such court decree and the parent with custody (or who had custody at the time the child reached the age of majority) has remarried, the order of benefit coordination will be as follows:

      (a) The plan of the parent with custody is primary and pays benefits first;

      (b) The plan of the step-parent with custody pays benefits second;

      (c) The plan of the parent without custody pays benefits third; and

      (d) The plan of the step-parent without custody, if any, pays benefits fourth.

F. A plan that covers you as an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

G. A plan that covers you as a current full-time employee or as a Dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal

employee or as an employee who is eligible because of Contributions or payroll deductions previously made to the Plan.

H. If a person is covered under the Plan as both an Employee and a Dependent spouse, the Plan will coordinate benefits and will pay primary employee benefits and secondary Dependent benefits, up to the maximums provided in the Schedule of Benefits.

I. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, retiree or Dependent, the COBRA Continuation Coverage is secondary unless the COBRA Continuation Coverage under this Plan is being used because he/she has a preexisting condition. In that circumstance, this Plan will pay primary benefits on only the claims related to the condition defined as a preexisting condition under the other plan.

J. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

K. If a Retiree or Dependent is covered under any other group health plan or other type of medical insurance coverage or Medicare, the Plan will always pay its benefits after all other plans and insurance coverage and Medicare have paid their benefits.

13.05 Coordination of Benefits Implementation Rules.

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

A. Release or obtain information considered necessary;

B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and

C. Recover payments in excess of the amount that should have been paid by this Plan.

13.06 Coordination of Benefits with Medicare.

A. When You are an Active Employee.

If you are an active Employee, this Plan will be primary and pay benefits first. If you are an Active Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

B. When You are a Retired Employee.

If you retire and are eligible for Retired Employee Coverage, Medicare will have primary responsibility and this Plan will pay second.

If you or your Dependent is eligible for Medicare and have not enrolled in Medicare Parts A and B (or a plan selected in place of Medicare Part A and B), the Plan will assume that you have enrolled in and will coordinate benefits under Medicare Parts A and B. This means that this Plan will only pay benefits equal to what it would have paid if you were enrolled in Medicare Parts A and B and you will be responsible for any difference.

C. End Stage Renal Disease (ESRD).

There are special rules that apply to the first 30 months of an ESRD, (the initial 30-month period). The primary/secondary rules depend on whether the covered individual is eligible for Medicare due to age or Disability as of the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary.

1. Eligibility because of the Employee's active status.

   If you are eligible for benefits because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second.

   If during the initial 30-month period the Employee becomes eligible for Retired Employee Coverage, the Plan will continue to pay as the primary plan during the balance of the 30-month period.

   After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

2. Eligibility because of the Employee's retired status.

   If you are retired and not otherwise eligible for Medicare at the time you become entitled to Medicare ESRD benefits, the Plan will have primary responsibility for ESRD during the initial 30-month period and Medicare will pay second.

   If you are retired and already eligible for Medicare at the time you become entitled to Medicare ESRD benefits, Medicare will have primary responsibility for ESRD during the initial 30-month period and this Plan will pay second.

   After the initial 30-month period, Medicare continues to pay primary and the Plan pays second.

SECTION 14: SUBROGATION OR REIMBURSEMENT

14.01 Reimbursement to the Plan.

The Fund's right of subrogation and reimbursement arises when benefits are paid on behalf of you or your Dependent as a result of an injury or illness for which another party may be responsible. If the Fund pays any benefits that arise out of the injury or illness which results or could result in a claim against a Third Party, acceptance of these benefits under the Plan means you agree to reimburse the Fund for all expenses paid on your or your Dependent's behalf.

14.02 Third Parties Defined.

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

A. Any person or entity legally responsible for your injury;

B. Other benefit plans;

C. An insurance company, including but not limited to the party at fault's insurance;

D. Workers' compensation; or

E. Any other person or entity that is obligated to make payments, which the Fund would otherwise be obligated to make.

14.03 Your Responsibilities.

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

A. You and/or your Dependent must immediately notify the Fund Office whenever a claim against a third party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.

B. You and/or your Dependent must cooperate with the Fund by providing, among other things, information requested by the Fund concerning subrogation or reimbursement. You must provide the Fund Office with:

   1. A signed Subrogation and Reimbursement Agreement;

   2. The names and addresses of all potential third parties and their insurer, adjusters and claim numbers;

   3. Accident reports; and

   4. Any other information the Fund Office requests.

C. If you fail to meet your responsibilities, the Fund may withhold future benefit payments until you comply with these requirements.

D. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Fund the right to prosecute your claim and maintain an action against the third party on your behalf.

14.04 If You Are Reimbursed by a Third Party.

The Fund is entitled to 100% reimbursement of all medical and Short Term Disability claims paid on your and/or your Dependent's behalf, related to the injury or illness, from all Third Party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

A. First, the Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the injury or illness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Illinois Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA); then

B. Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above, even if you and/or your Dependent are not fully compensated for the loss. The Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all third parties.

You and/or your Dependents shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover 100% of the benefits paid. Such action includes, but is not limited to:

A. Initiating a claim to compel compliance with these terms or the terms of the Subrogation and Reimbursement Agreement;

B. Withholding benefits payable to you or your Dependents until you or your Dependents comply; or

C. Initiating such other equitable or legal action it deems appropriate.

D. The Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recover payment.

SECTION 15: CLAIMS AND APPEALS PROCEDURES

15.01 General Information.

A. Exhaustion of Remedies.

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action.

If your appeal is denied, no legal action can be brought with respect to a claim under the Plan after 90 days from the date of decision on external appeal.

B. Discretionary Decision Making Authority of the Trustees.

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of the Plan and to define the terms used in the Plan. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan. No determinations involved in or arising under the Trust Agreement or the Plan will be subject to the grievance or arbitration procedure established in any collective bargaining agreement between the Association and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such collective bargaining agreements.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

15.02 Filing Your Initial Claim for Benefits.

A. What is a Claim?

A claim for benefits is a request for Plan benefits that a participant makes in accordance with the Fund's reasonable claims procedures.

If you make an inquiry about the Plan's provisions without a claim form, the Fund will not treat the inquiry as a claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, it will not be treated as a claim for benefits.

A claim may fall into one of the following categories:

1. Post-service claim – a claim for payment is requested for a treatment or supply that has already been received;

2. Disability claim – a claim for Short-Term Disability Benefits;

3. Pre-service claim – a claim for Pre-Certification for a treatment or supply that requires approval in advance of obtaining care;

4. Urgent care claim – a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function, 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 treatment that is the subject of the claim; or

5. Concurrent care claim – a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved. When a participant presents a prescription to a participating pharmacy to be filled out under the terms of this Fund, that request is not a claim under these procedures. However, if the request for a prescription is denied, in whole or in part, the participant may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim.

To file a claim for benefits offered under this Plan, you must generally submit a completed claim form within 24 months from the date that the service for the charge is rendered. **Please note that Death, AD&D and Short-Term Disability claims must be submitted in a shorter time-frame as described below.**

1. Hospital, Physician and Medical Claims

   Hospital, Physician and Medical Claims are generally filed by providers. If a claim is filed by a provider, the provider will not automatically be considered a claimant's authorized representative. A claim form is not required except for expenses resulting from an Accident. Itemized bills must be sent to the Fund Office for payment and must identify the diagnosis. If the bill is not marked as paid, payment for the benefit will be made directly to the provider of services. Conversely, if the bills are marked as paid, payment will be made to you. In all cases, an explanation of benefits will be sent to you explaining who was paid, how much was paid and when the payment was made.

   Claims must be submitted within 24 month after the date of service. In the case of a work-related injury, the Fund must receive a determination letter from the Employer regarding the payment or denial of workers' compensation benefits.

2. Prescription Drug Claims

   You can avoid the need for filing direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the PBM Claims Department as identified on your identification card.

3. Health Reimbursement Account (HRA) Claims

   Claims should be submitted in accordance with Section 3.04(B) and must be submitted within 24 months of the date of service. Such claims are considered post-service claims.

4. Dental Claims

   If the service will not exceed $500, the Dentist may proceed with the work and send the itemized bill to the Fund Office for payment. Such claims must be received within 24 months after the dental work has been completed. If the itemized bill is marked as paid, reimbursement will be sent to you; otherwise, payment will be submitted directly to the provider. Such claims are considered post-service claims.

   If the service will exceed $500, the Dentist should submit a pre-determination of benefits and send it to the Fund Office for prior approval, within ten days of his initial examination. Such claims are considered pre-service claims.

5. Optical Claims

   Payment for services is made on a reimbursement basis only. You must pay the provider and submit the original itemized paid receipts to the Fund Office for reimbursement. Expenses are applied to the annual benefit maximum based on the date the services are performed and the date the lenses, frames, contacts, etc. are ordered, not the date of payment. Benefits are not payable twice for the same pair of eyewear. Claims must be filed within 24 months of incurring the expense. Such claims are considered post-service claims.

6. Death and AD&D Benefits

   You or your beneficiary (in the event of your death), may call the Fund Office and request a claim form. A claim must be submitted within two (2) years after the date of death for the Death Benefit and within 30 days of the date of loss, or as soon as reasonably possible for the AD&D Benefit. Such claims are considered post-service claims.

7. Short-Term Disability Claims

   You may call the Fund Office and request a disability income claim form. You should fill out the appropriate sections on the claim form and give the form to the Physician to complete, sign and return to the Fund Office. The form must contain the Physician's original signature and not a stamp. A new claim form must be completed and returned to the Fund Office after each two weeks, or less frequently, as determined by the Fund, of continuing Disability to recertify benefits. The Board of Trustees reserves the right to require a second opinion by the Physician of its choice, for any disability benefit claim.

C. Where to File a Claim.

1. Hospital, Physician & Medical Claims

   All Hospital, Physician and medical claims in general, (both PPO and non-PPO providers) should be filed electronically with Blue Cross Blue Shield of Illinois. The Fund will consider a

claim to have been filed as soon as it is received at the Fund Office. Both PPO and non-PPO providers should complete the claim form and send it electronically to Blue Cross Blue Shield of Illinois.

2. Prescription Drugs

   For more information on where to file a prescription drug claim, please contact the PBM at the number located on the back of your identification card.

3. All other Claims

   All other claims may be filed at the Fund Office, 18520 Spring Creek Drive, Suite B, Tinley Park, IL 60477.

15.03 Initial Claim Determination Timeframes.

A. Claim Filing Deadline.

A claim is considered to have been filed on the day it is received by the Fund in accordance with the claims filing procedures in Section 15.02(B), even if the claim is incomplete. In the event that a claim is not submitted in accordance with the timeframes provided in Section 15.02(B), the claim will not be considered unless, the Board of Trustees determines that there is good cause for filing a claim outside the prescribed timelines.

B. Claim Processing Timeframes.

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Plan's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim.

The amount of time the Plan can take to process a claim depends on the type of claim.

1. Post-service Claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 30 days from the Plan's receipt of the claim.

   (b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

   (c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, the claim will be decided on the basis of the information that the Plan has at that time and the claim may be denied. During the period in which you are allowed to supply additional information, the normal time period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you

respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

2. Short-Term Disability Claims

   (a) The Plan will make a decision on your Short-Term Disability claim and notify you of the decision within 45 days.

   (b) If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Plan will make its decision within 30 days of the time the Plan notifies you of the delay.

   The Plan may delay the period for making a decision for an additional 30 days, provided the Plan Administrator notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, before the expiration of the first 30-day extension period.

   (c) If an extension is needed because the Plan needs additional information from you to process the claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, the claim will be decided on the basis of the information that the Plan has at the time and the claim may be denied.

   During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information or at the expiration of the 45 days if you do not respond, the Plan will make its decision on the claim and notify you within 30 days.

3. Pre-Service Claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 15 days from the Plan's receipt of the claim.

   (b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

   (c) If an extension is needed because the Plan needs additional information from you to process the claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, the claim will be decided on the basis of the information that the Plan has at the time and the claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you

respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

4. Urgent Care Claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 72 hours from the Plan's receipt of the claim.

   (b) If an extension is needed because the Plan needs additional information from you to process the claim, the Plan will notify you of such extension within 24 hours. In that case, you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, the claim will be decided on the basis of the information that the Plan has at the time and the claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or until you respond to the request (whichever is earlier). The Plan then has 48 hours to make a decision and notify you of the determination.

5. Concurrent Care Claims

   (a) If the concurrent care claim is urgent and made at least 24 hours prior to the end of the already authorized treatment, the Plan will notify you of its decision as soon as possible but not later than 72 hours after receipt of the claim.

For other concurrent care claims, the pre-service limits apply.

15.04 Notice of Initial Decision.

You must be provided with a notice of the initial determination about the claim within certain timeframes after the claim is received. The notice must provide the following information:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the denial of benefits or other Adverse Benefit Determination;

C. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;

D. A description of any additional material or information that is needed to process the claim and an explanation of why the information is needed;

E. A copy of the review procedures and time periods to appeal the claim, a statement of the participant's right to bring a civil action under ERISA following an Adverse Benefit Determination on review;

F. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on the claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to the participant at no cost upon request; and

G. If the participant's health or Short-Term Disability claim was denied on the basis of medical necessity, Experimental Care or Treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on the claim or a statement that it is available to the participant at no cost upon request.

15.05 Appeal Procedures.

A. Appeal Filing Deadline.

You have the right to a full and fair review if your claim for benefits is denied by the Fund. You must file your appeal in writing, unless the appeal is of an urgent care claim, which may be submitted orally by telephone. You must make your request to the Fund Office within 180 days after you receive notice of denial except with respect to a Death Benefit and AD&D claim. You must file a request for an appeal of the denial of a Death Benefit or AD&D claim within 60 days after you receive notice of the denial. Your application for appeal must be in writing and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting a written statement.

B. Internal Appeal Process.

The appeal process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

    a. It was relied upon by the Plan in making the decision;

    b. It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

    c. It demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or

    d. It constitutes a statement of Plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on the claim, without regard to whether their advice was relied upon in deciding the claim.

3. Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

4. A different person will review the claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and testimony as part of your appeal. The decision will be made on the basis of a full and fair review of the record, including such additional evidence and testimony that you submit.

5. If the claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental Care or Treatment), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Internal Appeal.

1. Urgent Care Claims

   If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

2. All Non-Urgent Pre-Service Care Claims

   If the appeal is for a non-urgent pre-service care claim, you will be notified no later than 30 days after receipt of the request for appeal.

3. Short-Term Disability, Death, AD&D and Post-Service Care Claims

   Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if the request for review is received within 30 days of the next regularly scheduled meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the request for review may be necessary. The Plan will advise you in writing in advance if this extension will be necessary. Once a decision on review of the claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

15.06 Notice of Decision on Internal Appeal.

The Plan will provide you with a written decision, in a culturally and linguistically appropriate manner, on any internal appeal of your claim. However, if the claim is an urgent care claim, the Fund Office may notify you of the decision in writing, via fax or orally via telephone. The notice of a denial of a claim on appeal will state:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the determination;

C. Reference to the specific Plan provision(s) on which the determination is based;

D. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

E. A statement of your external appeal rights, an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal;

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes; and

G. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule, guideline or protocol or a statement that it is available upon request at no charge. If the determination was based on medical necessity or because the treatment was Experimental Care or Treatment or other similar exclusion, the Plan will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that it is available upon request at no charge.

15.07 External Review Procedures for Medical, Dental and Vision Claims.

A. External Review Filing Deadline.

If your claim is not a claim for Short Term Disability or Death Benefits under the Plan and is denied under the internal appeals procedures, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. External Review Process.

The external review process works as follows:

1. Determination of Eligibility for Review

   Within five business days of the Plan's receipt of the request for external review, the Plan must determine whether:

   (a) You are or were covered under the Plan at the time of service or requested service;

   (b) The Adverse Benefit Determination relates to a medical necessity determination or rescission of coverage;

   (c) You have exhausted or are deemed to have exhausted the Plan's internal appeal process; and

   (d) You have provided all information and forms required to process an external review.

   Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request

is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

2. Referral to an Independent Review Organization (IRO)

If the request is eligible for review, the Plan will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:

(a) The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

(b) The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO must send notice of such to you and the Plan within one business day.

(c) The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.

(d) The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or

documents are available and the clinical reviewer or reviewers consider it appropriate.

3. Request for an Expedited External Review

You may request an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the IRO must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. External Review Process.

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

D. Content of Notice of Decisions on External Review.

The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all of the following:

1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act Section 2793.

E. Guidance under the Patient Protection and Affordable Care Act of 2010.

These external review procedures apply to health care claims (i.e., medical, prescription drug, dental and vision claims) that are denied on appeal by the Trustees. They are intended to comply with the interim safe harbor provisions contained in the U.S. Department of Labor Technical Release 2010-01. As such time as the guidance is revised or replaced by the DOL, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with the Patient Protection and Affordable Care Act of 2010.

15.08 Physical Examination.

The Trustees have the right and opportunity, at the Plan's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while the claim for Plan benefits is pending.

15.09 Payment of Claims.

The Plan will make payments due immediately upon receipt by the Fund Office of proper written proof of loss. The Plan may pay all or a portion of any benefits provided for health care services to the provider, unless you direct otherwise in writing at the time you file the claim. The Plan does not require that the services be rendered by a particular provider.

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

15.10 Authorized Representatives.

An authorized representative may complete the claim form for you so long as you previously designated the authorized representative to act on your behalf. The Plan may request additional information to verify that the person is authorized to act on your behalf.

15.11 Benefit Payment to an Incompetent Person.

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent or to a person who in the opinion of the Trustees is unable to administer such payments properly because of mental or physical Disability. The Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose(s) for which paid if they are paid:

A. Directly to such person;

B. To the legally appointed guardian or conservator of such person;

C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or

D. By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

15.12 Misstatement by Plan Participant.

If you make a misstatement in any application or claim for benefits, such a misstatement, except for a fraudulent misstatement, may not be used in any legal contest unless the Plan furnishes you with a copy of the document containing the misstatement.

SECTION 16: DEFINITIONS

16.01 Definition of Plan Terms.

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.

B. **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

1. A determination of an individual's eligibility to participate in the Plan;

2. A determination that a benefit is not a covered benefit;

3. The imposition of an exclusion or other limitation on otherwise covered benefits; or

4. A determination that a benefit is Experimental Care or Treatment or not Medically Necessary or appropriate.

C. **Board of Trustees and/or Trustees** means the Trustees and Board of Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the International Association of Heat and Frost Insulators Local 17 Welfare Fund. The Board of Trustees is the "administrator" of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.

D. **Covered Employment** means employment of an Employee by an Employer for which contributions to this Fund are required.

E. **Custodial Care** means care designed to help a disabled person with daily living activities when:

1. There is no plan of active medical treatment to reduce the Disability; or

2. The plan of active medical treatment cannot be reasonably expected to reduce the Disability.

F. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular dental service rendered.

G. **Dependent** means any one of the following individuals:

1. An Employee's spouse (marriage license and birth certificate required). This term shall apply to same-sex couples who were legally married in a jurisdiction that recognizes same-sex marriages.

2. Each child of an Employee from the date he or she first becomes a child of the Employee to the end of the calendar month in which such child attains age 26 (birth certificate required).

3. An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

    a. Such incapacity began before the end of the calendar year such child attains age 26; and

    b. Such child is chiefly dependent upon the Employee for financial support and maintenance; and

    c. Proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.

An Employee's children include natural and legally adopted children, children placed in the Employee's home for adoption, foster child and step children. A Dependent child will also include a child of an eligible Employee who has been appointed legal guardian by a court of competent jurisdiction. Proof of such guardianship may be required.

H. **Disability** means a physical or mental condition which prevents an Employee from engaging in gainful activity for an Employer, based on medical proof of such disability or such other proof as is acceptable to the Trustees.

I. **Disability Hours** means the number of days for which an Employee is paid for a Disability multiplied by eight (8) hours.

J. **Disqualifying Employment** means work in the "Heat and Frost Insulator Industry" as defined in the Pension Plan for which contributions are not submitted on the employee's behalf.

K. **Employee** means (1) all employees of Employers for which the Employer is required, under the terms of a collective bargaining agreement, to pay contributions to the Plan on their behalf, (2) all active full-time Employees of the Union, (3) all active full-time Employees of the International Association of Heat and Frost Insulators Local 17 Welfare Fund, International Association of Heat and Frost Insulators Local 17 Pension Fund, International Association of Heat and Frost Insulators Local 17 Annuity Fund, and International Association of Heat and Frost Insulators Local 17 Apprentice Training Program, (4) other employees of an Employer covered by a participation agreement with the Fund that provides for contributions on their behalf, and (5) a traveler working in the jurisdiction of Local 17 territory who is a member of another Local and meets the Fund's eligibility requirements (except for a traveler whose home Local has a Reciprocal Welfare Agreement with the Fund).

L. **Employer** means any person, firm, association, partnership or corporation which is a signatory to a collective bargaining agreement which requires contributions to this Fund. Employer also means the Union, the International Association of Heat and Frost Insulators Local 17 Welfare Fund, the International Association of Heat and Frost Insulators Local 17 Pension Fund, the International Association of Heat and Frost Insulators Local 17 Annuity Fund, the International Association of Heat and Frost Insulators Local 17 Apprentice Training Program and any other entity that has entered into a participation agreement with the consent of the Trustees which does

in fact make contributions to the Fund as provided for in the Fund's Trust Agreement and has agreed in writing to be bound by such Trust Agreement.

M. **Experimental or Investigative Treatments and Procedures** applies to a service, procedure, drug, device, or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria:

1. Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body;

2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis;

3. Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval;

4. Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials or (3) 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

5. Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

N. **Fund and/or Welfare Fund** means the International Association of Heat and Frost Insulators Local 17 Welfare Fund.

O. **Fund Office** means the office of the International Association of Heat and Frost Insulators Local 17 Welfare Fund.

P. **Home Health Care Agency** is an organization, or its distinct part, that meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

2. It has established policies for governing the services that it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;

3. It provides for the supervision of its services by a Physician or registered professional nurse;

4. It is licensed according to all the applicable laws of the state in which it is located; and

5. It is eligible to participate in Medicare.

Q. **Hospice Organization** means an organization that meets all of the following conditions:

1. Its primary purpose is to provide a facility or program designed to supply a caring environment to support the physical and emotional needs of the terminally ill (life expectancy of six months or less) and their family;

2. Approved for its stated purpose by Medicare;

3. Accredited by the Joint Commission on the Accreditation of Health Care Facilities; and

4. Licensed, certified, or accredited in the state in which it operates.

R. **Hospital** means a lawfully operating institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses, and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a Hospital operated by the United States Government, unless the claimant is required to pay such expense.

S. **Hours** means the accumulated number of hours for which an Employee worked and for which a contribution is made to the Fund.

T. **Inpatient** means a person who, while confined in a Hospital or Skilled Nursing Care Facility, is assigned a bed in any department of a Hospital or Skilled Nursing Care Facility other than in its outpatient department and for whom a charge for room and board is made by Hospital or Skilled Nursing Care Facility.

U. **Medically Necessary** means a service or supply that:

1. Is consistent with the symptoms of diagnosis and treatment of the person's injury or Sickness;

2. Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and

3. Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

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

W. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

X. **Mental or Nervous Disorder** means (1) a Mental Illness or (2) a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.

Y. **Morbid Obesity** means the condition of severe overweight and characterized by all of the following:

1. A Body Mass Index (BMI) of 45 or greater;

2. At least 100 pounds over ideal weight; and

3. Two or more clinically serious conditions, as diagnosed by a Physician.

Z. **Pension Credit Years** are based on a participant's years of credited service under the Pension Plan, except that no more than one year of credited service shall be counted during any one calendar year for determining the number of Pension Credit Years under this Plan for purposes of Retiree Eligibility under Section 2.02.

AA. **Pension Plan or Pension Fund** means the International Association of Heat and Frost Insulators Local 17 Pension Fund.

AB. **Physician and/or Surgeon** means a person licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license.

AC. **Plan and/or Welfare Plan** means this document as adopted by the Trustees and as amended by the Trustees.

AD. **Preventive Services** means:

(a) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided in (d) below;

(b) Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) With respect to women, to the extent not described in paragraph (a) above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

AE. **Qualifying Events** are certain events that would cause an individual to lose health coverage. Qualifying events include voluntary or involuntary termination of employment (for reasons other than gross misconduct), reduction in the number of hours of employment, covered employee's becoming entitled to Medicare, divorce or legal separation of the covered Employee, death of the covered Employee or loss of Dependent child status under the Plan rules.

AF. **Reciprocal Welfare Agreement** means an agreement entered into by the Fund with another welfare fund which specifies the terms and conditions under which contributions for a Local 17 member working in the jurisdiction of another union or a member of another union working in the Local 17 jurisdiction are forwarded to the member's home fund.

AG. **Sickness** includes pregnancy, childbirth, abortion and related medical conditions among other illnesses.

AH. **Skilled Nursing Care Facility** means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or injury which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (RN).

AI. **Usual and Customary Fee or Charges** means the following:

Medical Expenses

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as payment in full under its contract with a Plan PPO or similar organization.

2. For service or supply where the fee is not determined under (1) above, the amount the Fund would have paid if the item had been covered under any such Plan PPO contract as represented to the Fund by the network administrator.

3. For service or supply where the fee cannot be determined under (1) or (2) above, the fee shall be based on 125% of the amount that would be allowed by Medicare, except as described in (4) below.

4. For outpatient facility charges and ambulatory surgical center charges where the fee cannot be determined under (1) or (2) above, the fee shall be based on 150% of the Medicare grouper rate.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under subsections (1), (2), (3) and (4) above.

Dental Expenses

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as payment in full under its contract with a Plan PPO or similar organization.

2. For service or supply where the fee is not determined under (1) above, the fee will be equal to the 90th percentile of the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply as determined by the Board of Trustees. "Area" means metropolitan area or a county, or a greater area if needed to find a cross section of providers of a comparable service or supply.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under subsections (1) and (2) above.

AJ. **Union** means the International Association of Heat and Frost Insulators Local 17 of Chicago, Illinois.

AK. **Vacation Hours** means the hours of vacation time for which an Employee is paid but has not worked.

Vacation Hours are determined as follows:

Pension Hours in the Previous Calendar Year	Vacation Hours in the Current Calendar Year
0 – 399	0
400 – 799	40
800 – 1199	80
1200 – 1599	120
1600 +	160

AL. **Other Terms**

Additional terms are defined within the Plan at the corresponding Section.

Terms		Section
1.	350 Hour Rule	2.01
2.	Accidental Death and Dismemberment Benefit	5.01
3.	Active Employee Benefits	2.01
4.	COBRA Continuation Coverage	2.04
5.	Continued Eligibility	2.01
6.	Coverage Quarters	2.01

7.	Covered Medical Expenses	7.07
8.	Death Benefit	4.01
9.	Dental Benefit	9.01
10.	Diagnostic and Preventive Services	9.06
11.	Eligibility Hours	2.01
12.	Eligibility Quarters	2.01
13.	Employee Assistance Program Benefit	11.02
14.	Family Medical Leave Act (FMLA)	2.01
15.	Family Protection Benefit	2.03
16.	Initial Eligibility	2.01
17.	Look-Back Rule	2.01
18.	Major Medical Benefit	7.01
19.	Mail Order Program	8.04
20.	Prescription Drug Benefit	8.01
21.	Qualified Medical Child Support Order	2.03
22.	Reinstatement of Eligibility	2.01
23.	Retail Card Program	8.04
24.	Retired Employee Coverage	2.02
25.	Schedule of Benefits .	1.01
26.	Vision Benefit	10.01
27.	Six-Month Layoff Rule	2.01
28.	Short-Term Disability Benefit	6.01
29.	Workers' Compensation Disability	2.01

SECTION 17: ADDITIONAL PLAN INFORMATION

17.01 Plan Name.

International Association of Heat and Frost Insulators Local 17 Welfare Fund.

17.02 Board of Trustees.

A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union which have entered into collective bargaining agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the address and the telephone number below:

Board of Trustees of the International Association of Heat and Frost Insulators Local 17 Welfare Fund
18520 Spring Creek Drive
Tinley Park, Illinois 60477
(708) 468-8000

As of January 1, 2015, the Trustees of the Fund are:

Union Trustees	Employer Trustees
Mr. John Crinion International Association of Heat & Frost Insulators Local 17 Welfare Fund 18520 Spring Creek Drive Tinley Park, Illinois 60477	Mr. Peter Castellarin M&O Insulation Company P.O. Box 759 Homewood, Illinois 60430
Mr. Thomas McGrath International Association of Heat & Frost Insulators Local 17 Welfare Fund 18520 Spring Creek Drive Tinley Park, Illinois 60477	Mr. Jeffrey Corrado Imico, Inc. 1110 Heinz Drive, Unit D East Dundee, Illinois 60118

17.03 Plan Sponsor and Administrator.

The Board of Trustees is the Plan Sponsor and Plan Administrator.

17.04 Plan Numbers.

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 36-6600740.

17.05 Agent for Service of Legal Process.

Johnson & Krol, LLC
300 South Wacker Drive
Suite 1313
Chicago, Illinois 60606

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the above address.

17.06 Fund's Website.

The Fund Office's website can be found by logging onto www.local17fund.com and following the links to the Welfare Fund. Once you have reached the Fund's website, you may access various forms and information about this Plan.

17.07 Source of Contributions.

The benefits described in this Welfare Fund booklet are provided through Employer contributions and any applicable required self-payments. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements. The amount of self-payments is determined by the Trustees.

17.08 Collective Bargaining Agreement.

The Fund is maintained in accordance with a collective bargaining agreement between the Illinois Regional Insulation Contractors Association, Inc. and the International Association of Heat and Frost Insulators Local 17 of Chicago, Illinois. Other agreements may be in effect from time to time. The agreements specify the contributions required.

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

17.09 Trust Fund.

All assets are held in Trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis, except for Death Benefits for Active Employees and AD&D which are insured.

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

17.10 Discretionary Authority of Fund Administrator.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to

them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

17.11 Plan Year.

The records of the Plan are kept separately for each plan year. The plan year is the calendar year that begins on January 1 and ends on December 31.

17.12 Type of Plan.

This Plan is maintained for the purpose of providing death, accidental dismemberment, disability, medical, dental, vision, prescription drug, and employee assistance benefits to participants in the event of death, Sickness or Accident. The Plan benefits are shown in the applicable Schedules of Benefits in Section 1 of this booklet.

17.13 Gender.

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

17.14 Assignment.

No participant, Dependent or beneficiary entitled to any benefits under this Plan shall have the right to assign, alienate or impair in any manner his legal or beneficial interest, or any interest in assets of the Fund, or benefits of this Plan. Neither the Fund nor any of the assets thereof, shall be liable for the debts of any participant, Dependent or beneficiary entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceedings.

Notwithstanding the above, the Fund shall have the sole discretion to choose to pay benefits to the service provider on behalf of a participant and/or a Dependent upon authorization of such payment by the execution of a claim form assignment statement and if the Physician or supplier agrees to accept the Usual and Customary Charge as the full charge for the items or services provided (except co-payments, co-insurance and deductibles). The Fund does not guarantee the legal validity or effect of such assignment nor does it guarantee that it will choose to honor all or any such authorizations.

17.15 Amendment and Termination.

You do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

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

17.16 HIPAA.

A. Privacy Policy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice is available from the Fund Administrator.

This Plan and the Plan Sponsor, will not use or further disclose information ("protected health information") that is protected by HIPAA, except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Fund also hires professionals and other companies to assist it in providing health care benefits. The Fund will require all of its business associates to also observe HIPAA's privacy rules.

You will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Fund or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Fund maintains a privacy notice, that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office if:

1. You need a copy of the privacy notice;

2. You have questions about the privacy of your health information; or

3. You wish to file a complaint under HIPAA.

B. HIPAA Security Procedures.

The Fund will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The Board of Trustees shall, in accordance with the Security Regulations:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information ("PHI") that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate Separation" means the Board of Trustees will use PHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee or fiduciary of the Fund who uses or discloses PHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's sanction policy.

3. Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Take appropriate action related to any Security Incident of which it becomes aware.

The above HIPAA Security Procedures do not apply to PHI (1) that the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.504(f)(1)(ii) or (iii)) or (2) that qualifies as Summary Health Information and that the Fund receives or supplies for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). Unless defined otherwise in the Plan booklet, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

17.17 The Fund's Use and Disclosure of Your Protected Health Information.

A. How the Fund Uses and Discloses Your Protected Health Information.

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

The Fund will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Fund will disclose PHI to the Pension Fund, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment.

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

1. Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, Plan maximums and co-payments as determined for an individual's claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Subrogation of health benefit claims;

5. Establishing Employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Fund.

C. Definition of Health Care Operations.

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

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Fund, including formulary development and administration, development or improvement of methods of payment or coverage policies;

7. Business management and general administrative activities of the Fund, including, but not limited to:

    a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

    b. Customer service, including the provision of data analyses for policyholders, Plan Sponsors, or other customers;

    c. Resolution of internal grievances; and

    d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

D. The Fund's Disclosure of Protected Health Information to the Board of Trustees.

For purposes of this section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description and Plan Document, or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Fund, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. Report to the Fund any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make the information available that is required to provide an accounting of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of HHS for the purposes of determining compliance by the Fund with HIPAA;

10. If feasible, return or destroy all PHI received from the Fund that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

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

1. The Plan Administrator; and

2. Staff designated by the Plan Administrator.

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

17.18 Statement of ERISA Rights.

As a participant in the International Association of Heat and Frost Insulators Local 17 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

A. Receive Information About Your Plan and Benefits.

You have the right to:

1. Examine, without charge, at the Plan Administrator's office, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.
3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

You also have the right to:

1. Continue health care coverage for yourself 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.

2. In the event that you or your Dependent needs a certificate of creditable coverage, please contact:

The International Association of Heat & Frost Insulators
Local 17 Welfare Fund
18520 Spring Creek Drive, Tinley Park, IL 60477
(708) 468-8000

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

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 the Plan documents or the latest annual report from the Fund and do not receive them within 30 days, you may file a lawsuit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all the Plan's claims and appeals procedures before filing a lawsuit.

If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file a lawsuit. 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. Receive Assistance With Your Questions.

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

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

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

A. By calling (866) 444-3272;

B. Sending electronic inquires to www.askebsa.dol.gov; or

C. Visiting the website of the EBSA at www.dol.gov/ebsa.

APPENDIX A: OFFICE EMPLOYEE ELIGIBILITY FOR LOCAL 17 AFFILIATED ORGANIZATIONS

Employees of Local 17 affiliated organizations are eligible for benefits under these provisions ("covered"), except for bargaining unit alumni. Active Employee Benefits and Retired Employee Coverage are the same as those provided to other eligible Employees as described in Section 1: Schedules of Benefits.

Local 17 affiliated organizations include the (1) International Association of Heat and Frost Insulators Local 17 Welfare Fund, (2) International Association of Heat and Frost Insulators Local 17 Pension Fund, (3) International Association of Heat and Frost Insulators Local 17 Annuity Fund, (4) International Association of Heat and Frost Insulators Local 17 Apprentice Training Program, and (5) International Association of Heat and Frost Insulators Local 17 of Chicago, Illinois.

A. INITIAL ELIGIBIITY.

Covered individuals that are employed full time (as defined by law) by a Local 17 affiliated organization will be eligible for benefits on the first day of the month immediately following two full calendar months of active employment. However, in no event shall coverage begin later than the 91st day following the first day of employment.

For example, Sarah was first employed by an affiliated organization on January 15, 2014, and will complete two months of full time employment on March 15, 2014; so she is eligible for benefits on April 1, 2014.

Individuals that are employed on a temporary or other basis and that are reasonably expected to have less than 1,000 Hours during a calendar year or the 12-month period that begins on his first day of employment, are not eligible for coverage.

If an individual, however, has Hours during a calendar year or the 12-month period that begins on his first day of employment which total 1,000 or more, coverage will be provided retroactively as if the individual had been hired as a full time employee on his initial start date. All required contributions will be made retroactively as well beginning with the first Hour worked.

B. CONTINUED ELIGIBILITY.

Once a covered individual completes two full calendar months of active employment, his coverage will continue if he was credited with at least 350 Hours during the preceding Eligibility Quarter.

C. TERMINATION OF ELIGIBILITY.

Covered individuals who terminate employment with an affiliated organization, will be eligible for benefits until the last day of the Coverage Quarter following the corresponding Eligibility Quarter for which the covered individual was credited with at least 350 Hours.

D. ELIGIBILITY FOR RETIREE BENEFITS.

Employees of an affiliated organization shall be eligible for Retired Employee Coverage under the requirements in Section 2.02.