NORTHWEST PLUMBING AND PIPEFITTING INDUSTRY

HEALTH, WELFARE AND VACATION TRUST

Alternate Plan

October 1, 2016

For Participating Local Unions #26 & #44

Summary Plan Description

311J 05-2017

A MESSAGE FROM THE TRUSTEES

We are pleased to provide you with this updated booklet describing the Alternate Plan benefits of the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust as of October 1, 2016.

As you will note, the following changes were made to your Plan recently:

- Premera replaced First Choice as the Plan's preferred provider organization (PPO).
- Certain clinical trials are now covered by the Plan.
- The annual medical deductible and coinsurance maximum was increased.
- The prescription drug benefit includes new provisions for brand-name drugs, specialty drugs and step-therapy.

This booklet provides important information for you and your family. Please read this booklet carefully and keep it to use as a reference guide. If, after reading this booklet you have questions, please contact the Administration Office for assistance.

Thank you for using your Plan benefits responsibly.

Sincerely yours,

The Board of Trustees

BOARD OF TRUSTEES

Management	Labor
Paul Thibodaux	Todd Taylor
David Nelson	Kevin Dolan
Russ Williams	Pat Perez

To keep your eligibility records up to date, notify the Administration Office in writing about any change in:

- Address
- Dependent status (birth, adoption, legal placement for adoption, legal guardianship, marriage, legal separation, divorce, child custody, death)
- Other insurance available to you or any covered dependent
- Designated beneficiary
- Eligibility for Medicare, whether enrolled or declined

Submit any changes to the Administration Office on a new enrollment form.

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IMPORTANT CONTACTS

For information about...	Contact...	At...
Eligibility Health & Welfare Benefits Vacation Benefits	Administration Office *Mailing Address* PO Box 34203 Seattle, WA 98124-1203 *Street Address* 7525 SE 24th St, Suite 200 Mercer Island, WA 98040-2341	(206) 441-7574, option 4 (866) 417-4240, option 4 *www.nwplumberstrust.com*
Medical Claims Note: Preferred providers will bill Premera Blue Cross directly	Administration Office *Mailing Address* NWPPI Health, Welfare and Vacation Trust PO Box 34687 Seattle, WA 98124-1687	(206) 441-7574, option 0 (866) 417-4240, option 0
Prescription Drug Program	CVS/caremark	(866) 818-6911 *www.caremark.com*
Preferred Provider Network	Premera Blue Cross	(800) 810-2583 *www.premera.com*
Hospital Preauthorization Individual Case Management	Qualis Health	(800) 783-8606
Tobacco Cessation Program	Alere Wellbeing	(866) 784-8454 *www.freeclear.com*

WEBSITE AVAILABLE

The Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust established a website to provide you with immediate access to your Plan information. The site, located at *www.nwplumberstrust.com,* includes the following Trust related material:

- Forms – Medical, Vacation, Legal Documents, and Notices
- Links to Health Plan Preferred Provider Networks
- Plumbing and Pipefitting Sites, and Other Useful Sites
- HIPAA Privacy Notice and Information

This site will also provide a link to "My Trust Login", which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number, or your WPAS ID number as shown on your ID card (omit entering the leading letters). A PIN will be assigned and mailed to you upon your written request to the Administration Office. For security purposes you may not choose your own PIN. "My Trust Login" information includes the following data:

- Personal Information – name, address, gender, birth date, marital status, etc.
- Health Eligibility – eligibility in the current and past three months
- Hours/Contributions – statement showing last three employers reporting hours and contributions to the Trust on your behalf
- Dependent Enrollment Information

If you have any questions about the contents of the website or access to "My Trust Login" information, please contact the Administration Office at (206) 441-7574 or toll free (866) 417-4240.

IMPORTANT INFORMATION

Plan benefits are paid directly by the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust. There is no insurance carrier that guarantees benefits. All benefits will be paid from current Trust assets and established Trust reserves and only to the extent that sufficient funds are available.

The Trustees can change or discontinue all privileges and other eligibility provisions, including benefit coverage under this Plan at any time. Employees do not earn a nonforfeitable right to the benefits of the Plan.

The monthly self-contribution rate for the self-pay programs does not pay for the cost of the programs. Contributions made on behalf of active employees participating in the active employees' plan subsidize a substantial portion of the self-pay programs. **If subsidization is not present in the future, it *will* be necessary to modify the contribution rates, benefits, and/or eligibility provisions of these programs.** In this regard, the Trustees have determined that if any sponsoring local union should withdraw from participation in the Plan, or cease to be a party to a labor management agreement requiring contributions to this Plan, then self-payment privileges accruing to a member or former member of such local union, or a dependent of such member or former member, shall be terminated or changed as to benefit levels or rates for personal coverage in the discretion of the Trustees, as the circumstances may require, upon 60 days prior written notice from the Trust.

Only the personnel at the Administration Office are authorized by the Board of Trustees to answer questions concerning the Trust's Plan of benefits. No participating employer, employer association, labor organization, or any employee of theirs, has any authority in this regard.

The Board of Trustees maintains the exclusive right to interpret the Trust's Plan and the right to rely on the advice of professional advisors.

SUMMARY OF BENEFITS

The following provides a brief summary of your benefits. For a complete description of the benefits listed below, refer to the appropriate section in this booklet.

MEDICAL BENEFITS	
Annual deductible (per calendar year)	
• Individual	$300
• Family (maximum)	$900
Coinsurance percentage reimbursed by the Plan	After the deductible is met – 80% of the first $5,000 of covered expenses per person, then 100% for the rest of the calendar year
Annual medical coinsurance maximum (excludes annual deductible and hospital deductible)	$1,000
Hospital deductible (per admission)	
• Preferred hospital	$100
• Non-preferred hospital	$300
Annual benefit limit	None
PRESCRIPTION DRUG BENEFITS	
• Retail Pharmacy (34 days)	
➢ generic coinsurance you pay	20%
➢ brand-name (no generic available) coinsurance you pay	20%
➢ brand-name (generic available) coinsurance you pay	20% plus the difference in cost between the brand name drug and the generic drug
• Mail Service Pharmacy (90 days)	
➢ generic copay	$10
➢ brand-name (no generic available) copay	$30
➢ brand-name (generic available) copay	$30 plus the difference in cost between the brand name drug and the generic drug

Note: All claims, and information to complete claim must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.

ELIGIBILITY RULES

Your eligibility is based on working for a participating employer who makes contributions to the Trust on your behalf. Your eligibility is also based on your credited hours of service, as described in detail in this section.

It is your continuing responsibility to check with the Administration Office to make certain that contributions are being properly made on your behalf for hours worked.

If you perform work under the terms of the labor-management agreement requiring contributions to this Plan, but your employer fails to pay the contributions to the Plan on those hours, such hours **will not** be credited, and you may be denied eligibility. The Board of Trustees is authorized to permit coverage in special circumstances, such as an employer's insolvency or bankruptcy.

An employee must be eligible in order to obtain benefits. To be initially eligible an employee must accumulate a minimum number of hours and their employer must have contributed on their behalf. After initial eligibility has been established, self-payment is permitted in order to retain coverage. It is important to remember that you must be eligible in order to obtain benefits for yourself and your dependents.

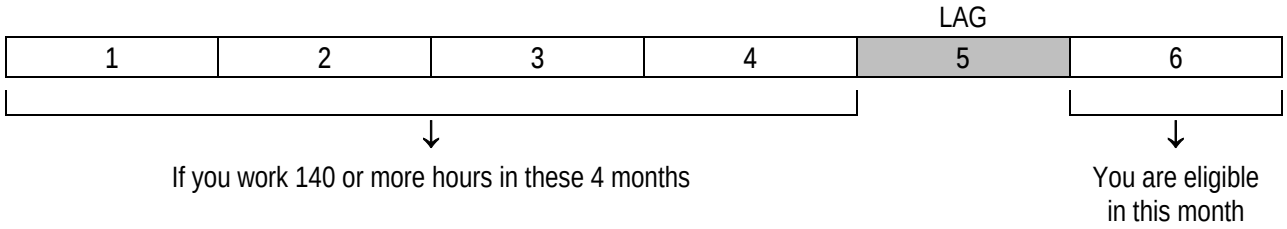
Enrollment

You must submit an enrollment form when you first become eligible and any time your family status changes (such as through marriage, birth or adoption of a child, a child losing dependent eligibility due to age, or divorce). You may also be required to submit copies of your marriage certificate or other legal documents. The enrollment form is available from the Trust's website (*www.nwplumberstrust.com*), your local union or the Administration Office and should be submitted to the Administration Office as listed on the form.

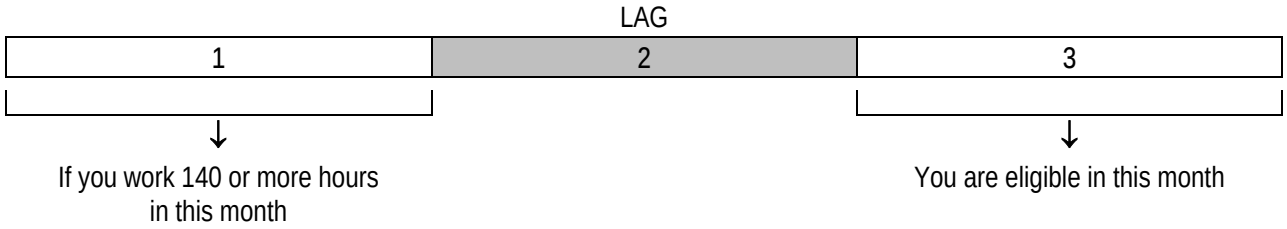
Initial Eligibility

As an employee, you will become initially eligible on the first day of the *second month* following the month in which you have accumulated at least 140 hours at the current - hourly contribution rate, within no more than four consecutive months.

EXAMPLE



If you work the 140 or more hours in one month, you are eligible on the first day of the second following month.



The lag month is necessary for the Administration Office to process reported hours.

Continuing Eligibility

You maintain your eligibility by:

- Working under a labor-management agreement requiring contributions to this Plan for 140 or more hours per month, or
- Using hours accumulated in your "hour bank" (see below), or
- Making a self-payment (see page 12), or
- By a combination of work, use of your hour bank and self-payments.

Proration of Hours

If your employer contributes at an amount that is different from that required under the Master Labor Agreement, your hours will be prorated accordingly.

As an example, if the current Master Labor Agreement has an $4.63 per hour contribution rate and your employer contributes at $4.00 per hour, your hours worked will be prorated as follows:

$$\frac{\$4.00}{\$4.63} = 86\%$$

140 hours worked x 86% = 120 hours credited to your hour bank

Your Hour Bank

Your hour bank and eligibility are determined as follows:

- Each month, all hours for which contributions have been made are added to your hour bank (a separate record is maintained for each employee).
- 140 hours are deducted from your hour bank for each month in which you and your dependents are eligible for coverage.
- Eligibility will always be the second month following the month in which you accumulated enough hours in your hour bank for eligibility.
- After deducting 140 hours for the current month, you are allowed to accumulate up to a maximum of 700 hours in your hour bank. The following shows the future eligibility you may earn:

Total Hours in Your Hour Bank	Total Months of Future Eligibility
Under 140 hours	0 months
140 but under 280 hours	1 month
280 but under 420 hours	2 months
420 but under 560 hours	3 months
560 but under 700 hours	4 months
700 maximum hours	5 months

- Whenever your hour bank has less than 140 hours you lose eligibility. However, you may self-pay the difference between your hour bank and 140 hours (see self-payment rules starting on page 12) to obtain eligibility.
- When your hour bank has less than 140 hours and no hours are added to the account for 12 months, the balance of such hours will be forfeited unless you have been engaged in military service covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA). See page 9 for details on USERRA.
- Members who had more than 700 hours reserve after deducting from their hour bank for March 2007 eligibility are allowed to carry these excess hours until their hour bank drops below 700 hours, after which the 700 hour maximum will be in effect.

Dependent Eligibility

Coverage for eligible dependents begins on the same date as the employee. New dependents are covered on the date of marriage or birth, or in the case of adoption, the date the child is legally placed in the employee's home.

Eligible dependents include:

- An employee's legal spouse
- An employee's children through age 25, including:
  - Natural children
  - Legally adopted children and children placed for adoption
  - Children who depend on you by virtue of a court order or for whom you have legal custody
  - Stepchildren
  - Foster children

Dependent children who are primarily dependent on the employee because of physical or mental disability may be continued as eligible dependents provided the dependent was covered immediately prior to their 26th birthday, and the incapacity occurred prior to their 26th birthday. This dependent coverage will remain in effect as long as the employee

maintains coverage under the Plan and the physical or mental disability continues. Proof of such incapacity must be provided to the Trust and must be furnished thereafter as required by the Administration Office.

In accordance with Federal law, the Plan also provides benefits to certain dependent children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Administration Office for details. You or your dependents may obtain, without charge, a copy of the procedures governing medical child support orders and determinations from the Administration Office.

When Participation in the Plan Ends

You cease to be a participant in the Plan on the earliest of:

- The first day of any month on which your hour bank is credited with fewer than 140 hours.
- When the Plan is terminated or is amended so as to exclude you from eligibility.
- At the end of the month in which you commence active duty expected to exceed 30 days, with the armed forces of any country.

Your dependents' coverage under the Plan will also terminate when your eligibility terminates. In addition, your dependent's coverage under the Plan will terminate on the last of the month in which:

- The dependent ceases to be an eligible dependent.
- Your eligible dependent enters military service.

Freezing Hour Banks

Your accumulated hour bank may be frozen under the following conditions:

- **Authorized noncovered employment –** If you accept temporary employment with any Federal agency, or with any state, county, city or political subdivision, or with any school board, or port commission district authority, or any other employer specifically identified by a collective bargaining agreement as authorized noncovered employment, you may freeze your hour bank, upon written request and Trustee approval. If approved, your hour bank will be frozen for a period of six months beginning with the first day of the month following the month in which your written request is received. One or more six month extensions of the freeze on your hour bank may be approved upon proof satisfactory to the Trustees that your authorized noncovered employment remains temporary. Your hour bank will be reactivated when you notify the Trust that you have returned to a hiring hall status. If the Trust is not notified within 15 days of your return from temporary employment, the hour bank will be unfrozen. Once unfrozen, your hour bank will again begin to be used for providing ongoing eligibility for Plan benefits.

- **Military service –** If you leave covered employment to perform military service that is covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to have your hour bank frozen until you return from military service. See page 9 for details on USERRA.

The United Association Reciprocity Program

Your Trust is signatory to the United Association Reciprocity agreement for the transfer of money between Trusts that are also signatory to this agreement. This allows you to work in other jurisdictions and have your health and welfare contributions sent back to this Trust. Contributions made under the reciprocity program allows your coverage to be maintained in this Plan, even if you are working outside of the jurisdiction covered by the Plan.

Vacation money is not transferred and remains at the visited Trust.

Please contact your Business Manager or the Administration Office for details regarding these agreements.

Continuing Your Coverage Under USERRA

If you leave covered employment to perform military service that is covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue your medical and prescription drug coverage for you and your dependents for up to 24 months. If your military service lasts less than 31 days, coverage will be continued at no cost to you. If your military service lasts more than 30 days, a monthly self-payment will be required at the rate established by the Trustees.

Under USERRA, you must notify your employer before taking leave unless you are prevented from doing so by military necessity or other reasonable cause. You should also tell your employer how long you expect to be gone. Upon release from military duty, you must return, or apply to return, to covered employment or hiring hall status within the following time limits:

- **Less than 31 days of military service –** next calendar day following completion of service plus time required for safe transportation to your residence plus 8 hours.
- **31-180 days of military service –** within 14 days.
- **More than 180 days of military service –** within 90 days.

If you're hospitalized for or convalescing from an illness or injury that occurred during your military service, the above, deadlines will be extended while you recover, but generally not for longer than 2 years.

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

If you have hour bank eligibility at the time your military service begins and you elect not to continue your coverage under USERRA, you may freeze your hour bank. Alternatively, if you elect to continue your coverage under USERRA, you may either freeze your hour bank

and begin making self-payments immediately or you may run out your hour bank coverage before you begin making self-payments. Any balance in your hour bank will be retained for the duration of your military service. You may continue to self-pay for coverage under USERRA for a maximum of 24 months unless you fail to return to covered employment or hiring hall status within the above deadlines, in which case your USERRA coverage will terminate on the day after the deadline has passed.

To ensure proper crediting of service under USERRA, you should notify the Administration Office when you take USERRA leave. You should also tell the Administration Office how long you expect to be gone and notify the Administration Office when you apply for reemployment after your leave. Please call the Administration Office for details on service under USERRA.

Family and Medical Leave Act (FMLA)

This Federal law may apply to family and medical leaves when you work for an employer with 50 or more employees within a 75-mile radius.

To be eligible, you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements, and if your employer has enough employees to be covered under the FMLA, the law requires your employer to continue contributions for you and your dependents' medical and prescription drug coverage for up to 12 weeks during a 12-month period while you are on family or medical leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse, or parent
- Your own serious health condition

You should contact your employer as soon as you think you are eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other obligations under FMLA.

When your coverage ends, you and your dependents will be able to continue coverage through self-payment (see page 12).

Note: If you do not return to work with your employer after your leave, the FMLA permits your employer, under certain circumstances, to recover the amount it contributed on your behalf during your FMLA leave.

Participation of Stockholders, Officers and Directors of Closely-Held Corporations

The Board of Trustees of the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Plan allow participation of persons who have an interest as stockholders, officers or directors in closely-held corporations provided such persons are working in job classifications described in a labor-management agreement between the corporate employer and the sponsoring Union at least 50% of the time subject to the following rules:

- Employee/stockholders, officers or directors must be designated separately on monthly reporting forms.
- Employers must verify that the employee/stockholder, officer or director work at least 50% of the time on an annual basis in job classifications described in the labor-management agreement.
- Employers shall be obligated to pay on 160 hours per month with respect to employee/stockholders, officers and directors.

COBRA SELF-PAY CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you, your legal spouse or eligible dependents do not qualify for coverage in any month, you may continue some or all of the health benefits lost by making COBRA self-payments to the Trust.

The Administration Office for the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust is responsible for administering COBRA continuation rights for the Trust. All communications must be in writing; identifying you, the eligible employee, if different; the Trust's name and sent to the following address:

Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust
PO Box 34203
Seattle, WA 98124-1203

Qualifying Events

As an eligible employee, you have a right to choose continuation coverage if you lose coverage because of:

- A reduction in your hours of employment
- Termination of your employment, including retirement

As a lawful spouse of an employee, you have the right to choose continuation coverage if you lose coverage due to one of the following qualifying events:

- Termination of your spouse's employment or reduction in your spouse's hours of employment
- Death of your spouse
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

As an eligible dependent child of an employee, you have the right to choose continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination of the employee parent's employment or reduction in the employee parent's hours of employment:
- Death of the employee parent
- Parents' divorce or legal separation
- The employee parent becomes entitled to Medicare
- Ceasing to be a "dependent child" as defined under this Plan

COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your covered dependents have the responsibility to inform the Administration Office of a loss of coverage resulting from a divorce, legal separation or a child losing dependent status. If you or your covered dependents have a loss of coverage because of these events, you must notify the Administration Office in writing at the address listed above, within 60 days of the date of the above qualifying events. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan.

Your employer is responsible for informing the Trust of any other qualifying event. The Board of Trustees, though, reserves the right to determine whether coverage has, in fact, been lost due to a qualifying event.

Election of COBRA

If the Administration Office has been properly notified that a qualifying event has occurred, it will notify you, your lawful spouse and each of your eligible dependents of your right to elect self-pay continuation coverage. It is your obligation to notify the Administration Office of the addresses where you want notices to be sent. You and your dependents must keep the Administration Office informed of any change of address.

Under the law, you have 60 days to inform the Administration Office that you want self-pay continuation coverage. This 60-day period runs from either the date coverage ends or the date the Administration Office sends you notice of your right to continue coverage (whichever is later). If you do not choose continuation coverage, health coverage for you and your family will end. However, an eligible spouse and/or eligible dependent may elect the self-pay continuation coverage even if the employee does not.

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. If you elect COBRA and acquire a new dependent, you may add the new dependent to your COBRA coverage by providing written notice to the Administration Office within 60 days of acquiring the new dependent. The written notice must identify the employee, the new dependent, and the date the new dependent was acquired, and be mailed to the Administration Office at the address listed above. It should also include a completed enrollment form and a copy of the marriage or birth certificate, adoption decree, or other verification of dependent status, as appropriate.

Children acquired through birth, adoption or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs as discussed on page 15.

Available Coverage

If you chose continuation coverage, you are entitled to the same benefits you had while covered under active employment.

You and/or your eligible dependents may elect medical and prescription drug coverage only.

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date your Trust coverage would have ended if monthly self-payments were not made.

Monthly Self-Payments Required

You or your covered dependents are responsible for the full cost of continuation coverage. Self-payments for COBRA coverage are due on the first of each month for that month's coverage and must be sent to the Administration Office. Coverage will be terminated if payment is not postmarked or received by the Administration Office within 30 days of this due date. The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election. Your initial payment must cover all months for which you want coverage and be retroactive to when your Trust coverage ended. If your initial payment is not received or postmarked within 45 days of when you elected coverage, your right to continuation coverage will be lost.

Length of Continuation Coverage

Continuation coverage for yourself and/or your dependents may last for up to 18 months following loss of coverage because of termination of employment or reduction in hours. However, if you are an employee who has exhausted your COBRA self-pay coverage and are:

- sick or unable to work in the industry as a result thereof, or are unemployed and actively seeking employment in the industry covered by this Plan, and
- not engaged in substantial, gainful employment (employment which pays you 2/3 of your indexed pre-disability/termination earnings),

you may, upon prior Trustee approval, continue to pay for an additional six months of continuation coverage for yourself and your dependents. Thereafter, with subsequent prior Trustee approval at six month intervals, you may continue to self-pay for a total of 36 months.

For all other qualifying events (death of employee, divorce or legal separation from employee, employee becoming entitled to Medicare or a child no longer qualifying as a dependent under the Plan) continuation coverage for your dependents may last for up to 36 months.

However, continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Administration Office on a timely basis for the next monthly coverage period.
- You or your covered dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking continuation coverage).

- You or your covered dependent provides written notice that you wish to terminate your coverage.
- You or your covered dependent becomes entitled to Medicare benefits after the date of your COBRA election.
- The date the Plan terminates or the date your employer no longer participates in the Trust unless your employer or its successor does not offer another health plan for any classification of its employees which formerly participated in the Trust.

Length of Continuation Coverage – Disabled Individuals

If you, or your spouse or any dependent covered by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of the 18 month continuation coverage, the entire family of the disabled individual can receive an additional 11 months of continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Administration Office in writing within 60 days of the later of your qualifying event or your receipt of your Social Security Disability Determination, and prior to the end of your initial 18-month period of continuation coverage. If the disabled individual is subsequently found to not be disabled, you must notify the Administration Office within 30 days of this determination.

Length of Continuation Coverage – Second Qualifying Event

Covered dependents who are entitled to COBRA continuation coverage as the result of a participating employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event (e.g., an event which would have caused coverage to end if it occurred first) occurs during the initial 18 months of continuation coverage. Possible second qualifying events are the participating employee's death, a divorce or legal separation from the participating employee, a child losing dependent status or the participating employee becoming entitled to Medicare during the initial 18 months of continuation coverage.

If a covered dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Administration Office in writing within 60 days of the second qualifying event. Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage for your dependents extend beyond a total of 36 months.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If your Medicare or other group health coverage already existed when you elect COBRA, however, you can be eligible for both.

If you have coverage under a Trust-sponsored plan based on COBRA and you are eligible to enroll in Medicare Part A and B based on age or disability, and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have

received short-term disability benefits for less than six months. If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

If you have other group health coverage, it will pay primary and the Trust's continuation coverage will be secondary.

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that a failure to maintain health coverage can result in penalties under Federal law:

- You can lose the right to avoid having pre-existing condition exclusions apply to you, in limited circumstances, under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap; and

- You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

Health Insurance Coverage Options

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Terminating your COBRA coverage by failing to pay premiums does not generally allow you to immediately enroll in coverage provided through the Marketplace.

For more information about insurance options available through a Health Insurance Marketplace, visit *www.healthcare.gov*.

Additional Information

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's *www.dol.gov/esba*.

To help insure you receive necessary notices, it is your responsibility to notify the Administration Office if your address or that of any family member changes. If you have any questions regarding your eligibility/COBRA, please contact the Administration Office.

Other Self-Pay Rules

In addition to the standard COBRA continuation coverage provisions, the Board of Trustees has adopted the following expanded provisions:

- If you are an employee who is unable to work in the industry as a result of a sickness or disability, or you are unemployed and actively seeking employment in the industry covered by the Plan, you may self-pay at subsidized rates.
- If you are an employee being dispatched by the Union to a job that does not provide benefits and does not require employer contributions to any health and welfare plan, you will be entitled to make self-payments at a subsidized rate.
- If you are the covered spouse of an employee who dies while covered by the Plan, you will be entitled to make self-payments at a subsidized rate. However, if you remarry during the self-payment period, the self-pay rate shall increase to the full COBRA rate.

The Board of Trustees reserves the right to determine the rate of self-payment and to adjust the rate from time to time, as may be appropriate in the Board's sole discretion, up to the maximum rate that may be charged according to the law.

MEDICAL BENEFITS

Medical benefits as designed to reimburse you for covered expenses for medically necessary treatment after you satisfy the deductible.

Deductibles

Annual Deductible

Each year, for most benefits, you must pay an annual deductible before the Plan begins paying benefits. The annual deductible is $300 per individual per calendar year, up to a family maximum of $900 per year. This deductible applies separately to each employee or dependent (up to the $900 family maximum) during each calendar year.

Deductible Carryover Provision

Covered medical charges incurred during the last three months of a calendar year and applied toward all or part of the annual deductible will be carried over and used to satisfy all or part of the annual deductible for the next calendar year.

Common Accident Deductible Provision

If two or more covered family participants are injured in a common accident, they need satisfy only one annual deductible of $300 in the calendar year of the common accident, for the therapeutic treatment of the injuries sustained in the common accident.

Hospital Inpatient Deductible

There is also a separate hospital inpatient deductible per hospital admission per eligible participant. The deductible at a preferred (PPO) hospital is $100; at a non-preferred hospital it is $300. This is in addition to the annual deductible (described above) and there is no family maximum. This deductible only applies if you or a dependent is admitted to a hospital.

In determining when one hospital admission ends and a new one begins, all hospital admissions are considered as having occurred during one hospital admission unless:

- The latest hospital admission is due to causes entirely unrelated to the cause of all previous admissions, or
- The individual concerned has been free of hospital admissions for at least 90 days.

Coinsurance Percentage

After you pay the annual deductible, the medical benefits of the Plan pays 80% of the first $5,000 for most covered medical expenses in a calendar year. You pay the remaining 20%, to a maximum of $1,000 in a calendar year. The $1,000 maximum applies to each covered member of your family.

Annual Medical Coinsurance Maximum

Once you have paid $1,000 in covered medical expenses (excluding the annual deductible

and any hospital inpatient deductible) during a calendar year, the Plan will pay 100% of most covered medical expenses for the remainder of the calendar year. The $1,000 maximum applies to each covered member of your family.

Please note: Certain expenses, including durable medical equipment, artificial limbs and implanted devices, do not apply to the medical coinsurance maximum. The Plan covers these items at a constant 80%.

Annual Out-of-Pocket Maximum for Essential Health Benefits

In accordance with the Affordable Care Act (ACA), your annual out-of-pocket expenses for essential health benefits provided by preferred providers cannot exceed the maximum limit allowed under the ACA. In general, the Plan's out-of-pocket maximum limits are lower than the maximum limit allowed under the ACA. To ensure compliance with the ACA, the Plan monitors your out-of-pocket expenses on essential health benefits provided by preferred providers to ensure they do not exceed the maximum ACA limits.

Maximum Lifetime or Annual Medical Benefit

There is no maximum lifetime or annual benefit under the Plan for you or your eligible dependents, for claims incurred on or after January 1, 2014.

Preferred Provider Program

The Trust has contracted with Premera Blue Cross to provide care to Trust members and their dependents at discounted rates. For a list of preferred hospitals and medical providers, call Premera at (800) 810-2583 or visit their website at *www.premera.com*. Follow these steps to locate a preferred provider on-line:

1. Log onto *www.premera.com* and select the "Find a Doctor" option.

2. Under the Visitor option, select "Search for Providers in our Widest Networks."

3. Type the following information in to the "I'm Looking For" search bar: the type of provider for which you are looking, your location and your network.

   (Note: on the network drop box menu, select the "Heritage and Heritage Plus" network. From there you will be able to search for and locate preferred providers in your area.)

It is your choice whether or not you use a preferred provider. However, you will save money for both the Plan and yourself by using a Premera provider, because Premera providers have agreed to discounted fees, which will result in lower out-of-pocket expenses.

For physician visits, the Plan will reimburse you at 80%, after the yearly deductible is met, regardless of whether or not you use a provider in the Premera network. However, out-of-network reimbursement is 80% of the "usual, customary, and reasonable" (UCR) charge. If your out-of-network doctor charges more than the UCR amount, you pay the balance. This isn't an issue when you see Premera preferred providers, since the amount paid by the Plan and the amount you pay is based on the fees agreed to between the provider and Premera.

When you obtain services at a preferred hospital, the Plan will pay 80% of the discounted fees after a **$100** hospital inpatient deductible, in addition to the annual deductible. If your doctor admits you to an out-of-network hospital, the Plan will pay 80% of covered charges after you pay a **$300** hospital inpatient deductible, in addition to the annual deductible. When you've met the required annual deductible and hospital inpatient deductible and reached your out-of-pocket maximum, the Plan will pay 100% of covered charges for the remainder of the calendar year.

If you are anticipating a non-emergency hospitalization, it is to your advantage to make sure your physician or surgeon has admitting privileges at one of the preferred hospitals, so your benefits can be paid at the preferred level.

The $300 hospital inpatient deductible will apply to all admissions to an out-of-network hospital, *except* in the following instances:

- You have an emergency that prevents you from going to a preferred hospital.
- Necessary services are not available from a preferred hospital.
- You are eligible for other coverage, and, under coordination of benefit rules (see page 41) this Plan is secondary.

Hospital Preauthorization/Continued Stay Review Program

Qualis Health is a medical review organization that provides services to this Plan. They will work with you and your doctor to ensure medically necessary services are provided in the right setting at the right time. When there are possible healthcare alternatives, Qualis Health professionals may present those options to you and your physician. This may help to avoid unnecessary or more expensive medical procedures while promoting patient safety.

How the Program Works

When there is a hospitalization, you, a family member, your physician, or the hospital should contact Qualis Health at (800) 783-8606. When you call, please be prepared to give Qualis Health the following information:

- Name and insurance identification of the employee who is covered under the Plan
- Name and phone number of your doctor
- Name of the hospital
- Surgical or diagnostic procedure

In addition, your doctor or hospital will be asked to give clinical information about your hospitalization. Qualis Health will evaluate the medical necessity of healthcare services and the appropriateness of the level of care. When the medical services meet criteria, the clinical reviewer will certify the hospital admission. Please note that a certified admission does not guarantee coverage – you must be eligible at the time services are provided and the services must be a covered medical expense.

When criteria are not met, the case is then reviewed by a Qualis Health physician consultant. The physician consultant reviews the case and offers to talk to your doctor. Then the Qualis Health physician consultant makes a decision about the medical necessity and appropriateness of the hospitalization.

Process for Non-Emergency Hospital Admissions

As soon as you are scheduled for a hospital admission, you should call Qualis Health toll-free at (800) 783-8606 to start the review process. If you call after normal business hours, you will receive a recorded message instructing you to leave your name and phone number. Your call will be promptly returned the next business day, and Qualis Health professionals will complete the preauthorization process by contacting your doctor or hospital.

Process for Emergency Admissions

If you or an eligible dependent require an emergency hospital admission, call Qualis Health at (800) 783-8606 as soon as possible, but no later than 48 hours from the time of admission to the hospital.

Process for Maternity Admissions

Inpatient hospital stays for childbirth are allowed for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section delivery. You may be discharged earlier as long as you and your provider agree. It is still recommended that you contact Qualis Health at (800) 783-8606 prior to admission so your course of treatment throughout the hospital stay can be tracked.

Process for Continued Stay Reviews

On the last certified hospital day, Qualis Health will contact your hospital, or doctor to learn when you will be discharged. If your doctor feels an extension of your hospitalization is required, Qualis Health professionals will review your progress and determine whether the additional requested hospital days are medically necessary. Qualis Health professionals will work with your doctor and the hospital staff to promote timely and appropriate discharge from the hospital.

When Services are Non-Certified

When Qualis Health determines requested healthcare services are not medically necessary, you and your doctor are informed of this determination by telephone. In addition, a letter is sent to you and your doctor explaining the reason for the decision as well as your right to appeal. The Trust provides an appeal process, outlined on page 60 of this booklet, for care or treatment that is non-certified due to denial, suspension, or reduction in services requested.

The final decision regarding medical treatment is made between you and your doctor. You should follow whatever course of treatment you and your doctor believe to be most appropriate. However, without Qualis Health's certification, the Plan may reduce your benefits or disallow charges.

Impact of Preauthorization

You will receive the maximum benefits available if you use the program and receive Qualis Health's certification of the healthcare services. If you do not comply with the requirement to obtain preauthorization and continued stay review certification, the Plan may review the hospitalization after you are discharged to determine whether the services were medically unnecessary, which may result in a reduction in benefits, or in a denial of charges.

Individual Case Management

Qualis Health also provides case management services for this Plan. Case management is a mostly silent program that gets involved in case of serious illness (such as cancer) or catastrophic injury (such as a serious car accident). In these cases, Qualis Health will work with you and your provider to determine treatment options that will provide the most beneficial or cost-effective care in your specific case. In some cases, Qualis Health may authorize medical benefits that would not normally be covered under the Plan subject to approval by the Administration Office. You must receive this authorization from Qualis Health before receiving the service. The final decision on the course of your treatment will rest with you and your provider.

This program is used infrequently but it is helpful to patients who are seriously ill or injured. In no circumstance should this case management interfere with the quality or integrity of a patient's care.

Covered Medical Expenses

Covered medical expenses include only the following charges incurred by an eligible participant for the diagnosis and therapeutic treatment of pregnancy, disease, or non-occupational accidental injury.

- **Acupuncture** for treatment of pain and anesthesia only, limited to 10 visits per calendar year.
- **Ambulance** service when used to transport an eligible participant directly from the place where injured or stricken by a disease to the nearest hospital where treatment is available. If medically necessary, as determined in writing by the treating physician, your Plan will provide coverage for round trip professional ambulance transportation from a nursing home or other location to the nearest hospital where you can receive the medically necessary treatment. Reasonable air ambulance charges are also covered if medically necessary, as determined in writing by a treating physician.
- **Ambulatory surgical facility** services and covered supplies.
- **Anesthesia** and its administration.
- **Artificial limbs**, eyes, ears, organs and other parts of the body required as a result of a disability that caused the loss of the natural limb, eye, ear, organ or other part of the body. Such items shall be paid at a constant 80%. Your share of these charges does not count toward your medical out-of-pocket maximum.

- **Chiropractic care** limited to 25 visits per calendar year.
- **Coronary care unit** and **intensive care unit** charges.

  Inpatient hospital services are subject to the procedures of the Hospital Preauthorization/Continued Stay program outlined on page 20.
- **Cosmetic surgery** required for the prompt repair of an accidental injury, treatment of a congenital abnormality, the initial reconstruction following or coinciding with surgery covered under the Plan and required for treatment of illness or disease provided the cosmetic surgery occurs within one year of the applicable accident, birth, or surgery (unless delayed due to medical necessity).
- **Dental treatment** as required for the prompt repair or alleviation of damage to natural teeth, tissues of the mouth or the jaw caused solely by accidental bodily injury which occurs within one year of the accident (unless delayed due to medical necessity).
- **Diabetes self-care training,** limited to one training course per lifetime.
- **Diagnostic x-ray and laboratory** examinations.
- **Durable medical equipment** including the rental or purchase of wheelchairs, hospital beds and crutches. The Administration Office has the right to determine the appropriate circumstances for authorizing the rental or purchase of any such items on a non-discriminatory basis. Replacement of such items will only be covered when the old equipment is no longer serviceable. Such covered durable medical equipment fees shall be paid at a constant 80%. Your share of these charges does not count toward your medical out-of-pocket maximum. Maintenance, including labor fees and part costs, of the equipment is not covered.
- **ECG-monitored exercise programs** at approved cardiac rehabilitation centers for 12 weeks for certain conditions (contact the Administration Office for additional information).
- **Home health care** services provided to a patient in the patient's home by an approved home health care agency when given in place of confinement in a hospital or skilled nursing facility. To be eligible for these benefits, all of the following conditions must be met:
  - Home health care services must be for medically necessary treatment of an illness or injury covered under the Plan.
  - The physician must establish a written plan of treatment and certify that confinement in a hospital or skilled nursing facility would be required in the absence of home health care benefits. See the definition of a home health care plan of treatment on page 54.
  - The patient must be homebound, which means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another.

Covered services are those provided by a registered nurse, registered physical therapist, a certified occupational therapist, an American Speech and Hearing Association certified speech therapist, a certified inhalation therapist, and/or a home health aide acting under the direct supervision of one of the above therapists and performing services specifically ordered by the physician. Also covered are medical supplies, drugs, and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital or skilled nursing facility, but only to the extent that the charges would have been covered if the patient had remained in the hospital or skilled nursing facility.

For a list of exclusions specifically related to home health care, see page 33.

- **Hospice care** services provided by an approved hospice agency for you or your covered dependent who is terminally ill with a life expectancy of six months or less.

  Benefits are payable as specified below for medically necessary treatment for the terminally ill patient as prescribed by a physician. The physician must establish and periodically review (at least every two months) a written treatment plan that describes the hospice care to be provided.

  Expenses incurred in connection with an inpatient hospice care confinement are considered covered medical expenses to the same extent as expenses incurred for other inpatient confinements in a hospital. (The regular benefits of this plan also apply to hospital outpatient facility and skilled nursing facility expenses).

  The services of an approved hospice agency are covered in the patient's home only if the patient would have been ill enough to be hospitalized. The patient must be homebound, which means that leaving the home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another.

  All services, except for those of a physician, must be provided and billed by the hospice agency. Covered hospice care benefits are limited to the following:

  – Physician services.
  – Nursing services by a registered nurse (RN), or a licensed practical nurse (LPN).
  – Physical therapy services by a registered physical therapist.
  – Speech therapy services by a certified speech therapist.
  – Home health aide services that are specifically ordered to the treatment plan by the physician.
  – Respiratory therapy services.
  – Drugs and medicines dispensed by or through the hospice agency, that are legally obtainable only upon a physician's written prescription or that would have been provided on an inpatient basis, and insulin.
  – Medical supplies normally used by hospital inpatients and dispensed by the hospice agency.

- Nutritional supplements, such as diet substitutes administered intravenously or through hyperalimentation.
- Rental of durable medical equipment.

The patient's family may apply to the Administration Office for an extension of benefits if the patient's life expectancy extends beyond six months if the patient exhausts any hospice benefit limit specified above. Limited extensions will be granted if it is determined that the treatment is medically necessary.

For a list of exclusions specifically related to hospice care, see page 33.

- **Hospital** services and supplies rendered during confinement in connection with the diagnosis and therapeutic treatment of a participant, except room and board charges in excess of the full cost of semi-private accommodations.

  Emergency room charges are also covered, provided they are medically necessary for the treatment of the condition.

  Inpatient hospital services are subject to the procedures of the Hospital Preauthorization/Continued Stay program outlined on page 20.

- **Immunizations** of a routine nature are available at no cost to you, under both the preventive care benefit (see page 29) and the prescription drug benefit (page 36). Only immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and publicized in the Centers for Disease Control (CDC) annual immunization schedules for children and adults are covered.

- **Massage therapy**, but only if prescribed by a physician (MD or DO) or chiropractor for treatment of a specific covered medical condition. Massage therapy is limited to 10 visits per calendar year.

- **Mastectomies** are covered the same as any other treatment and benefits include:
  - Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

  The reconstructive benefits are available for covered individuals who are receiving benefits for a mastectomy and elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the attending physician.

- **Mechanical, electric or electronic devices** attached to or implanted within the body and used to perform a health monitoring or therapeutic function necessitated by a physiogenic cause. Such items shall be paid at a constant 80%. Your share of these charges does not count toward your medical out-of-pocket maximum.

- **Mental health** services include the following:
  - Inpatient and outpatient professional services of a physician (MD or DO), a psychologist (PhD), or a masters level mental health therapist under the direct supervision of an MD, DO, or PhD.
  - Inpatient charges for room, board, general nursing care, and other services and supplies furnished by an approved treatment facility for medically necessary treatment. ***This benefit is subject to the procedures of the Hospital Preauthorization/Continued Stay Review Program as outlined on page 20.***
  - This Plan does not cover facilities that strictly provide a residential setting; school programs; or educational materials or programs and referral services.
- **Nursing services** rendered by a registered graduate nurse, other than one who ordinarily resides in your home, or who is a member of your immediate family.
- **Nutrition counseling** is covered for four visits for each covered medical condition listed below, when such services are prescribed by an MD or DO as part of an approved self-care program. The covered medical conditions applicable to this item are:
  - Diabetes
  - Pulmonary disease
  - Cardiac disease
  - Renal failure
  - Hepatic insufficiency
  - Hyperlipidemia
  - Genetic metabolic disorder
  - Other known risk factors for cardiovascular or diet related diseases
- **Occupational therapy/physical therapy/speech therapy/other therapy** services, delivered by a provider who is authorized and licensed to provide the therapy, as follows:
  - Rehabilitative care to correct the effect of illness or injury
  - Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. The Plan also covers habilitative therapy services for autism spectrum and other disorders classified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as mental disorders.
  - Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.
- **Organ transplant expenses** are covered provided the transplant is ***preauthorized by Qualis Health.***

– Pre-certification approval for transplants is based on these criteria:
  - Your provider submits a written recommendation and supporting documentation.
  - Your medical condition requires the requested transplant based on medical necessity.
  - The requested procedure is not considered experimental or investigational.
  - The procedure is performed at a facility and by a provider approved by Qualis.
– After Qualis pre-certification, the following list of natural organs, natural organ parts and artificial organ parts are included:

  Natural Organs:
  - Heart
  - Heart/lung (combined)
  - Kidney
  - Kidney/pancreas (combined)
  - Lungs (single/bilateral)
  - Liver

  Natural Organ Parts:
  - Cornea
  - Skin, bone and tendons
  - Bone marrow (including self-donated and unrelated donors) but only as follows:

    With regard to autologous (self-donor) bone marrow transplants, coverage is available for treatment only of the following malignancies/conditions:
    - Non-Hodgkins lymphoma
    - Hodgkins lymphoma
    - Acute lymphocytic or non-lymphocytic leukemias

    Autologous bone marrow transplants for other conditions will not be covered.

    With regard to allogeneic (related or unrelated) bone marrow transplants, coverage is available for treatment only of the following malignancies/conditions:
    - Acute lymphocytic leukemia
    - Acute non-lymphocytic leukemias
    - Chronic myelogenous leukemia
    - Aplastic anemia
    - Hodgkins lymphoma

- Non-Hodgkins lymphoma
- Severe combined immunodeficiency (no AIDS)
- Wiskoll-Aldrich syndrome
- Infantile malignant osteoporosis
- Homozygous beta-thalassemia

Allogeneic bone marrow transplants for conditions other than those listed above will not be covered.

Artificial Organ Parts:

- Joint replacement (but for functional reason only), skin, heart valves, grafts and patches (vascular), pacemaker, metal plates and eye lens.

– Benefits are not provided for:

- Organ donor expenses, or any expense arising from or related to organ donation or organ receipt regardless of whether the participant is the donor or the recipient of the organ.
- Nonhuman, artificial or mechanical transplants, except as specifically provided under "Artificial Organ Parts" above.
- Experimental or investigational procedures as defined on page 53.
- Services in a non-approved transplant facility.
- Transplant expenses when government funding of any kind is available, or when the recipient is not eligible under this Plan.
- Lodging, food or transportation costs, unless specifically approved by the Administration Office.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.
- More than one transplant (subject to the limits specified above) if the transplant is not successful.

- **Oxygen** and its administration.

- **Orthognathic surgery,** for dependent children only, when surgical intervention is required for the correction of a malocclusion. Treatment is subject to the following conditions:

  – Before the course of treatment is started, a predetermination of eligibility must be obtained from the Administration Office. No benefits for treatment will be paid without a predetermination.

  – Once a predetermination form has been submitted, the Administration Office, at the Trust's expense, may request a second opinion of the medical necessity for such treatment. If such second opinion deems the treatment unnecessary, the pre-determination may be denied.

- **Physician and surgeon services** for covered medical treatment and performance of covered surgery. Covered services that may be received in the hospital, at home, in the doctor's office, or elsewhere include:

  – Charges for an assistant surgeon will be covered at 20% of the allowed amount of the surgeon's fee. If the surgeon's assistant is a registered nurse or physician's assistant, charges will be covered at 10% of the allowed amount of the surgeon's fee.

  – If two or more surgical procedures are performed at the same time in the same operative field, the benefit payable is 100% of the allowed amount for the first procedure, 50% of the allowed amount for the second procedure, and 25% of the allowed amount for the third or any additional procedures.

- **Pregnancy** or resulting childbirth or miscarriage are covered for an *employee or spouse only*. The covered charges of a licensed birthing center will be provided only to the extent that such charges would have been covered in a hospital. Maternity services are covered the same as any other condition. The Plan does not restrict hospital benefits for covered mothers to less than 48 hours following normal vaginal delivery, and 96 hours following cesarean delivery.

- **Prescription drugs** received from a retail pharmacy or through the mail order pharmacy are covered under the separate prescription drug benefit described on pages 36 to 40.

- **Preventive care services** will be covered at 100%, with no coinsurance or deductible, when performed by a **Preferred Provider**. The following services are covered:

  – Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings, as well as counseling in defined areas. A complete list of these services and screenings can be reviewed at *www.uspreventiveservicestaskforce.org/recommendations*.

  – Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at *www.cdc.gov/vacines*.

  – Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).

  – Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at *www.hrsa.gov/womensguidelines*.

  The preventive services listed above that are performed by a **non-Preferred Provider** will be covered, subject to the Plan's deductible and coinsurance.

  If you have any questions about what is covered under the Plan's preventive care benefit, please contact the Administration Office.

- **Skilled nursing facility** as follows:
  - Skilled nursing facilities are facilities that primarily provide convalescent care for patients transferred from accredited general hospitals.
  - Employee and dependent convalescent care for all covered conditions will be provided for a maximum of 70 days per condition when the patient has been hospitalized in an accredited general hospital for at least five days and has been admitted to the skilled nursing facility within 14 days after discharge from the hospital. This prior hospitalization requirement may be waived with Administration Office approval. Important: The facility must be approved by the Joint Commission for Accreditation of Hospitals or by Medicare.
- **Substance abuse** (alcoholism or drug dependency) services include the following:
  - Inpatient and outpatient professional services of a physician (MD or DO), and state certified chemical dependency counselor.
  - Inpatient charges for room, board, general nursing care, and other services and supplies furnished by an approved treatment facility for medically necessary inpatient treatment of alcoholism or drug dependency.

  Inpatient hospital services are subject to the procedures of the Hospital Preauthorization/Continued Stay program outlined on page 20.

  The Plan does not cover recovery houses that provide an alcohol or drug-free residential setting, alcohol or drug information, educational materials or programs and referral services, or school programs.
- **TMJ** surgery is covered subject to the following conditions:
  - Before the course of treatment is started, a predetermination of eligibility must be obtained from the Administration Office. No benefits for treatment will be paid without a predetermination.
  - Once a predetermination form has been submitted, the Administration Office, at the Trust's expense, may request a second opinion of the medical necessity for such treatment. If such second opinion deems the treatment unnecessary or inadvisable, the predetermination may be denied.
- **Tobacco cessation program** is available with no coinsurance or deductible for eligible members, spouses, and dependent children age 18 or older, for one treatment per calendar year. To participate, you need to contact Alere Wellbeing and enroll in their Quit for Life Program. The program provides personalized telephone counseling, educational materials, online interactive tools and free nicotine replacement products (such as nicotine patches and gum). For information on the program or to register, call 866-Quit-4-Life (866-784-8454).
- **X-ray**, radium, and radioactive isotopes therapy.

Extension of Medical Benefits Due to Disability

If eligibility terminates while a participant is totally disabled, that participant may continue to obtain benefits under the medical and prescription drug benefits of the Plan for the condition causing the total disability, provided they remain continuously disabled. Eligibility will be continued until the end of the calendar year following the calendar year in which eligibility terminated, or until the participant has access to other health coverage, such as through a spouse or some other source like Medicare. To receive this extension of benefits, the participant must apply to the Administration Office within 30 days after the date coverage would otherwise terminate. Written proof of disability from their physician will be required.

As used in this section "totally disabled" means:

- The individual is prevented because of injury or illness from engaging in his or her customary occupation and is performing no work of any kind for pay or profit; or

- The covered dependent is prevented because of injury or illness from engaging in substantially all of the normal activities of a person of like age and gender in good health.

Medical Benefit Exclusions

No benefits will be paid, unless required by law, for:

1. Disease or injury arising out of, caused by, or contributed to by any employment or occupation for compensation or profit for which coverage is available under any workers' compensation law or similar source of coverage or for which such coverage would have been available if the participant or beneficiary had been properly enrolled to receive it.

2. Services for medical, surgical or hospital care for any illness, non-occupational injury or physical disability received prior to the date your coverage begins under this Plan.

3. Diabetic or orthopedic shoes, routine, palliative, and cosmetic foot care including, but not limited to, callus or corn paring and trimming of toenails (except radical surgery for ingrown nails), except as medically necessary, as determined by your physician.

4. Radial keratotomy, refractive keratoplasty, and other surgery to treat refractive error that is correctable with eye-glasses or contact lenses.

5. Visual training or orthoptics unless the treatment arises from vestibular neuritis, labyrinthitis, or any other diseases of the vestibular system that cause balance disorders. Treatment must be determined to be medically necessary and the most appropriate level of care as determined by the Administration Office.

6. Hearing aids or the fitting of them.

7. Substance abuse except as described on page 30.

8. Routine physicals, immunizations, driving license or employment physicals or other health or check-up examinations not made during the course of or in connection with the rendering of medical treatment for a disease or injury, except as covered under the preventive care benefit (see page 29).

9. Devices or implants used to treat sexual dysfunction.

10. Drugs or devices not approved for marketing and for the prescribed use by the U.S. Food and Drug Administration.

11. Except for medically necessary treatment of conditions protected by the Mental Health Parity Act, the Plan excludes transsexual surgery or any costs arising from, relating to, or in preparation for such surgery.

12. Services, supplies, and other artificial means to induce pregnancy including but not limited to artificial insemination, invitro fertilization, embryo transfer, gamete intra fallopian transfer, embryo implant, surrogate motherhood, and cryogenic storage costs.

13. Reversal of voluntary sterilization.

14. Charges for services of a personal nature, such as charges for radio, television, telephone, guest meals, guest beds, etc.

15. Treatment for obesity, including but not limited to, weight-loss programs, surgery, reversal of surgery or complications arising from surgery or treatment of obesity.

16. Dental work for dental treatment, except as may be required for the prompt repair or alleviation of damage to natural teeth, or tissues of the mouth or jaw, caused solely by accidental bodily injury which occurs within one year of the accident (unless delayed due to medical/dental necessity).

17. Charges for cosmetic surgery and complications arising from cosmetic surgery, except as described on page 23.

18. Organ donor expenses and any expense arising from or related to organ donation or organ receipt, regardless of whether the participant is the donor or the recipient of the organ.

19. Charges relating to dependent children's pregnancies or resulting complications, except for certain preventive woman's services referenced on page 29.

20. Medical expenses will not be paid in the case of self-inflicted injuries except where there is mental instability with medical evidence to show that the injuries resulted from this instability.

21. Travel or transportation, whether by ambulance or otherwise, unless the charges are for professional ambulance service used to transport a participant when medically necessary as described on page 22.

22. The following home health care expenses are not covered:

- Maintenance or custodial care
- Homemaker or housekeeping services
- Supportive environmental services or equipment such as, but not limited to, wheelchair ramps or support rails
- Services provided or performed by household members, family, or friends
- Unnecessary and inappropriate services
- Social services
- Psychiatric care for family members
- Separate transportation charges
- Any services or supplies not specifically mentioned as covered.

23. The following hospice care expenses are not covered:

- Services of volunteers
- Services to other family members, including bereavement counseling
- Food, clothing or housing
- Supportive environmental services or equipment such as, but not limited to, wheelchair ramps or support rails
- Homemaker or housekeeping services
- Services provided or performed by household members, family or friends
- Psychiatric care for family members
- Services of financial or legal counselors
- Services or supplies not included in the written treatment plan or not specifically set forth as a covered benefit
- Spiritual counseling
- Any services or supplies not specifically mentioned as covered.

24. General health care convenience items (e.g. shower benches).

25. Educational programs, even if required because of an injury, illness or disability of a covered participant. Examples of non-covered expenses include, but are not limited to: educational services, supplies or equipment such as books, computers and software, printers or tutoring; programs to enhance or remedy concentration, memory, motivation, reading, self-esteem or communication skills; special education services and associated

costs in conjunction with sign language education for the patient or other family members; communication aids or devices.

26. Habilitative, education, or training services, or treatment for dyslexia except for prescription medication and professional charges for management of such medication, unless covered by the occupational therapy/physical therapy/speech therapy/other therapy benefit (see page 26).

27. Custodial care as defined on page 53.

28. Any condition resulting from military service, declared or undeclared war, invasion, civil war or hostilities.

29. Charges over and above the usual, customary, and reasonable (UCR) charges as defined on page 56.

30. Expenses that the covered participant would not be required to pay or that would not have been charged if there was no plan coverage.

31. Experimental or investigational services or supplies as defined on page 53.

32. Any condition arising from, resulting from, or related to the commission of a felony committed by the injured person.

33. Charges for services provided by any person who is related to you by blood or marriage.

34. Expenses for any services or supplies that are not medically necessary in light of the disease or injury being treated (see page 55 for a definition of medically necessary).

35. Services and supplies not specifically covered by the Plan.

36. Charges or requested information submitted more than one year after the date of service.

37. Services and supplies for which benefits are recoverable under motor vehicle or any other insurance or through subrogation as described on page 46.

38. Charges for missed appointments, preparing reports or forms, and submitting claims.

39. Charges for autologous blood, except if used during surgery or related hospital stay.

40. Non-durable or deluxe medical equipment. Durable medical equipment (DME) not suited for all activities of daily living, specialized DME such as swimming legs, exercise equipment, etc.

41. Charges for shipping, freight, or handling charges.

42. Equipment that can be used without a medical condition, such as hot tubs, spas, tanning beds, or weight equipment.

43. Light treatment and equipment purchase or rental for seasonal affective disorder (SAD).

44. Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.

45. Eating disorders, including appetite control, food addictions or other eating disorders, (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and present significant symptomatic medical problems).

46. Telephone or other medical consultations where the person is not physically seen by a physician or other covered medical provider.

47. Implantation, unless the person is totally edentulous (without teeth) and the gum is severely resorbed and cannot support regular dentures or when necessary due to an accidental injury to sound natural teeth, provided treatment is done within one year of the injury and the Plan received certification from the treating physician that treatment could not be completed earlier due to the severity of the patient's injuries.

48. Chelation therapy (except for acute arsenic, gold, mercury or lead poisoning).

49. Rolfing therapy.

50. Glasses or contact lenses (except for initial placement following cataract surgery and initial lens implant required because of cataract surgery).

51. Extra charges for a lab test or x-ray exam performed outside of normal operating hours or automated lab tests.

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy program (up to a 34 day supply) or the Mail Service Pharmacy program (up to a 90 day supply). Both programs are administered by CVS/caremark.

Retail Pharmacy

The retail pharmacy program is designed for short term or single use medications.

CVS/caremark has contracted with pharmacies nationwide. This includes most major chains as well as many independent local pharmacies. These pharmacies have agreed to fill prescriptions at negotiated price levels that should save both you and the Plan money. However, you may use any pharmacy; the choice is yours each time you fill a prescription.

The CVS/caremark retail pharmacy network works as follows:

1. Take your prescription or have your doctor send it to a network pharmacy and present your health plan ID card to the pharmacy.

2. The pharmacy will have access to the Plan's on-line eligibility and Plan provisions and will confirm your eligibility. Once your eligibility for benefits is confirmed, the pharmacy will ask you to pay according to the following schedule:

   - **Generic Drugs –** 20% of the cost of the prescription, for up to a 34 day supply

   - **Brand-Name Drugs (generic substitute not available) –** 20% of the cost of the prescription, for up to a 34 day supply

   - **Brand-Name Drugs (generic substitute available) –** 20% of the cost of the prescription plus the difference in cost between the brand-name drug and the generic drug, for up to a 34 day supply

3. The pharmacist will then fill your prescription and bill the Plan directly for remaining costs. You will not have to fill out any claim forms.

A list of CVS/caremark participating pharmacies can be obtained by calling CVS/caremark member services at (866) 818-6911, or accessing the CVS/caremark website at *www.caremark.com*.

If you choose to use a pharmacy that is not in the CVS/caremark network, or you do not present your health plan ID card to the pharmacist, you will need to pay for the prescription in full and then send the receipt and claim form to:

CVS/caremark
PO Box 52136
Phoenix, AZ 85072-2136

These claims will be reimbursed at the network pharmacy's negotiated rate, less the appropriate coinsurance. This usually means you will pay more for your prescription than if you used a CVS/caremark network pharmacy.

Mail Service Pharmacy

The mail service program is designed for maintenance medications needed for ongoing or chronic conditions.

It is your choice whether to obtain drugs at retail or through mail service. Mail service may save you money.

For prescriptions ordered through the mail service, the following co-payments apply for each prescription:

- **Generic Drugs –** $10 copay, for up to 90 day supply

- **Brand-Name Drugs (generic substitute not available) –** $30 copay, for up to 90 day supply

- **Brand-Name Drugs (generic substitute available)** - $30 copay plus the difference in cost between the brand-name drug and the generic drug, for up to a 90 day supply

You can get started with mail service by a variety of ways:

- Calling CVS/caremark. Be sure to have your ID card, doctor's contact information and prescription information and payment method ready for the representative and CVS/caremark will reach out to your doctor on your behalf.

  - CVS/caremark Customer Care at (866) 818-6911

  - CVS/caremark's FastStart program for mail service at (866) 239-4543 or (800) 875-0867

- Asking your doctor to send a prescription to CVS/caremark mail service for maintenance medications once your doctor has determined the dose best for you. Your doctor may phone, fax or electronically prescribe to mail service.

- Mailing a 90 day prescription and mail service order form to CVS/caremark. Allow up to at least two weeks from the day you submit your order for delivery of your medicine. Ask your doctor for a 30 day supply you can fill at retail while you wait for the mail service order if you choose this option. A mail service order form can be found on-line at *www.caremark.com*.

Make your check payable to "CVS/caremark" or furnish your credit card number and expiration date. Please do not send cash.

You can order refills online, by mail, by phone, or smart phone app – any time day or night. To order online, register at *www.caremark.com*.

Prescription Drug Out-of-Pocket Maximum

For claims incurred on or after January 1, 2016 your annual out-of-pocket expense (copayments and coinsurance) will not exceed $4,850 per person or $9,700 per family.

Prescription drugs filled at retail or mail order apply to the out-of-pocket maximum. However, the following charges will not apply to the prescription drug out-of-pocket maximum:

- Your copayment or coinsurance if you purchase your medication from a non-network pharmacy, or
- The difference between the billed charge and the contracted rate for prescriptions purchased without using your health plan ID card, or
- The difference in cost between a brand name and generic drug when a brand-name drugs is purchased when a generic drug is available.

Preventive Care Prescription Drugs

Your Plan offers certain preventive service benefits at no cost to you. Some services may be covered under your prescription drug benefit while others may be covered under your medical benefit. These no-cost benefits are part of the Affordable Care Act (ACA). A current list of services may be found at *www.hhs.gov;* see "Preventive Services Covered Under the Affordable Care Act". This list is subject to change.

Specialty Drugs

Prior authorization is required for specialty drugs. Specialty drugs share some of the following characteristics:

- High cost
- Unique storage or shipping requirements
- May require patient compliance and safety monitoring
- Potential for significant waste due to the high costs
- Prescribed for complex conditions like multiple sclerosis, rheumatoid arthritis, cancer as well as others

Specialty drugs are limited to the lesser of one fill or a 30 day supply.

An up to date list of specialty drugs may be obtained from the prescription benefit manager's website *www.cvsspecialty.com.*

Specialty Step Therapy

For initial select specialty prescriptions, participants and their physicians will be required to use preferred specialty drugs before non-preferred products are accessible. This program is intended to provide participants with coverage that is most effective, both on a treatment and financial basis. Prescription therapies (conditions) subject to the specialty step therapy program may be subject to change.

If you do not try one of the alternative drugs as part of the step therapy program, your prescription will be denied by the Plan.

If your doctor, for medical reasons does not want to prescribe one of the preferred drugs, they must call CVS/caremark for authorization.

Routine Immunizations

Routine immunizations are available from many retail pharmacies at no copay. Check with your local pharmacy regarding available services offered; service may vary by location.

The plan provides benefits for routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at *www.cdc.gov/vaccines*.

Prescription Drug Coordination of Benefits (COB)

If you and/or your eligible dependents are covered under another group health plan which provides prescription drug benefits, and you submit your prescription claims to the other plan first, this Plan will coordinate benefits and may reimburse you for all or a portion of any copays or coinsurance that you were required to pay under the other plan.

For reimbursement, submit a copy of the Explanation of Benefits (EOB) from the other health plan and the itemized drug receipt to:

CVS/caremark
PO Box 52136
Phoenix, AZ 85072-2136

Prescription Drug Exclusions

The following are some of the common categories of drugs that are excluded from this prescription drug benefit and not covered by the Plan;

1. Any drugs for illness, disease or injury provided in whole or in part by state or federal Workers' Compensation laws or other legislation.

2. Cosmetic drugs or health and beauty aids.

3. Nontherapeutic vitamins, dietary supplements, or herbal remedies unless specifically stated as covered for preventive care, as stated in the section above.

4. Weight loss drugs or supplements.

5. Over-the-counter drugs, unless prescribed and specifically provided for preventive care as stated in the section above or otherwise noted.

6. Fertility and infertility drugs.

7. Medications (such as Viagra), prescribed for treatment of erectile dysfunction.

8. Devices to treat erectile dysfunction.

9. Claims received after the 12 month filing limit.

10. Drugs administered or taken while confined in the hospital, skilled nursing facility, rest home, nursing home or similar institution.

11. Drugs administered by an oral health provider (dentist).

12. Drugs prescribed for the treatment of conditions, which are not within the medical uses approved by the FDA or the manufacturer (i.e. off label uses).

13. Drugs which are considered experimental or investigational as defined on page 53.

14. Drugs reimbursable by any government program – national, state, county, or municipal.

15. Medicines not requiring a prescription, except insulin.

16. Drugs lost, stolen, or damaged. However, one replacement per drug, per person, per calendar year can be requested for non-narcotic prescriptions. Call CVS/caremark or the Administration Office for specific requirements.

17. Drugs in excess of those with quantity limits.

18. Certain drugs that are not included on the CVS/caremark Standard Formulary may be excluded from coverage. To view the CVS/caremark Standard Formulary (Performance Drug List), please visit *www.caremark.com*. or call (866) 818-6911.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) With Other Plans

If a participant is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pays.

The primary plan (which is the plan that pays benefits first) pays the benefits that are payable under its terms as if there were no other coverage.

The secondary plan (which is the plan that pays benefits after the primary plan has paid) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed 100% of total allowable expenses. The amount of benefits the secondary plan pays will not exceed the amount it would have paid had it been the primary plan.

Order of Benefit Determination

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

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

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

- There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as a retired employee, then the order of benefits is reversed, so that the plan covering the person as a dependent pays first, and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More than One Plan

- The plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:
  - the parents are married;
  - the parents are not separated (whether or not they ever have been married);
  - the parents have joint custody either through a court order or otherwise and there is no court order specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child; or
  - the child is over age 18 and neither parent has custody.

- If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.

- The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

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

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

- If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
  - The plan of the custodial parent pays first; and
  - The plan of the spouse of the custodial parent pays second; and
  - The plan of the non-custodial parent pays third; and
  - The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

- The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first, and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.
- If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

- If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.
- If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than this rule.

Rule 5: Longer/Shorter Length of Coverage

- If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.
- To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
- The start of a new plan does not include a change:
  - in the amount of scope of a plan's benefits;
  - in the entity that pays, provides or administers the plan, or
  - from one type of the plan to another (such as from a single employer plan to a multiple employer plan).
- The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Benefit Credits

If, because of the coordination provision, the Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowed expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would normally be allowed.

Right to Collect and Release Needed Information

In order to receive benefits, the participant must give the Administration Office any information which is needed to coordinate benefits. Failure to provide information about other coverage may be considered fraud.

Effect of Medicare on Active Employees

When you reach the age of eligibility to enroll in Medicare Part A and B, you will have the opportunity to elect either to be covered by the Trust's health care Plan or Medicare. In order that you may make a meaningful choice, you will be given the following information:

- The specific terms and conditions of the Fund's Plan.
- The consequences of choosing the Trust's Plan and the extent to which Medicare may supplement these benefits.
- The consequences of electing Medicare instead of the Trust's Plan.

We suggest you contact the Administration Office approximately three to six months prior to becoming Medicare-eligible to make this election.

Effect of Medicare on COBRA Self Pay Employees

Benefits are coordinated with Medicare when you become eligible for or are eligible to enroll in Medicare Part A and B. If a Medicare eligible participant or dependent does not elect Medicare, or goes to a provider who does not participate in Medicare, benefits will be paid as if Medicare had paid as primary. Benefits under COBRA are also coordinated with other coverage an employee or his dependents may have.

If the claimant has coverage through an active employee plan, benefits will be determined under the active plan first. Medicare will be secondary and then this Plan will calculate its payment under the Coordination of Benefits provisions. If the claimant does not have active coverage, Medicare will be primary, and this Plan will pay secondary to Medicare.

Benefits payable by Medicare will be considered when determining how much is payable by this Plan. The maximum benefit payable under the Plan for Medicare eligible services will be the difference between the Medicare allowable cost and the Medicare payable amount. If you use a provider who is not participating in Medicare,

you are responsible for the difference between the Medicare allowable cost and the amount charged by the provider, as well as the amount Medicare would have paid.

This Plan Does Not Supplement Medicare

This Plan does not provide benefits that supplement a Medicare HMO or other Medicare Advantage plan.

Necessity of Applying for and Maintaining Medicare Coverage

It is necessary to apply for and maintain Medicare coverage. Although Part A coverage (hospital charges) is automatic on the attainment of age 65, or sooner based on disability or end-stage renal disease, Part B coverage (physician's charges) requires application and the payment of a monthly premium. If you do not enroll for Medicare when first eligible to do so, a penalty may be added on to your monthly Part B premium. Please contact your local Social Security Office for detailed information.

Coordination with Medicare for Participants with End Stage Renal Disease (ESRD)

Medicare becomes the primary payor for ESRD on the 31st month of coverage for the duration of ESRD coverage.

Coordination with Motor Vehicle or Other Insurance

Medical benefits are reduced to the extent available proceeds from other insurance, when combined with the benefits of this Plan, exceed actual charges for services and supplies otherwise covered under this Plan. "Other insurance" includes motor vehicle, homeowners, premises liability, or similar contract of insurance and personal health insurance or health service contracts. "Motor vehicle insurance" includes motor vehicle medical, personal injury protection ("PIP"), motor vehicle no-fault, and motor vehicle uninsured or underinsured motorist insurance.

THIRD PARTY REIMBURSEMENT (SUBROGATION)

The Plan excludes medical and prescription drug benefits for any injury or illness caused by the act or omission of another person, (known as the "third party"), where a potential opportunity for recovery exists from the third party, including, but not limited to, an injury or illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (i.e. coverage for underinsured or uninsured motorist), homeowners policy or commercial premises policy. If an eligible individual has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the eligible individual, may advance benefits pending the resolution of the claim. However, the Plan's payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery.

If the Plan provides benefits, the Plan is entitled to reimbursement of all benefits paid, regardless of whether the eligible individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the eligible individual complies with the terms of the Plan and any agreement to reimburse, the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, as described below.

Prior to advancing funds on the eligible individual's behalf, the Plan can require that an eligible individual and the eligible individual's attorney execute an agreement acknowledging this Plan's reimbursement right, and provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved and a factual description of the accident and/or injury or illness.

When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into a trust account or escrow and held there until the Plan's claims are resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the eligible individual, or the individual who receives or distributes the recovery funds shall be liable for any loss the Plan suffers as a result.

If reasonable attorney fees are incurred by the eligible individual in recovering from the third party or insurer, the Plan pays a percentage of attorney fees on the amount reimbursed to the Plan, not to exceed the percentage actually charged by the attorney to the eligible individual. If reasonable costs are incurred by the eligible individual in recovering from the third party or insurer, the Plan pays a pro rata share of the costs, based upon the Plan's share of the gross recovery to the total gross recovery. Costs incurred solely for the benefit of the eligible individual shall be the responsibility of the eligible individual. The Plan's payment of attorney fees and costs is contingent on compliance with the Plan's reimbursement provisions and/or the agreement to reimburse.

The Plan may cease advancing benefits, if there is a reasonable basis to determine that the eligible individual or the eligible individual's attorney will not honor the terms of the Plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.

After recovery by the eligible individual, and pending reimbursement to the Plan, the Plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the eligible individual's family members, by denying such payments until the amount of benefits provided has been recovered. The Plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.

If the Plan is not reimbursed, it may bring an action against the eligible individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the Plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

Motor Vehicle Accidents

Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payment insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.

The Plan will not pay benefits for health care costs to the extent that the eligible individual is able to, or is entitled to, recover from motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent an eligible individual has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The Plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the Plan's Third-Party Reimbursement Provision.

If the Plan pays benefits before motor vehicle insurance payments are made, the Plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the eligible individual and, when applicable, the Plan may recover benefits the Plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which the eligible individual obtains in accordance with the Plan's Third-Party Reimbursement Provisions.

Repayment of Improperly Paid Benefits

If the Plan mistakenly makes a payment for the participant (or beneficiary) to which they are not entitled, if the Plan pays a participant (or beneficiary) who is not eligible for benefits at all or if a participant fails to observe the Plan's Reimbursement provision, the Plan has the right to recover the payment from the participant paid or anyone else who benefited from it, including a provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan which has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future

benefits payable to the affected participant or any other individual where eligibility is established through the same participant. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes.

VACATION PLAN

The Vacation Plan is funded through employer contributions in an amount specified in the appropriate labor-management agreement.

Your employer sends the Administration Office the hourly contributions to be deposited in the Trust. The vacation contribution is added to your paycheck and necessary taxes are withheld.

Individual employee accounts are maintained in the Administration Office. Every month, individual employee accounts are updated, listing total amounts credited.

Withdrawing Vacation Benefits

To withdraw vacation benefits, present or mail a properly endorsed form to the Administration Office.

An individual other than the employee may collect vacation benefits for the employee at the Administration Office only after presenting a completed Vacation Withdrawal Form including an original endorsement by the employee containing the name of the person collecting the withdrawal. The endorsement must be in the following form:

> "I hereby authorize (NAME) to withdraw my vacation benefits
>
> **DATE**
> **EMPLOYEE SIGNATURE"**

You or the person you designated to collect the withdrawal will be required to present identification satisfactory to the Administration Office.

Only vacation money that has been processed by the Administration Office will be paid in full at the time of withdrawal.

If you have completed an Electronic Vacation Fund Transfer Enrollment form, payouts will be made directly to your bank account once a month on the 15th of each month. If the 15th of the month falls on a weekend or a holiday, your vacation money will be deposited on the last working day prior to the 15th. Please be sure to contact the Administration Office if you change banks or account numbers. Copies of the Electronic Vacation Fund Transfer Enrollment form are available on our web site at *www.nwplumberstrust.com* or from the Administration Office.

If you have not completed an Electronic Vacation Fund Transfer Enrollment form, your monthly vacation payout will be made to the home address you provided. There is a $5.00 administrative check processing fee for issuance of each hard copy check sent to your home. To avoid being charged the $5.00 fee, you must complete an Electronic Vacation Fund Transfer Enrollment form and have your checks deposited to your bank.

Deadline for Withdrawals

All money credited to your vacation account must be withdrawn by the end of the following calendar year in which it was earned. (i.e. Money initially contributed by employers in calendar year 2012 must be withdrawn by December 31, 2013.)

If you do not withdraw funds within this time period, an automatic vacation withdrawal request card will be mailed to your last known address. If no claim for such funds is made by you or your beneficiary for one year after written notice has been mailed, your vacation funds will be forfeited and applied to the costs of maintaining and administering the Northwest Plumbing & Pipefitting Industry Health, Welfare and Vacation Trust.

If You Transfer Employment

Any employee who has vacation credit and either transfers to U.A. Local #32, U.A. Local #598 or leaves the jurisdiction of the State of Washington may withdraw all vacation benefits that are processed at the time application is made.

If You Die

If you die, your vacation benefits will be paid to the beneficiary you designated on the Trust's enrollment form on file at the Administration Office.

If you do not designate a beneficiary or if your designated beneficiary dies before you, vacation benefits will be paid in the following order:

- To your spouse
- If your spouse does not survive you or if you are unmarried, to your surviving children, in equal shares
- If there are no surviving children, to your parents, equally, or to the survivor
- If neither parent survives you, to your surviving siblings, in equal shares
- If there are no surviving siblings, to your executors or administrators or the persons entitled to your net estate under the laws of intestate succession of the state of your residence at the time of your death; however, no payment will be made to any state by default
- In the event no designated beneficiary or heir survives you and makes claim within four years of your death, there will be no payment; the benefit will be deemed non-payable and considered as contributed toward the cost of maintaining the Plan.

Any person entitled to benefits may submit an affidavit to the Trustees in a form prescribed by the Trustees. Upon delivery of such affidavit, the Trustees may pay the amount determined to the person delivering the affidavit and the Trustees shall thereafter be discharged and released to the same extent as if they dealt with your personal representative. Any person due payment, delivery, transfer or issuance is made answerable

and accountable therefore to any personal representative of the estate or to any person having a superior right.

Benefits May Not Be Assigned

The vacation account is not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or other charge by any employee or any other person. The money credited to a vacation account is subject to withdrawal only at the time and in the manner described in this section and is not otherwise payable.

DEFINITIONS

Here are definitions of terms used in this booklet:

Accident is an unexpected and sudden event which the person does not foresee.

Accidental injury means an injury caused by external, violent and accidental means. The term "accidental injury" shall not include any chewing injury.

Active employee is the participant working in covered employment who is eligible under the Plan as a result of employer contributions, reserve hours or a combination of both.

Administration Office means Welfare & Pension Administration Service, Inc. which acts as the Plan's administrative agent under a contract with the Board of Trustees.

Allowed amount means:

- The fee negotiated by Premera if a service or supply is provided by a preferred provider, or
- The usual, customary and reasonable charge if a service or supply is provided by an out-of-network provider.

Ambulatory surgical facility means a facility that meets professionally recognized standards and is certified by either Medicare or a national affiliation as an outpatient surgical facility. It is not the office or clinic of one or more physicians.

Approved treatment facility is a facility that provides treatment for mental health or chronic alcoholism and/or substance abuse and that is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Birthing center means a facility for the normal delivery of a child or children operating under the direction and control of the Washington State Department of Social and Health Services or the equivalent department of another state.

Covered provider is a person licensed or certified in the state where the services are performed and practicing within the scope of their license or certification as required by law, including the following:

- A physician or surgeon (MD or DO) and any legally licensed podiatrist (DPM), dentist (DMD) or dental surgeon (DDS), chiropractor (DC), naturopath (ND), optometrist (OD) or psychologist (PhD) performing services within the scope of his license.
- Acupuncturists (LAC) are covered for treatment of pain and anesthesia only.
- Licensed master level mental health therapists are covered when prescribed and under the direct supervision of a physician or psychologist.
- Licensed massage therapists are covered only if prescribed by an MD, DO, or DC for treatment of a specific covered medical condition.

- Licensed nurses, licensed physical therapists and licensed occupational/speech therapists, as prescribed by a physician.
- Nutrition counselors are covered when prescribed by an MD or DO as part of an approved self-care training program.

No charges of a service provider listed will be paid if the service provider is related by blood or marriage to the participant receiving services, or if the condition or treatment is not covered under the Plan.

Custodial care is care that does not require the continuing services of skilled medical or allied health professionals and that is designed primarily to assist the patient in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of custodial care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

Durable medical equipment is equipment that is ordered by a physician and can withstand repeated use, is only for treatment of a medical condition, is generally not useful to the patient in the absence of the medical condition, is not for exercise, is not for prevention purposes, is usable only by the patient, and is manufactured solely for medical use.

Experimental or Investigational means a service or supply if any of these applies:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status;
- Federal law classifies the drug, device or medical treatment under an investigational program;
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis; or
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies of clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below),

For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by

the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure (except as provided below).

Exceptions: A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;
- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

The Administration Office shall investigate each claim for benefits that might include experimental or investigational treatment. The Administration Office may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Home health aide means an individual who is employed by an approved home health agency or an approved hospice agency and who provides part-time or intermittent personal care, ambulation and exercise, household services essential to health care at home, assistance with medications ordinarily self-administered, reports of changes in a patient's condition and needs, and completion of appropriate records. The home health aide must be under the supervision of a registered nurse, physical therapist, occupational therapist, speech therapist or inhalation therapist.

Home health care agency means a public or private agency or organization that administers and provides home health care and is either a Medicare certified home health care agency by the Washington State Department of Social and Health Services or the equivalent department of another state.

Home health care plan of treatment is a program for continued care and treatment established in writing by the patient's attending physician. This plan of treatment must be periodically reviewed by a physician. In addition, the patient's physician must periodically

certify that proper treatment of the injury or illness would have required continued confinement in a hospital or skilled nursing facility if the home health care plan of treatment were not available.

Hospice agency means a public or private agency or organization that administers and provides hospice care and is either a Medicare certified hospice agency or certified as a hospice care agency by the Washington State Department of Social and Health Services or the equivalent department of another state.

Hospital means an institution licensed as a hospital by proper authority for the care and treatment of sick and injured persons and having facilities for diagnosis and 24-hour registered nursing service as well as the full time attendance of a physician.

Hospitals are covered if licensed as such by the state or area in which it is situated. Nursing homes, rest homes, homes for the aged and similar institutions not maintaining regular hospital standards, are not included in this coverage. Confinement in a special unit of a hospital used primarily as a nursing, rest or convalescent home will be considered confinement in an institution other than a hospital. Charges made by government hospitals, which you are not required to pay, also are excluded, except as required by law.

Illness means a bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same or related cause; mental disorder; or pregnancy.

Medically necessary service or supply is one that meets the following criteria. The fact that the service or supply is furnished, prescribed, recommended or approved by a physician does not, by itself, make it medically necessary. A service or supply is medically necessary if:

- It is required to diagnose or treat the patient's condition, and the condition could not have been diagnosed or treated without it.
- It is consistent with the symptom or diagnosis and the treatment of the condition.
- It is the most appropriate service or supply that is essential to the patient's needs.
- It is appropriate as good medical practice.
- It is professionally and broadly accepted as the usual, customary and effective means of diagnosing or treating the illness, injury or condition.
- When applied to inpatient care, it cannot be safely provided on an outpatient basis.

Mental illness includes only those disorders listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other mental disorders.

Participant means any individual defined as an employee, dependent or any other individual who is entitled to benefits or is receiving benefits under the Plan.

Plan means the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Plan which provides medical, prescription drug and vacation benefits.

Usual, customary and reasonable: In determining the usual, customary and reasonable (UCR) charges made by a provider, the Administration Office takes into consideration without limitation:

- The fees that fall within the customary range of fees charged in a locality by most providers of a similar training and experience for the performance of a similar service or medical procedure.

- Unusual circumstances or medical complications requiring additional time, skill and experience in connection with a particular service or medical procedure.

The Administration Office makes the final determination as to whether or not the fee is "usual, customary and reasonable." Charges in excess of the usual, customary and reasonable fee, as determined by the Administration Office, will not be the responsibility of this Plan.

BENEFIT CLAIM PROCEDURES

These procedures set forth the requirements for filing a claim for benefits with the Trust, the time frames for making an initial determination on properly submitted claims, the contents of a denial of benefits, the procedures for filing an appeal, the Trust's appeal procedures and the participant's rights if an appeal is denied. These procedures are intended to help assure the consistent processing of claims and claim appeals. The Board of Trustees shall interpret and administer these procedures in accordance with the requirements of applicable law.

Filing a Claim

To constitute a claim, the participant or beneficiary must comply with the procedures set forth below.

To be considered a claim, the participant must request that the Trust provide benefits for a specific service or supply. All claim supporting documentation and additional information that is requested to process that claim **must be submitted within one year** from the date expenses for the services or supplies for which benefits are sought were first incurred. Unless the participant can establish to the Board of Trustees' satisfaction that it was not possible to file a claim within this one-year period, failure to submit a claim will result in a permanent denial of benefits. Subject to the special provisions dealing with urgent claims, claims must be submitted in writing by a participant or their authorized representative to the proper address.

The Trust may require additional information on any claim to process claims or to ensure compliance with Plan requirements. This may include inquiries related to eligibility, the nature of services or supplies provided, coordination of benefits, other insurance, third party reimbursement requirements or other Plan provisions. Failure to provide this required information in the timely filing period (one year from the date of service) will result in the denial of a participant's claim for benefits.

Requirements for Specific Claims

The Board of Trustees has established the following requirements for filing claims:

Medical Claims

In most situations, providers will submit bills to Premera directly. If the provider does not bill directly, participants should request an itemized statement of the services and charges including a diagnosis and submit it to:

NWPPI Health, Welfare and Vacation Trust
PO Box 34687
Seattle, WA 98124-1687

Prescription Drug Claims

See pages 36 to 40 for details on how to file a claim for the prescription drug benefits administered by CVS/caremark.

Procedures for Processing Claims

Properly filed claims will be processed in accordance with the following guidelines:

Post-Service Medical and Prescription Drug Claims

A post-service claim is any properly filed claim for medical or prescription drug benefits that is not a pre-service claim and does not involve urgent care. A post-service claim will generally be processed within 30 days of receipt. This period may be extended up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies you within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to your failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information required to process the claim, and you will be provided at least 45 days to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Pre-Service Health Claims

These procedures apply only to properly filed claims which must be preauthorized to receive full benefits from the Plan. Currently, these are inpatient admissions to hospitals, and for any transplant.

Claimants will be notified within five days if additional information is required to complete a pre-service claim or to allow processing. Claimants will be provided 45 days to submit any additional information. The time period for making a determination will be tolled from the date the information is requested until the earlier of the date information is received or 45 days have passed.

A decision on a pre-service claim will be made within 15 days. If additional time is necessary, the Administration Office may extend this 15-day period by an additional 15 days by providing notice to the participant prior to the expiration of the initial 15-day period.

If services which require preauthorization have been provided and the issue is what payment, if any, will be made, the Administration Office will process the claim as a post-service health claim.

Urgent Care Health Claims

Urgent care claims are claims for services where the application of the normal time periods for making non-urgent care determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or expose him or her to severe pain that cannot be adequately managed without the care or treatment. Urgent care claims may be filed, orally or in writing, by a participant or a health care provider (physician, osteopath, licensed nurse practitioner) with knowledge of the participant's medical condition. Participants will be informed within 24 hours if additional information is needed to process the claim. Claimants will have at least 48 hours to submit the additional

information. The Administration Office will develop procedures for identifying urgent care claims. This may include seeking additional information from the participant or his or her providers about why the treatment is considered to be urgent care.

If treatment constituting urgent care has been provided and the issue is what payment, if any, will be made, the Administration Office will process the claim as a post-service claim.

Notice of Administrative Denial

A denial of benefits will provide the following information:

- The reason for the denial.
- A reference to the Plan provision relied on.
- A description of any additional material or information needed to perfect the claim and an explanation of why such material or information is needed.
- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature or an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.
- An explanation of the Trust's appeal procedures. The denial will be mailed to the participant at his or her last known address.

Appeal of Benefit Denial

If you apply for benefits and are ruled ineligible by the Administration Office acting for the Trustees, if you believe you did not receive the full amount of benefits to which you are entitled, or if you are otherwise adversely affected by any action of the Trustees, you have the right to appeal to and request the Board of Trustees or its designated Appeal Committee (hereinafter collectively "the Board") to conduct a hearing in the matter, provided that you make such a request, in writing, within the time limits provided in these procedures. Medical and prescription drug benefit claims appeals must be filed within 180 days of an adverse benefit determination.

The Board will then conduct an initial hearing at which it will consider all written evidence submitted by you in support of your position. Thereafter, the Board will issue a written decision reaffirming, modifying or setting aside the former action. If you are not satisfied with the initial decision of the Board, you may, within 30 days of the date the initial decision is mailed to you, request an oral hearing before the Board. At that time, you may present any additional information that you believe is relevant to your appeal. You may be represented at any such hearing by an attorney or any other representative of your choosing. Thereafter, the Board will issue a final written decision reaffirming, modifying or setting aside the former action.

A failure to file a claim appeal within 180 days of the denial will serve as a bar to any claim for benefits or for other relief from the Trust.

Appeal Procedures

The procedures specified below shall be the exclusive procedures available to a participant who is dissatisfied with an eligibility determination or benefit award or who is otherwise adversely affected by an action of the Trust or its authorized claims payers. These procedures must be exhausted before a claimant may file suit under Section 502 (a) of ERISA.

Information To Be Provided Upon Request

The participant, and/or his or her authorized representative, may upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered or generated in making the benefit determination. It will also include internal guidelines, procedures or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Board of Trustees that disclosure is appropriate, relevant documents do not include any other individual's medical or claim records or information specific to the resolution of other individuals' claims.

If a denial is based upon a medical determination, an explanation of that determination and its application to the claimant's medical circumstances is also available upon request.

Conduct of Hearings

Except for urgent care and pre-service health claims, an appeal will be presented to the Board at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following receipt of the appeal.

The Board will initially review the administrative file consisting of all documents relevant to the claim. It will also review all additional information submitted by or on the participant's behalf. The review will be de novo and without deference to the initial denial.

If the denial is based on medical judgment, the Board will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. The Board may have an individual with a different licensure review a matter if they are trained to deal with the condition involved. The health care professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual. The Board will identify by name any individuals consulted for medical or vocational advice.

If the claimant is not satisfied with the decision of the Board after the initial review, the claimant or his or her representative will be allowed to appear before the Board and present additional evidence or witnesses in support of their position. If the claimant elects to appear before the Board, a copy of the administrative file will be mailed to the participant upon request. If the claimant does not elect to appear, the hearing will be determined based on the administrative file and the comments of any witnesses consulted.

If the claimant does appear at the hearing (or if the Board otherwise determines that such a

record is appropriate) a stenographic record shall be made of any testimony provided. The Board may, in its discretion, set conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters occurring during a specific hearing.

Issuance of a Decision

The Board will provide the claimant written notification of its final decision within five days. Where appropriate, the Board may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing. The decision will set out the specific reasons for an adverse decision, reference the Plan procedure involved, inform the claimant that all information relevant to the individual's claim is available upon request and free of charge, notify the claimant of his or her rights under section 502 (a) ERISA, identify any internal rule or guideline relied on (or reference that it is available free of charge), and if a denial is based on a medical judgment, an explanation of the medical judgment applied to the claimant's case or a statement that such information is available.

If a decision cannot be reached at the initial meeting at which an appeal is heard, the Board may defer a decision on an appeal until the next quarterly scheduled appeals meeting, provided that written notice is provided to the claimant.

Modifications to the Appeal Procedures for Pre-Service and Urgent Care Claims

The following modifications will be made in the appeal procedures described above for claims involving pre-service claims or urgent care claims.

Pre-Service Claims

Pre-service health claims will be conducted in accordance with the above procedures with the following modifications:

- A decision or an appeal of a denial of pre-service health claim will be issued within 30 days of receipt of the appeal.
- Unless the appeal hearing coincides with a quarterly Board of Trustees meeting, the appeal hearing will be conducted by a telephone conference call. The claimant or his authorized representative may participate to the extent necessary for the Board of Trustees to develop an adequate record. If the claimant wishes to appear in person, he or she may elect to postpone the hearing until the next quarterly Board of Trustees meeting.

Urgent Care Claims

Appeals involving denial of urgent care will be subject to the following modifications:

- An initial decision will be made within 72 hours if the initial claim was complete when submitted or an additional 48 hours after receiving additional information if it was necessary to process the claim.
- An appeal may be made orally or in writing.

- A health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization.
- Information will be provided to the claimant or authorized representative via telephone, facsimile or other expedited method.
- A decision will be issued within 72 hours of an appeal of an initial denial.

External Review

If a claimant remains dissatisfied after the Board of Trustees issues its decision on a claim appeal, he or she may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If the claimant requests an external review, such request is subject to the following:

- The Plan's internal claim appeal process must be exhausted before external or judicial review can be sought.
- External reviews are only available for appeals involving medical judgment or the retroactive rescission of coverage.
- A claimant has four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end the claimant's ability to seek external review.

Requests for external review should be sent to the Administration Office at the following address:

Attention Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request. The preliminary review will be expedited if the request satisfies the requirements for an expedited external review. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization.

Expedited External Review

A claimant may request an expedited external review if the claimant received:

- An adverse denial of benefits which involves a medical condition for which the timeframe for completing an expedited appeal to the Board of Trustees would seriously jeopardize the claimant's life or health or the claimants' ability to regain maximum function and the claimant filed a request for an expedited appeal to the Board of Trustees; or
- An adverse decision on appeal to the Trustees which involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant's life or health of the claimant's ability to regain maximum function, or the decision concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the Independent Review Organization with the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a response to the claimant within 45 days after it has received the request to review.

If a claim satisfies the requirements for an expedited external review, the Independent Review Organization will provide a response to the claimant with 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

Judicial Review of Appeal

If a claimant remains dissatisfied after the issuance of the Trustees' decision on appeal, or issuance of the Independent Review Organization's decision, the claimant may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal. The question on review will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

Ongoing Review of Policy

The Board will periodically review these procedures to ensure compliance with governing regulations. The Board will require the Administration Office to provide annual reports summarizing the procedural histories and results of any appeals made pursuant to these procedures. A record of decisions on benefit claim appeals will be maintained.

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes PHI as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information.

Protected Health Information

PHI generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearing house; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary" as defined under the Privacy Rules.

To Make or Obtain Payment

The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Plan or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

To Facilitate Treatment

The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating physician to another physician so that the physician may ask for your x-rays.

To Conduct Health Care Operations

The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants.

Health care operations include: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees

The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor), and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans.

Summary health information is information that summarizes participants' claims information but from which names and other identifying information has been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative

When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Administration Office. You are responsible for ensuring that your address with the Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law

In addition, the Trust will disclose your health information where applicable law requires. This includes:

1. In Connection With Judicial and Administrative Proceedings

   The Trust may disclose your health information to a health oversight agency for authorized activities (including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which health information is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or

domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

2. When Legally Required and For Law Enforcement Purposes

   The Trust will disclose your protected health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

3. To Conduct Public Health and Health Oversight Activities

   The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law.

   The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. In the Event of a Serious Threat to Health or Safety

   The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

5. For Specified Government Functions

   In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

6. For Workers Compensation

   The Trust may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

7. To Business Associates

   The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

Authorization to Use or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization.

Generally**,** you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Additionally, your written Authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information or any disclosure involving direct or indirect remuneration to the Trust.

Your Rights With Respect To Your Health Information

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid by you out-of-pocket and in full. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the Trust's labor costs in responding to the request.

Right to Receive Confidential Communications

You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting

You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for treatment, payment or health care operations; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications

If the Trust participates in fundraising, you have the right to opt out of all fundraising communications.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, *www.nwplumberstrust.com*.

Privacy Contact Person/Privacy Official

To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, *www.nwplumberstrust.com*:

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124-1203
Toll Free: 866-417-4240
Fax No.: 206-441-9110

Privacy Official
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124-1203
Toll Free: 866-417-4240
Fax No.: 206-441-9110

Duties of the Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

SPECIAL DISCLOSURE INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. This Summary Plan Description reflects the contents of the Plan as of October 1, 2016. From time to time, additional supplemental information will be supplied to participants indicating changes in Plan contents.

Name of Plan and Trust Fund

This Plan is known as the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Alternate Plan.

The Trust Fund through which the Plan is provided is known as the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Trust.

Name and Address of Administrator

This Plan is sponsored and administered by a Labor-Management Board of Trustees. The name, address and telephone number are:

Board of Trustees
Northwest Plumbing and Pipefitting Industry Trust Funds
7525 SE 24th St, Suite 200
Mercer Island, WA 98040-2341

or

PO Box 34203
Seattle, WA 98124-1203

(206) 441-7574
(866) 417-4240

Participating Employers and Local Unions

This Plan was established and is maintained as a result of collective bargaining between employers and local unions. A complete list of employers and local unions participating in the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administration Office and is available for examination by participants and beneficiaries.

Employers make contributions to the Plan in the amount required by the following Labor-Management Agreements between employers and local unions of the Plumbers & Pipefitters Council of the Northwest (U.A. Locals No. 26 & 44).

The local unions party to the Labor-Management Agreements are:

U.A. Local #44
3915 East Main
Spokane, WA 99202
(509) 624-5101

U.A. Local #26
780 Chrysler Drive
Burlington, WA 98233-4100
(360) 486-9300

A copy of the labor-management agreement or any other collective bargaining agreement between participating employers and local unions may be obtained by participants and beneficiaries upon written request to the Administration Office and is available for examination by participants and beneficiaries.

Trustees' Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is: EIN 91-0611843; and the Plan Number is 501.

Type of Plan

This Plan is a self-funded program providing benefits for medical, prescription drug, and vacation benefits.

Type of Administration

This Plan is administered by a Board of Trustees representing participating employers and participating local unions with the assistance of a contract administrator.

Name and Address of Agent for Service of Legal Process

The Board of Trustees has designated Les M. Coughran of McKenzie Rothwell Barlow & Coughran, P.S. as agent for purposes of accepting services of legal process on behalf of the Plan. Each member of this Board of Trustees is also authorized to accept service of legal process on behalf of the Plan.

Current Board of Trustees

Management Trustees	Labor Trustees
Paul Thibodaux c/o WPAS, Inc. 7525 SE 24th St, Suite 200 Mercer Island, WA 98040-2341	Todd Taylor U.A. Local #26 780 Chrysler Drive Burlington, WA 98233
David Nelson c/o WPAS, Inc. 7525 SE 24th St, Suite 200 Mercer Island, WA 98040-2341	Kevin Dolan U.A. Local #26 780 Chrysler Drive Burlington, WA 98233
Russ Williams McClintock & Turk 516 Sycamore Street Spokane, WA 99202	Pat Perez U.A. Local #44 3915 East Main Avenue Spokane, WA 99202

Termination of Plan Coverage

Benefits coverage will terminate on the earliest of the following days:

- On the last day of the month following the month in which a participant fails to meet the eligibility requirements set by the Plan.
- On the date a participant enters the armed services of the United States except for periods of service less than 31 days.
- In case of dependents, on the last day of the month that the dependent ceases to be a dependent within the definition given (see page 7 for definition) and fails to elect continuation of coverage.
- Upon termination of the Plan or Trust.
- If a sponsoring union local terminates its participation in this Plan, then individuals under the jurisdiction of such sponsoring union local shall not be eligible for self-payment privileges, and shall lose all retiree self-payment privileges.

Any participant who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

- The failure of the participant or dependent to file a complete and truthful claim application.
- When the dependent has other coverage, benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two plans. See pages 41-45 of this booklet.
- Failure of the participant to submit a claim within one year of the incurred expense.
- Benefits will not be paid if they fall within any limitation or exclusion described in the Plan.
- Failure of a participant to comply with the subrogation obligations (see page 46).

An employee's coverage under the vacation plan is based on the rules on pages 49-51 of the booklet.

Source of Contributions

The Plan is funded primarily with contributions negotiated as part of various collective bargaining agreements between management and labor, and where applicable, self-payments by individual participants who meet the eligibility rules described on pages 12-17.

Entities Used for Accumulation of Assets and Payments of Benefits

All benefits are paid directly from the Trust's assets. The employer contributions are received and held in trust by the Board of Trustees which pays benefits and administrative expenses. Funds remaining after the payment of benefits and other expenses of operating the Plan, if any, are likewise held in trust and invested by the Board of Trustees.

Stop-loss insurance is currently provided by The Union Labor Life Insurance Company, 8403 Colesville Rd. Silver Spring, MD 20910.

Plan Year

The plan year is January 1 through December 31.

Future of the Plan

The Trustees intend to continue this Plan indefinitely. However, in accordance with the Trust Agreement, the Trustees reserve the right to change benefits and contribution rates at any time, or to terminate the Plan if necessary.

If the Trust were to terminate at any time in the future, the Trustees would be obligated to use the remaining funds for the exclusive purpose of providing health and welfare benefits for eligible employees and their dependents, or other such purposes as may be permitted by law for such a Trust fund.

Your ERISA Rights

As a participant in the Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan Administration Office and at other locations (worksites and union halls), all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

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

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

Prudent Action by Plan Fiduciaries

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

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

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

Assistance With Your Questions

If you have questions about your plan, you should contact the Administration Office. If you have any questions about this statement or your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact t the nearest office of the Employee Benefits Security Administration, US Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.