

**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE FUND**

LAKE CHARLES, LOUISIANA

SUMMARY PLAN DESCRIPTION

**as of
July 1, 2003**

HOW TO FILE A CLAIM

If you or your eligible Dependents become ill or injured and you believe you may be entitled to benefits under this Plan:

1. You should telephone the Fund Office at (337) 433-1447.
2. The Fund Office will tell you if you are eligible for benefits under this Plan.
3. The Fund Office will furnish you with a claim form.
4. You should complete the claim form on behalf of the person for whom the claim is being made.
5. Mail the completed form and all bills pertaining to the claim to the Fund Office:

**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE FUND**

822 North Lakeshore Drive
Lake Charles, LA 70601

**ALL ELIGIBLE INDIVIDUALS ARE REMINDED THAT
THEY MUST NOTIFY THE FUND OFFICE WHEN:**

1. There is a change of address.
2. There are new Dependents to be covered. (Provide certified copies of the birth certificates)
3. There is a divorce or legal separation. (Provide court certified divorce or legal separation papers)
4. There is a marriage. (Provide a certified copy of the marriage license)
5. There is a death. (Provide a certified copy of the death certificate)
6. There is a change of beneficiary. (You must submit a new enrollment card)
7. There is an accident which results in Workers' Compensation benefits. (Advise the Fund Office of the date of the accident, the claim number and the duration of the disability)
8. An Injury is suffered or you have an Illness which results in permanent and total disability.
9. A Dependent ceases to be a Dependent (for example, is employed, becomes age 19, is no longer a full-time student or marries).

NOTE: Submitting claims forms, filing claims and providing proper documentation is your responsibility. If an itemized bill, which includes a diagnosis code and CPT code does not accompany your claim, the Fund Office will not process the claim until all required information has been received. In addition, if you are filing a claim and this Office is the secondary payer, an itemized bill that includes a diagnosis code and CPT code as well as the primary payer's explanation of benefits MUST accompany the claim. Otherwise, the Fund Office will not process the claim until all required information has been received.

It is your responsibility to file complete claims in a timely manner. Failure to do so may adversely affect the payment of your claim.

NOTICE

This Plan will not be deemed to constitute a contract of employment or give any Employee of a Contributing Employer the right to remain in the service of the Employer or to interfere with the

right of the Employer to discharge any Employee. These issues are covered by your Collective Bargaining or Participation Agreements.

You MUST satisfy all of the eligibility provisions in order to be eligible for the benefits of this Plan. Possession of this Booklet does not automatically entitle you to the benefits provided by this Plan.

The Trustees have full and exclusive authority to determine, in their sole discretion, all questions of coverage and eligibility, the level and type of benefits provided, the methods of providing or arranging for benefits and other related matters. The Trustees also have full and exclusive authority to construe and interpret the provisions of the Agreement and Declaration of Trust establishing the Fund and the Amended and Restated Rules and Regulations establishing and setting forth this Plan. All such determinations, constructions or interpretations adopted by the Trustees in good faith shall be binding on all entities including, but not limited to, all Eligible Individuals covered under this Plan.

The Death, Accidental Death and Dismemberment and Medical benefits described in this Booklet are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and above the amount in this Fund available for such purpose.

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**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE FUND**

822 North Lakeshore Drive
Lake Charles, LA 70601
Telephone: (337) 433-1447
FAX: (337) 433-1449

Dear Eligible Individuals:

We are pleased to present you with the July 1, 2003 Edition of our benefit Booklet. Other than the January 1, 2003 elimination of the Hospital pre-certification penalty and Durable Medical Equipment pre-certification requirements, the benefits described in this Booklet are effective as of July 1, 2003.

The Death, Accidental Death and Dismemberment and Medical benefits are paid directly from the assets of the Trust Fund.

We urge you to read this new Booklet carefully so that you will understand the benefits to which you may be entitled. While it is hoped that everyone will enjoy good health at all times, we believe that you will feel, as we do, that the Plan benefits will provide financial security in times of need.

The Booklet is provided in two parts. The Booklet is followed by the Plan's Amended and Restated Rules and Regulations. Terms that are capitalized but not defined in this Booklet are defined in the official Plan document. Please remember that for your protection, only we, as the Trustees of the Trust Fund, are authorized to interpret this Plan. To be official, any information or opinion concerning your rights under the Plan must be communicated to you in writing and signed on our behalf. If you have any questions, please do not hesitate to contact the Fund Office.

Sincerely,

Board of Trustees

SCHEDULE OF BENEFITS
Active Employees - Plan A Option

Death and Accidental Death and Dismemberment Benefits Provided by the Fund

For Employees Only

Death Benefit..... \$10,000
 Accidental Death and Dismemberment..... \$5,000

Medical Benefits Provided by the Plan

For Employees and Eligible Dependents

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In-Patient (pre-admission certification required) Maximums: Major Medical	\$250,000 per Person per Calendar Year \$1,000,000 per Person per Lifetime	\$100 per Person per Confinement if not In-PPO Network		
Mental and Nervous	15 days in-patient and 30 days out-patient treatment per Person per Lifetime			

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Wellness Benefits: Mammography	\$100 per Person per Calendar Year	None	100%	100%
Pap Smear	\$100 per Person per Calendar Year	None	100%	100%
Prostate Exam	\$100 per Person per Calendar Year	None	100%	100%
Hospital: Room & Board	Avg semi-private rate	\$100 per Confine- ment; subject to \$500 Calendar Year deductible	70% URC	85% URC; \$100 per Confinement deductible waived
Intensive Care	2 X avg semi- private rate	\$100 per Confine- ment; subject to \$500 Calendar Year deductible	70% URC	85% URC; \$100 per Confinement deductible waived
Hospital Miscell- aneous		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Dr.'s Visits & Out- Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Emergency Accident (Treat- ment within 24 hours)		None Remaining Balance Subject to \$500 Calendar Year deductible	100% of URC of the first \$300 70% URC	100% of URC of the first \$300 85% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Out-Patient Surgery: Hospital		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Facility Charge		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Prescription Drugs	\$1,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	70% URC	70% URC
Durable Medical Equipment	\$2,000 per Per- son per Calendar Year maximum	Subject to \$500 Calendar Year deductible	70% URC	85% URC
Mental and Nervous: In-Patient	15 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	70% URC	85% URC
Out- Patient	30 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	50% URC	60% URC
* Effective November 1, 2001 and with respect to the benefits shown in this Plan A Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC - Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

SCHEDULE OF BENEFITS
Retired/Disabled Employees, Surviving Spouses and Dependents
Not Entitled to Medicare - Plan B Option

For Retired/Disabled Employees Only

Death Benefit..... \$1,500

For Retired/Disabled Employees, Surviving Spouses and Dependents Not Entitled to Medicare

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In-Patient (pre-admission certification required)		\$100 per Person per Confinement if not In- PPO Network		
Maximums: Major Medical	\$250,000 per Person per Calendar Year			
	\$1,000,000 per Person per Lifetime			
Mental and Nervous	1 day in-patient and 30 days out-patient treatment per Person per Lifetime			

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Hospital: Room & Board	Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Intensive Care	2 X Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Hospital Miscellaneous		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Dr.'s Visits & Out-Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Out-Patient Surgery: Hospital		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Facility Charge		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Prescription Drugs	\$1,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	60% URC	60% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Durable Medical Equipment	\$2,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	60% URC	70% URC
Mental and Nervous:				
In-Patient	1 day per Person per Lifetime	Subject to \$500 Calendar Year deductible	60% URC	70% URC
Out-Patient	30 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	50% URC	60% URC
Mammography	\$100 per Person per Calendar Year	None	100%	100%
Pap Smear	\$100 per Person per Calendar Year	None	100%	100%
Prostate Exam	\$100 per Person per Calendar Year	None	100%	100%
* Effective November 1, 2001 and with respect to the benefits shown in this Plan B Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC – Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

SCHEDULE OF BENEFITS
Retired/Disabled Employees, Surviving Spouses and Dependents
Entitled to Medicare - Plan C Option

For Retired/Disabled Employees Only

Death Benefit..... \$1,500

For Employees and Dependents

PART A	MEDICARE BENEFITS	PLAN BENEFITS
Hospital - First 60 days	All but Part A deductible.	Part A deductible
Hospital - Days 61-90	All but 25% of Part A deductible	25% of Part A deductible
Hospital - Days 91-150	All but 50% of Part A deductible	50% of Part A deductible
Hospital - Days 151-365	-0-	100% of expense which would normally be considered a Medicare Part A eligible expense
Skilled Nursing Facility * First 20 days	100% of the cost.	-0-
Days 21-100	All but 12.5% of Part A deductible	12.5% of Part A deductible
Home Health Care – Unlimited Visits as Medically Necessary	Full cost	-0-
Hospital Care - Two 90-Day Periods & One 30-Day Period	All but limited costs for out-patient drugs and in-patient respite care	Limited cost sharing for out-patient drugs and in-patient respite care
Blood	All but first 3 pints	First 3 pints

* Neither Medicare nor the Fund will pay for nursing home care or Custodial Care.

FOR RETIRED/DISABLED EMPLOYEES, SURVIVING SPOUSES AND THEIR ELIGIBLE DEPENDENTS ENTITLED TO MEDICARE - Continued

PART B	MEDICARE BENEFITS	PLAN BENEFITS
Medical Expenses	80% of Medicare-approved amount after Part B deductible	Part B deductible plus 20% of Medicare-approved amount
Home Health Care – Unlimited Visits as Medically Necessary	Full cost	-0-
Out-Patient Hospital	80% of Medicare-approved amount after Part B deductible	Part B deductible plus 20% of Medicare-approved amount
Blood	80% of approved amount after the first 3 pints	First 3 pints non-replaced plus 20% of balance of Medicare-approved amount

NOTE: 60 Reserve Days may be used only once. Days not used are not renewable.

A Benefit Period begins on the first day service is received as an in-patient in a Hospital and ends after the patient has been out of the Hospital or skilled nursing facility for 60 days in a row.

No coverage is provided either by Medicare or the Plan for drug charges, prescriptions or otherwise.

The Part B deductible must be satisfied only once each calendar year.

The Eligible Individual will be liable for charges higher than the Medicare approved amount unless the doctor or supplier agrees to accept Medicare's approved amount as the total payment for services rendered.

SCHEDULE OF BENEFITS
Active Employees on Extended Self-Payment - Plan D Option

For Active Employees Only

Death Benefit..... \$1,500

Employees and Dependents

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In-Patient (pre- admission certification required)		\$100 per Person per Confinement if not In-PPO Network		
Maximums: Major Medical	\$250,000 per Person per Calendar Year \$1,000,000 per Person per Life-time			
Hospital: Room & Board	Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Intensive Care	2 X Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Hospital Miscellaneous		Subject to \$500 Calendar Year deductible	60% URC	70% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Dr.'s Visits & Out-Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Emergency Accident (Treatment within 24 hours)		None	100% URC of the first \$300	100% URC of the first \$300
		Remaining Balance Subject to \$500 Calendar Year deductible	60% URC	70% URC
Durable Medical Equipment	\$2,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year Deductible	60% URC	70% URC
Out-Patient Surgery: Hospital Facility Charge		Subject to \$500 Calendar Year deductible	60% URC	70% URC
		Subject to \$500 Calendar Year deductible	60% URC	70% URC
* Effective November 1, 2001 and with respect to the benefits shown in this Plan D Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC - Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

NINE WAYS TO CONTROL YOUR HEALTH CARE COSTS

You **can** control your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing **all** nine ways to control your health care expenses, you will positively affect your pocketbook and your health.

1. **Treat yourself right.** Many Illnesses and Injuries can be prevented. Major Illness such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing Illness, both major and minor. Remember to wear your seatbelts when driving and take the time to be careful around your home to avoid unnecessary household accidents.
2. **Ask “dumb” questions.** Actually, the only dumb questions are the ones you don’t ask. Ask about charges on your Hospital bill if you don’t understand them. All Hospitals have people who can help answer your billing questions. Patients who are informed about what to expect during their Hospital treatment usually recover faster and with fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them! Inquire about the costs of medications. Generic drugs often cost less than name brands and your Physician will prescribe them if you ask. If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, get a second opinion from another Physician or health care professional.

Remember! You MUST pre-certify all non-emergency Hospital admissions and certify emergency admissions within the later of 72 hours or the next business day of the admission or on the first business day following an emergency weekend or holiday admission. *This is your responsibility.* Please call:

Intracorp toll-free at (800) 222-3711 BEFORE any non-emergency Hospital admission.

3. **Don’t be in when you can be out.** Ask your Physician about the use of out-patient services in your Hospital or Physician’s office for tests, treatments and many types of minor surgery. Out-patient care is always less expensive than a stay in the Hospital and can often accomplish the same objective.
4. **Use the emergency room for emergencies.** Your Hospital’s emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.
5. **Understand your coverage before you have to use it.** Make sure you understand your health coverage. Read this Booklet. It describes how the benefits will work and what is and what is not covered. If you have any questions, call the Fund Office.
6. **The shorter your stay, the less you pay.** When it’s practical, have tests performed before you enter the Hospital. Except in emergencies, avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary time waiting for surgery or special treatment. Also, it is important to leave the Hospital as soon as your Physician tells you that you are ready.

7. **Don't expect a "free" lunch.** Be a cost-conscious consumer. Even though our Plan or the government may pay for most of your health care needs, the services and treatment you receive are **never** free. If you make an effort to control how you use health care services, everyone will benefit.....especially you.
8. **Watch for early warnings!** Learn the early warning signs of diseases such as heart disease and cancer. Early detection of Illnesses could save your life and **will** save you money.
9. **Use PPO Providers.** Since the Fund pays more of the Covered Charges when you and your Dependents are admitted to a PPO Hospital and PPO providers discount their fees for our Members for other services, you and the Fund will save money! Therefore, you will have a lower out-of-pocket expense when utilizing the services of PPO providers.

These nine steps may lead you to better health and lower medical expenses!

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

Initial Eligibility. You will become eligible on the first day of the calendar month following a period of no more than 6 consecutive calendar months in which you complete 600 hours of work in Covered Employment for a Contributing Employer who contributes to the Fund on your behalf. Once you become eligible for the benefits provided by the Plan, your eligibility will be continued as explained under the “Continuation of Eligibility” section.

Initial and Continuation of Eligibility hours also include hours worked in another geographic jurisdiction, that have been reciprocated to this Fund by your Employer on your behalf. Hours worked at contribution rates other than the Plumbers Local Union No. 106 construction contribution rate will be pro-rated.

Continuation of Eligibility. Once you become eligible, you will continue to be eligible during each Benefit Month, so long as you work at least 120 hours in the corresponding Contribution Month for an Employer(s) in employment for which contributions to the Fund are required. Contribution Months and Benefits Months are determined in accordance with the following schedule:

Contribution Month 120 Hours Worked In:	Benefit Month Earn Eligibility For:
December	February
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January

A Covered Employee who meets this eligibility requirement will be eligible for the Plan “A” Schedule of Benefits.

Hour Bank. When a Covered Employee accumulates during any Contribution Month, after having become initially eligible for benefits under the Plan, hours worked for a Contributing Employer in excess of 150 hours, such excess hours shall be credited to an “Hour Bank”. The maximum number of hours that each Covered Employee may accumulated in his Hour Bank is limited to 600. He may then draw from his Hour Bank during future Contribution Months the number of hours needed by him to maintain his eligibility under the Plan, should he not have worked the required minimum number of hours, to the extent the combination of hours worked and total Hour Bank hours are sufficient to continue his eligibility. Additionally, any remaining Hour Bank hours will be used to reduce the first month’s COBRA self-payment.

Termination of Eligibility. Your eligibility will terminate on the earliest of the following:

1. The last day of the Benefit Month corresponding to the last Contribution Month for which you have a sufficient number of hours after deduction of any hours remaining in your Hour Bank to maintain eligibility, subject to the 6-month Total Disability continuation provisions if applicable; or
2. 31 days after the Covered Employee enters a military service leave of absence unless he has elected to continue coverage by making timely self-payments in the amount of the COBRA self-payment (subject to reinstatement rights upon re-employment to the extent required by the Federal law known as USERRA);
3. The date on which the Plan or Trust terminates; and
4. The date on which there are insufficient assets left in the Fund to pay benefits.

If your coverage terminates, you may be eligible to continue the health care benefits provided by the Plan under COBRA. See “COBRA Self-Payment and Continuation Coverage” for details.

Reinstatement of Eligibility. If your eligibility terminates because you do not have the required hours in your Hour Bank, you will again become eligible if your Hour Bank shows a total of at least 120 hours. Your reinstatement will be effective on the first day of the second calendar month following the month in which your Hour Bank balance returns to 120 hours. If you are not reinstated and you do not maintain eligibility through the Self-Payment provisions, your Hour Bank will be forfeited after a period of 24 consecutive months. Continuing coverage under the COBRA Self-Payment will not result in hours being credited to your Hour Bank.

Continuation of Eligibility During Total Disability. If you become Totally Disabled while otherwise covered as an active Employee, you will not have any hours deducted from your Hour Bank from the first day of the month in which your Total Disability commences. Your coverage (and your Dependents’ coverage) will automatically be continued during your Total Disability for up to 6 consecutive months. Thereafter, the hours in your Hour Bank will be used. You may then be allowed to continue your coverage by making self-payments in accordance with the COBRA Self-Payment Continuation Coverage provisions. A Covered Employee will be considered Totally Disabled if he is prevented by Illness or Injury from performing any and all of the usual duties of his occupation.

Eligibility Rules for Non-Bargaining Unit Employees. If you are a full-time Employee who is working a minimum of 30 hours per week and your Employer has signed a Non-Bargaining Unit Employee Participation Agreement, you will become eligible for the benefits provided by the Plan on the first day of the calendar month following the month your Employer has made contributions to the Fund on your behalf.

Employees Not Eligible. Self-employed persons, sole proprietors and partners are not eligible for the coverage provided by the Plan. Contributions cannot be accepted from them. Any inadvertent acceptance of contributions will not give any persons any rights for the benefits provided by this Plan.

RECIPROCAL ELIGIBILITY

If you are working in another Local Union's geographic jurisdiction and your Employer is bound by a Collective Bargaining Agreement to make contributions to another trust fund similar to that of this Fund, you may have your work hours and the contributions transferred from the other trust fund to this Trust Fund (also called your "Home Fund"). The number of hours to be credited will be determined by dividing the total dollar amount of your Employer's contributions received in connection with employment during a particular month by the Collective Bargaining Agreement hourly contribution rate in effect for the calendar month under the terms of the Agreements between Participating Employers and the Union. However, if the reciprocating Local Union has a rate less than the current Collective Bargaining Agreement rate, those hours will be pro-rated.

ELIGIBILITY RULES FOR RETIRED EMPLOYEES

Participation. If you retire and are receiving an Early, a Normal or a Disability monthly Pension benefit from the Plumbers and Steamfitters Local No. 106 Pension Fund, you may continue the Health and Welfare Plan benefits shown in either Schedule B or Schedule C for yourself and your eligible Dependents provided you:

1. Make written application no later than 30 days following the effective date of your retirement; and
2. Make the required self-payment on a timely basis; and
3. Do not work in Competitive Employment as that term is defined by the Plan.

If you and/or your Dependents are entitled to Medicare, you and/or they must register for Medicare Part A and enroll in either Medicare Part B or Part C.

On and after June 1, 2003, in order for you to be eligible to elect Retiree health care coverage for yourself and your Dependent/s, if applicable, you must have been otherwise eligible for the benefits provided by the Fund for at least one month during the most recent 12-month period prior to your retirement.

If you do not elect to continue the Health and Welfare Plan benefits for yourself and/or your Dependents at the time you retire or you marry after your retirement becomes effective, you may make written application for Schedule C coverage for yourself and any eligible Dependents during the 30-day period immediately before your and/or your spouse's 65th birthday.

The amount of the monthly self-payment is established by the Board of Trustees and may be changed from time to time.

Coordination of Benefits with Medicare. If you or one of your Dependents is eligible for Medicare, the benefits provided by the Plan will be coordinated with Medicare. **Remember – it is very important that anyone who is eligible for Medicare register for Medicare Part A and enroll in Medicare Part B or Part C.**

If You Have Any Questions. When you are thinking about retirement, you should call the Fund Office. The Fund Office staff will be happy to answer all of your questions about the benefits provided and the amount of the monthly self-payment.

ELIGIBILITY RULES FOR DEPENDENTS

Your eligible Dependents are your lawful spouse and your unmarried children who chiefly depend upon you for support and maintenance, are living with you in a parent/child relationship and are less than 19 years of age. Provided you are eligible for the benefits provided by the Plan, your Dependents will become eligible as follows:

1. On the date you become eligible provided the individual was your Dependent on that date; or
2. After you become eligible, on the date you acquire a Dependent through birth, marriage, adoption or placement for adoption or foster care; or
3. On the date specified in a Qualified Medical Child Support Order (“QMCSO”).

An unmarried dependent child who is a full-time student and is under 24 years of age may be eligible for benefits provided he is dependent upon you for support and maintenance. A “full-time student” is a dependent child who attends a high school, college, university, technical school, trade school or vocational school on a full-time basis. In the event your Dependent’s attendance during his final semester is less than full-time, his coverage will be continued until the end of that semester.

Stepchildren, foster children and legally adopted children (including children who have been placed in your home prior to adoption) may be included the same as your biological children provided they depend upon you for support and maintenance. In the case of foster children, adopted children or children placed in your home for purposes of adoption, to be covered after age 19, the Employee must have become legally responsible for them before they attained age 19. The Fund will comply with the terms and provisions of a Qualified Child Medical Support Order (QCMSO).

If a dependent child, when he reaches the age limit shown above, is covered under the Plan, chiefly depends upon you for support and maintenance and is continuously unable to maintain self-sustaining work due to a physical or mental disability, the child will continue to be considered an eligible Dependent until the earlier of the following dates:

1. The date he recovers from the disability; or
2. The date he no longer chiefly depends upon you for support and maintenance.

You must submit proof of the dependent child’s incapacity and dependency to the Fund within 31 days after the date he reaches the limiting age and as requested by the Fund; however, the Fund will not request this proof more than once a year after the 2-year period that follows the date the child reaches the age limit shown above.

A child will in no event be considered an eligible Dependent while he is covered as an Employee or is in the military.

COBRA SELF-PAYMENT AND CONTINUATION COVERAGE

This Plan will be administered in accordance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) which is a Federal law that requires your Employer to offer you and your eligible Dependents the opportunity to temporarily continue your existing health coverage at group rates in certain instances when your coverage under the Plan would otherwise end. The COBRA self-payment and continuation of coverage provisions are described in greater detail in Section 2.06 of the Plan. The following is a summary of your rights under COBRA.

Loss of Employee's Eligibility. If you are a Covered Employee who loses eligibility for health care benefits under the Plan because of a reduction of hours or termination of employment other than by reason of gross misconduct (this includes a failure to be credited with the minimum required hours to maintain eligibility after any available hours in your Hour Bank have been used to maintain eligibility), you and your eligible Dependents may elect to continue coverage under COBRA by making COBRA self-payments directly to the Fund Office, provided the individual does not become covered as a Covered Employee or a Dependent under any other group health plan or Medicare, unless that other plan contains an exclusion or limitation for any pre-existing conditions of the individual, in which case he may continue to make COBRA self-payments and be covered under this Plan.

For purposes of this Section, the term "Covered Employee" includes an individual who was an Employee covered under the Plan, is not currently working for a Contributing Employer, but is still covered under the Plan (other than under the self-payment provisions), without any interruption in coverage, due to either a sufficient number of hours in his Hour Bank (for up to 5 months after he ceases to work as a Covered Employee of a Contributing Employer) or because he is self-paying under the extended self-payment provisions.

Loss of Dependent's Eligibility. Your Dependents may also continue their coverage under this Plan by electing COBRA continuation coverage and by making COBRA self-payments directly to the Fund Office if their eligibility for Fund benefits is or would be lost because of one of the following reasons (provided that the Dependent does not become covered under another group health plan as an Employee or a Dependent unless the other plan contains an exclusion or limitation for any pre-existing condition of your Dependents):

1. You lose coverage due to insufficient hours in your Hour Bank (other than by reason of gross misconduct) and you do not elect COBRA self-payment and continuation coverage for the eligible Dependent; or
2. You die, become divorced or legally separated;
3. You become entitled for the benefits provided by Medicare; or
4. In the case of a dependent child, the failure of the Dependent to meet the Plan's definition of an eligible Dependent.

Notice. The Fund Office will notify you and your spouse of your COBRA continuation coverage rights when you become covered by the Fund. The Fund Office will also notify a Covered Employee who has lost coverage because of insufficient hours in his Hour Bank.

The Fund Office must be notified of your death or your Medicare entitlement. You and/or your eligible Dependents will receive the COBRA self-payment notification within 60 days of the loss of your Fund

benefits due to the Qualifying Event. Dependents whose coverage is affected by your divorce or legal separation, your death after your termination of employment, your eligibility for Medicare (at a time when you are no longer employed by a Contributing Employer), or the failure of a dependent child to meet the definition of a Dependent, are responsible for notifying the Fund Office of those facts within 60 days of the event.

If you or your Dependent are disabled (within the meaning of Title II or XVIII of the Social Security Act) at any time within the first 60 days of your COBRA coverage, you must notify the Fund Office within the earlier of 60 days of the date of such determination of disability or the end of the 18-month normal coverage period under this provision; you must also notify the Fund Office within 30 days of the date you or your Dependent is determined to no longer be disabled.

The Fund Office will then notify you and your Dependent of your rights under these provisions by the later of 30 days after its notice from the Contributing Employer, Employee, or Dependent or its own determination of loss of hours or 30 days after coverage would actually end.

Any notification to your spouse will be deemed notification to all other Dependents residing with your spouse at the time of the notice.

You or your Dependent will have until the later of 60 days from the date of the notice from the Fund Office or coverage is lost to notify the Fund Office of the election to continue coverage by making COBRA self-payments. Unless otherwise specified in an election, any election by you or your spouse will be deemed also to be an election on behalf of all other Dependents who would lose coverage due to the Qualifying Event.

In any event, should you or one of your eligible Dependents decline COBRA Continuation Coverage during this 60-day election period and then either you or they wish to change that decision, the initial election to decline may be rescinded but only during the same 60-day period. Such decision is not retroactive.

COBRA Self-Payment Amounts. The first month your Hour Bank falls below 120 hours credit, you are eligible to begin making COBRA self-payments.

The amount of the monthly COBRA self-payment(s) will be established by the Board of Trustees and is subject to change at their discretion. However, the cost of the first month of COBRA Continuation Coverage will be calculated based upon the number of Hour Bank hours needed less the number of hours remaining in your Hour Bank multiplied by the current hourly contribution rate. For example, assume that the Fund requires 120 Hour Bank hours to continue coverage and you have 50 hours remaining in your Hour Bank. Your first month's COBRA self-payment would be equal to 70 hours (120 hours – 50 hours) times the current hourly contribution rate. The amount of subsequent monthly COBRA self-payments would be at the rate set by the Board of Trustees.

The COBRA self-payment(s) charged will represent continuation of health care benefits provided for you and your Dependents by the Fund. In no event will the monthly COBRA self-payment amount exceed 102% of the “applicable premium”, as determined under Section 4980B(f)(4) of the Internal

Revenue Code of 1986, except in the case of a Covered Employee or Dependent whose COBRA self-payment eligibility period is increased from 18 to 29 months due to a disability, in which case the

COBRA self-payment amount will be no more than 150% of the applicable premium for any month beginning after the 18th month of coverage.

Continuation Coverage Period. Your and your eligible Dependents' right to continue coverage under this provision will be continued until the end of the month in which the earliest of the following events occurs:

1. The Plan ceases providing any health care coverage to any Eligible Individual.
2. Coverage ceases by reason of the failure of you or your Dependent to make the timely COBRA self-payments required by the Trustees.
3. You and/or your eligible Dependent become covered under Medicare or another group health plan that does not have a limitation or exclusion for any pre-existing condition of the Employee or Dependent (as the case may be).
4. For the loss of an Employee's coverage due to insufficient hours, except as provided in paragraph 5. below, 18 months have passed since the loss of coverage. For all other loss of coverage, 36 months have passed since coverage was lost.
5. In the case of disability (within the meaning of Title II or XVIII of the Social Security Act) of you or your Dependent at any time during the first 60 days of the Qualifying Event, the 18-month period in paragraph 4. will be increased to 29 months, as long as you or your Dependent remains disabled (or, if shorter, until another event in paragraphs 1. through 3. above, occurs). In particular, the coverage under this paragraph 5. will end on the earliest of:
 - a. the last day of the month in which the Social Security Administration determines under Title II or XVIII of the Social Security Act, that you or your Dependent are no longer disabled;
 - b. 29 months after the loss of coverage; or
 - c. the occurrence of an event referred to in paragraphs 1., 2. or 3.

Termination of COBRA Self-Payments. Once you fail to make the required COBRA self-payment within the specified time or have made the maximum number of COBRA self-payments specified above, you will no longer be permitted to make the COBRA self-payments described and you must re-qualify for the coverage provided by this Plan in accordance with the "Initial Eligibility" or "Reinstatement of Eligibility" provisions.

Payment of COBRA Self-Payment Premium for Employees and Dependents. Initial COBRA self-payment(s) retroactive to the date of the loss of your coverage must be paid no later than the 45th day after the date the Fund Office is notified of the person's election to make COBRA self-payments. Each subsequent COBRA self-payment is due on the first day of the month for which coverage is intended. COBRA self-payments received at the Fund Office later than 30 days after the due date will not be accepted, and the rights to make COBRA self-payment will terminate. **There will be no waivers granted.**

Trustee Rights Concerning Eligibles Making COBRA Self-Payments. The Board of Trustees reserves the right to request and receive from Employees and Dependents who are continuing coverage in

accordance with this provision, any pertinent information bearing on a person's eligibility for the benefits provided under the COBRA self-payment provisions of this Plan. The failure of any person to promptly respond to the Trustees' request for information may lead to the COBRA self-payments rights described being suspended or terminated, at the discretion of the Trustees.

COBRA Self-Pay Eligibles Affected by Multiple Events. No person may enjoy any one continuous COBRA self-payment coverage extension beyond 36 months from the end of the month in which the first event giving rise to COBRA self-payment rights with respect to that person occurred.

Continuation of Eligibility During a Military Leave. In the event you enter into a military service leave of absence (for example, active or inactive duty training or active duty in the United States Armed Forces or National Guard), you must notify the Fund Office and any service you have earned towards initial eligibility and your Hour Bank will be frozen during your military leave and restored if you return to work within 90 days of an honorable discharge from that military service. If, however, you do not return to work or are not available for work for a Contributing Employer within that 90-day period, you will forfeit your service and Hour Bank. You may continue the health care benefits provided by the Fund during the military leave of absence for yourself and your eligible Dependents provided you continue to make the required self-payment during the period of the leave subject to the 18-month COBRA maximum. However, you will not be charged a COBRA premium during the first 31 days of military leave. The above provision notwithstanding, this Plan will comply with all requirements of the Uniformed Services Employment and Re-employment Rights Act (USERRA) and all future amendments.

Family And Medical Leave Act (FMLA). If you are eligible for the benefits provided by this Plan and eligible for a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), your eligibility and Hour Bank will be preserved and you are entitled to continue the Fund's health care coverage during the period of the leave. You and your eligible Dependents are entitled to continue the same health care coverage you had under this Plan immediately before your FMLA leave. Of course, you will be subject to any changes in the Plan that are made while you are on FMLA leave to the same extent as if you had not taken leave.

As explained in the Fund's FMLA Policies and Procedures, your Employer **must** notify the Fund of the type and duration of the Family or Medical Leave that you have requested and are entitled to receive.

Your Employer **must also** continue to make contributions to the Fund to maintain your coverage during the FMLA leave at the hourly rate specified by the Board of Trustees.

RETIRED EMPLOYEES SELF-PAYMENT PROVISIONS CONTINUATION COVERAGE

In order to continue the Plan B or Plan C benefits provided by the Fund for yourself and any eligible Dependents, you must:

1. Have retired on an Early, a Normal or a Disability Pension from the Plumbers and Steamfitters Local No. 106 Pension Fund; and

2. Registered for Part A of Medicare and enrolled in Part B or Part C of Medicare; and
3. Make timely monthly self-payments; and
4. Not engage in Competitive Employment as defined in Section 1.18 of the Plan.

You (or your eligible Dependents) may continue to make monthly self-payments for the benefits shown in either Plan B or Plan C for as long as you meet the requirements specified above, make timely self-payments and your Dependents meet the Plan's definition of a Dependent.

CERTIFICATE OF CREDITABLE COVERAGE

If you lose eligibility for Option A, B or D benefits under this Plan or become eligible for COBRA continuation coverage you will receive a Certificate of Creditable Coverage. The Certificate provides information regarding the period of your coverage under this Plan. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new health plan under which you become covered. You may also request a copy of the Certificate at any time within 24 months after your coverage has terminated.

If your Dependent loses eligibility or becomes eligible for COBRA continuation coverage at a different time or for a different reason than you and this Plan is notified that the Dependent is no longer an eligible Dependent, your Dependent or the Dependent's guardian will receive a separate Certificate of Creditable Coverage for that Dependent. The Certificate provides the Dependent's information regarding the period of coverage under this Plan. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new health plan under which the Dependent becomes covered. This separate Certificate may also be requested at any time within 24 months after the Dependent's coverage has been terminated.

COST CONTAINMENT PROVISIONS

Choosing Qualified Physicians and Facilities. The Fund contracts with MultiPlan to provide qualified PPO Network Physicians and Facilities throughout the United States. When you need assistance choosing a PPO Network Physician or a PPO Network Facility for yourself or your Dependents, MultiPlan representatives are available 24 hours a day 7 days a week. Please call MultiPlan toll free at 1-800-557-6794 for a list of the Physicians and Facilities in the area you need. You may also access MultiPlan's website at www.multiplan.com.

Hospital Certification. Hospital Certification is a program which requires that you or your Dependent have a proposed non-emergency Hospital admission and confinement reviewed for medical necessity to determine whether or not an alternate type of care and/or treatment can be made effectively in another setting, or through a facility, other than a Hospital. **All** non-emergency hospitalizations must be pre-certified. The steps which you should take in the event you or one of your eligible Dependents is admitted to a Hospital on an emergency basis are explained below.

When Must the Hospital Certification be Obtained? The Hospital Certification program must be used whenever a Physician recommends a non-emergency Hospital confinement for either you or your Dependent.

What Must Be Done When a Hospital Admission is Recommended for Either You or an Eligible Dependent? The Hospital Certification program requires that the reasons for a proposed non-emergency hospitalization be reviewed by the contracted Hospital Certification provider prior to any non-emergency Hospital admission. To obtain this Review, you **must** call IntraCorp, the Fund's Hospital Certification and Concurrent Utilization Review provider at its **TOLL-FREE** number, 1-800-222-3711. A pre-admission certification form will be promptly mailed to you. You must complete and sign Section A of the form and the Physician recommending the Hospital admission must complete and sign Section B. The completed form must then be returned to the contracted Hospital Certification and Concurrent Utilization Review provider.

The Hospital Certification and Concurrent Utilization Review program medical professional, in consultation with your Physician, will determine whether or not hospitalization is Medically Necessary, or whether or not equally effective care and/or treatment can be provided in an alternate setting. After completion of the review, the Hospital Certification and Concurrent Utilization Review provider representative will notify you, your Physician and the Hospital of the findings. If your Physician recommends hospitalization for you or one of your Eligible Dependents and the hospitalization is approved, the Hospital Certification and Concurrent Utilization Review provider representative will assign an initial number of approved Hospital confinement days. If you need additional information regarding the number of days approved by IntraCorp, the Concurrent Utilization Review provider, please call 800-222-3711.

What Happens When Additional Days of Hospital Confinement are Required? If the initially approved Hospital days have all been used and you or your Dependent remain confined, the Hospital Certification and Concurrent Utilization Review provider representative will discuss your or your Dependent's particular health care needs and the rationale for your continued hospitalization with your Physician - this is the Concurrent Utilization Review process. If it is agreed that continued hospitalization is medically justified, additional days will be approved.

What Happens When an Emergency Hospitalization Occurs and There is not Time to go Through the Pre-Admission Certification Process? In the event you or one of your eligible Dependents is admitted to a Hospital on an emergency basis, you, a responsible family member or the attending Physician must call the Hospital Certification and Concurrent Utilization Review provider within the later of 72 hours or the next business day at its **TOLL-FREE** number, 1-800-222-3711, to notify the provider's representative of the confinement and provide the information required to establish an initial number of approved Hospital days.

Emergency hospitalization means a confinement which is required as a result of an accidental Injury or the unexpected onset of a serious Illness, either of which may reasonably be considered to be a threat to the life and/or well-being of either you or your Dependent.

Why Use the Hospital Certification Program for a Hospital Confinement? While this program will require some additional action on the part of you or your eligible Dependent, it will provide you and your Dependents with the assurance that a hospitalization, if approved, is Medically Necessary and that the care received will be delivered efficiently.

REMEMBER! YOU MUST USE THE HOSPITAL CERTIFICATION AND CONCURRENT UTILIZATION REVIEW PROGRAM ANY TIME YOUR PHYSICIAN RECOMMENDS A HOSPITAL CONFINEMENT FOR EITHER YOU OR ONE OF YOUR DEPENDENTS. YOU MUST ALSO USE THE PROGRAM IN THE EVENT OF AN EMERGENCY HOSPITAL ADMISSION.

HOW TO APPEAL A DENIED CLAIM

If you or one of your Dependents submits a claim for benefits and that claim is denied in whole or in part, you and your Dependents, if applicable, have the right to appeal that decision. Important definitions of words related to the appeal of a denied claim appear below:

1. **Adverse Benefit Determination.** The term "Adverse Benefit De-termination" means any denial, reduction or termination of, or failure to provide or make payment for (in whole or in part), a claimed benefit under the Plan.
2. **Concurrent Care Claim.** The term "Concurrent Care Claim" means a claim for an ongoing course of treatment over a period of time or number of treatments that is being reconsidered after the original pre-authorization and prior to the end of the course of treatment;
3. **Health Care Professional.** The term "Health Care Professional" means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law.
4. **Post-Service Claim.** The term "Post-Service Claim" means any claim for medical benefits under the Plan that is not a pre-service claim.
5. **Relevant.** The term "Relevant", with respect to the relationship of a document, record or other information to a claim, that the document, record or information:
 - a. Was relied upon in making the benefit determination;
 - b. Was submitted, considered or generated in the course of making the benefit determination;
 - c. Demonstrates compliance with administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with the Plan and that Plan provisions have been applied consistently with respect to similarly situated claimants; or

- d. Constitutes a statement of Plan policy or guidance concerning a denied treatment option or benefit for the claimant's diagnosis without regard to whether it was relied upon in making the benefit determination.

6. Claims Procedure. In order to receive a Plan benefit or a determination affecting receipt of a Plan benefit, a Participant or his authorized representative must submit a written claim for benefits on a form provided by or acceptable to the Plan. The written claim must be submitted to the Fund Office no later than 365 days from the date the expense or event, to which the claim relates, was incurred or took place. An expense is incurred on the date the service or supply giving rise to the expense was furnished. Each claim that is filed in accordance with the Claims Procedure will be processed for determination on whether and in what amount it is covered under the Plan, without regard to whether all necessary information accompanies the filing. The Plan will notify the claimant of its determination within a reasonable period of time appropriate to the medical circumstances after receipt of the claim and in accordance with the following:

- a. **Concurrent Care Claims.** For Concurrent Care Claims, any reduction or termination (other than by Plan amendment or termination) of a pre-approved course of treatment before its original pre-authorized ending is an Adverse Benefit Determination, of which notice will be given sufficiently in advance to allow the patient to appeal and obtain a determination on review before the treatment is reduced or terminated.
- b. **Post-Service Claims.** For Post-Service Claims, the Plan will notify the claimant of an Adverse Benefit Determination only no later than 30 days after filing. If necessary due to matters beyond the Plan's control, this 30-day period may be extended one time for up to 15 days provided the Plan notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary because of the claimant's failure to submit the information necessary to decide the claim, the notice extension will describe the required information and the response deadline of at least 45 days from the claimant's receipt of the notice.
- c. For any extension of time involving a Post-Service Claim, which is due to the claimant's failure to submit information necessary to decide the claim, the time period for making a determination will be suspended (or tolled) from the date of the notice of extension to the claimant until the earlier of:
 - (1) the date on which a response from the claimant is received by the Plan; or
 - (2) the response deadline of at least 45 days.

Nothing in this claims Procedure will preclude a voluntary extension of the response deadline if agreed to by both the claimant and the Plan.

- d. In the event of an Adverse Benefit Determination for any type of claim filed, the Plan's notice of determination to the claimant will list and explain:
 - (1) specific reason/s for the determination;
 - (2) reference to the specific Plan provision/s on which the determination is based;

- (3) a description of any additional material or information necessary to perfect the claim and the reasons why it is needed;
- (4) a copy of the Plan's Claims Review Procedure;
- (5) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if benefits are denied after review;
- (6) if an internal rule, guideline, protocol or similar criterion is relied upon in making the determination, either the specific rule, guideline, protocol or criterion or a statement that it was relied upon and that a copy will be provided free of charge upon request; and
- (7) if the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement applying the Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request..

7. **Claims Review Procedures.** If there is an Adverse Benefit Determination on a claim, the claimant may appeal the determination and receive a full and fair review in accordance with the following Claims Review Procedure:

- a. Within 180 days (or a reasonable period of time for a Concurrent Care claim) after receipt of an Adverse Benefit Determination, the claimant may make a written request for review to the full Board of Trustees. If a written request is not made timely, the initial decision on the claim will be final. If a written request for review is made timely, the claimant may submit written comments, documents, records and other information relating to the claim. The claimant may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his claim, and the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the initial determination, without regard to whether it was relied upon. The review on appeal will comply with the following requirements:

- (1) no deference will be given to the initial determination;
- (2) the review will take into account all comments, documents, records and information submitted by the claimant and relating to the claim, without regard to whether it was submitted or considered in the initial determination;
- (3) the review will be conducted by a named fiduciary of the Plan who did not make, and is not a subordinate of the person who made, the initial determination; and
- (4) if the initial determination is based in whole or in part on medical judgement, including determinations of whether a treatment, drug or other item is experimental or investigational, or not medically necessary or appropriate, the reviewer will consult with a Health Care Professional, with appropriate training and experience in the field of medicine involved in the medical judgement, who was not consulted, and is not a subordinate of any Health Care Professional who was consulted, in connection with the initial determination.

8. The Plan will make a decision on an appeal within a reasonable period of time after receipt of a claim that is filed in accordance with Claims Review Procedures without regard to whether all of the necessary information accompanies the filing.

In the case of a Post-Service Claim, the Plan's determination on review shall be made no later than the first meeting of the Board of Trustees that immediately follows such filing; however, if the claim is filed within 30 days prior to such meeting, the Board of Trustees shall have until their second meeting following such a further extension of time for processing due to special circumstances, and notify the claimant in writing, prior to the extension, of the special circumstances and the date by which a determination shall be made, they shall have until their third meeting following such filing by which to make a determination on review. The Plan shall notify the claimant of the final determination on review as soon as possible but no later than 5 days after it is made. For any extension of time required due to the claimant's failure to submit information necessary to decide the claim on review, the time period for making the benefit determination on review shall be suspended (or tolled) from the date on which notification of the extension is sent to the claimant, until the date on which notification of the extension is sent to the claimant, until the date on which the claimant responds to the request for additional information.

9. Nothing in these Claims Review Procedures will preclude a voluntary extension of the response deadline if agreed to by both the claimant and the Plan.

The Plan will provide the claimant with written notification of the Plan's benefit determination on review. In the case of an Adverse Benefit Determination on review, the notification will set forth the following information in a manner calculated to be understood by the claimant:

- a. The specific reason/s for the Adverse Benefit Determination.
- b. A reference to the specific Plan provision/s on which the determination is based.
- c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim and a statement of the claimant's right to bring an action under ERISA Section 502(a).
- d. Any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Adverse Benefit Determination or a statement that it was relied upon and that a copy will be provided free of charge upon request
- e. If the Adverse Benefit Determination is based on medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that will be provided free of charge upon request.
- f. A decision on review of any claim made under the Plan in accordance with the Claims Review Procedures will be final and binding on all persons.

10. **Time Limit on Legal Action.** In no event may legal action be brought by or on behalf of any individual to receive benefits under the Plan unless the individual or his legal representative has

first fully complied with and timely exhausted all of the requirements of the Claims Procedures and Claims Review Procedures under the Plan, and in no event will any such legal action be brought later than one year following a final determination of a claim under the Plan.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT
OF 1974 (ERISA)**

The following information concerning this Plan is being provided to you in accordance with government regulations:

1. The name and type of administration of the Plan:

The Plumbers and Steamfitters Local No. 106 Health and Welfare Fund is administered by a joint Board of Trustees consisting of Union representatives and Employer representatives.

2. The name and address of the Administrative Manager is:

Ms. Barbara Chapman
Plumbers & Steamfitters Local No. 106 Health & Welfare Plan
822 North Lakeshore Drive
Lake Charles, LA 70601
Telephone: (337) 433-1447

3. The names and business addresses of the Trustees are:

Union Trustees	Employer Trustees
Mr. Garland Broussard Plumbers & Steamfitters 106 822 North Lakeshore Dr. Lake Charles, LA 70601	Mr. John B. Cole Cole Air, Inc. 620 Marilyn Dr. Lake Charles, LA 776011
Mr. J. D. Doucet Plumbers & Steamfitters 106 822 North Lakeshore Dr. Lake Charles, LA 70601	Mr. Curtis Fontenot Fontenot Plumb. & Heat. Inc. 5728 Common St. Lake Charles, LA 70607
Mr. Jack Hicks Plumbers & Steamfitters 106 822 North Lakeshore Dr. Lake Charles, LA 70601	Mr. Billy Foreman Foreman's Plumb. & Piping, Inc. 222 Billy Foreman Rd. DeRidder, LA 70364
Mr. Michael Nunez Plumbers & Steamfitters 106 822 North Lakeshore Dr. Lake Charles, LA 70601	Mr. Mark Henning Henning Plumbing 3109 Common St., Suite 114 Lake Charles, LA 70601

4. In addition to the Board of Trustees and the Administrative Manager, the following people have been designated as agent for the service of legal process:

Louis L. Robein, Jr., Esq.
Robein, Urann & Lurye
2540 Severn Avenue, Suite 400
Metairie, LA 70002

Maria C. Cangemi, Esq.
Robein, Urann & Lurye
2540 Severn Ave, Suite 400
Metairie, LA 70002

5. The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 72-0545875. The Plan Number assigned by the Board of Trustees is 501.
6. For purposes of maintaining the Plan's fiscal records, the year-end date is June 30.

7. **Funding Medium:**

Benefits are provided from the Fund's assets which are accumulated under the provisions of Collective Bargaining and Participation Agreements and the Trust Agreement and held in a trust fund for the purpose of providing benefits to under the Plan covered Participants and defraying reasonable administrative expenses.

Financial Information:

8. **Contribution Source:**

All contributions to the Fund are made by Employers in accordance with Collective Bargaining and Participation Agreements between various Employers and Plumbers and Steamfitters Local Number 106.

The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour. Non-Bargained Employee Participation Agreements also require contributions to the Fund at a fixed rate.

The Administrative Manager will provide you, upon written request for the information, as to whether or not a particular Employer or employee organization (union) is contributing to this Plan on behalf of Participants working under the Collective Bargaining and/or Participation Agreements.

See the section entitled "Plan Documents and Reports" on Page 49 if you wish to obtain additional information about the Collective Bargaining and Participation Agreements.

9. **Plan Information:**

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described on Pages 17 through 25 of this Booklet.

10. Plan Regulations:

All of the types of benefits provided by the Plan are set forth in the Schedules of Benefits on Pages 5 through 14 of this Booklet. Complete terms of the benefits are set forth in the Plan's Amended and Restated Rules and Regulations.

11. Statement of ERISA Rights:

As a Participant in the Plumbers and Steamfitters Local No. 106 Health and 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 shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan including insurance contracts, Collective Bargaining and Participation Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor.
- Receive, free of charge, an initial copy of the most recent Summary Plan Description (SPD). You will receive the SPD as soon as practicable after the Fund Office receives contributions from a Contributing Employer on your behalf.
- Obtain, upon written request to the Administrative Manager, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining and Participation Agreements, and updated Summary Plan Description (in addition to the initial SPD that is provided to you free of charge as explained above). The Administrative Manager may make a reasonable charge of up to 25¢ per page for the copies.
- Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or Dependent 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 this coverage. Review the Summary Plan Description (the front part of this Booklet) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Participants of Plans A, B and D will be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending

practitioner, after consultation with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a practitioner obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your Administrative Manager at (337) 433-1447 for more information.

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

If your claim for a Health and Welfare Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in a Federal court. In such a case, the court may require the Administrative Manager 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 Administrative Manager. If you have a claim for a Health and Welfare Plan benefit which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations and/or medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay the 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. If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. You may contact the nearest area office of EBSA in Dallas, Texas at (214) 767-6831.

12. Claims Procedure:

The procedures to follow for filing a claim for benefits are set forth on Page 1 of this Booklet. All claims for benefits must be submitted on claim forms made available by the Fund Office and filed within one year from the date on which the expenses with respect to which the claim is made were

first incurred. Claims submitted must be accompanied by any information or proof requested and reasonably required by the Board of Trustees to process such claims.

13. Review and Appeals Procedures:

The Plan's Claims Review and Appeals Procedures are set forth in greater detail on Pages 78 through 81 in Section 10.01 of the Amended and Restated Rules and Regulations.

14. Plan Documents and Reports:

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- A. Trust Agreement;
- B. Collective Bargaining and Participation Agreements;
- C. Plan Documents and all Amendments;
- D. Form 5500 or full Annual Report filed with the Internal Revenue Service and the Department of Labor; and
- E. List of Contributing Employers.

You may also obtain copies of these documents by writing for them. The cost of the copies will be up to 25¢ per page. If you prefer, you can arrange to examine these reports, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. A summary of the Annual Report, which gives details of the financial information about the Plan's operation is furnished free of charge to all participants.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE AMENDED AND RESTATED RULES AND REGULATIONS OF THE PLUMBERS AND STEAMFITTERS LOCAL NO. 106 HEALTH AND WELFARE TRUST FUND. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN, WHENEVER IN THEIR SOLE DISCRETION, CONDITIONS SO WARRANT.

The preceding Booklet may contain many of the answers to your questions about your eligibility and the benefits provided by our Plan. We have also included the Plan's Amended and Restated Rules and Regulations and hope that the following Article and Page references will make it easier for you to locate specific Sections in the Plumbers and Steamfitters Local No. 106 Health and Welfare Fund Amended and Restated Rules and Regulations:

ARTICLE AND PAGE REFERENCES

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Totally Disabled and Retired Employee Definitions	Article I	39
Dependent Definition	Article I	39
Contributing Employer Definition	Article II	45
Initial Employee Eligibility	Article II	45
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Termination of Employee Eligibility	Article II	46
Reinstatement of Employee Eligibility	Article II	47
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**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE TRUST FUND**

RULES AND REGULATIONS AMENDED AND RESTATED

as of July 1, 2000

Unless Otherwise Provided Herein

I. ARTICLE I - DEFINITIONS

Section 1.01. Trust Agreement and Trust. The terms “Trust Agreement” and “Trust” shall mean the Agreement and Declaration of Trust establishing the Plumbers and Steamfitters Local No. 106 Health and Welfare Fund effective July 1, 1973 and as amended from time to time.

Section 1.02. Participation Agreement. The term “Participation Agreement” shall mean an agreement in form and content acceptable to the Trustees which evidences the commitment of the Employer of non-collectively bargained Covered Employees to be bound by the terms and provisions of the Trust Agreement.

Section 1.03. Plan. The term “Plan” shall mean the program of benefits set forth in these Amended and Restated Rules and Regulations.

Section 1.04. Fund. The term “Fund” shall mean the Plumbers and Steamfitters Local No. 106 Health and Welfare Trust Fund. The term Fund shall also mean the Board of Trustees established by the Trust Agreement, where applicable.

Section 1.05. Board of Trustees. The term “Board of Trustees” shall mean the Board of Trustees established by the Trust Agreement.

Section 1.06. Covered Employee. The term “Covered Employee” shall mean any person who meets the eligibility rules in Section 2.02.

Section 1.07. Totally Disabled Employee. The term “Totally Disabled Employee” shall mean any person who is prevented by reason of Illness or Injury from performing any and all of the usual duties of his occupation.

Section 1.08. Retired Employee. The term “Retired Employee” shall mean any person who is receiving an Early, Normal or Disability Pension from the Plumbers and Steamfitters Local Union No. 106 Pension Fund.

Section 1.09. Dependent. The term “Dependent” shall mean:

- A. The Covered Employee’s lawful spouse.
- B. The Covered Employee’s unmarried children from birth to age 19 years. The terms child and children include:

1. natural children;
 2. stepchildren;
 3. adopted children or children placed for adoption provided such children have been placed in the Covered Employee's home by a court of competent jurisdiction and the Covered Employee has assumed a legal obligation for such children; and
 4. foster children provided such children have been placed in the Covered Employee's home by a court of competent jurisdiction and the Covered Employee has assumed a legal obligation for such children.
- C. The Covered Employee's unmarried children from age 19 to age 24 provided that any unmarried child age 19 or over shall be considered an eligible Dependent only if he is a full-time student as defined by a high school, college, university or other approved institution of higher learning. In the event the Dependent's full-time student status is less than that required above at such institution during the final semester, said Dependent's coverage shall be continued through that semester.
- D. An unmarried child of any age who is unable to earn a living because of a mental or physical handicap is also considered an eligible Dependent provided:
1. he was covered under the Plan immediately before the attainment of the limiting age;
 2. the Covered Employee submits satisfactory proof of the Dependent's incapacity and dependency on the Covered Employee to the Fund within 31 days of such Dependent's attainment of the limiting age.
- E. Children will in no event be considered eligible Dependents while covered as an Employee. In order to be considered eligible Dependents, children must:
1. be living with the Covered Employee in a parent-child relationship unless otherwise eligible as described in Section 1.09.C;
 2. be dependent on the Covered Employee for support and maintenance; and
 3. however, if the child is other than the Covered Employee's natural child, stepchild, adopted child, child placed for adoption or foster child, such child will be considered as a Dependent for purposes of this Plan only if the child has been duly placed in the Covered Employee's home by order of a court of proper jurisdiction and only if the child is financially dependent upon the Covered Employee for financial support; and
 4. children who are required to be covered by the Qualified Medical Child Support Order ("QMCSO"), within the meaning of ERISA Section 609(a), will be considered as eligible Dependents.
- F. Proof of a Dependent's eligible status required by the Fund includes, but is not limited to certified copies of:
1. marriage license;
 2. court decree of divorce;
 3. birth certificate;
 4. court order of guardianship or placement for adoption;
 5. Qualified Child Medical Support Order (QCMSO);
 6. Physician's statement of mental or physical incapacity; and
 7. educational institution certification of full-time attendance.

Section 1.10. Eligible Individual. The term “Eligible Individual” shall mean each Covered Employee, Retired Employee or Disabled Employee who is eligible to continue coverage as set forth in Section 2.06 and makes the required self-payment and each of his Dependents, if any.

Section 1.11. Physician. The term “Physician” shall mean a Doctor of Medicine (M. D.) or Doctor of Osteopathy (D. O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place the service is rendered. For covered services, Doctors of Dental Surgery (D. D. S.), Doctors of Dental Medicine (D. M. D.), Doctors of Surgical Chiropody (D. S. C.) and Doctors of Podiatry (Pod. D.), when acting within the scope of their licenses, are deemed to be Physicians.

Section 1.12. Hospital. The term “Hospital” shall mean:

- A. An institution which is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals.
- B. Any other institution which is operated pursuant to law under the supervision of a staff of Physicians and with 24-hour-a-day nursing service provided by or under the supervision of a Registered Nurse (R. N.) and which is primarily engaged in providing:
 - 1. general in-patient medical care and treatment of ill or injured persons through medical, diagnostic and major surgical facilities, all of which must be provided on its premises or under its control; or
 - 2. specialized in-patient medical care and treatment of ill or injured persons through medical and diagnostic facilities (including X-Ray and laboratory) on its premises, under its control or through a written agreement with a Hospital (as defined above) or with a specialized provider of those services.
- C. In no event shall the term Hospital include a convalescent nursing home or an institution or part of which:
 - 1. is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged; or
 - 2. furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living; or
 - 3. is operated primarily as a school.

Section 1.13. Free Standing or Walk-In Clinic. The term “Free Standing or Walk-In Clinic” shall include clinics and centers which have been established solely for the purpose of treating minor medical emergencies and Illnesses on an out-patient basis. Hospitals and other facilities which provide for treatment on an in-patient basis shall not be considered Free Standing or Walk-In Clinics.

Section 1.14. Skilled Nursing Facility. The term “Skilled Nursing Facility” shall mean an institution that provides room and board and skilled nursing services for medical care. It must:

- A. Have one or more licensed nurses on duty at all times supervised on a 24-hour basis by a Registered Nurse (R.N.) or Physician.

- B. Have the services of a Physician available at all times by an established agreement.
- C. Comply with the legal requirements which apply to its operation and keep daily medical records on all patients.

Skilled Nursing Care Facility excludes an institution or part of one used mainly for rest care, care of the aged, care of drug addicts or alcoholics, custodial care or educational care.

Section 1.15. Custodial Care. The term “Custodial Care” shall mean:

- A. Room and Board and other institutional or nursing services which are provided for a person due to his age or mental or physical condition mainly to aid the person in daily living.
- B. Medical services which are given merely as care to maintain the person’s present state of health and which cannot be expected to improve a medical condition to a great extent.

Section 1.16. Federal Medicare and Medicare. The terms “Federal Medicare” and “Medicare” shall mean the benefits provided under Title XVIII of the Social Security Amendments of 1965 as amended.

Section 1.17. Occupational Injury and Illness. The terms “Occupational Injury and Illness” shall mean any Injury or Illness:

- A. Covered by any Workers’ Compensation or occupational disease law.
- B. Arising from or sustained in the course of any occupation or employment for compensation, profit or gain.

Section 1.18. Competitive Employment. The term “Competitive Employment” shall mean work (including self-employment):

- A. as a Plumber, Steamfitter or Pipefitter performed in the same;
- B. Industry covered by the Plan; or
- C. Trade or craft (including supervisory work) covered by the Plan; or
- D. Geographical area of the Plan.

After January 1, 1995, the definition of Competitive Employment is employment or self-employment in any capacity with or by any Employer, Contractor or other business entity engaged in the Plumbing, Pipefitting, Heating and Air Conditioning industries in the same geographic covered by the Plan.

Section 1.19. Covered Employment. The term “Covered Employment” shall mean work performed under the trade autonomy of the Plumbers and Steamfitters Local Union within the occupational and geographical jurisdiction of the Union under a Collective Bargaining or Participation Agreement with a Contributing Employer requiring contributions to be submitted to the Plan on the Covered Employee’s behalf.

Section 1.20. Complications of Pregnancy. The term “Complications of Pregnancy” shall mean:

- A. Conditions resulting in Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy.
- B. Non-elective cesarean section or ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation from which a viable birth is not probable.

Section 1.21. Hospice. The term “Hospice” shall mean a health care program which is:

- A. Licensed or certified by the appropriate state agency in the state where the Hospice is located.
- B. Accredited by the Joint Commission on the Accreditation of Hospitals.

The Hospice must provide a Hospice care program to terminally ill individuals who have 6 months or less to live.

Section 1.22. Unnecessary Services and/or Supplies. The term “Unnecessary Services and/or Supplies” shall mean those charges for any service or supply not determined to be Medically Necessary for the care of the patient’s Illness or Injury and charges made by a Hospital to the extent that they are allocable to scholastic education or vocational training of the patient as determined by the Board of Trustees.

Section 1.23. Ambulatory Surgical Center. The term “Ambulatory Surgical Center” shall mean any public or private establishment with an organized medical staff of Physicians with permanent facilities that are equipped and operated primarily for the purposes of performing surgical procedures, with continuous Physician services and Registered Nurses whenever the patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

Section 1.24. Hospital Certification. The term “Hospital Certification” shall mean the process performed by an independent entity with whom the Fund has a contractual agreement to determine the medical necessity of a Hospital confinement.

Section 1.25. Medically Necessary. The term “Medically Necessary” shall mean those services, treatments or supplies provided by, or under the direction of, a Hospital or Physician that are required in the judgement of the Trustees to identify or treat an Injury or sickness and which are:

- A. Consistent with the symptoms or diagnosis and treatment of the Covered Employee’s or Dependent’s condition, disease, ailment or Injury;
- B. Appropriate according to standards of good medical practice;
- C. Not solely for the convenience of a Covered Employee or Dependent, Physician or Hospital; or

D. The most appropriate which can be safely administered to the Covered Employee or Dependent.

Section 1.26. Reasonable, Usual and Customary Expense. The term “Reasonable, Usual and Customary Expense” shall mean the usual, reasonable and customary fees or charges for the covered services rendered and the covered supplies furnished as determined for the geographical area in which such services are rendered or supplies are furnished.

Section 1.27. Experimental and Investigative Expense. The term “Experimental and Investigative Expense” shall mean the use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any such items requiring Federal or other governmental agency approval and for which such approval had not been granted at the time services were rendered.

Section 1.28. Preferred Provider Organization (PPO). The term “Preferred Provider Organization (PPO)” shall mean the entity with whom the Fund has a contractual agreement to provide services and/or supplies to eligible Covered Employees and Dependents at a reduced cost.

Section 1.29. Plan Year. For purposes of the operation of the Plan with respect to the application of claims payment and Deductibles, the term “Plan Year” shall mean the calendar period January 1st through December 31st of each year.

Section 1.30. Deductible Amount. The term “Deductible Amount” shall mean the Calendar Year and Non-PPO Hospital Deductible Amounts as shown in Appendices A through D.

The overall Plan Deductible Amount applies separately to all Covered Charges incurred by or on behalf of each Eligible Individual once during each Plan Year (except as specified under Family Limit).

In order that the Calendar Year Deductible Amount shall not be applied late in one Plan Year and soon again in the following Plan Year, any Covered Charges incurred during the last 3 months of a Plan Year which apply toward the Calendar Year Deductible Amount may also be applied toward the Deductible Amount for the following Plan Year.

Section 1.31. Family Limit. After 3 Eligible Individuals have each satisfied the Calendar Year Deductible Amount during any Plan Year, Covered Charges incurred by or on behalf of any other members in the family during the remainder of that Plan Year shall not be subject to the Calendar Year Deductible Amount.

Section 1.32. Common Accident. If 2 or more Eligible Individuals in a family are injured in the same accident, all Covered Charges arising out of the accident shall be combined and only one Calendar Year Deductible Amount shall apply to all expenses incurred in connection with such accident during that Plan Year and again during the next Plan Year.

If one of these Eligible Individuals incurs Covered Charges in the same Plan Year that do not relate to the Common Accident, the Calendar Year Deductible Amount for these charges shall be reduced by the charges for that Eligible Individual that were used toward the Common Accident Deductible Amount.

ARTICLE II - ELIGIBILITY FOR BENEFITS

Section 2.01. Definitions. The following definitions govern this Article:

A. Contributing Employer. The term “Contributing Employer” shall mean any Employer who:

1. has a Collective Bargaining, Participation or other written Agreement with the Union or the Trustees requiring periodic contributions to be made to this Fund; or
2. signs a copy of the Trust Agreement; or
3. is accepted for participation in this Plan by the Trustees or is or was a party to the Trust Agreement.
4. the term Contributing Employer shall also include the Fund and the Union if it:
 - (a) becomes obligated pursuant to a Participation Agreement with the Trustees to contribute to the Fund on behalf of its Non-Bargained Covered Employees on substantially the same basis upon which other Participating Employers are contributing to the Fund; and
 - (b) is accepted for participation in this Plan by the Trustees; and
 - (c) makes contributions to this Fund as required by the Participation Agreement.

B. Union. The term “Union” shall mean any local union accepted for participation into this Plan by the Trustees.

C. Covered Employee. The term “Covered Employee” may include other Employees of the Employer participating in this Plan other than those Employees covered by the Collective Bargaining Agreement upon approval of the Board of Trustees provided, however, that all Non-Bargaining Unit Employees of such Employer must participate, or none may; and provided further, that the Employer must execute a Non-Bargaining Unit Employee Participation Agreement in a form determined by the Board of Trustees.

It is understood and agreed that those individuals who participate in this Plan as Non-Bargaining Unit Employees of a Participating Employer may not share the same compensation method as do Bargaining Unit Employees and that establishing different contributions methods for each different type of Non-Bargaining Unit Employee would be cumbersome and difficult. Therefore, it is agreed that all Non-Bargaining Unit Employees shall have contributions made on their behalf at a flat monthly rate basis with the rate to be determined by the Board of Trustees.

Section 2.02. Eligibility Rules for Covered Employees:

A. Initial Eligibility. A Covered Employee shall become eligible on the first day of the month following the month in which he has been employed by a Contributing Employer or Employers for a total of 600 hours provided he worked the 600 hours during a 6 consecutive month period. A Covered Employee who meets this eligibility requirement shall remain eligible during the Benefit Month corresponding to the month in which his initial eligibility is established. A Covered Employee shall be required to establish Initial Eligibility under the Plan only once, after which time his eligibility shall be continued as provided below.

B. Continuation of Eligibility. Once having become eligible, a Covered Employee shall continue to be eligible during each succeeding Benefit Month, so long as he works at least 120 hours in the corresponding Contribution Month for an Employer(s) in employment for which contributions to the

Fund are required. Contribution Months and Benefits Months are determined in accordance with the following schedule:

Contribution Month 120 Hours Worked In:	Benefit Month Earn Eligibility For:
December	February
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January

A Covered Employee who meets this eligibility requirement shall be eligible for the Plan "A" Schedule of Benefits.

When a Covered Employee accumulates during any Contribution Month, after having become initially eligible for benefits under the Plan, hours worked for a contributing Employer in excess of 150 hours, such excess hours shall be credited to an "Hour Bank". The maximum number of hours that each Covered Employee may accumulate in his Hour Bank is limited to 600. He may then draw from his Hour Bank during future Contribution Months the number of hours needed by him to maintain his eligibility under the Plan, should he not have worked the required minimum number of hours, to the extent the combination of hours worked and total Hour Bank hours are sufficient to continue his eligibility. Additionally, any remaining Hour Bank hours shall be used to reduce the amount of any self-payment made under the provisions outlined below.

C. Termination of Eligibility. A Covered Employee's eligibility shall terminate on the earliest of the following:

1. the last day of the Benefit Month corresponding to the last Contribution Month for which the Covered Employee has a sufficient number of hours to maintain eligibility after deduction of any hours remaining in his Hour Bank and subject to the 6-month Total Disability continuation provisions, if applicable;
2. 31 days after the Covered Employee enters a military service leave of absence unless he has elected to continue coverage by making timely self-payments in the amount of the COBRA self-payment (subject to reinstatement rights upon re-employment to the extent required by the Federal law know as USERRA);
3. the date on which the Plan or the Trust terminates;
4. the date on which there are insufficient assets left in the Fund to pay benefits to any Eligible Individual.

Section 2.03. Reinstatement of Eligibility. Once a Covered Employee has gained eligibility under the Plan and subsequently forfeited his eligibility, he shall once again become eligible only upon satisfying the requirements for “Continuation of Eligibility” as outlined under Subsection 2.02.B.

Section 2.04. Continuation of Eligibility of Totally Disabled Covered Employee. Any Covered Employee who shall be Totally Disabled in accordance with the rules of this Plan shall receive 120 hours of work credit for each month, or a proportionate share thereof for each day, during which he is Totally Disabled.

This work credit accumulation shall cease when the Total Disability ceases or such work credits total 720 hours, whichever occurs first.

Section 2.05. Eligibility Rules for Dependents.

A. **Establishment and Continuation of Eligibility.** An individual shall be eligible for this Plan’s benefits provided to Dependents during any period the individual qualifies as a Dependent as that term is defined in Section 1.09.

Dependent coverage shall become effective:

1. on the date the Covered Employee’s coverage becomes effective, if on that date such person is a Dependent; or
2. if later, on the date the Covered Employee acquires the Dependent through birth, marriage, adoption or placement for adoption or foster care; or
3. on the date specified in a Qualified Medical Child Support Order (QMCSO).

B. **Termination of Eligibility.** Subject to the eligible Dependent’s right to continue coverage under COBRA, if any, the eligibility of the Dependent shall terminate on the earliest of the date:

1. the Covered Employee’s eligibility terminates except in the event of the Covered Employee’s death in which case the Dependent’s eligibility may be continued until the exhaustion of the deceased Employee’s Hour Bank; or
2. he no longer qualifies as a Dependent, as that term is defined in Section 1.09; or
3. of his entrance into military service; or
4. he is covered as an Employee.

Section 2.06. Consolidated Omnibus Reconciliation Act of 1985 (COBRA) Continuation of Coverage Provisions. In accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Trustees shall determine when a “Qualifying Event” has occurred. The date of such determination shall be the date on which a Covered Employee’s eligibility under the Plan would otherwise terminate, due to his failing to meet the requirements for continuation of eligibility (other than by reason of gross misconduct) as outlined under the previous Sections of this Article II.

A. **Loss of Eligibility.** If a Covered Employee loses eligibility for the health care benefits provided by this Plan because of insufficient hours in his Hour Bank (other than a termination of employment for gross misconduct), he and/or his eligible Dependents may continue such coverage by making COBRA self-payments directly to the Fund Office, provided the individual does not, after the date

of his COBRA election, become covered as a Covered Employee under any other group health plan unless that other plan contains an exclusion or limitation for any pre-existing condition of such individual in which case he may continue to make payments and be covered. For purposes of this Section 2.06., the term Covered Employee shall include an individual who was a Covered Employee covered under the Plan, is not currently work-ing for a Contributing Employer, but is still covered under the Plan without any interruption in such coverage, due to sufficient hours in his Hour Bank (for up to 5 months after he ceases to work as a Covered Employee of a Contributing Employer).

If a Covered Employee's failure to continue eligibility and his insufficiency of credited hours are due to retirement, such Covered Employee may be eligible to elect coverage under this Section 2.06. in lieu of the coverage provided under Section 2.07. After he elects the basis upon which he wishes to continue coverage, the Retired Employee shall not be permitted to change his election after 60 days following the date he loses coverage.

A Covered Employee's Dependents may continue the health care benefits provided by the Fund by making COBRA self-payments directly to the Fund Office if eligibility for this Plan's benefits is lost because of one of the following reasons (provided the Dependent does not become covered under another group health plan as a Covered Employee or a Dependent unless such other plan contains an exclusion or limitation for any pre-existing condition of such Dependent):

1. the death, divorce or legal separation of a Covered Employee; or
2. the eligibility for Medicare by a Covered Employee who is continuing coverage in accordance with this Section 2.06; or
3. in the case of a dependent child, the failure of such Dependent to meet the definition of Dependent as that term is defined in Section 1.09; or
4. the Covered Employee loses coverage due to insufficient hours in his Hour Bank (other than by reason of gross misconduct) and he does not elect continuation coverage for such Dependent.

B. Notice. The Fund Office shall notify all Covered Employees and spouses of their rights under this Section 2.06 at the Covered Employee's commencement of coverage under this Plan. The Fund Office shall also notify (at his last known address) a Covered Employee who has lost coverage because of insufficient hours.

The Fund Office must be notified of the death of a Covered Employee or the Medicare entitlement of any Covered Employee who is continuing coverage under this Section 2.06 (if the Covered Employee is still employed by the Contributing Employer) within 60 days of a loss of a Covered Employee's Fund benefits due to such event. Dependents whose coverage under this Plan is affected by divorce or legal separation of a Covered Employee, the death of a Covered Employee after his termination of employment, the eligibility for Medicare by a Covered Employee who is continuing coverage in accordance with this Section 2.06 (at a time when he is no longer employed by a Contributing Employer) or the failure of a Dependent child to meet the definition of Dependent as that term is defined in Section 1.09 are responsible for notifying the Fund Office of those facts within 60 days of the event.

Any Covered Employee or Dependent who is disabled (within the meaning of Title II or XVIII of the Social Security Act as amended) at any time within the first 60 days of his COBRA coverage must also notify the Fund Office within the earlier of:

1. 60 days of the date of such determination of disability; or
2. the end of the 18-month coverage period under this Section 2.06; or

The Fund Office shall then notify the Covered Employee and Dependent of his rights under these provisions within 30 days after the later of:

3. its notice from the Contributing Employer, Covered Employee, Dependent or its own determination of loss of hours; or
4. the date coverage would actually end.

Any notification to a Covered Employee's spouse shall be deemed notification to all other Dependents residing with such spouse at the time of the notice.

5. each Covered Employee or Dependent shall have until the later of 60 days from the date:
 - a. of the notice from the Fund Office; or
 - b. coverage is lost, to notify the Fund Office of the election to continue coverage by making COBRA self-payments.

Unless otherwise specified in an election, any election by a Covered Employee or his spouse shall be deemed also to be an election on behalf of all other Dependents who would lose coverage due to the Qualifying Event.

Should a Covered Employee or eligible Dependent initially decline COBRA Continuation Coverage during the above-referenced 60-day period, such Eligible Individual may revoke such declination provided such revocation occurs prior to the end of such 60-day period. Such decision is not retroactive.

C. COBRA Self-Payment Amounts. The amount of the monthly COBRA self-payment(s) shall be established by the Board of Trustees and is subject to change at their discretion. Notwithstanding the preceding sentence, the initial COBRA Self-Payment Amount shall be calculated based upon the 120 hours required for one month's coverage less the number of hours remaining in the Employee's Hour Bank multiplied by the current hourly contribution rate. The COBRA self-payment(s) charged shall represent continuation of the health care benefits provided for Covered Employees and Dependents by the Fund.

1. **18-Month Continuation Period.** In no event shall the monthly COBRA self-payment amount exceed 102% of the "applicable premium" as determined under Section 4980B(f)(4) of the Internal Revenue Code of 1986 as amended;
2. **Disability Continuation.** In the event of a Covered Employee's or eligible Dependent's disability within the first 60 days of COBRA coverage, health care benefits may be continued for an additional 11-month period beyond the 18-Month Continuation Period up to a maximum of 29 months. The monthly COBRA self-payment amount shall not exceed 150% of the

“applicable premium” as determined under Section 4980B(f)(4) of the Internal Revenue Code of 1986 as amended.

D. Maximum Number of COBRA Self-Payments. The rights of a Covered Employee and/or his eligible Dependent to continue coverage under this Section 2.06. shall be continued until the end of the month in which the earliest of the following events occurs:

1. the Fund ceases providing any benefits to any participant;
2. coverage ceases by reason of the failure of the Covered Employee or Dependent to make the timely COBRA self-payments required by the Trustees;
3. the Covered Employee and/or his eligible Dependent become covered under Medicare or another group health plan that does not have a limitation or exclusion for any pre-existing condition of the Covered Employee or Dependent (as the case may be);
4. for the loss of coverage due to insufficient hours, except as provided in Subsection 5. below, 18 months have passed since the loss of coverage.

For all other losses of coverage, 36 months have passed since the loss of coverage. In the case of multiple Qualifying Events, in no event shall coverage be extended for more than 36 months from the date of initial loss of coverage;

5. in the case of a disability (within the meaning of Title II or XVIII of the Social Security Act as amended) of a Covered Employee or Dependent at any time within the first 60 days of COBRA coverage, the 18-month period in Subsection 4. above shall be increased to 29 months as long as the Covered Employee or Dependent remains disabled (or, if shorter, until another event in Subsections 1. through 3. above occurs). In particular, the coverage under this Subsection 5. shall end of the earliest of:

- a. the last day of the month in which the Social Security Administration determines under Title II or XVIII of the Social Security Act, that you or your Dependent are no longer disabled; or
- b. 29 months after the loss of coverage; or
- c. the occurrence of an event referred to in Subsections 1., 2. or 3.

E. Termination of COBRA Self-Payments. Once a Covered Employee fails to make the required COBRA self-payments within the specified time or has made the maximum number of COBRA self-payments specified in Subsection D. of this Section 2.06. he shall no longer be permitted to make the COBRA self-payments described and must requalify for coverage under this Plan in accordance with Section 2.02. of this Article.

F. Payment of COBRA Self-Payment Premium for Covered Employees and Dependents. Initial COBRA self-payment(s) retroactive to the date of loss of coverage must be paid no later than the 45th day after the date the Fund Office is notified of the person’s election to make such COBRA self-payments. Each subsequent COBRA self-payment is due on the first day of the month for which coverage is intended. COBRA self-payments received at the Fund Office later than 30 days after the due date shall not be accepted, and rights to COBRA self-payments shall terminate. There shall be no waivers granted.

- G. Trustee Rights Concerning COBRA Self-Payment Eligibles.** The Board of Trustees reserves the right to request and receive from Covered Employees and Dependents who are continuing coverage in accordance with this Section 2.06. any pertinent information bearing on the eligibility of such persons for the benefits provided under the COBRA self-payment provisions of this Plan. The failure of any such person to promptly respond to the Trustee's request for such information may lead to the COBRA self-payment rights described being suspended or terminated, at the discretion of the Trustees.
- H. COBRA Self-Payment Eligibles Affected by Multiple Events.** Notwithstanding anything to the contrary, no person may enjoy any one continuous COBRA self-payment coverage extension under this Plan beyond 36 months from the end of the month in which the first event giving rise to COBRA self-payment rights with respect to that person occurred.

Section 2.07. Retired and/or Disabled Employees Self-Payment Provisions. A Retired and/or Disabled Employee may continue coverage for himself and his eligible Dependents under the provisions of this Section 2.07 by making the required self-payment to the Fund provided the Retired and/or Disabled Employee:

A. Not Entitled to Medicare:

1. retires on an Early, a Normal or a Disability Pension from the Plumbers and Steamfitters Local No. 106 Pension Fund; and
2. makes written application to the Fund Office no later than 30 days following the effective date of his retirement; and
3. does not engage in Competitive Employment as defined in Section 1.18.

B. Entitled to Medicare:

1. retires on an Early, a Normal or a Disability Pension from the Plumbers and Steamfitters Local No. 106 Pension Fund; and
2. makes written application to the Fund Office no later than 30 days following the effective date of his retirement; and
3. does not engage in Competitive Employment as defined in Section 1.18; and
4. registers for Part A of Medicare and enrolls in Part B or Part C of Medicare if applicable.

- C.** The provisions of Subsections A and B above notwithstanding, in the event the Retired and/or Disabled Employee does not elect to cover his spouse or marries after the prescribed time limit, subsequent application for coverage may be made provided such application is made within the 30-day period immediately prior to the spouse's 65th birthday and within 30 days following the marriage. In addition, in the event the Retired and/or Disabled Employee does not elect to cover himself, he may make an application for coverage within the 30-day period immediately prior to becoming eligible for Medicare.

The benefits for a Retired and/or Disabled Employee who makes the required self-payment on behalf of himself and any eligible Dependents shall be as shown in Appendices B or C. Such benefits may be continued until either the Retired or Disabled Employee fails to meet the criteria specified above or,

with respect to Dependent coverage, the Dependent ceases to be an eligible Dependent as defined by this Plan.

On and after June 1, 2003, in order to be eligible to elect Retiree health care coverage for himself and his Dependent/s, a Retiree must have been otherwise eligible for the benefits provided by the Fund for at least one month during the most recent 12-month period prior to his retirement.

Once a Retired Employee has been notified by the Fund Office of said Retired Employee's self-payment privileges, it shall be the responsibility of such Retired Employee to remit the required self-payment amount. Failure to timely submit self-payments results in loss of coverage. Re-enrollment is not permitted.

The amount of the monthly self-payment shall be established by the Board of Trustees as determined from time to time.

A. Section 2.08. Alternate Eligibility Rules for Non-Bargaining Unit Employees. A person who is working a minimum of 30 hours per week as a bona-fide full-time Employee of an Employer who, as a signatory to a Non-Bargaining Unit Employee Participation Agreement, has agreed to contribute to the Fund on behalf of all of its Non-Bargained Employees, becomes eligible for Plan benefits on the first day of the calendar month following the month contributions are made on his behalf. In order for full-time Employees to be eligible for this Plan's benefits, Participating Employers must have made monthly contributions equal to 173 hours multiplied by the current hourly contribution rate.

B. Section 2.09. Reciprocity. If a Covered Employee has contributions on his behalf by an Employer bound by a Collective Bargaining Agreement to make such contributions to another trust fund similar to that of this Trust Fund, he may, upon making written request in accordance with a Reciprocal Agreement, if any, between the trustees of such other trust and this Trust Fund, have such contributions transferred from such other trust fund to this Trust Fund for credit in hours to his Hour Bank. The number of hours to be so credited shall be determined by dividing the total dollar amount of all such contributions received in connection with employment during a particular month by the hourly contribution rate in effect for the calendar month under the terms of the Agreements between Participating Employers and the Union. However, if the reciprocating trust fund has an hourly contribution rate less than the current Collective Bargaining Agreement contribution rate, those hours shall be pro-rated.

C. Section 2.10. Service in the Armed Forces. In the event a Covered Employee is on or enters into a military service leave of absence within the meaning of the Federal law known as the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), his credited hours for eligibility and his Hour Bank, if any, shall be preserved during the military service leave of absence and reinstated upon his return to employment with a Contributing Employer. If he is covered at the time his military service leave commences, he may continue the health care coverage under the Plan for himself and his eligible Dependents, if any, until the day he applies for or returns to work in Covered Employment, subject to an 18-month maximum. For the first 31 days of the leave, the only required cost for continuation of health care coverage shall be the contributions, if any, he was required to make for such coverage at the time the leave commenced; however, after the first 31 days, he shall be required to pay the monthly COBRA self-payment amount other-wise payable for such coverage in order to continue it during the period of the leave.

D. The Covered Employee must notify the Fund as soon as he is called up for military service in order to protect his health care coverage.

E. Section 2.11. Family and Medical Leave Act (FMLA). In the event a Covered Employee is eligible for Family and Medical Leave in accordance with the Family and Medical Leave Act of 1993 (“FMLA”), his credited hours shall be preserved and he shall be eligible for the health care coverage under the Plan during such FMLA leave period provided the conditions set forth in the Fund’s FMLA Policies and Procedures are satisfied.

A FMLA leave shall mean a leave of absence, intermittent leave or leave on a reduced schedule not to exceed 12 work weeks in a 12-month period, as determined and certified by a Contributing Employer pursuant to FMLA, the regulations promulgated thereunder and the Fund’s FMLA Policies and Procedures.

F. The Covered Employee’s Employer must notify the Fund, in accordance with the Fund’s FMLA Policies and Procedures, of the type and duration of FMLA leave the Covered Employee has requested and is entitled to receive. The Covered Employee’s Employer must also continue to make contributions to the Fund to maintain coverage during the FMLA leave period at the rate per hour specified by the Board of Trustees.

G. Provided the Covered Employee meets the necessary requirements, the Covered Employee and his eligible Dependents shall be eligible for the same benefits to which the covered employee and his eligible Dependents were entitled immediately prior to taking the FMLA leave (subject to any changes in the Plan that might occur during such FMLA leave).

H. Section 2.12. Certificate of Creditable Coverage. In the event an Employee loses eligibility for benefits under this Plan or becomes eligible for COBRA continuation coverage, such Employee shall receive a Certificate of Creditable Coverage. The Certificate provides information regarding the period of the Employee’s coverage under this Plan. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new health plan under which the terminated Employee becomes covered. The terminated Employee may also request a copy of the Certificate at any time within 24 months after his coverage has terminated.

I. If the Employee’s Dependent loses eligibility or becomes eligible for COBRA continuation coverage at a different time or for a different reason than the Employee and this Plan is notified that the Dependent is no longer an eligible Dependent, a separate Certificate of Creditable Coverage shall be provided for that Dependent. This separate Certificate may also be requested within 24 months after the Dependent’s coverage has been terminated.

ARTICLE III - COVERED EMPLOYEE DEATH BENEFIT

Section 3.01. Benefit. Immediately upon receipt of due proof of the death of a Covered Employee while eligible under the Plan, the Fund shall pay, subject to the provisions of the Plan, the amount of the Death Benefit as shown in Appendices A through D. All benefits provided hereunder are governed by and are subject in every respect to the pro-visions of the Plan which alone constitutes the agreement under which payments are made.

Other than as listed in Section 3.08., Exclusions, the Fund shall pay the Death Benefit shown in Appendices A through D on a 24-hour basis regardless of the cause of death.

Section 3.02. Designation of Beneficiary. Each Covered Employee shall designate a Beneficiary in writing, which designation shall be filed with the Fund Office. If, at the death of the Covered Employee, there shall be no surviving designated Beneficiary as to all or any part of the Death Benefit payable, such benefit shall be paid, in the discretion of the Trustees, to any one of the following surviving relatives of the Covered Employee:

- A. Wife;
- B. Husband;
- C. Mother;
- D. Father;
- E. Child or children;
- F. Brother or sister; or
- G. The personal representative of the Covered Employee.

In the event the Beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, the Plan, at its option and until claim is made by the duly appointed guardian, committee or other legally authorized representative of such Beneficiary, may make payments of the proceeds otherwise payable to such Beneficiary at a rate not exceeding \$50 per month to any relative by blood or connection by marriage of such Beneficiary or to any other person or institution whom the Trustees shall find to have assumed custody and principal support of such Beneficiary.

Payment made to any one or more of the above named persons shall, to the extent of such payment, release the Trustees from all liability.

The Covered Employee may change the designated Beneficiary from time to time by filing a written notice of change with the Fund Office. Said change of Beneficiary shall be effective as of the date the Covered Employee shall sign the notice of change, whether or not the Covered Employee shall be living on the date of filing same, but without prejudice to the Trustees on account of any payment made before a notice of change shall have been filed.

Section 3.03. Assignment. The Death benefit provided by the Plan is non-assignable.

Section 3.04. Continuation of the Death Benefit During Total Disability. In the event of the Total Disability as herein defined of any Covered Employee as that term is defined by the Plan, such person's eligibility for a Death Benefit shall not be terminated in accordance with the Plan provisions, but shall be continued in force by the Plan, without payment, during the continuance of such Total Disability for a period not exceeding 12 months from the date his coverage would otherwise have terminated in accordance with the Plan provisions. If the Covered Employee dies within such 12-month period, due proof of the uninterrupted existence of such Total Disability until death must be furnished to the Trustees within one year after the death occurs.

If the Plan receives, within the 3-month period immediately preceding the termination of the one-year continuation period provided above, due proof of the Total Disability as defined herein of any Covered Employee, such person's eligibility for the Death Benefit shall be continued without payment during such Total Disability for an additional period of one year, and for further periods of one year each, provided due proof of the continuance of such Total Disability for an additional period of one year, and for further periods of one year each, submitted to the Fund during the three months immediately preceding each year.

The term "Total Disability" as used herein shall mean any disability commencing while the Covered Employee is eligible under the Plan and prior to his 60th birthday which results from Injury or Illness and which wholly and continuously prevents the Covered Employee from performing any work or engaging in any occupation for wages or profit.

The term "Permanent Total Disability" shall mean any Total Disability as defined above that has existed continuously for at least 6 months, or up to the date of death, if death occurs within such 6-month period.

Without regard to other causes of disability and notwithstanding anything herein contained to the contrary, Permanent Total Disability shall be recognized to exist if the Covered Employee, prior to his 60th birthday, shall suffer loss of sight in both eyes, the loss of both hands or both feet or of one hand and one foot.

Section 3.05. Examinations. The Trustees shall have the right at any time during the first two years after receipt of due proof of Total Disability, and thereafter one a year, to require proof of the existence and continuation of such Total Disability and to make examination of the disabled Covered Employee.

The Fund shall also have the right and opportunity to make an autopsy in the case of death, where it is not forbidden by law.

Section 3.06. Rights After Termination of Disability. If any Covered Employee ceases to be Totally Disabled and returns to the class or classes of persons eligible for coverage under the Plan by resuming gainful employment, his coverage shall be continued accordingly.

If any Covered Employee ceases to be Totally Disabled and does not re-turn to the class or classes of person eligible for coverage under the Plan by resuming gainful employment, his coverage shall terminate immediately.

Section 3.07. Notice of Written Claim. Written notice of the death of a Covered Employee whose coverage is continued as described herein must be given to the Fund within 12 months after the date of death. If such notice is not given, the Fund shall not be liable for any payment on account of such death.

Section 3.08. Exclusions. No Death Benefit is payable if the Covered Employee's death occurred as a result of any one of the following causes:

- A. Intentional self-destruction or attempted self-destruction or intentionally self-inflicted Injury, while sane or insane;

- B. Insurrection, war or any act attributable;
- C. Participation in a riot;
- D. Commission of an assault or felony;
- E. Disease of the body or mental infirmity or as a result of a medical or surgical treatment or diagnosis;
- F. Ptomaine or bacterial infection except for pyogenic infection occurring simultaneously with and in consequence of a visible accidental contusion or wound;
- G. Voluntary ingestion of poison or asphyxiation from or inhaling of gas; or
- H. Travel in any aircraft as a pilot or crewman.

**ARTICLE IV - PLAN A COVERED EMPLOYEE
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

Section 4.01. Benefit Provisions. In accordance with the terms and provisions of the Plan, Accidental Death and Dismemberment benefits are provided to Plan A Covered Employees on a 24-hour basis. Upon receipt of notice and due proof of loss, as required herein, from which it shall appear that:

- A. A Covered Employee, while covered for Accidental Death and Dismemberment benefits under the Plan shall have sustained any of the Losses listed in the following Table of Losses as a direct result of accidental Injury; and
- B. Said Loss occurred independently of all other causes, as evidenced by a visible contusion or wound on the exterior of the body (except in the case of drowning or internal Injuries revealed by an autopsy); and
- C. The date of occurrence of such Injury was not more than 90 days prior to the date such Loss was sustained,

the Fund shall pay, subject to the terms, provisions and requirements hereof, to the Covered Employee or his designated Beneficiary or other person, in the event there should be no designated Beneficiary, the sum or sums of money specified for such Loss and set forth in the Table of Losses below, and in Appendix A. The term "Principal Sum" shall mean the sum payable as a benefit due to the accidental death or dismemberment to or on account of a Covered Employee as set forth in Appendix A.

Section 4.02. Benefits. In the event a Covered Employee suffers a dismemberment Loss, the Plan shall pay as follows:

TABLE OF LOSSES

<u>In the Event of Loss of:</u>	<u>The Benefit Will Be</u>
Life	The Principal Sum
Both Hands or Both Feet	The Principal Sum
Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand	1/2 the Principal Sum
One Foot	1/2 the Principal Sum
Sight of One Eye	1/2 the Principal Sum

With respect to hands or feet, the term “Loss” shall mean dismemberment by severance at or above the wrist or ankle joint. With respect to eyes, the term “Loss” shall mean the entire and irrevocable loss of sight. If two or more of the Losses listed herein result from the same accidental Injury, the Plan shall pay only for the Loss for which the largest benefit is provided.

Section 4.03. Exclusions. No Accidental Death and Dismemberment shall be paid for any loss which results directly or indirectly, wholly or partly from:

- A. Intentional self-destruction or attempted self-destruction or intentionally self-inflicted Injury, while sane or insane;
- B. Insurrection, war or any act attributable;
- C. Participation in a riot;
- D. Commission of an assault or felony;
- E. Disease of the body or mental infirmity or as a result of a medical or surgical treatment or diagnosis;
- F. Ptomaine or bacterial infection except for pyogenic infection occurring simultaneously with and in consequence of a visible accidental contusion or wound;
- G. Voluntary ingestion of poison or asphyxiation from or inhaling of gas; or
- H. Travel in any aircraft as a pilot or crewman.

Section 4.04. Beneficiary. A Covered Employee may designate or change a Beneficiary on the same basis as outlined in Article III, Death Benefit.

Section 4.05. Examination. The Plan shall have the right and opportunity to examine the Covered Employee whose Injury is the basis of a claim when and so often as it may reasonably require during the pendency of a claim.

Section 4.06. Facility of Payment. Any benefit resulting from an accidental dismemberment Loss shall be paid to the Covered Employee or his personal representative or guardian.

In the event the Covered Employee is incapable of giving a valid release for any payment due, the Plan, at its option and until claim is made by the duly appointed guardian, committee or other legally authorized representative of such Covered Employee, may make payments of the proceeds otherwise payable to such Covered Employee at a rate not exceeding \$50 per month to any relative by blood or connection by marriage of such Covered Employee or to any other person or institution whom the Trustees shall find to have assumed custody and principal support of such Covered Employee.

Section 4.07. Notice and Proof of Claim. Written notice of Injury upon which any claim may be based must be given to the Fund not more than 20 days following the date of the Injury for which benefits may be claimed unless it is not otherwise feasible to do so.

Notice given by or on behalf of the claimant to the Trustees or to any authorized agent of the Trustees with particulars sufficient to identify the Covered Employee shall be deemed to be notice to the Trustees. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

The Fund, upon receipt of the notice required by the Plan shall furnish to the claimant such forms as are usually furnished by it for filing proof of Loss. If such forms are not so furnished within 15 days after the Fund receives such notice, the claimant shall be deemed to have complied with the requirements of the Plan as to proof of Loss upon submitting, within the time fixed in the Plan for filing proofs of Loss, written proof covering the occurrence, character and extent of the Loss for which claim is made.

Affirmative proof of any Loss on which claim may be based must be furnished to the Fund not later than 90 days after the date of such Loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

**II. ARTICLE V - COMPREHENSIVE MEDICAL BENEFITS
III. FOR EMPLOYEES AND DEPENDENTS**

Section 5.01. Benefits. If an Eligible Individual receives therapeutic treatment and/or care for an Illness or Injury subject to the terms and conditions stated, the Plan shall pay in accordance with the Schedules of Benefits reflected in Appendices A through D.

All non-emergency in-patient Hospital confinements must be pre-certified and all emergency in-patient Hospital confinements must be certified as Medically Necessary within the later of 72 hours or the next business day of the admission by the contracted Hospital Certification organization.

Before benefits become payable for a Covered Charge incurred while confined as an in-patient in a Non-PPO Hospital, a separate additional Deductible Amount of \$100 shall be required for the Hospital confinement.

All amounts payable are subject to the Maximum Amounts set forth in this Article V and in Appendices A through D. Effective November 1, 2002 and with respect to the benefits shown in Appendices A, B and D, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of an Eligible Individual's residence, Covered Charges incurred by such Eligible Individual shall be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.

Effective for charges incurred on or after November 1, 2002, and with respect to benefits shown in the Appendices A, B and D as a result of an emergency situation (either an accident or onset of a sudden illness), the Plan shall pay covered charges incurred by an Eligible Individual at a Non-PPO Hospital or from a Non-PPO Physician at the In-Network PPO co-insurance percentage applicable provided either:

- A. There were no PPO provider Hospitals or Physicians within an 80-mile radius of the accident or sudden illness onset giving rise to the emergency; or
- B. The Non-PPO Hospital or Physician utilized was the closest facility or Physician at the time of the emergency.

A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made rendered or obtained.

Section 5.02. Hospital and Free-Standing Surgical Facility Pre-Payment Provisions. In the event an Eligible Individual enters into a pre-payment agreement with a Hospital or free-standing surgical facility which results in a reduction in the amount which would otherwise have been charged for an in-patient confinement or out-patient procedure, after the application of any required Deductible, the Plan shall pay 100% of the charges not to exceed the applicable percentages shown in Appendices A through D.

Section 5.03. Covered Charges. After any applicable Plan Deductible, the Plan will pay Covered Charges as shown in Appendices A through D. Covered Charges include charges for the following services and supplies which are certified by the attending Physician to be Medically Necessary for treatment of a non-occupational Injury or Illness except for those Limitations and Exclusions listed in Section 5.16:

- A. Charges made by a Hospital for semi-private room and board and medical supplies. If a Hospital does not have semi-private accommodations, Covered Charges shall mean an amount equal to 90% of the Hospital's average private room rate.

If the Eligible Individual receives care in an Intensive, Cardiac or Neonatal Care Unit, two times the semi-private room rate shall be considered a Covered Charge.

- B. Charges made by a Hospital in connection with:
 - 1. emergency treatment of an accidental Injury or surgical operation requiring Hospital facilities even though the Eligible Individual is not confined in the Hospital;
 - 2. pre-admission X-Ray and laboratory tests in the Hospital's out-patient department provided a confinement starts within 7 days; and

3. in-patient dental work or treatment if due to an accidental Injury to sound natural teeth which occurs while the Eligible Individual is covered.
- C. Charges made by a Physician for diagnosis, treatment and surgery. Oral and maxillofacial surgery shall be limited to charges for the excision of tumors, extraction of impacted wisdom teeth and the treatment of accidental Injuries occurring while the Eligible Individual is covered by this Plan. No other charges for treatment or surgery for or to the teeth, gums, jaws or any dependent tissues shall be considered eligible under this Plan.
 - D. Charges incurred for prescription drugs as set forth in Appendices A through D provided a Physician's written prescription is required to obtain the drug and the drug has been approved by the Federal Drug Administration (FDA).
 - E. Charges for prosthetic appliances to replace a limb or organ if the appliance is the first one or a replacement due to pathological changes or normal growth; casts; splints; trusses; braces; crutches.
 - F. Charges for the use of radium and radioactive isotopes;
 - G. Charges for air and ground ambulance service, medication, X-Ray services, laboratory tests, oxygen and physiotherapy.
 - H. Charges for the surgical treatment of the Temporo-mandibular Joint up to a maximum of \$5,000 per Eligible Individual per lifetime.
 - I. Charges for the voluntary sterilization of the male and female reproductive systems.
 - J. Charges incurred for the surgical procedure known as stapedectomy for the treatment of otosclerosis up to a per surgical procedure maximum of the Reasonable and Customary allowance attributable to the Fund Office's mail zip code.
 - K. Charges for physical therapy provided:
 1. the physical therapy has been recommended by a Physician;
 2. there is a reasonable assurance improvement shall result;
 3. the physical therapy is performed by a registered physical therapist; and
 4. the physical therapy occurs no more frequently than on the following treatment schedule:
 - a. 3 times per week during the first month;
 - b. 2 times per week during the second month; and
 - c. 1 time per week during the next two months.
 - L. Effective January 1, 2003, charges for the rental or purchase of Durable Medical Equipment not to exceed the per Employee or eligible Dependent per Calendar Year maximum as shown in Appendices A, B and D. Durable Medical Equipment includes, but is not limited to, such items as wheel chairs, Hospital-type beds, equipment to administer oxygen and breathing assistance apparatus.

M. Effective March 1, 2003, charges attributable to the initial collection and one-year storage of cord blood up to a maximum of \$2,000 provided the Eligible Employee or Spouse has previously lost a child due to a genetic condition that may be treatable by using stored cord blood.

Section 5.04. Plan A and Plan D Supplemental Accident Benefit. If an Eligible Individual sustains an accidental Injury while covered, the Plan shall, subject to the terms and conditions stated, pay charges of professional medical treatment recommended by a Physician and incurred within 24 hours from the date of the accident. The Plan shall pay 100% of the first \$300 of Covered Charges plus the co-insurance percentage as reflected in Appendix A and Appendix D of any excess Covered Charges incurred as a result of such accident in accordance with the applicable provisions of this Article.

Professional medical treatment shall mean only the following services and supplies:

- A. Charges made by a Hospital for room and board and other services.
- B. Charges made by a Physician for diagnosis, treatment and surgery.
- C. Charges for X-Ray and laboratory examinations.

Section 5.05. Skilled Nursing Care Facility Benefits.

- A. **Benefits.** Comprehensive medical benefits shall include charges made by a Skilled Nursing Care Facility for the:
 - 1. daily room and board charges for each day of confinement; and
 - 2. Skilled Nursing Care Facility's other charges incurred for medical care on a day for which room and board benefits are payable.

To qualify as Covered Charges, the Eligible Individual's attending Physician must certify that 24-hour Skilled Nursing Care is Medically Necessary.

Benefits shall be paid in accordance with Sections 5.01, 5.02 and 5.03.

- B. **Period of Skilled Nursing Care Facility Confinement.** A Period of Skilled Nursing Care Facility Confinement means a period that:
 - 1. begins with confinement to the Skilled Nursing Care Facility. The confinement must begin after a Hospital confinement of 5 or more days from the same or a related cause and within 14 days after discharge from the Hospital; and
 - 2. ends on the 14th day in a row after the date the Eligible Individual is not confined to the Skilled Nursing Care Facility or a Hospital.

- C. **Limitations.** For Covered Charges made by a Skilled Nursing Care Facility incurred within a period of confinement, payment shall be made up to the Calendar Year and lifetime maximums.

Skilled Nursing Care Facility benefits are subject to the limitations set forth in Sections 5.15 and 5.16.

Section 5.06. Maternity Benefits. If an Eligible Individual (other than a dependent child) incurs charges as a result of pregnancy, childbirth or related medical conditions while covered, the Plan shall, subject to the terms and conditions stated, pay benefits in accordance with Sections 5.01 and 5.02. The routine physical examination of a newborn and nursery care furnished to a newborn well baby while the mother is confined in the same Hospital are considered Covered Charges.

However, no benefits shall be payable in connection with an elective abortion except when the mother's life would be endangered if the fetus were carried to term or except for medical complications arising from an abortion.

Benefits are also payable for Covered Charges incurred by a dependent child due solely to Complications of Pregnancy as defined in Section 1.20, as if such charges were incurred by a Covered Employee or a de-pendent spouse. Pregnancy expenses of a dependent child not due to Complications of Pregnancy are not considered Covered Charges.

In any event, this Plan shall comply with the Newborn's and Mother's Health Protection Act of 1996 (NMHPA) by not restricting benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, less than 96 hours following a cesarean section or requiring a health care provider to obtain authorization from the Plan (or its utilization review company) for a length of stay not in excess of these periods.

Section 5.07. Hospice Care Benefits. After the Calendar Year and any required Out-of-Network Non-PPO Deductibles, the Plan shall pay the Covered Charges which are incurred by an Eligible Individual for Hospice Care:

A. **In-Patient.** After the Calendar Year and any required Hospital and/ or Out-of-Network Non-PPO Deductibles, the Plan shall pay on the following basis:

1. **Plan A:** PPO Covered Charges shall be paid at 85% and Out-of-Network Non-PPO shall be paid at 70%; *
2. **Plan B:** PPO Covered Charges shall be paid at 70% and Out-of-Network Non-PPO shall be paid at 60%; *
3. **Plan C:** PPO and Out-of-Network Non-PPO Covered Charges shall be paid at 20% of Medicare's approved amount;
4. **Plan D:** PPO Covered Charges shall be paid at 70% and Out-of-Network Non-PPO shall be paid at 60%. *

B. **Out-Patient.** After the Calendar Year and any required Out-of-Network Non-PPO Deductible, the Plan shall pay on the following basis:

1. **Plan A:** PPO Covered Charges shall be paid at 85% and Out-of-Network Non-PPO shall be paid at 70%; *
2. **Plan B:** PPO Covered Charges shall be paid at 70% and Out-of-Network Non-PPO shall be paid at 60%; *
3. **Plan C:** PPO and Out-of-Network Non-PPO shall be paid at 20% of Medicare's approved amount;
4. **Plan D:** PPO Covered Charges shall be paid at 70% and Out-of-Network Non-PPO shall be paid at 60%. *

- * In the event there is no PPO provider within an 80-mile radius of an Employee's or Dependent's residence, the Plan shall pay the PPO co-insurance up to a maximum of \$2,000 per lifetime.
- 5. Such payment for out-patient Hospice Covered Charges shall be made provided all of the following conditions are met:
 - a. services are ordered and approved by a Physician before the services begin;
 - b. the services are provided in lieu of Hospital services or Hospital confinement;
 - c. services are part of a Home Hospice Care program designed to meet the special physical, psychological, spiritual and social needs of dying people and their families;
 - d. services are provided by one of the following:
 - (i) a Hospice; or
 - (ii) a health service agency operated, including necessary licenses, according to the laws of the state or the locality in which the services are provided.
 - (iii) Hospice Care Expenses for the following services and supplies:
 - (A) professional nursing service expenses by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for part-time or intermittent professional nursing services; or
 - (B) medical supplies and equipment suitable for use in the home which are covered by the Plan when the Employee or his Dependent is confined to a Hospital;
 - (C) part-time or intermittent home health aide services provided by a home health aide under the supervision of an R.N.

Home Health Aide Services include, but are not limited to, helping the Eligible Individual with:

- (1) bathing and care of the mouth, skin and hair;
- (2) bowel and bladder care;
- (3) getting in and out of bed and walking;
- (4) exercises prescribed and taught by appropriate professionals;
- (5) medication ordered by the Physician;
- (6) household services essential to the home health care provided such services would be performed while the Employee or his Dependent was confined in a Hospital or skilled nursing facility;
- (7) reporting changes in the Employee's or his Dependent's condition to the supervising nurse.

Section 5.08. Mammography Benefits. If, while covered by this Plan, a female Employee or a dependent spouse covered under Plan A incurs expenses for a low-dose mammography screening to determine the presence of occult breast cancer, the Calendar Year Deductible shall be waived and the Plan shall pay 100% of the Covered Charges up to a maximum benefit payment of \$100 per Calendar Year for:

- A. A baseline mammography once between the ages of 35 and 39.

- B. One baseline mammography every 2 years (or one each year based on the Eligible Individual's Physician's recommendation) for women ages 40 through 49.
- C. One baseline mammography each year for women age 50 and over.
- D. Any other mammogram without regard to age provided the:
 - 1. mammogram is recommended by the Eligible Individual's Physician; and
 - 2. Eligible Individual or the Eligible Individual's mother or sister, has had a history of breast cancer.

Plan B Eligible Individuals are also covered under this Section 5.08.

The term low-dose mammography shall mean the X-Ray examination of the breast using equipment dedicated specifically for mammography, including the X-Ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast and with at least 2 views of each breast.

In the event there are combined charges for the professional and technical components of the examination, the Plan shall pay 100% of the Usual, Reasonable and Customary charges up to a maximum benefit of \$40 for the professional component and up to \$60 for the technical component.

Benefits payable for a routine screening mammogram shall not prejudice benefits payable for diagnostic mammograms.

Section 5.09. Pap Smears. If, while covered by this Plan, a female Employee or a dependent spouse covered under Plan A incurs expenses for an annual pap smear screening and associated Physician's office visit, the Plan shall pay 100% of the Usual, Reasonable and Customary Covered Charges up to a maximum benefit payment of \$100 and the Calendar Year Deductible amount shall be waived.

Plan B Eligible Individuals are also covered under this Section 5.09.

The routine preventative pap smear benefit is available no more frequently than once every 12 calendar months. However, this limitation does not apply to any benefits payable for a diagnostic pap smear.

Section 5.10. Prostate Examination. If, while covered by this Plan, a male Employee or a dependent spouse over age 40 covered under Plan A incurs expenses for a routine digital rectal prostate examination or a prostate-specific antigen (PSA) blood test, the Plan shall pay 100% of the Usual, Reasonable and Customary Covered Charges up to a maximum benefit payment of \$100 associated with the examination and the Calendar Year Deductible shall be waived.

The benefit for the routine digital rectal examination applies to the Physician's charge for the examination and does not include laboratory and radiology charges or any other expense as a result of the examination unless a diagnosis is made. The benefit for the PSA blood test includes Physician and laboratory expenses.

Plan B Eligible Individuals are also covered under this Section 5.10.

The routine preventative prostate examination or PSA blood test benefits are available no more frequently than once every 12 calendar months. However, this does not prejudice any benefit payable for a diagnostic prostate examination or PSA blood test.

Section 5.11. Mental Illness and/or Nervous Disorder Benefits. If, while covered by this Plan, an Eligible Individual incurs expenses for the treatment of a Mental Illness and/or Nervous Disorder, the Plan shall pay benefits in accordance with the Schedules of Benefits as set forth in Appendices A through D provided such care and/or treatment is provided by a Psychiatrist.

Section 5.12. Large Case Management. The Board of Trustees, in its sole and absolute discretion, may approve medical benefits not otherwise covered by this Plan and may approve payment for such benefits up to 100% of Covered Charges if such benefits are for an Eligible Individual and constitute alternative medical care not otherwise available under this Plan provided such medical care and/or treatment is as a result of a medical condition that is otherwise covered under this Plan.

Such alternative medical care and/or treatment must be based upon a qualified medical opinion of a Physician recommending such care and/or treatment and must be at the consent of the Eligible Individual receiving such care and/or treatment.

The Board of Trustees shall give special consideration to alternative medical care that would limit this Plan's costs when compared to procedures, treatments and/or supplies that would otherwise be used under this Plan in lieu of such alternative medical care and/or treatment.

Section 5.13. Maximum Amounts. The Maximum Amount payable under the comprehensive medical benefits during each Calendar Year and the Eligible Individual's lifetime is set forth in Appendices A through D.

Section 5.14. Automatic Reinstatement. If comprehensive medical benefits have been paid for an Eligible Individual, an amount equal to the benefits paid up to a maximum of \$5,000 shall be automatically reinstated on January 1st of each Plan Year.

Section 5.15. Extended Benefits. If an Eligible Individual is Totally Disabled on the date his coverage terminates, benefits are extended to apply to Covered Expenses incurred after termination for continued treatment of the Injury or Illness causing such Total Disability, but in no event shall benefits be payable for charges incurred after recovery from the Total Disability or the end of 90 days, whichever occurs first. This extension of benefits shall cease to apply on the date the Eligible Individual becomes eligible under any other group plan. The Eligible Individual shall notify the Fund of such other coverage.

For the purposes of this Section 5.15, a Covered Employee shall be deemed to be Totally Disabled if he prevented by Illness or Injury from performing any work for compensation or gain. An eligible Dependent shall be deemed to be Totally Disabled if he is prevented by Illness or Injury from engaging in all of the normal tasks for that person's age and family status.

Section 5.16. Limitations and Exclusions. Benefits shall not be payable for the following services and supplies even when determined to be Medically Necessary:

- A. Charges not ordered by a Physician.
- B. Charges for dental work, treatment or dental X-Rays, except that this limitation does not apply to the following:
 - 1. Hospital charges for necessary in-patient care;
 - 2. charges incurred in connection with the treatment of tumors;
 - 3. charges for the surgical removal of impacted wisdom teeth; or
 - 4. care or treatment of congenital defects in a child who becomes covered at birth.
- C. Charges for transportation except for air and ground ambulance service to and from the nearest facility capable of rendering care and/ or treatment of the Illness or Injury causing the care and/or treatment.
- D. Charges for hearing aids or their fittings.
- E. Charges for eye refractions; eyeglasses or contact lenses or their fitting, except for the first pair of glasses or lenses prescribed as a result of:
 - 1. cataract surgery; or
 - 2. an accidental Injury to the lens of the eye which occurs while the Eligible Individual is covered under this Plan.
- F. Charges for analysis of vision or the testing of its acuity; biomicroscopy, field charting or aniseikonia investigation; orthoptic or visual training; service or devices to correct vision or for advice on such service.

In addition, no payment shall be made for any expenses incurred for radial keratotomy surgery, keratomileusis surgery, laser surgery or any such other procedures unless it is determined that such surgery is necessary to save the eyesight of the Eligible Individual, and only if a Physician states that glasses or contact lenses will not protect or correct the Eligible Individual's eyesight.

- G. Charges for health examinations, except due to an Illness or accidental Injury unless otherwise considered a Covered Charge by this Plan.
- H. Charges for the surgical treatment of temporo-mandibular joint (TMJ) syndrome which are in excess of the amount specified in Subsection 5.03.H.
- I. Charges for any expenses incurred for routine care and other treatments or procedures which are not Medically Necessary unless otherwise considered a Covered Charge by this Plan.
- J. Charges not in accordance with generally accepted professional medical standards or for experimental treatment.

In addition, no payment shall be made for any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a specific Illness or accidental Injury except as specifically outlined.

- K. Charges for Custodial Care, as defined in Section 1.15, to assist an Eligible Individual in meeting the activities of daily living.

- L. Charges for an Illness or Injury resulting from participation in a riot or insurrection or in the commission of, or attempt to commit, a felony or assault.
- M. Hospital charges incurred on Friday, Saturday or Sunday for a non-emergency Hospital confinement that begins on one of those days or for any days prior to the day before the date of surgery. Earlier days of confinement shall be covered only if Medically Necessary for the Eligible Individual's health and well-being, as certified by the attending Physician.
- N. Charges related to any transplant other than a corneal transplant.
- O. Charges for services or supplies to diagnose or treat infertility including artificial insemination; in-vitro fertilization or other procedures involving the eggs and sperm; implantation of an embryo developed in-vitro; drug therapy; ovulation induction therapy; and monitoring laboratory, radiology and ultrasound studies. In addition, charges incurred for surrogate motherhood are not covered.
- P. Charges incurred for confinement in a Hospital owned or operated by the Federal government unless the Eligible Individual is legally required to pay for such charges in the absence of the benefits provided by the Plan. However, benefits shall be payable for reasonable and customary charges otherwise covered under this Plan which were incurred by the Employee or his eligible Dependent at a Veteran's Administration facility; or the Covered Employee, as an armed service retiree, or his eligible Dependent, for services or supplies which are not related to military service.
- Q. Charges due to war, whether declared or undeclared.
- R. Charges which an Eligible Individual would not legally have to pay if there were no coverage.
- S. Other than with respect to the Death and/or Accidental Death and Dismemberment benefits and/or as outlined in Subsection 5.16.F, Charges for an Injury or Illness due to employment with any Employer or self-employment for compensation or profit covered by any Workers' Compensation Law or Act or similar legislation. **(Charges for work-related Injuries are NOT eligible regardless of whether Workers' Compensation coverage is available.)**
- T. Charges in connection with cosmetic surgery unless due to an accidental Injury occurring while the Eligible Individual is covered under this Plan, for the correction of congenital defects in a child who becomes covered at birth or in conjunction with the Women's Health and Cancer Rights Act of 1998 as explained in Section 5.17.
- U. Charges for the reversal of any voluntary sterilization procedure.
- V. Charges which are primarily for the Eligible Individual's convenience or comfort or that of the Eligible Individual's family caretaker, Physician or other medical provider.
- W. Charges in connection with private duty nursing.
- X. Effective January 1, 2003, charges attributable to any type of Durable Medical Equipment repair or replacement of Durable Medical Equipment unless the replacement is as a result of a change in the

Eligible Employee's or Dependent's physical condition or the physical growth of a dependent child. Regardless of whether or not there has been a change in the physical condition of an Eligible

Employee or Dependent or physical growth of a dependent child, the Fund shall not consider replacing an item of Durable Medical Equipment more frequently than once during a 5-year period.

- Y. Charges attributable to services and/or supplies received from a Physician, Hospital, Ambulatory Surgical Center or Free-Standing or Walk-In Clinic that does not meet the definition of those terms as set forth in Article I of these Amended and Restated Rules and Regulations.
- Z. Charges attributable which are incurred for services, treatment and/or surgical procedures rendered in connection with any over-weight condition or condition of obesity.
- AA. Charges incurred as a result of treatment and/or consultation with a psychologist, social worker or marriage counselor.
- BB. Charges incurred as a result of or in connection with the prevention, cure and/or treatment of any condition of alcohol abuse or narcotism (drug addiction) or drug abuse for any Eligible Individual regardless of whether or not the condition is a primary or secondary diagnosis.
- CC. Charges incurred for any special education rendered to any Eligible Individual. This Exclusion applies regardless of the type of education, the purpose of the education, the recommendation of the attending Physician or the qualifications of the individual or individuals rendering the special education.
- DD. Charges submitted in connection with a Physician's or other provider's completion of claim forms required by the Plan for the processing of claims.
- EE. Charges incurred which are in excess of the Usual, Reasonable and Customary fees for services, supplies, care and/or treatment.
- FF. Charges incurred as a result of an Experimental and/or Investigative procedure as that term is defined in Article I of these Amended and Restated Rules and Regulations.
- GG. Charges incurred as a result of a surgical sex transformation or reassignment.
- HH. Charges incurred for care and/or services rendered solely for observation and/or diagnostic testing and charges incurred for care and/or service, whether in-patient or out-patient, rendered solely as a preventive measure unless otherwise specifically covered by the Plan.
- II. Charges incurred for the surgical installation of a Cochlear implant or other such device unless hearing may be restored only through such surgical procedure.
- JJ. Charges incurred for services and/or supplies related to any sexual dysfunction and/or inadequacy.
- KK. Charges incurred for care, treatment and/or services rendered by a Doctor of Chiropractic (D. C.).
- LL. Charges incurred in connection with or as a result of anorexia nervosa, bulimia or any such other eating disorder.
- MM. Charges incurred for or in connection with the removal of an organ or a portion of an organ for donor purposes.

NN.Charges for any Injury or Illness for which a Third Party of any kind is liable (see Section 7.10 for a definition of Third Party) However, the Fund will pay for these otherwise excluded charges provided the Eligible Individual signs the Fund's Subrogation and Reimbursement Agreement (please refer to Section 7.10).

OO. Charges attributable to stem cell transplantation.

Neither the Fund nor the Plan shall be liable to provide benefits for services or supplies not reasonably necessary for the care or treatment of Injuries or Illnesses. Furthermore, the Plan and the Fund shall not provide benefits for services, treatments or supplies for the care and treatment of Injuries or Illnesses which are in excess of the Usual, Reasonable and Customary charges or are in excess of such charges as would have been made for such care and treatment in the absence of the benefits provided by the Plan.

In determining the satisfaction of any applicable Plan Deductibles and the payment of benefits, a charge for any care, service, treatment and/or supply shall be considered to have been incurred on the date the care, service, treatment and/or supply was rendered or purchased.

Section 5.17. Notice Regarding Mastectomy Coverage. Eligible Individuals have a right to be notified of the availability of coverage required by the Women's Health and Cancer Rights Act of 1998 so that they may be assured that they are treated in accordance with Federal law if the need arises. In accordance with those requirements, this Plan includes coverage for breast reconstruction surgery as part of a mastectomy procedure. Breast reconstruction surgery in connection with a mastectomy shall, at a minimum, provide for:

- 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 for all stages of mastectomy, including lymphedemas, all in a manner determined in consultation with the consulting Physician and the patient. As part of this Plan's Schedules of Benefits, such benefits are subject to this Plan's appropriate cost control provisions such as annual deductibles and co-insurance provisions.

IV. ARTICLE VI - COORDINATION OF BENEFITS

Section 6.01. Benefits Subject to This Provision. The benefits provided under Article V are subject to the following additional provisions and limitations.

Section 6.02. Definitions.

- A. **Any Other Plan.** The term "Any Other Plan" shall mean any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:
 - 1. group, blanket or franchise insurance coverage;
 - 2. services plan contracts, group practice, individual practice and other pre-payment coverage;
 - 3. any coverage under labor-management trustee plans, union welfare plan, employer organization plans or employee benefit organization plans; and

4. any coverage under governmental programs, and any coverage required or provided by any statute, including Title XVIII of the Social Security Act of 1965 as amended, whether or not the Eligible Individual has registered for Part A or enrolled in Part B or Part C of Medicare.

The term Any Other Plan shall be construed separately with respect to each benefit or service which reserves the right to take the benefits or services of Any Other Plan into consideration in determining its benefits and that portion which does not.

- B. **This Plan.** The term “This Plan” shall mean those benefits provided in Article V of these Amended and Restated Rules and Regulations.
- C. **Allowable Expense.** The term “Allowable Expense” shall mean any necessary, reasonable and customary item of medical expense incurred, a portion of which is covered under This Plan or Any Other Plan covering the Eligible Individual for whom a claim is made.

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

The Fund shall not be required to determine the existence of Any Other Plan or the amount of benefits payable under Any Other Plan except This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under Any Other Plan only if the Fund is furnished with information concerning the existence of Any Other Plan by the Eligible Individual, insurance company, organization, agency of government, Contributing Employer or other person.

- D. **Claim Determination Period.** The term “Claim Determination Period” shall mean a period commencing with any January 1st and ending at 12 o’clock midnight on the next succeeding December 31st or that portion of such period during which the Eligible Individual with respect to whose expense a claim is based has been covered under This Plan.

Section 6.03. Effect on Benefits.

- A. This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Eligible Individual during such period, the sum of the benefits that would be payable under Any Other Plan in the absence in them of provisions of similar purpose to this provision would exceed such Allowable Expenses.
- B. As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Eligible Individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of:
 1. such reduced benefits; and
 2. all the benefits payable for such Allowable Expenses under Any Other Plan, except as provided in Subsection D.3. of this Section 6.03.

shall not exceed the total of such Allowable Expenses. Benefits payable under Any Other Plan include the benefits that would have been payable had claim been duly made for them, and in the

case of benefits payable under Parts A, B or C of Medicare, the benefits that would have been payable had the Eligible Individual enrolled for coverage under the Medicare plan.

- C. If Any Other Plan covering the Eligible Individual contains a similar non-duplication of benefits provision which coordinates its benefits with those of This Plan and would, according to its rules, determine its benefits after the benefits of This Plan have been determined and the rules set forth in Subsection D. of this Section 6.03 would require This Plan to determine its benefits before Any Other Plan, then the benefits of Any Other Plan shall not be considered for the purposes of determining the benefits due under This Plan.
- D. For the purposes of Subsection C. of this Section 6.03, the rules establishing the order of benefit determination are as follows:
1. when Any Other Plan does not contain any non-duplication provisions, the benefits under Any Other Plan shall be paid first;
 2. the benefits of This Plan and Any Other Plan which cover the person on whose expense a claim is based as a Covered Employee shall be determined before the benefits of This Plan and Any Other Plan which covers such person as a laid-off or Retired Employee or as a Dependent;
 3. the benefits of This Plan and Any Other Plan which cover the person on whose expense a claim is based as a Dependent of a Covered Employee shall be determined before the benefits of This Plan and Any Other Plan which covers such person as a former Covered Employee or a Dependent of a former Covered Employee;
 4. when This Plan and Any Other Plan cover the person on whose expense a claim is based as a dependent child, the benefits of This Plan and Any Other Plan which cover the parent whose birthday (month and day only) occurs first during a Plan Year shall be determined before the benefits of the plan which covers the parent whose birthday (month and day only) occurs later in the Plan Year;

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

- a. when the parent with custody of the child has not remarried, the benefits of This Plan and Any Other Plan which cover the child as a Dependent of that parent will be determined first. The benefits of This Plan and Any Other Plan which cover the child as a Dependent of the parent without custody shall be determined second;
 - b. when the parent with custody of the child has remarried, the order of benefit determination is as follows:
 - (i) This Plan or Any Other Plan of the parent with custody;
 - (ii) This Plan or Any Other Plan of the step-parent;
 - (iii) This Plan; or
 - (iv) Any Other Plan of the parent without custody.
 - c. if there is a court decree stating which parent's plan (whether This Plan or Any Other Plan) shall pay first, that order shall supersede any order given in Subsections a. or b. above.
5. when This Plan and Any Other Plan cover the person on whose expense a claim is based as a dependent child and Any Other Plan does not contain the birthday rule as set forth in Subsection 4. of this Subsection 6.03.D. but uses the benefit determination provision which is based on the

parent's gender, then This Plan shall also use that benefit determination provision when applicable;

6. when the rules in Subsections 1. through 5. do not establish an order of benefit determination, the benefits of This Plan or Any Other Plan which has covered the person on whose expense a claim is based for the longer period of time shall be determined before the benefits of This Plan or Any Other Plan which has covered such person the shorter period of time;
- E. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Plan during any Claim Determination Period, such benefit that would be payable in the absence of this provision shall be reduced proportionately and such reduced amount shall be charged against any applicable benefit limit of This Plan.
- F. In the event an acceptable claims settlement agreement between This Plan and Any Other Plan which also provides coverage to the Eligible Individual cannot be reached, This Plan shall limit its payment to 50% of the amount allowed in any compromised settlement.

Section 6.04. This Plan's Coordination with Medicare.

A. **This Plan is Primary to Medicare.** This Plan shall be primary to Medicare in accordance with the following provisions:

1. **End Stage Renal Disease (ESRD).** Benefits for Covered Charges shall be payable under This Plan without regard to a covered person's entitlement to Medicare as an ESRD patient for up to a maximum of 30 months from the first month the covered person is entitled to Medicare unless the covered person is already entitled to Medicare due to attaining age 65 or another disability resulting in Medicare's primary payer status.
2. **Entitlement to Other Coverage Due to Employment Status.** Benefits for Covered Charges shall be payable under This Plan without regard to a covered person's entitlement to Medicare provided such covered person is:
 - (i) a Covered Employee age 65 or older; or
 - (ii) a Dependent of a Covered Employee is age 65 or older.

B. **This Plan is Secondary to Medicare.** In all other instances, This Plan shall be secondary to Medicare in accordance with the following provisions:

1. **Coordination of Benefits.** In the event the foregoing Subsection 6.04.A. does not apply, benefits otherwise payable under This Plan for Covered Charges shall be calculated after Medicare has either made payment or determined a benefit is payable in conjunction with Subsection 6.04.B.2. below subject to the applicable Deductible and co-insurance percentage. In no event shall the sum of benefit payable under This Plan and Medicare exceed the total of such Covered Charges.
2. **Covered Persons are Considered Enrolled.** Benefits shall be considered payable by Medicare for purposes of this Section regardless of whether or not the covered person eligible for Medicare has:
 - (i) enrolled in or applied for benefits under Medicare Parts A, B or C; or
 - (ii) has failed to take any other action required by Medicare to qualify for benefits; or

(iii) would have received benefits payable by Medicare had the covered person received services in a facility to which Medicare would have paid benefits.

C. **Allowable Expenses Defined.** For purposes of this Section, the term “Allowable Expenses” shall mean the Usual, Reasonable and Customary Charges as determined by This Plan which are for medical care and treatment of the type covered under both Medicare and This Plan.

Section 6.05. Right to Receive and Release Necessary Information. For purposes of determining the applicability of and implementing the terms of this provision, This Plan or any provision of similar purpose of Any Other Plan, This Plan and Fund may, with the consent of the Eligible Individual, release to or obtain from an insurance company or other organization or person, any information with respect to any person which This Plan or Fund deems to be necessary for such purposes. Any Eligible Individual claiming benefits under This Plan shall furnish to This Plan and Fund such information as may be necessary to implement this provision.

Section 6.06. Facility of Payment. Whenever payments which should have been made under This Plan in accordance, with this provision have been made under Any Other Plan, the Fund shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision; and amounts so paid shall be deemed to be benefits paid under This Plan and to the extent of such payments, the Fund and This Plan shall be fully discharged from liability under This Plan.

Section 6.07. Right of Recovery. Whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund and This Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following as the Fund shall determine:

- A. Any person to or for or with respect to whom such payments were made.
- B. Insurance companies, service plans or any other organizations.

V. ARTICLE VII - GENERAL PROVISIONS

Section 7.01. Proof of Claims. All Hospital benefits shall be paid by the Fund to the Hospital and all other benefits shall be paid to the Covered Employee as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character and extent of the event for which the claim shall be paid.

Section 7.02. Assignment of Benefits. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person. However, any Covered Employee may direct that benefits due him be paid to an institution in which he or his eligible Dependent is hospitalized or to any provider of health care services or supplies rendered or to be rendered.

Section 7.03. Time Limit on Filing of Claims and Legal Actions. Benefits shall be paid by the Fund only if notice of claim is made within one year from the date on which expenses with respect to which claim is made were first incurred.

No legal action or filing of a lawsuit to recover or relating to benefits under This Plan or the Fund shall be brought prior to the individual's timely exhaustion of all Plan claims filing and appeals procedures including the timely filing of an appropriate notice of claim with all documents and proof required in support thereof, and, if the claim is denied in whole or in part, the timely submission of a written request for review by the Board of Trustees pursuant to Section 10.01 hereof. In no event shall legal action or filing of a lawsuit be brought later than one year following a final decision of the claim on review pursuant to the claims appeals procedures set forth in Section 10.01 of This Plan.

Section 7.04. Facility of Payment. In the event the Fund determines that the Eligible Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Individual has not provided the Fund with an address at which he can be located for payment, the Fund may, during the lifetime of the Eligible Individual, pay any amount otherwise payable to the Eligible Individual, to the spouse or to a relative by blood of the Eligible Individual or to any other person or institution determined by the Fund to be equitably entitled. In the event of the death of the Eligible Individual before all amounts payable under these Amended and Restated Rules and Regulations have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Individual:

- A. Lawful spouse.
- B. Child or children.
- C. Mother or father.
- D. Brothers or sisters.
- E. The Eligible Individual's estate.

as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund to the extent of such payment.

Section 7.05. Disputed Claims. No Covered Employee, eligible De-pendent, Beneficiary or other person shall have any right or claim to benefits from the Plan other than as specified in these Amended and Restated Rules and Regulations. Any dispute as to eligibility, type, amount or duration of benefits under these Amended and Restated Rules and Regulations or any amendment or modification shall be resolved pursuant to these Amended and Restated Rules and Regulations, the Trust Agreement and a claims procedure adopted by the Board of Trustees.

Section 7.06. Physical Examination. The Fund, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim and shall also have the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms as well as other forms and methods of administration and procedure shall be solely determined by the Fund.

Section 7.07. Workers' Compensation. The benefits provided by this Plan are not in lieu of, and do not affect, any requirement for coverage by Workers' Compensation insurance laws or similar legislation.

Section 7.08. Trust Agreement. The provisions of these Amended and Restated Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement and in the event of any conflict between the provisions of these Amended and Restated Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section 7.09. Interpretation of This Plan. The Trustees have full and exclusive authority to determine, in their sole discretion, all questions of coverage and eligibility, the level and type of benefits provided, the methods of providing or arranging for benefits and other related matters. The Trustees shall also have full and exclusive authority to construe and interpret in their sole discretion the provisions of the Agreement and Declaration of Trust establishing the Fund and the Amended and Restated Rules and Regulations establishing and setting forth the Plan. All such determinations, constructions or interpretations adopted by the Trustees in good faith shall be binding on all entities including, but not limited to, all Eligible Individuals.

Section 7.10. Subrogation Agreement and Authorization for Reimbursement.

- A. The Plan and its Trustees shall be subrogated to all the rights of recovery, claims, or actions any Covered Employee or Dependent may possess against any Third Party, as defined below, insofar as it is necessary for the Plan to recover from any Third Party all sums forwarded, paid, or assumed by the Plan pursuant to the terms of this Plan on behalf of the Covered Employee or Dependent, including all reasonable costs incurred by the Plan in enforcing the liability of the Third Party. Third Party shall mean, for the purposes of this Section 7.10 and any related Section of this Plan, the person(s) or entities that caused the accident, injury, or illness suffered by the Covered Employee or Dependent and any and all insurance companies of these person(s) or entities, and any and all of the Covered Employee's or Dependent's insurance companies, including uninsured/underinsured coverage.
- B. The Plan and its Trustees shall possess the right to receive reimbursement from the Covered Employee or Dependent for all payments made pursuant to the terms of this Plan on behalf of the Covered Employee or Dependent, for which a Third Party is or may be liable, including all reasonable costs incurred by the Plan in enforcing this right of reimbursement against the Covered Employee or Dependent, including actual attorneys' fees incurred.
- C. The Plan's right of subrogation contained in Section 7.10 A above and the Plan's right of reimbursement contained in Section 7.10 B above are independent of each other and the Plan may, in its Trustees' sole discretion, enforce these rights separately or together or at different times. The Plan's decision to choose to proceed in any manner under these terms does not constitute a waiver of the Plan's rights to any unchosen right or remedy at a later time.
- D. The Plan and its Trustees may pursue these rights of subrogation and reimbursement directly or through intervention in any action filed by a Covered Employee or Dependent, and may seek to enforce its subrogation and reimbursement rights and payment out of any settlement, compromise,

judgment, or from any source whatsoever received by or on behalf of the Covered Employee or Dependent.

- E. Should the Plan or a Covered Employee or Dependent recover in any manner or be awarded any sums of money for any claim or any action against any Third Party, whether by compromise, settlement, judgment or any source whatsoever, that recovery or award shall first be attributed to the satisfaction and/or reimbursement of any and all costs, payments, or expenses of the Plan paid out on behalf of the Covered Employee or Dependent, on a dollar-for-dollar basis according to the following priority:
 - 1. The Plan's costs of collection and enforcement of these subrogation and reimbursement rights, including actual attorneys' fees, shall be deducted first;
 - 2. The Plan's payments made to or on behalf of a Covered Employee or Dependent pursuant to the terms of the Plan shall be deducted second;
 - 3. Any remainder after the full payment of the items described in 1 and 2 above shall be paid to the Covered Employee or Dependent and/or their attorney;
 - 4. Pursuant to this priority of payment schedule, the Plan and its Trustees specifically disclaim the "make-whole" and "common fund" doctrines.
- F. Should a Covered Employee or Dependent recover in any manner or be awarded any sums of money from a Third Party, that recovery or award shall first be attributed to the satisfaction and/or reimbursement of any and all claims the Covered Employee asserted, or could have asserted, for payments made by the Plan to or on behalf of the Covered Employee or Dependent arising from the circumstances creating the Third Party's legal liability, and shall be subject to the terms of this Section 7.10, particularly subsection E. Further, any characterization by the Covered Employee or Dependent, their attorney, the Third Party, or any Court of the sums recovered as "general damages," "pain and suffering," or other classification shall not be binding on the Plan or its Trustees and shall have no effect on the Covered Employee's or Dependent's obligation to first apply all sums awarded or received as provided in subsection E above.
- G. The Plan and its Trustees may require the Covered Employee or Dependent to take all actions as are necessary or appropriate to recover payments made by the Plan on behalf of the Covered Employee or Dependent from any Third Party. Any request by the Plan or its Trustees must be in writing. The Plan and its Trustees may also institute suit in the Plan's name and/or in the name of the Covered Employee or Dependent against any Third Party, or may intervene in any suit brought by a Covered Employee or Dependent against any Third Party. Neither the Covered Employee nor the Dependent shall do anything after any loss to prejudice the Plan's subrogation and reimbursement rights.
- H. The Plan and its Trustees shall retain the right to include in any Subrogation and Reimbursement Agreement to be executed by a Covered Employee or Dependent any and all terms, rights, responsibilities, remedies and/or exclusions the Plan and Trustees, in their sole discretion, deem relevant and necessary to protect the Plan's subrogation and reimbursement rights.
- A. The Plan and its Trustees shall retain the right, in their sole discretion, to withhold from a Covered Employee or Dependent any and all payments that are to be paid to or on behalf of a Covered Employee or Dependent by the Plan, for any accident, injury, or illness suffered by Covered

Employee or Dependent at any time whatsoever, if the Covered Employee or Dependent in any manner: harms or prejudices the Plan's and Trustees' subrogation and reimbursement rights, violates any provisions of this Section 7.10 or related Sections, and/or violates the terms of any Subrogation and Reimbursement Agreement signed by the Covered Employee or Dependent. This right to withhold benefits is limited to the amount of payments made by the Plan to or on behalf of the Covered Employee or Dependent and which are lost, harmed, or in any other manner prejudiced by the conduct of the Covered Employee or Dependent, including the Plan's actual costs and attorneys' fees.

- J. The Plan and its Trustees are not responsible for any attorneys' fees and court costs incurred by a Covered Employee or Dependent. These expenses are the sole responsibility of the Covered Employee or Dependent, and any sums due the Plan pursuant to these subrogation and reimbursement rights shall not be diminished or in any way reduced by such expenses. However, the Trustees shall, in their absolute discretion, have the right to accept full or partial responsibility for these expenses if they so choose, in writing.
- K. Any amounts recovered by the Plan in excess of amounts the Plan is entitled to pursuant to these subrogation and reimbursement rights shall be paid to the Covered Employee or Dependent; however, the Trustees retain the right to decide, in their absolute discretion, whether this excess shall be paid directly to the Covered Employee or Dependent, or instead used as a credit against liability of the Plan for further payment to or on behalf of the Covered Employee or Dependent which has arisen or may arise from the Injury or Injuries that form the basis of the claim asserted by or on behalf of the Covered Employee or Dependent.
- L. The Trustees shall have the absolute discretion to interpret the terms of this Section 7.10 and any related Section of the Plan and to settle subrogation and reimbursement claims on any basis they deem warranted and appropriate under the circumstances.

Section 7.11. Severability Clause. Should any provision of these Amended and Restated Rules and Regulations be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

VI. ARTICLE VIII - AMENDMENT AND/OR TERMINATION

Section 8.01. Trustees' Rights to Amend and/or Terminate This Plan. In order that the Fund may carry out its obligation to maintain within the limits of its resources a program dedicated to providing the maximum possible benefits for all Eligible Individuals, the Board of Trustees expressly reserves the right in its sole discretion, at any time and from time to time a non-discriminatory basis and to the maximum extent allowed by law, to:

- A. Terminate or amend either the amount or condition with respect to any benefits, even though such termination or amendment affects existing Illness or Injury claims.
- B. Alter or postpone the method of payment of any benefit.
- C. Amend or rescind any other provision of these Amended and Restated Rules and Regulations.

A. ARTICLE IX - DISCLAIMER

Section 9.01. Limitation of Liability. Other than any specific stop-loss coverage provided for individual claims in excess of a specified amount and/or aggregate stop-loss coverage for overall Plan claims in excess of a specified percentage of this Plan's estimated annual claims cost, none of the benefits provided in these Amended and Restated Rules and Regulations are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purpose.

VII. ARTICLE X - CLAIMS APPEALS PROCEDURES

Section 10.01. Claims and Review Procedures.

A. **Definitions.** The following terms, when used in this Section as capitalized terms, shall have the meaning set forth in these definitions:

1. **Adverse Benefit Determination.** The term "Adverse Benefit De-termination" means any denial, reduction or termination of, or failure to provide or make payment for, in whole or part, a claimed benefit under the Plan;
2. **Concurrent Care Claim.** The term "Concurrent Care Claim" means a claim for an ongoing course of treatment over a period of time or number of treatments that is being reconsidered after the original pre-authorization and prior to the end of the course of treatment;
3. **Health Care Professional.** The term "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law;
4. **Post-Service Claim.** The term "Post-Service Claim" means any claim for medical benefits under the Plan that is not a pre-service claim;
5. **Relevant.** The term "Relevant" means, with respect to the relationship of a document, record or other information to a claim, that the document, record or information:
 - a. was relied upon in making the benefit determination;
 - b. was submitted, considered or generated in the course of making the benefit determination without regard to whether it was relied upon;
 - c. demonstrates compliance with administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with the Plan and that Plan provisions have been applied consistently with respect to similarly situated claimants; or
 - d. constitutes a statement of Plan policy or guidance concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether it was relied upon in making the benefit determination; and

B. **Claims Procedure.** In order to receive a Plan benefit or a determination affecting receipt of a Plan benefit, a Participant or his authorized representative must submit an initial written claim for benefits on a form provided by or acceptable to the Plan at least once per calendar year. Thereafter, any written, itemized bill or invoice seeking payment by a participant or provider will constitute a Post-Service Claim. The date a claim is received and date stamped in the office is considered the filing date. The claim must be submitted to the Fund Office no later than 365 days

from the date the expense or event, to which the claim relates, was incurred or took place. An expense is incurred on the date the service or supply giving rise to the expense was furnished.

Each claim that is filed in accordance with the Claims Procedure will be processed for determination on whether and in what amount it is covered under the Plan, without regard to whether all the necessary information accompanies the filing. The Plan shall notify the claimant of its determination within a reasonable period of time appropriate to the medical circumstances after receipt of the claim and in accordance with the following:

1. **Concurrent Care Claims.** For Concurrent Care Claims, any reduction or termination (other than by Plan amendment or termination) of a pre-approved course of treatment before its original pre-authorized ending is an Adverse Benefit Determination, of which notice shall be given sufficiently in advance to allow the participant to appeal and obtain a determination on review before the treatment is reduced or terminated. Any concurrent claim that does not qualify as an urgent care claim will be decided as a Post-Service Claim, as appropriate;
2. **Post-Service Claims.** For Post-Service Claims, the Plan shall notify the claimant of an Adverse Benefit Determination no later than 30 days after filing. If necessary due to matters beyond the Plan's control, this 30-day period may be extended one time for up to 15 days provided the Plan notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary because of the claimant's failure to submit the information required to decide the claim, the notice of extension shall describe the required information and the response deadline of at least 45 days from the claimant's receipt of the notice; the notice will also advise the participant that his failure to supply the requested information will result in a denial of the claim.
3. **Extension.** For any extension of time involving a Post-Service Claim, which is due to the claimant's failure to submit information necessary to decide the claim, the time period for making a determination shall be suspended from the date of the notice of extension to the claimant until the earlier of:
 - a. the date on which a response from the claimant is received by the Plan; or
 - b. the response deadline of at least 45 days. Nothing in this Claims Procedure shall preclude a voluntary extension of the response deadline if agreed to by both the claimant and the Plan.
4. **Adverse Benefit Determination.** In the event of an Adverse Benefit Determination for any type of claim filed, the Plan's notice of determination to the claimant shall set forth:
 - a. specific reason(s) for the determination;
 - b. reference to the specific Plan provision(s) on which the determination is based;
 - c. a description of any additional material or information necessary to perfect the claim and the reasons why it is needed;
 - d. a copy of the Plan's Claims Review Procedure;
 - e. a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if benefits are denied after review;
 - f. if an internal rule, guideline, protocol or similar criterion is relied upon in making the determination, either the specific rule, guideline, protocol or criterion or a statement that it was relied upon and that a copy will be provided free of charge upon request; and

g. if the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request

5. **Claims Review Procedure.** If there is an Adverse Benefit De-termination on a claim, the claimant may appeal the determination and receive a full and fair review in accordance with the following Claims Review Procedure.

Within 180 days (or a reasonable period of time for a Concurrent Care Claim) after receipt of an Adverse Benefit Determination, the claimant may make a written request for review to the full Board of Trustees. If a written request for review is not made timely, the initial decision on the claim shall be final. If a written request for review is made timely, the claimant may submit written comments, documents, records and other information relating to the claim. The claimant may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to his claim, and the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the initial determination, without regard to whether it was relied upon. The review on appeal shall comply with the following requirements:

- a. no deference shall be given to the initial determination;
- b. the review shall take into account all comments, documents, records and information submitted by the claimant and relating to the claim, without regard to whether it was submitted or considered in the initial determination; and
- c. if the initial determination is based in whole or part on medical judgment, including determinations of whether a treatment, drug or other item is experimental or investigational, or not medically necessary or appropriate, the reviewer shall consult with a Health Care Professional, with appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted, and is not a subordinate of any Health Care Professional who was consulted in connection with the initial determination

6. **Decision on the Appeal.** The Plan shall make a decision on appeal within a reasonable period of time after receipt of a claim that is filed in accordance with Claims Review Procedure without regard to whether all the necessary information accompanies the filing.

In the case of a Post-Service Claim, the Plan's determination on review shall be made no later than the first meeting of the Board of Trustees that immediately follows such filing; however, if the claim is filed within 30 days prior to such meeting, the Board of Trustees shall have until their second meeting following such filing to make a determination on review. If the Board of Trustees require a further extension of time for processing due to special circumstances, and notify the claimant in writing, prior to the extension, of the special circumstances and the date by which a determination shall be made, they shall have until their third meeting following such filing by which to make a determination on review. The Plan shall notify the claimant of the final determination on review as soon as possible but no later than five days after it is made.

Nothing in this Claims Review Procedure shall preclude a voluntary extension of the response deadline if agreed to by both the claimant and the Plan.

7. **Written Notification.** The Plan shall provide the claimant with written notification of the Plan's benefit determination on review. In the case of an Adverse Benefit Determination on review, the notification shall set forth the following information in a manner calculated to be understood by the claimant:
- a. the specific reasons for the adverse determination;
 - b. reference to the specific Plan provisions on which the determination is based;
 - c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the claim and a statement of the claimant's right to bring an action under ERISA Section 502(a);
 - d. any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination or a statement that it was relied upon and that a copy will be provided free of charge upon request;
 - e. if the adverse determination is based on medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request; and
 - f. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

A decision on review of any claim made under the Plan in accordance with the Claims Review Procedure shall be final and binding on all persons.

- C. **Time Limit on Legal Action.** In no event may legal action be brought by or on behalf of any individual to recover benefits under the Plan unless the individual or his legal representative has first fully complied with and timely exhausted all of the requirements of the Claims Procedure and Claims Review Procedure under the Plan, and in no event shall any such legal action be brought later than one year following a final determination of a claim under the Plan.

SCHEDULE OF BENEFITS
Active Employees - Plan A Option

Death and Accidental Death and Dismemberment Benefits Provided by the Fund

For Employees Only

Death Benefit..... \$10,000
 Accidental Death and Dismemberment..... \$5,000

Medical Benefits Provided by the Plan

For Employees and Eligible Dependents

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In- Patient (pre-admission certification required) Maximums: Major Medical	\$250,000 per Person per Calen- dar Year \$1,000,000 per Person per Lifetime	\$100 per Person per Confinement if not In-PPO Network		
Mental and Nervous	15 days in-patient and 30 days out- patient treatment per Person per Lifetime			

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Wellness Benefits: Mammography	\$100 per Person per Calendar Year	None	100%	100%
Pap Smear	\$100 per Person per Calendar Year	None	100%	100%
Prostate Exam	\$100 per Person per Calendar Year	None	100%	100%
Hospital: Room & Board	Avg semi-private rate	\$100 per Confine- ment; subject to \$500 Calendar Year deductible	70% URC	85% URC; \$100 per Confinement deductible waived
Intensive Care	2 X avg semi- private rate	\$100 per Confine- ment; subject to \$500 Calendar Year deductible	70% URC	85% URC; \$100 per Confinement deductible waived
Hospital Miscell- aneous		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Dr.'s Visits & Out- Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Emergency Accident (Treat- ment within 24 hours)		None Remaining Balance Subject to \$500 Calendar Year deductible	100% of URC of the first \$300 70% URC	100% of URC of the first \$300 85% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Out-Patient Surgery: Hospital		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Facility Charge		Subject to \$500 Calendar Year deductible	70% URC	85% URC
Prescription Drugs	\$1,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	70% URC	70% URC
Durable Medical Equipment	\$2,000 per Per- son per Calendar Year maximum	Subject to \$500 Calendar Year deductible	70% URC	85% URC
Mental & Nervous: In-Patient	15 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	70% URC	85% URC
Out- Patient	30 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	50% URC	60% URC
* Effective November 1, 2001 and with respect to the benefits shown in this Plan A Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC - Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

SCHEDULE OF BENEFITS
Retired/Disabled Employees, Surviving Spouses and Dependents
Not Entitled to Medicare - Plan B Option

For Retired/Disabled Employees Only

Death Benefit..... \$1,500

For Retired/Disabled Employees, Surviving Spouses and Dependents Not Entitled to Medicare

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In-Patient (pre-admission certification required)		\$100 per Person per Confinement if not In-PPO Network		
Durable Medical Equipment	\$2,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	60% URC	70% URC
Maximums: Major Medical	\$250,000 per Person per Calendar Year \$1,000,000 per Person per Lifetime			
Mental and Nervous	1 day in-patient and 30 days out-patient treatment per Person per Lifetime			

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Hospital: Room & Board	Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Intensive Care	2 X Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Hospital Miscellaneous		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Dr.'s Visits & Out-Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Out-Patient Surgery: Hospital		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Facility Charge		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Prescription Drugs	\$1,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year deductible	60% URC	60% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Mental and Nervous: In-Patient	1 day per Person per Lifetime	Subject to \$500 Calendar Year deductible	60% URC	70% URC
Out-Patient	30 days per Person per Lifetime	Subject to \$500 Calendar Year deductible	50% URC	60% URC
Mammography	\$100 per Person per Calendar Year	None	100%	100%
Pap Smear	\$100 per Person per Calendar Year	None	100%	100%
Prostate Exam	\$100 per Person per Calendar Year	None	100%	100%
* Effective November 1, 2001 and with respect to the benefits shown in this Plan B Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC – Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

SCHEDULE OF BENEFITS
Retired/Disabled Employees, Surviving Spouses and Dependents
Entitled to Medicare - Plan C Option

For Retired/Disabled Employees Only

Death Benefit..... \$1,500

For Employees and Dependents

PART A	MEDICARE BENEFITS	PLAN BENEFITS
Hospital - First 60 days	All but Part A deductible.	Part A deductible
Hospital - Days 61-90	All but 25% of Part A deductible	25% of Part A deductible
Hospital - Days 91-150	All but 50% of Part A deductible	50% of Part A deductible
Hospital - Days 151-365	-0-	100% of expense which would normally be considered a Medicare Part A eligible expense
Skilled Nursing Facility *		
First 20 days	100% of the cost.	-0-
Days 21-100	All but 12.5% of Part A deductible	12.5% of Part A deductible
Home Health Care – Unlimited Visits as Medically Necessary	Full cost	-0-
Hospital Care - Two 90-Day Periods & One 30-Day Period	All but limited costs for out-patient drugs and in-patient respite care	Limited cost sharing for out-patient drugs and in-patient respite care
Blood	All but first 3 pints	First 3 pints

* Neither Medicare nor the Fund will pay for nursing home care or Custodial Care.

FOR RETIRED/DISABLED EMPLOYEES, SURVIVING SPOUSES AND THEIR ELIGIBLE DEPENDENTS ENTITLED TO MEDICARE - Continued

PART B	MEDICARE BENEFITS	PLAN BENEFITS
Medical Expenses	80% of Medicare-approved amount after Part B deductible	Part B deductible plus 20% of Medicare-approved amount
Home Health Care – Unlimited Visits as Medically Necessary	Full cost	-0-
Out-Patient Hospital	80% of Medicare-approved amount after Part B deductible	Part B deductible plus 20% of Medicare-approved amount
Blood	80% of approved amount after the first 3 pints	First 3 pints non-replaced plus 20% of balance of Medicare-approved amount

NOTE: 60 Reserve Days may be used only once. Days not used are not renewable.

A Benefit Period begins on the first day service is received as an in-patient in a Hospital and ends after the patient has been out of the Hospital or skilled nursing facility for 60 days in a row.

No coverage is provided either by Medicare or the Plan for drug charges, prescriptions or otherwise.

The Part B deductible must be satisfied only once each calendar year.

The Eligible Individual will be liable for charges higher than the Medicare approved amount unless the doctor or supplier agrees to accept Medicare’s approved amount as the total payment for services rendered.

SCHEDULE OF BENEFITS
Active Employees on Extended Self-Payment - Plan D Option

For Active Employees Only

Death Benefit..... \$1,500

Employees and Dependents

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Major Medical		\$500 per Calendar Year per Person (max 3 per Family)		
Hospital In-Patient (pre- admission certification required)		\$100 per Person per Confinement if not In-PPO Network		
Maximums: Major Medical	\$250,000 per Person per Calendar Year \$1,000,000 per Person per Life-time			
Hospital: Room & Board	Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Intensive Care	2 X Avg semi-private rate	\$100 per Confinement; subject to \$500 Calendar Year deductible	60% URC	70% URC; \$100 per Confinement deductible waived
Hospital Miscellaneous		Subject to \$500 Calendar Year deductible	60% URC	70% URC

Benefit	Amount	Deductible	Co-Insurance (of Eligible Charges) *	
			Out-of-PPO Network	In-PPO Network
Dr.'s Visits & Out-Patient Surgery done in Dr.'s Office		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Other Covered Charges		Subject to \$500 Calendar Year deductible	60% URC	70% URC
Emergency Accident (Treatment within 24 hours)		None	100% URC of the first \$300	100% URC of the first \$300
		Remaining Balance Subject to \$500 Calendar Year deductible	60% URC	70% URC
Durable Medical Equipment	\$2,000 per Person per Calendar Year maximum	Subject to \$500 Calendar Year Deductible	60% URC	70% URC
Out-Patient Surgery: Hospital Facility Charge		Subject to \$500 Calendar Year deductible	60% URC	70% URC
		Subject to \$500 Calendar Year deductible	60% URC	70% URC
* Effective November 1, 2001 and with respect to the benefits shown in this Plan D Option, in the event there is no provider of Preferred Provider Organization services and/or supplies within an 80-mile radius of your or your eligible Dependents' residence, Covered Charges incurred by you and they will be paid at the In-Network PPO co-insurance percentage up to a maximum benefit payment of \$2,000 per Eligible Individual per lifetime.				
Any charges applied to the Calendar Year deductible during October, November and December apply towards the next year's Calendar Year deductible.				
URC - Usual, Reasonable and Customary.				
PPO Network includes MultiPlan, Inc.				

NOTE: All non-emergency Hospital confinements must be pre-certified and all emergency Hospital admissions must be certified within 72 hours or the next business day after the admission.

**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE FUND**

1. OUT-OF-WORK-LIST CERTIFICATION

To whom it may concern:

On this ____ day of _____, 20__, in compliance with the Plumbers and Steamfitters Local No. 106 Health and Welfare Plan's return to work in Covered Employment provisions as governed by USERRA, _____ appeared at the Union Hall ____ days after being honorably discharged from active duty service in the _____.
Branch of Service

He presented a copy of his honorable discharge papers showing the date of his discharge. He has indicated that he wishes to be placed on the Plumbers and Steamfitters Local No. 106 out-of-work-list.

_____, was placed on the out-of-work-list on the ____ day of _____, 20__. He is available to return to work in Covered Employment on _____.

Attested to by:

Union Representative

Date

**PLUMBERS AND STEAMFITTERS LOCAL NO. 106
HEALTH AND WELFARE FUND**

BOARD OF TRUSTEES

UNION TRUSTEES

Mr. Garland Broussard
Mr. J. D. Doucet
Mr. Jack Hicks
Mr. Michael Nunez

EMPLOYER TRUSTEES

Mr. John B. Cole
Mr. Curtis Fontenot
Mr. Billy Foreman
Mr. Mark Henning

FUND OFFICE

Plumbers and Steamfitters Local No. 106 Health and Welfare Fund
822 North Lakeshore Drive
Lake Charles, LA 70601
Telephone: (337) 433-1447
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FUND CONSULTANT

The Segal Company
6575 West Loop South, Suite 610
Bellaire, TX 77401

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