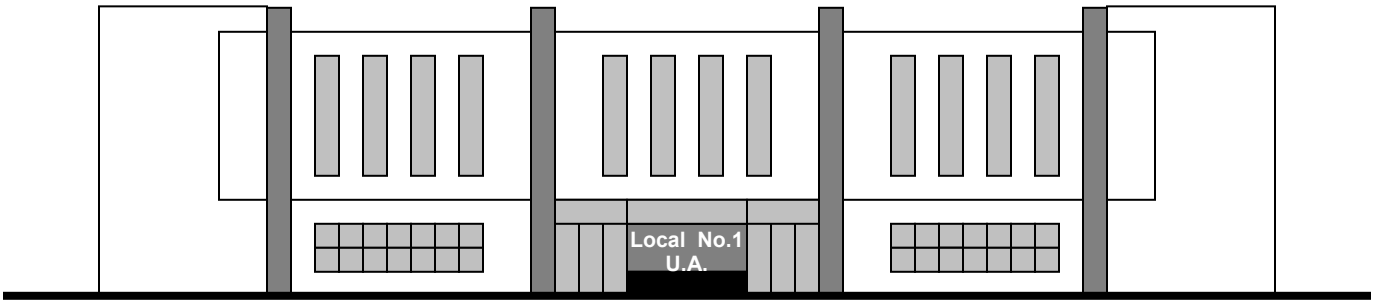
WELFARE FUND

SUMMARY PLAN DESCRIPTION
MES HELPER

www.ualocal1funds.org



PLUMBING INDUSTRY BOARD - PLUMBERS LOCAL UNION No.1

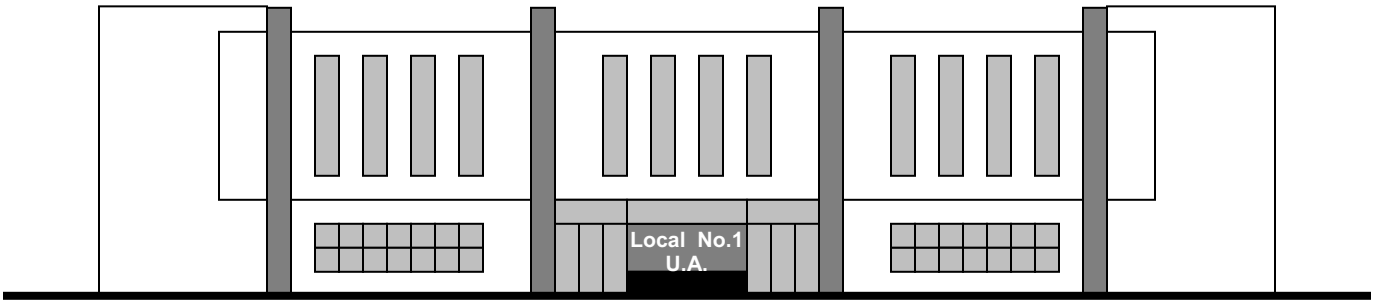
158-29 GEORGE MEANY BOULEVARD, HOWARD BEACH, NEW YORK 11414

2014

WELFARE FUND

SUMMARY PLAN DESCRIPTION
MES HELPER

www.ualocal1funds.org



PLUMBING INDUSTRY BOARD - PLUMBERS LOCAL UNION No.1

158-29 GEORGE MEANY BOULEVARD, HOWARD BEACH, NEW YORK 11414

2014

October 2014

Introduction

A Message to MES Helpers from the Board of Trustees

To All Eligible Employees:

This booklet describes the benefits provided by the Plumbers Local Union No. 1 Welfare Fund (the "Plan") (as amended through June 2014) as well as information that must be included to comply with the Employees Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan is a group health plan that provides hospital, major medical, prescription drug, and optical benefits for you and your eligible dependents.

This booklet serves as both the Plan document and the Summary Plan Description (the "SPD"). It supersedes all prior SPD's, Plan rules and other notices.

As in the past, you are not required to make any payment toward the cost of the program, which is financed by employer contributions as a result of the collective bargaining agreement between Plumbers Local Union No. 1, and your employer. However, if you lose eligibility for benefits, you may elect to continue your eligibility through the Continuation Coverage Plan. This booklet outlines the eligibility rules, describes the conditions governing the payment of benefits, and explains the procedures you should follow in filing a claim as well as an appeal procedure should your claim be denied.

We urge you to study this booklet and make full use of the coverage to which you are entitled, but we also call on you to take steps to preserve your benefits. In these days of escalating medical costs, it is important to assure that Plan assets are neither wasted nor misused.

The Trustees may modify or eliminate any of the benefits described herein or the qualification requirements for such benefits. The Trustees have the sole and complete authority and discretion to interpret this booklet and to make final determinations regarding its provisions. No benefits are guaranteed.

If the Trustees change the benefits or eligibility rules described in this booklet, you will be notified accordingly. Please keep any such notices with this booklet so that you will always have complete information about the Plan.

If you have any questions concerning your benefits or your eligibility to participate, please call the Fund Office, Welfare Department at (718) 835-2700.

Sincerely,
Plumbers Local Union No.1 Welfare Fund

The Board of Trustees

Notice of Grandfathered Health Plan

The Plumbers Local Union No. 1 Welfare Fund believes this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (718) 835-2700. You may also contact the Employee Benefits Security Administration, United States Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Plan Document and the Summary Plan Description

This booklet provides a summary of the benefits for participants in the Plumbers Local Union No. Welfare Fund (as amended through June 2014) as well as information that must be included to comply with the Employees Retirement Income Security Act of 1974, as amended ("ERISA").

The Plan is a group health plan that provides hospital, major medical, prescription drug, dental and optical benefits for you and your eligible dependents. This booklet serves as both the Plan Document and the Summary Plan Description (the "SPD"). It supersedes all prior SPD's, Plan rules and other notices. The Trustees may modify or eliminate any of the benefits described herein or the qualification requirements for such benefits. The Trustees have the sole and complete authority and discretion to interpret this booklet and to make final determinations regarding its provisions. No benefits are guaranteed. If the rules or benefits change you will receive written notice explaining the changes. Please be sure to read all Plan communications and keep them with this booklet.

TABLE OF CONTENTS

WHO CAN BECOME ELIGIBLE

Eligibility for benefits from the Plumbers Local Union No. 1 Welfare Fund (the "Plan") is based upon hours worked by MES Helpers under Collective Bargaining Agreements between Employers and Plumbers Local Union No. 1 ("Local 1" or the "Union") affiliated with United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada AFL-CIO which obligate Employers to report and pay contributions to this Plan on your behalf. You must satisfy certain eligibility requirements described on pages 2-10 of this booklet.

Eligibility can also be based upon contributions received for hours worked under a Participation Agreement between the Plan and an Employer which obligates the Employer to report and pay contributions to this Plan on behalf of the Employees covered by the Participation Agreement.

The rules and benefits described in this booklet apply to you if you are employed as an MES helper.

This booklet uses different terms to refer to categories of Employees who are affected by Plan rules. These terms and some other related terms are explained below and in the "Definitions" section found on page 120 of this booklet:

An "*Employee*" is an individual who is covered by a Collective Bargaining Agreement or a Participation Agreement that requires his or her Employer to make contributions to this Plan on his or her behalf. Contributions on an Employee's behalf are made for hours worked in accordance with the applicable Agreement.

A "*Collective Bargaining Agreement*" is an agreement between an Employer and Local 1 that requires the Employer to make contributions to this Plan.

A *"Participation Agreement"* is an agreement between the Trustees of this Plan and an Employer that requires the Employer to make contributions to this Plan.

"*Covered Employment*" is work under a Collective Bargaining Agreement or Participation Agreement for which contributions must be paid to this Plan.

An "*Eligible Employee*" is an Employee who has satisfied the requirements for eligibility for benefits from this Plan as described in this booklet and who is currently eligible for benefits.

An *"Active Eligible Employee"* is an Employee whose eligibility for benefits is based on hours worked for which his or her Employer must make contributions. Therefore, Employees who are eligible under the Plan based completely on payment of COBRA premiums are Eligible Employees but are not Active Eligible Employees. Employees who are eligible under Unemployment Continuation of Coverage, Workers' Comp Continuation of Coverage, and Disability Continuation of Coverage are also Active Eligible Employees.

A "*Retired Employee*" is an Employee who has qualified for and is receiving Retiree Benefits from this Plan. An Employee becomes a Retired Employee on the effective date of his Pension.

Initial Eligibility for Employees

You will be eligible for benefits from this Plan as an Active Eligible Employee on the first day of the calendar month following three (3) consecutive months of Covered Employment with contributing Employers in which you are credited with at least 270 hours in Covered Employment under this Plan. For example, if you first begin work in Covered Employment in October and you are credited with at least 270 hours between October and December, you will be eligible for benefits on January 1.

Probationary employees are not covered by this Plan. Hours worked by a Helper prior to becoming a second term Helper (Probationary Period) are not credited for purposes of eligibility in this Plan.

The Plan does not allow you to make contributions in order to gain or continue eligibility. In certain circumstances, however, you may pay COBRA premiums or make a self-payment to purchase continued health coverage. These special circumstances are described in the Section entitled "COBRA Continuation Coverage."

Reciprocal Plans - This Plan also has reciprocal agreements with certain other welfare plans of U.A. Local Unions. You can continue eligibility if you provide the Fund Office with documentation of hours worked in Covered Employment for an employer outside of Local 1's jurisdiction. When contributions are received or verified by this Plan from a reciprocal Plan, you will be credited with no less than the actual hours worked for eligibility purposes under this Plan. Effective January 1, 2013, if a reciprocal Plan makes contributions at a rate that is less than this Plan's contribution rate, your credited hours will be prorated. If a reciprocal Plan makes contributions at a rate that is greater than this Plan's contribution rate, you will be credited with additional prorated hours. Contributions made to this Plan, which are forwarded to a reciprocal Plan, will not be counted for eligibility purposes in any way by this Plan. If you have a question regarding whether a certain welfare fund has a reciprocal agreement with this Plan, please call the Fund Office.

Confirming Eligibility - Eligibility is based on payroll reports, with monthly cut-off dates determined by each Employer. The Fund Office will notify you of your coverage as soon as eligibility can be determined. However, because contribution reports reflecting hours worked in one month are not due and processed until late in the following month, the Fund Office cannot certify in advance when benefits will start or end.

There is a special rule solely for the purposes of establishing initial eligibility or reestablishing eligibility. Pursuant to this rule, if you work hours in one month but your Employer reports those hours in the following month due to the Employer's payroll cutoff date, the hours can be credited in the month in which the hours were worked. If the hours are credited for the month in which they were worked in order to establish initial eligibility or to reestablish eligibility, the hours will not be credited for the month in which they are reported. In other words, there is no double-counting of hours for eligibility or other purposes. This special rule is not available for continuing eligibility.

You should keep track of the hours you work each month. If you are working for a Delinquent Employer *(i.e., an employer who has failed to pay the contributions owed to this Plan on your behalf)*, the Plan will credit you with up to 35 hours per week for each week of your employment with the Delinquent Employer for purposes of continued eligibility in this Plan subject to the following requirements. Proof in the form of pay stubs and/or reports submitted

directly from the Employer indicating work hours must be submitted to the Fund Office. **However, you will not be credited for any hours worked for a Delinquent Employer after the date on which Local 1 directs you to leave employment with the Delinquent Employer.**

Termination of Eligibility for Employees

You and your Eligible Dependent(s) will lose eligibility for benefits on the last day of the sixth month following the most recent period of three (3) consecutive months in which you work at least 270 hours in Covered Employment. This period is called the "*Eligibility Period*". For example, if you are credited with at least 270 hours in Covered Employment between January and March and you are not credited with any hours after March, you will lose eligibility on September 30th [six (6) months after March].

If you lose eligibility and you are willing and able to work in Covered Employment, you may be eligible for the Unemployment Extension of Coverage described on pages 6-9.

Continuing Eligibility during Family and Medical Leave

If you are employed by an Employer who is covered under the Family and Medical Leave Act of 1993 (the "FMLA"), you may be entitled to take up to 12 weeks of unpaid job-protected leave each year due to your illness, or to care for your seriously ill child, Spouse or parent; the birth of your child or placement of a child with you in the case of adoption or foster care or a "qualifying exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, if you are a qualifying family member or next to kin of a covered military service member, you may be able to take up to 26 work weeks of leave in a single 12 month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

In order to be eligible for FMLA leave, you must have been employed at least 12 months by an Employer and provided at least 1,250 hours of service to the Employer. If your Employer employs fewer than 50 employees, you will not be eligible for FMLA leave unless the Employer's total number of employees within a 75 mile radius equals or is greater than 50.

Employers covered by the FMLA are required to maintain medical coverage for Employees on FMLA leave whenever such coverage was provided before the leave was taken and on the same terms as if the employee had continued to work. This means that an Employer is required to continue making contributions to the Plan on your behalf while you are on FMLA leave. Please contact the Fund Office if you are planning to take FMLA leave so that the Plan is aware of the Employer's responsibility to report and contribute during the FMLA leave. If you do not return to work after your FMLA leave ends, you may be required to repay your Employer the amount that it contributed to the Plan during your FMLA leave. However, if your failure to return to work is due to the serious health condition of you or a family member or other circumstances beyond your control, the repayment rule will not apply.

Any dispute between you and your Employer concerning the application of FMLA to your leave or the obligation of the Employer must be resolved between you and your Employer. If you have questions about the FMLA, you should contact your Employer or the nearest office of Wage and Hours Division, listed in most telephone directories under U.S. Government, Department of Labor and Employment Standards Administration.

Extension of Eligibility for Active Eligible Employees during Periods of Temporary Disability

If you are *an Active Eligible Employee who is "Temporarily Disabled "*– i.e. you satisfy the definition of temporarily disabled below and you are either receiving State Disability Benefits, Workers' Compensation Benefits, or you satisfy the definition of temporarily disabled below but are not receiving State Disability or Workers' Compensation Benefits, you continue to be eligible under this Plan for up to thirty (30) months from the date eligibility would otherwise terminate. However, such Temporary Disability Extension cannot exceed 50% of the length of the period in which you were eligible for benefits from this Plan measured immediately preceding the date of disability. Effective January 1, 2013, if you reject COBRA and elect the Temporary Disability Extension, an additional 18 month extension is available following your Temporary Disability Extension. The cost for the additional 18 month extension is the amount equal to 100% of the COBRA premium. If you elect COBRA Continuation Coverage, you are not eligible for the Temporary Disability Extension.

Examples of Eligibility Scenarios effective January 1, 2013:

- If you had been eligible for benefits 10 months prior to becoming disabled and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 5 months of the Disability Continuation of Coverage at no cost plus an additional 18 months of coverage at the cost of 100% of the COBRA rate.
- If you had been eligible for benefits for 18 months prior to becoming disabled and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 9 months of the Disability Continuation of Coverage at no cost plus an additional 18 months of coverage at the cost of 100% of the COBRA rate.
- If you had been eligible for benefits for 60 months prior to becoming disabled and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 30 months of the Disability Continuation of Coverage at no cost plus an additional 18 months of coverage at the cost of 100% of the COBRA rate.

You will be covered at the same level of benefits for which you were eligible immediately before becoming Temporarily Disabled. For purposes of this benefit, *"Temporarily Disabled*" means that you are temporarily unable to engage in the following types of employment due to an illness or injury:

- Employment with any Contributing Employer;
- Employment with any Employer in the same or related business as a Contributing Employer;

- Self-employment in the same or related business as a Contributing Employer; or
- Employment or self-employment in any business which is under the jurisdiction of the Union.

In order to qualify for this extension, you must provide the details of the illness or injury, including a description of the illness or injury, the date of onset of the illness or injury, and proof of State Disability Benefits or a Workers' Compensation claim number, if applicable. If you receive Temporary Disability Benefits for an extended period of time, you may be required to submit a C-4 Medical Report (or similar document) to the Plan supporting your entitlement to continued coverage. You must notify your Employer within 30 days of the accident or the onset of the illness and notify the Plan within two (2) years from the date of the accident or onset of the illness.

If your eligibility is extended, you must provide a notarized statement each month affirming that you are disabled along with proof of disability, such as an affidavit documenting the disability. This information must be submitted to the Fund Office by the 20th of each month following the month for which the notarized statement is given. You must notify the Plan immediately if you return to Covered Employment and provide proof of Covered Employment.

The Trustees may terminate your Temporary Disability Extension if you fail to submit (i) monthly proof of the continued receipt of State Disability Benefits or Workers' Compensation benefits, (ii) the monthly notarized statement, or (iii) any additional information requested by the Plan.

You may be required to (i) appear before the Trustees or a Committee of the Trustees, (ii) submit additional evidence of your disability status, (iii) submit to an Independent Medical Examination periodically during the period of extended coverage. The Trustees may rely on the results of Independent Medical Examination in determining whether to continue the Temporary Disability Extension, and they may terminate the Temporary Disability Extension if the result of the Independent Medical Examination indicates that you are not disabled. Your Temporary Disability Extension may also be terminated if you (i) fail to appear before the Trustees or Committee when requested, (ii) fail to submit additional information requested by the Trustees, (iii) present false information to the Trustees, (iv) fail to provide relevant information, or (v) you return to work.

If your illness or injury was caused directly or indirectly by another party, the Plan's Subrogation provisions apply. See pages 113-115.

Effect of Permanent Disability Award on Eligibility for Temporary Disability Extension

You are not eligible for this extension if you are permanently disabled. If you qualify for a permanent Social Security Disability Award, you are no longer Temporarily Disabled. You must notify the Fund Office immediately if you become eligible for a permanent Social Security Disability Award. If you receive a Social Security Disability Award and fail to notify the Fund Office, the Plan is required to seek reimbursement of the lesser of the amount you would have paid in retroactive COBRA premiums (if COBRA had been elected instead of the Temporary Disability Extension) or actual claims paid after you received the Social Security Disability Award.

Effect of Retirement on Eligibility for Temporary Disability Extension

Eligibility under this extension will terminate for a Retired Employee on your effective date of your pension.

Extension of Eligibility during Periods of Unemployment

This benefit is available during periods for which the Union certifies there is unemployment in the jurisdiction of Local 1. If your eligibility terminates under the rules of this Plan because of unemployment, you may apply for an Unemployment Extension within one year from the date your eligibility would otherwise terminate. Generally, under the Unemployment Extension, you may continue to be eligible under this Plan for up to six (6) months of coverage at no cost from the date your eligibility would otherwise terminate, plus an additional twelve (12) months of coverage for a payment of 25% of the COBRA Continuation of Coverage rate.

However, the total extension cannot exceed 50% of the length of the period during which you were eligible for benefits from this Plan, measured immediately preceding the date of unemployment. Effective January 1, 2013, if you reject COBRA and elect the Unemployment Extension, an additional 18 month extension is available once the Unemployment Extension of up to 18 months is exhausted. The cost for the additional 18 month extension is 100% of the amount of the COBRA premium. If you elect COBRA Continuation Coverage, you are not eligible for the Unemployment Extension.

Examples of Eligibility Scenarios effective January 1, 2013:

- If you had been eligible for benefits 10 months prior to becoming unemployed during a period in which the Union has certified there is unemployment in the jurisdiction of Local 1 and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 5 months of the Unemployment Extension at no cost plus an additional 18 months of coverage at the cost of 100% of the COBRA rate.

- If you had been eligible for benefits for 12 months prior to becoming unemployed during a period in which the Union has certified there is unemployment in the jurisdiction of Local 1 and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 6 months of the Unemployment Extension at no cost plus an additional 18 months at the cost of 100% of the COBRA rate.

- If you had been eligible for benefits for 36 months prior to becoming unemployed during a period in which the Union has certified there is unemployment in the jurisdiction of Local 1 and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 18 months of the Unemployment Extension. The first six (6) months of the Unemployment Extension would be at no cost and the next twelve (12) months would be at 25% of the COBRA rate. Following the Unemployment Extension, you are also eligible for an additional 18 months of coverage at the cost of 100% of the COBRA rate.

You must submit a request in writing and present evidence that you are unemployed and are collecting, have collected or are unable to collect unemployment benefits during the Eligibility Period. If your eligibility is extended, you must provide a notarized statement each month that you are not working, or have been working in Covered Employment and have been laid off again within the month, and are ready, willing and able to work in Covered Employment, or have returned to Covered Employment. This statement must be submitted to the Fund Office in person no earlier than the 20th of each month preceding the month for which the notarized statement is given and no later than the 20th of each month following the month for which the notarized statement is given. However, if you return to Covered Employment, you can submit the statement by mail with copies of current paystubs during the timeframes stated above.

Examples of evidence that you are unemployed:

- If you had been eligible for benefits prior to the unemployment, you will need to provide evidence that you are unemployed and collecting or have collected or are unable to collect unemployment benefits during the Eligibility Period.
- The Eligibility Period is the six (6) months following the most recent period of three (3) consecutive months in which you worked at least 270 hours in Covered Employment.
- If March is the end of the period in which you worked at least 270 hours in Covered Employment, your Eligibility Period is the six-month period from April through September. Evidence that you are unemployed and collecting or have collected or are unable to collect unemployment will be required for April through September when claiming an extension for October Benefits.
- A statement from the NYS Department of Labor Unemployment Insurance Division is acceptable evidence that you are unemployed and collecting or have collected or are unable to collect unemployment benefits during the Eligibility Period.

Example of Due Date:

- If you are claiming an extension for October Benefits, a notarized statement is due no earlier than September 20th and no later than November 20th.

For purposes of continued eligibility in this Plan during the Unemployment Extension, you will be deemed eligible for benefits on a monthly basis for up to eighteen (18) months from the date your eligibility would otherwise terminate upon your submission of the above-described proof of unemployment.

If, pursuant to a referral by Local 1, you become employed as a provisional employee by the city, state or federal government during periods of unemployment, you will not be covered by this Plan while employed as a provisional employee. In that case, you can continue to be eligible under this Plan for up to eighteen (18) months following the end of the provisional employment either upon your return to Covered Employment or under the Unemployment Extension. However, the Unemployment Extension cannot exceed 50% of the length of the period during which you were eligible for benefits from this Plan, measured immediately preceding the provisional employment, as described above.

An Unemployment Extension of eligibility for benefits may be terminated if you become employed in any of the following categories of employment:

- Employment with any contributing Employer;
- Employment with any Employer in the same or related business as a contributing Employer;
- Self-employment in the same or related business as a contributing Employer; or
- Employment or self-employment in any business which is under the jurisdiction of the Union.

The Trustees may require you to (i) appear before the Trustees or a Committee of the Trustees, or (ii) submit additional evidence of your unemployed status, such as your tax returns, and your efforts to find work. The Trustees may terminate your Unemployment Extension if (i) you fail to submit in person the monthly notarized statement, (ii) you fail to appear before the Trustees or Committee when requested, (iii) if you fail to submit additional information requested by the Trustees, (iv) you present false information or fail to provide relevant information to the Trustees, (v) you return to work, or (vi) if you refuse work offered to you. Eligibility for this benefit is available as long as the Union certifies that there is unemployment in the jurisdiction of Local 1.

Effect of Retirement on Eligibility for Unemployment Continuation of Coverage

Eligibility under this extension will terminate for a Retired Employee on your effective date of your pension.

Reinstatement of Eligibility for Employees

If your eligibility has terminated, you may become eligible again by satisfying the Initial Eligibility requirements described on pages 2-4. A Retired Employee who returns to work must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements described on pages 2-4.

Termination of Eligibility during Service in the Armed Forces

Eligibility During and After Periods of Military Service

Generally, if you terminate employment with a contributing Employer, your coverage under the Plan continues through the end of the sixth month following the most recent period of three (3) consecutive months in which you work at least 270 hours in Covered Employment ("Eligibility Period"). However, if you enter the "*Uniformed Services*" as defined in the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and you otherwise meet the requirements of USERRA (see below), your eligibility will be extended for the period described below, both upon your departure from and return to Covered Employment.

When you leave: If you leave Covered Employment to enter the Uniformed Services as defined in USERRA, your eligibility and that of your Dependent(s) will continue for the longer of 30 days or through the end of the Eligibility Period. You may then self-pay for continuation coverage for the lesser of 24 months or the remaining period of qualified military service under the procedures set forth below for COBRA Continuation Coverage.

When you return: If you return to Covered Employment after being discharged other than dishonorably from the Uniformed Services and you otherwise meet the requirements of USERRA (see below), your coverage will be reinstated on the day you return to work in Covered Employment. Your eligibility (and that of your Eligible Dependent(s)) will continue through the end of the Eligibility Period as it existed on the date that you departed Covered Employment to enter the Uniformed Services as if the period of qualified military service had not occurred. At the end of that period of extended eligibility, if you have not yet worked sufficient hours in Covered Employment to again meet the requirements for Continuing Eligibility, you may then self-pay for continuation coverage under the procedures set forth below for COBRA Continuation Coverage until you again meet the requirements for Continuing Eligibility or until the maximum period of COBRA Continuation Coverage is reached, whichever first occurs.

Notwithstanding the above, the Plan provided continuous eligibility through December 31, 2014 for a covered Employee who entered the Uniformed Services and provided the Plan with proof of such service.

Your coverage under this Plan will be secondary to any coverage provided as a result of your service in the military. The Plan coverage will be primary for your Eligible Dependent(s).

Requirements of USERRA: The requirements of USERRA that you must meet to be covered by this section include:

- You (or an appropriate military officer) must give advance written or verbal notice to your Employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable or precluded by military necessity);
- You must not be dishonorably discharged upon the conclusion of the uniformed service;
- The cumulative length of all of your absences with the Employer due to uniformed service must generally be no longer than five (5) years;
- Upon leaving the uniformed service, you must report back to your pre-service Employer for reemployment and/or report to the Local Union hiring hall for a referral to Covered Employment within the following specified periods of time:
    - Uniformed service of less than 31 days or for any length for a fitness for duty examination – you must generally report for work on the first regularly-scheduled workday at least 8 hours after you arrive home from service.
    - Uniformed service of more than 30 days, but less than 181 days – you must generally report for work within 14 days after completion of service.
    - Uniformed service of more than 180 days – you must report for work within 90 days after completion of the service.

ELIGIBILITY FOR DEPENDENT(S)

Upon becoming eligible for benefits, certain of your Dependent(s) may also become eligible for benefits from this Plan. "*Eligible Dependent(s)*" are:

- Your "*Spouse*" to whom you are legally married. In the event of a same sex marriage, you are considered legally married to your spouse if you were lawfully married in a state or other foreign or domestic jurisdiction whose laws authorize the marriage of two individuals of the same sex, even if you now live in a jurisdiction that does *not* recognize same sex marriages. The Plan does not cover a former spouse. See below for notification requirements upon change of marital status.

- Your "*Dependent Children"* from enrollment until the end of the calendar month in which such children attain age 26. Prior to December 31, 2013, children who were eligible for other employment-based coverage other than the plan of a parent or step-parent were not eligible for enrollment. On or after January 1, 2014, your children will qualify as Eligible Dependent(s) even if they are eligible for other employment-based coverage other than the plan of a parent or step-parent.

- "Dependent Children" are your biological, legally adopted children (including children placed with you for adoption); legally placed foster children or children of your current Spouse. Your Grandchildren are not covered by the Plan unless that child is placed for adoption with you or has been adopted by you.

- Your *"Disabled Dependent Child"* is your Dependent Child over age 26 who is incapable of self-support due to a physical or mental disability. The child must remain continuously disabled, unmarried and incapable of self-support and must either (a) be permanently and totally disabled, live with you for more than one-half of the year and not provide more than one-half of his or her own support or (b) depend on you for more than one-half of his or her financial support. A Disabled Dependent Child remains eligible only so long as you are eligible. You must provide the Fund Office with medical evidence of the child's disability within 45 days of the child's 26th birthday and annually thereafter. However, under certain conditions, you will be permitted to provide the Fund Office with medical evidence every five years thereafter. Please call the Fund Office for more information about this provision.

- The Newborn Child of your unmarried dependent, who lives with you for more than one-half of the calendar year or depends on you for more than one-half of his or her financial support, limited to **30 days from date of birth**, unless the Newborn Child is adopted by you or is in the process of being adopted by you.

Each Eligible Dependent must be listed on an Enrollment Form signed by you and filed with the Fund Office. If you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your Dependent(s). However, you must file with the Fund Office an enrollment form within 90-days after the marriage, birth, adoption or placement for adoption. Eligibility for enrollment received following this 90-day period may be accepted by the Fund. However, eligibility will be effective from the first day on the month in which enrollment was accepted by the Fund. Each change in Dependent Enrollment

(adding or terminating a Dependent) after the initial enrollment must be submitted with evidence or proof of Dependent status satisfactory to the Trustees.

Note: Effective on or after August 1, 2012, an Enrollment Form may be filed within 180 days after the marriage, birth, adoption or placement for adoption.

Effect of Change in Marital Status on Eligibility

If there is a change in your marital status, such as a divorce or legal separation, you are responsible for notifying the Fund Office immediately. Any benefits paid by the Plan on behalf of a divorced Spouse or stepchild after the date of divorce is the responsibility of the Employee and the former spouse.

You and your former spouse will be jointly and severally liable for any amounts paid on behalf of your former spouse or stepchild following a divorce. In addition to having to repay the Plan the costs of any benefits provided on behalf of such former spouse or stepchild, the Trustees have sole discretion to terminate your eligibility and the eligibility of your Eligible Dependent(s) if you fail to notify the Fund Office of your divorce.

Special Enrollment (HIPAA/SCHIP)

If you are declining enrollment for yourself or your Dependent(s) (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependent(s) in this Plan if you or your Dependent(s) lose eligibility from that other coverage (or if the employer stops contributing towards your or your Dependent's other coverage). However, you must request enrollment within 30 days after termination of your or your Dependent's other coverage (or after the employer stops contributing towards the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependent(s). However, you must request an Enrollment Form within 30 days after the marriage, birth, adoption or placement for adoption.

You and your Dependent(s) may also enroll in this Plan if you (or your Dependent(s)) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your Dependent(s)) lose eligibility for that coverage. You must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

You and your Dependent(s) may also enroll in this Plan if you (or your Dependent(s)) become eligible for a premium assistance program through Medicaid or SCHIP. You must request enrollment within 60 days after you (or your Dependent(s)) are determined to be eligible for assistance.

To request special enrollment or obtain more information, contact the Fund Office.

Dependent Eligibility Following Death of Employee

Dependent(s) who are eligible for benefits at the time of the death of the Eligible Employee continue to be covered by the Plan at no cost for six (6) months following the date of death

of the Employee. Thereafter, Dependent(s) may elect to purchase COBRA Continuation Coverage for 30 additional months at 65% of the COBRA rate, until 36 months from the date of the Employee's death. See page 22.
The Spouse of a deceased Eligible Employee may continue to purchase Plan coverage after the 36 months of COBRA Continuation Coverage at 65% of the COBRA rate until the Spouse becomes eligible for Medicare or until the Spouse remarries, if earlier.

Termination of Dependent Coverage

Benefits for Eligible Dependent(s) end on the earliest of the following:

- The date the Employee's eligibility terminates (see page 3);
- For the Employee's spouse and any step-child(ren), the first day of the month following the date the Employee and the step-child(ren)'s parent are divorced;
- Six (6) months after the date of death of an Eligible Employee;
- The date a Dependent becomes an Active Eligible Employee under this Plan;
- Upon the Dependent's entry into military service;
- If you are covered under the Surviving Spouse Continuation of Coverage, coverage will extend up to three (3) months following the death of an Eligible Retired Employee.

You are be able to remove your spouse and any dependent children who have reached age 18 from your coverage under the Fund. In order to remove your spouse or dependent child(ren) (age 18 or over) from your coverage, you will need to submit a request in writing to the Fund Office and provide any additional information that may be required by the Fund.

If you remove your spouse or dependent child(ren) (age 18 or over) from coverage, they will **not** be eligible for COBRA coverage because the voluntary opting out of coverage is not a qualifying event under COBRA.

In addition, if you remove an eligible individual from coverage, there will be very limited opportunities to re-enroll the individual in coverage. One opportunity is "Special Enrollment." In this case, if you terminated coverage for your spouse or dependent child(ren) (age 18 or over) because they had other health coverage, you will be able to re-enroll them in this Fund if they lose eligibility from that other coverage (or if the employer stops contributing toward that other coverage). In that case, you must request re-enrollment within 30 days after termination of such other coverage (or after the employer stops contributing to the other coverage).

If your spouse or other dependent does not qualify for Special Enrollment, you will have an opportunity to re-enroll that individual one time per consecutive "rolling" 12-month periods measured from the date that you terminated the individual from coverage. For example, if you terminate your spouse from coverage effective December 1, 2013, in the absence of eligibility for Special Enrollment, you will not be able to re-enroll your spouse for coverage

until December 1, 2014. In addition, you must give at least 30 days advance notice of your intent to re-enroll your spouse. In this example, you would have to notify the Fund Office in writing by no later than November 1, 2014 to apply for re-enrollment. If you do not re-enroll your spouse for coverage beginning December 1, 2014, then you will have to wait until December 1, 2015 (with 30 days advance notice required). Such coverage will be prospective only; retroactive coverage will **not** be provided.

Please note that your Employer will be required to make the same hourly contribution to the Fund for your coverage even if your spouse or other dependents opt out of coverage. Thus, it does **not** make financial sense for Active Employees to terminate coverage for dependents. However, if you are a surviving spouse of a deceased Eligible Employee receiving coverage for which you pay a portion of the cost, your premium will be lower if you drop a dependent from coverage.

The Fund Office may investigate the status of any Dependent. The Fund Office may require copies of court orders, property settlement agreements, divorce orders, birth certificates, paternity determinations, guardianship orders, adoption papers, tax returns or any other document or information related to the determination of an individual's status as a Dependent.

Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders ("QMCSOs"). QMCSOs require health plans to recognize State court orders, which the Plan determines to be a QMCSO as defined by federal law. A QMCSO requires the Plan to provide coverage to an Eligible Employee's child even if the Employee does not have custody of the child.

A QMCSO is a judgment, decree or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree or order. To be a QMCSO, a judgment, decree or order must require the child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support. The order must include:

- the name and last known mailing address (if any) of the Employee and the name(s) and mailing address of each child covered by the order,
- a reasonable description of the type of coverage to be provided by the Plan,
- the period of coverage to which the order pertains, and
- the name of the Plan.

Such an order is not qualified if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan will notify, in writing, the Eligible Employee and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the Eligible Employee and each affected child in writing of its determination as to whether an order is a QMCSO. Employees and their Dependent(s) can obtain a copy of the procedures, without charge, from the Fund Office.

Communication with Custodian of Child

Upon request, Plan correspondence will be sent directly to the person having custody of the Employee's Dependent Child, if other than the Employee.

ELIGIBILITY FOR RETIRED EMPLOYEES

Special Eligibility Rule for Retired Employees Covered by Prior Plans on May 31, 1998:

Retired Employees and their Dependent(s) who were eligible for Retiree Benefits from one of the Prior Plans on May 31, 1998 and who have remained retired will be Eligible Retirees and Eligible Dependent(s) for benefits from this Plan, effective June 1, 1998. If a Retired Employee returns to any employment of any type before electing Retiree Coverage from this Plan, the individual may not elect Retiree Coverage.

Retirees for whom there is no record of their eligibility for Retiree Benefits from one of the Prior Plans on May 31, 1998 must furnish the Fund with proof that they were eligible at the time of retirement from the Prior Plan and meet the following requirements:

- **Service -** One of the Prior Plans covered the Employee for at least 36 months of the 60 months immediately preceding retirement. For this purpose, periods of self-payment and periods on the Local 2 Referral List between October 1, 1994 and through June 30, 1997 will be treated as covered periods; and

- **Age -** The Employee was at least 60 years of age when he or she initially retired or became totally and permanently disabled before age 60 as demonstrated by receipt of a Social Security Disability Award. In the case of a disabled Retired Employee, the Employee is eligible for Retiree Benefits from this Plan so long as he or she is disabled and until he or she is Medicare eligible, at which time coverage will continue under the Medicare Wrap-Around Program provided by the Plan; and

- **Other -** The Employee maintains coverage for Part B, if eligible under Medicare, by self-paying the Part B premium. **NOTE: Failure to elect Medicare Part B coverage will result in a reduction of benefits.**

Coverage for Surviving Spouse of Retired Employee who Retired Prior to May 31, 1998

If you would have been eligible for coverage under this Special Rule, then your Surviving Spouse will be eligible. The Surviving Spouse must furnish the Plan with records to demonstrate that the Retired Employee was eligible as described above. The Spouse must also furnish records to prove that he or she was the Spouse at the time the Retired Employee was eligible and that the Spouse has not remarried.

Eligibility Rule Effective January 1, 2008

An Employee is a Retired Employee on the effective date of his Pension. If you initially retire on or after January 1, 2008 and you are receiving a pension from the Plumbers and Pipefitters National Pension Fund, you will be eligible for Retiree Benefits from this Plan if you meet the following requirements. You must satisfy both the applicable Service and Age requirements. In addition, you must elect Retiree coverage at the time of retirement.

- **Service**

  1. If you first enter the industry on or after January 1, 2007, you must have been eligible for benefits from this Plan for at least ten (10) years and for at least eighty-four (84) out of the last one hundred and twenty (120) months, prior to the start of your retirement. Months during which you were covered under the Plan by virtue of COBRA are not counted in determining whether you satisfy the 84 of 120 eligibility months service test

  2. If you first entered the industry before January 1, 2007, you must have been eligible for benefits from this Plan for the time period shown in the following schedule:

Effective Date	Minimum Years Eligible	Number of Months Eligible	Out of the Last
January 1, 2009	7	60	84 Months
January 1, 2010	8	72	96 Months
January 1, 2011	9	84	108 Months
January 1, 2012	10	84	120 Months

  Note: Months during which you were covered under the Plan by virtue of COBRA are not counted in determining whether you satisfy the eligibility service test.

  3. In addition to satisfying requirement 1 or 2 above, as applicable, you must have at least 500 hours of work reported to this Plan for the last three (3) years prior to the year of retirement combined. If disabled, you must have had 500 hours reported during the 36-month period prior to the commencement of your disability.

- **Age** – You must be at least age 60 or have become Totally and Permanently Disabled before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Benefit Award."

NOTE - If you leave the industry, you may not meet the service requirement described above and will not be eligible for Retiree Continuation of Coverage Benefits. In order to become eligible for Retiree Continuation of Coverage Benefits, you must return to work and remain eligible for benefits from this Plan long enough so that you satisfy the applicable service requirement. The period that you must return to work and remain eligible as an Active Employee in order to be eligible for Retiree Continuation of Coverage Benefits will vary depending on how long you were out of the industry and the service required at the time as illustrated above.

Effect of Becoming Eligible for Medicare

Upon becoming eligible for Medicare, Medicare is the primary coverage. For maximum benefits, you ***should*** maintain coverage for Part B by self-paying the Medicare Part B premium. **Failure to elect Medicare Part B coverage will result in a reduction of benefits.** Once Medicare-eligible, you and your Eligible Dependent(s) will have retiree Medicare Wrap Around benefits under this Plan, which does not cover expenses that would be covered by Medicare Part B. See pages 86 - 87 for a description of this benefit.

If you meet the above-described age and service requirements, you are not required to make self-payments for Retiree Benefits. However, if you retire **before** age 60 and elect Retiree Continuation Coverage, you will be required to pay an amount equal to the COBRA rate in effect at the time. The Plan's rules concerning eligibility for and the cost of Retiree Benefits are summarized as follows:

- If you retire before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Plan and you satisfy the requirements to continue eligibility under Extension of Eligibility During Periods of Temporary Disability, you will not be required to elect COBRA or make self-payments.

- If you retire before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Plan and if you are not eligible for the Extension of Eligibility During Periods of Temporary Disability, you will be required to elect COBRA and pay the COBRA rate in effect at the time,. However, if the Social Security Disability Award is granted, your eligibility for Retiree benefits and payments are then determined in accordance with the rules for Employees who initially retire on or after January 1, 2008.

- Retiree Continuation Coverage is available to Retired Employees from age 55 until age 65. If you meet the eligibility requirements of the Plan at age 65, the Plan's benefits coordinate with Medicare, and you will then be eligible for the Medicare Wrap Around Program. See page 71.

- If you retire before age 60, you are not eligible for the Medicare Wrap Around Program or any other coverage from the Plan at age 65 or after. Nor are you eligible for COBRA Continuation Coverage upon reaching age 65 (unless you are within the 18-month COBRA period measured from the date of retirement).

- If you retire at age 60 or older, or at any age in the case of Total and Permanent Disability, and meet the eligibility requirements of the Plan, you will be eligible for coverage from the Plan at no cost until age 65 at which time you will be covered by the Medicare Wrap Around Program. See pages 86-87.

- If you are eligible for benefits from the Plan based on your receipt of Workers' Compensation Benefits, your coverage will continue as described on pages 4-5, regardless of whether you have elected to begin receipt of a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the National Pension Plan. If the Social Security Disability Award is granted, you will qualify for Retiree Coverage. If the Social Security Disability Award is denied, your eligibility for Retiree Coverage and payments will be determined in accordance with the rules for Employees who initially retire on or after January 1, 2008.

If You Retire*…	Can Receive Retiree Benefits	Pays the following % of the COBRA Rate
Before Age 60	Ages 55 to 64	65%
At Age 60 or older	Ages 60 to 65 then Medicare Wrap Around Program	No Payment Required
Total & Permanent Disability Retirement at any Age	From Date of Disability Retirement to Medicare eligibility; then Medicare Wrap Around Program	No Payment Required

*Remember you must have been eligible for benefits from this Plan for at least ten (10) years and meet all other requirements.

Important Reminder

You must elect Retiree Continuation of Coverage at time of retirement. Failure to elect Retiree Continuation of Coverage at time of retirement will result in forfeiture of all eligibility for Retiree Coverage. Under no circumstances can you elect Retiree Coverage after expiration of the date upon which to elect such coverage.

Medicare Part D Prescription Drug Coverage

Everyone with Medicare is eligible for prescription drug coverage with Medicare prescription drug coverage and Medicare Advantage Plans (private insurance companies). The enrollment period for Part D Plans will begin on October 15 and end on December 7 of each year. If you are eligible for a Medicare Advantage Plan, you may also join or switch Medicare Advantage Plans from January 1 through March 31 but you cannot join or drop Medicare prescription drug coverage during this time. Before making your choice, be sure to get all the answers and find out what plan best fits your needs since you will be expected to remain enrolled in the plan you choose for at least one year.

A Member, Dependent and/or Surviving Spouse who is eligible for benefits under the rules of this Plan will continue to be eligible for benefits notwithstanding his/her eligibility for Medicare Part D. However, a **Member, Dependent and/or Surviving Spouse who actually enrolls in a Medicare Part D Prescription program will no longer be eligible for any benefits under this Plan.**

COBRA will be offered to the Spouse/Surviving Spouse or Dependent of a Medicare-eligible Member if he or she elects to enroll in a Medicare Part D Prescription program and the Spouse and/or Dependent is not Medicare-eligible. A monthly premium will be charged for the COBRA Continuation of Coverage.

A Retired Employee Dependent and/or Surviving Spouse who was eligible for Retiree Benefits under the Medicare Wrap-Around Plan who previously dropped coverage to enroll in a Medicare Part D Prescription Drug Plan can reenroll with the Plan each year from October 15 to December 7 with benefits effective January 1, subject to verification of disenrollment from the Medicare Part D Prescription Drug Plan. However, if the Retired Employee drops Medicare prescription drug coverage but does not reenroll in the Medicare Wrap-Around Plan (which includes prescription drug coverage), the Retired Employee will pay a penalty under the Medicare Prescription Drug Plan, if he or she later enrolls in Medicare Part D prescription drug coverage after more than 63 continuous days without "creditable prescription drug coverage" (that is, coverage that was to pay out, on average, at least as much as standard Medicare prescription drug coverage) from another source (such as Medicare or Medicare Advantage Plan or Spouse's employer or union plan). The Retired Employee may also have to wait to re-enroll in Medicare Part D Prescription Drug Plan until the following year.

Termination of Retiree Benefits

Your benefits terminate upon your death or if you stop receiving pension benefits or return to work in the Plumbing and Pipe Fitting Industry. If you return to work, you must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements described on page 2.

COBRA CONTINUATION COVERAGE

In certain circumstances in which coverage for benefits from this Plan would otherwise end due to certain events called "Qualifying Events," an Employee or Dependent can pay to continue benefits for a limited period. This extended coverage is called COBRA Continuation Coverage and is available to both Employees and Dependent(s) who are covered by this Plan on the day before the Qualifying Event – for example, the termination of employment – that causes the loss of Plan coverage.

You are responsible for paying the full cost of this coverage. The COBRA rates are established by the Trustees and can change from time to time. **COBRA Coverage does not include life insurance and weekly disability benefits**.

COBRA Rules for Employees

You may choose COBRA Continuation Coverage for yourself, your Spouse and/or your Dependent Child(ren). Coverage can be continued for up to 18 months from the date that you would lose coverage under the Plan because of the termination of your employment (for reasons other than gross misconduct) or because you do not have sufficient hours of Covered Employment for which contributions are received by the Plan to continue eligibility.

Under certain circumstances, coverage may be extended for a total of 29 months following termination of your employment or a reduction in hours of employment at an additional premium. To qualify for the additional 11 months of coverage, you or your Eligible Dependent must have a determination of disability from the Social Security Administration. Your disability would have to have started before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage for this extension to apply. You must file the determination from the Social Security Administration with the Plan within the later of 60 days of the date of the Social Security Disability determination or the date of the Qualifying Event or the date you would lose coverage under the Plan or the date you are informed of the notice requirement and procedure for the COBRA disability extension. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members. See "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 24.

If COBRA Continuation Coverage is extended because of a disability and the disability ends, you must notify the Plan within 30 days of a final determination by the Social Security Administration that the disabled individual is no longer disabled, or, if later, within 30 days of the date you are informed of this notice requirement and procedure. COBRA Continuation Coverage ends if Medicare Coverage begins before the 29-month period expires or if the disabled person recovers from the disability and has already received 18 months of COBRA Continuation Coverage.

COBRA Rules for Dependent(s)

If you choose not to purchase COBRA Continuation Coverage, your Spouse and/or Dependent child(ren) can separately purchase COBRA Continuation Coverage for themselves by making the election and the required monthly premium payments. The COBRA Continuation Coverage for Dependent(s) can be continued for up to 18 months (29 months if a disabled person elects coverage) if coverage would otherwise end because of your termination of Covered Employment or a reduction in your hours of Covered Employment. However, coverage can be continued for up to 36 months for your Spouse and Dependent child(ren) if their coverage would otherwise end because of:

- your death;
- your divorce or legal separation from your Spouse;
- a child's loss of status as a Dependent under the Plan (See page 13); or
- you become entitled to Medicare after the date of the qualifying event.

If your family experiences another Qualifying Event while receiving COBRA Continuation Coverage, your Spouse and Dependent Child(ren) may receive additional months of COBRA Continuation Coverage, up to a maximum of 36 months. This extension is available to your Spouse and Dependent Child(ren) if you die or become entitled to Medicare (Part A, Part B or both), or if you and your Spouse get divorced or legally separated or if your Dependent Child stops being eligible under the Plan as a Dependent Child, but ONLY if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan if the first Qualifying Event had not occurred.

COBRA Continuation Coverage and Medicare

If you are age 65 or over **OR** are disabled and covered by Medicare before you elect COBRA continuation coverage, and subsequently elect COBRA continuation coverage from this Plan, Medicare will pay first and your COBRA continuation coverage under this Plan will pay second.

If you have End-Stage Renal Disease (ESRD) and are covered by Medicare (as a result of ESRD) and are or become covered by COBRA continuation coverage from this Plan, this Plan will pay first during the first 30 months of eligibility/entitlement to Medicare and Medicare will pay second. After the 31st month after the start of Medicare coverage, if you are or become covered under COBRA Continuation Coverage, Medicare pays first and your COBRA continuation coverage under this Plan pays second. Note that this provision does not extend the maximum periods of COBRA Continuation Coverage and that once you exhaust the maximum COBRA period, your coverage under this Plan will end.

See the Coordination of Benefits section for more detail on how this Plan coordinates with Medicare.

Notification Requirements for COBRA Continuation Coverage

An Employee, Spouse or Dependent Child must notify the Plan in writing within 60 days of a divorce, legal separation or a child's loss of Dependent status under the Plan. An Employee's Dependent(s) should also notify the Plan in writing within 60 days of the Employee's death. An Employer must notify the Plan within 60 days of an Employee's death or eligibility for Social Security benefits. The Plan will determine when an Employee's eligibility for benefits would end due to termination of Covered Employment or reduction in hours of employment for which contributions are received by the Plan. *See* "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 24.

Following receipt of a notice or after an Employee's loss of eligibility due to termination of Covered Employment or reduction in hours of employment for which contributions are received by the Plan is determined, the Plan will notify you and your Dependent(s) of your rights to purchase COBRA Continuation Coverage and the cost of the coverage.

Election of COBRA Continuation Coverage

You and each of your Dependent(s) have an independent right to elect COBRA Continuation Coverage. To elect COBRA Continuation Coverage, you and/or your Spouse and/or Dependent Child must complete an election form provided by the Fund Office and submit it to the Fund Office within 60 days after the later of (i) the date coverage would otherwise end or (ii) the date the Employee, Spouse or Dependent child receives the notice of the right to elect COBRA Continuation Coverage. *See* "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 24.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- All health benefits provided by the Plan terminate;
- An Employee, Spouse or Dependent Child who has elected COBRA Continuation Coverage does not make the required payments to the Plan on time;
- An Employee becomes covered under Medicare after the date of the Qualifying Event; or
- An Employee, Spouse or Dependent Child becomes covered by another group health plan after the date of the Qualifying Event, unless that replacement plan limits coverage due to pre-existing conditions and the pre-existing condition limitation actually applies to the Employee, Spouse or Dependent after coverage under this Plan is taken into account.

Where to Send Notices and Information in Connection with COBRA Continuation Coverage

Notices and information concerning COBRA Continuation Coverage or questions concerning COBRA Continuation Coverage should be sent to:

Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd. 2nd Floor
Howard Beach, NY 11414
Phone (718) 835-2700

Keep Your Plan Informed of Address Changes

You must keep the Plan informed of any changes in the addresses of you or your family members. Keep a copy for your records of any notices you send to the Fund Office.

Certificates of Creditable Coverage

If you or your eligible Dependent(s) lose health coverage under the Plan before December 31, 2014, the Plan will issue you a Certificate of Creditable Coverage showing how long you were covered under the Plan. You or your eligible Dependent(s) may request the Plan to provide you with a Certificate of Creditable Coverage at any time while you are covered under the Plan and within 24 months of losing coverage.

You will receive the Certificate of Creditable Coverage automatically if you or your eligible Dependent(s):

- lose coverage under the Plan;
- become entitled to COBRA Continuation Coverage; or
- when COBRA Continuation Coverage ceases.

The Certificate of Creditable Coverage provides evidence of prior health care coverage under the Plan. You may need to furnish this Certificate if you or your Dependent(s) become eligible under a group health plan or insurance policy that excludes certain medical conditions that existed prior to enrollment in the new plan. This Certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the six-month period prior to enrollment in the new plan. This requirement will cease to be in effect after December 31, 2014.

DESCRIPTION OF BENEFITS FOR ACTIVE EMPLOYEES

Provider Networks

The Plan has agreements with several "Preferred Provider Organizations" ("PPOs"). A PPO is a network of participating providers (hospitals, physicians, laboratories and radiological facilities) who have agreed to charge Eligible Employees and Eligible Dependent(s) a preferred or negotiated rate. PPO agreements help control medical costs.

Through the PPO networks, you will have choices regarding where to seek medical care. However, if you use a participating provider in a PPO network, your out-of-pocket expense will be lower than if you use a non-participating provider and, in some circumstances, you will not have any out-of-pocket expenses. In most cases, a small co-payment at the time of the visit is all that you will have to pay. (The Plan does not reimburse any co-payments made to providers.).

Services by Non-Participating Providers

The Plan will cover services received from a non-participating provider as if the services were performed by a participating provider under the following limited circumstances:

- Fees for services by a non-participating physician in connection with an emergency room visit covered by the Plan under the Emergency Room Benefit.
- Fees for services by a non-participating anesthesiologist when the services are provided in a participating hospital by a participating surgeon.
- Fees for non-participating Neonatal Intensive Care Unit (NICU) services, including services by a non-participating physician, provided following the birth of a child as a result of problems with delivery when the services are provided in a participating hospital.

Enrolling In Your Network

Enrollment information must be provided for all Employees and Dependent(s) including Medicare-eligible Employees and Dependent(s). You must notify the Fund Office in writing to enroll a Dependent. The Plan can only enroll those Dependent(s) of whom the Fund Office has knowledge. If you do not notify the Fund Office of a Dependent, the Dependent cannot be enrolled.

You are required to provide the enrollment information required by the Plan. If you do not have a required document (for example, a marriage certificate or birth certificate), you should contact the Department of Vital Statistics of the state involved. If you are unable to obtain a copy of the record after contacting the applicable Department of Vital Statistics, you should contact the Fund Office concerning alternative ways to document the required information.

If you do not provide the required enrollment information after notice by the Plan, the Plan may suspend payments on behalf of you and/or your Dependent(s) for whom documentation is missing until documentation satisfactory to the Trustees has been provided.

The following are the networks with which the Plan has arrangements. A listing of medical providers participating in the network will be furnished without charge as a separate document. Please contact the Fund Office for information about the various networks.

Hospital and Physician Networks

Empire Blue Cross/Blue Shield

The network includes physicians, hospitals, laboratories and other medical facilities that provide healthcare services. **Be sure to present your Identification Card whenever you receive any services at a Hospital.**

Other Preferred Provider Networks

CVS/Caremark (formerly Caremark)	*Prescription Benefits*
Vision Screening, Inc.	*Vision Benefits*
Vascular Diagnostic Assoc., P.C.	*Cardio Vascular Screening Benefits*
D.J. O'Grady Consultants, LTD	*Alcohol & Substance Abuse Benefits*

The names, addresses and phone numbers of all the Preferred Provider Networks with which the Plan has arrangements are listed on page 134.

SUMMARY OF BENEFITS FOR ACTIVE EMPLOYEES

The key to using your PPO plan is understanding how benefits are paid. Your first decision is whether to choose in-network or out-of-network providers. This choice determines the level of benefits you will receive.

The Plan utilizes Empire BlueCross BlueShield networks of Participating Providers (hospitals, physicians, laboratories and radiological facilities) who have agreed to charge Eligible Employees and Eligible Dependents a preferred negotiated rate. The Fund has these agreements with BlueCross BlueShield networks to help control medical costs. You can view and print up-to-date information about your Medical Benefits and Hospital Benefits by visiting *www.empireblue.com*, or request that information be mailed to you.

Effective January 1, 2014, a Point of Service (POS) Alternate Network is available for New York State eligible Participants and Dependents. This Network replaces the PPO for residents of NY State and certain parts of New Jersey and Connecticut. Eligible Participants and Dependents outside New York State will continue with the PPO as the POS is not available outside NY State.

Choosing In-Network or Out-of-Network Services

In-Network services are services provided by a physician, hospital or ancillary provider that has been selected by the POS/PPO to provide care to enrolled Employees and Dependent(s). In-network care provides the following advantages:

- You can choose any participating provider from your POS/PPO in New York State or the national network of your POS/PPO.
- You do not need a referral to see a specialist, so you direct your care.
- Benefits are paid after a co-payment for the office visit and many other services.
- Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy and home health care.
- Usually there is no claim form to file.

Out-of-Network services are healthcare services provided by a licensed provider outside your POS/PPO network. For most covered services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:

- You are responsible for an annual deductible and co-insurance, plus any amount above the “Allowed Amount” (the maximum the POS/PPO will pay for covered service).

- You will usually have to pay the provider at the time you receive care.
- You will need to file a claim form to be reimbursed by the POS/PPO.
- For physician, hospital or healthcare facility services received from outside providers, the benefits paid are subject to an annual deductible.
- After the deductible, the Plan pays 70% of the first $5,000 of eligible expenses per Employee or dependent or 70% of the first $12,500 of eligible expenses per family per calendar year and the Employee is responsible for the balance. Thereafter, 100% of eligible expenses are paid for that calendar year.

If you live or travel outside of your POS/PPOs local operating area, Empire provides a network of participating physicians, hospitals or labs through the following program:

BlueCard® PPO Program - Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers. By presenting your Empire I.D. card to a provider participating in the BlueCard® PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. Call 1-800-553-9603 or visit www.empireblue.com to locate participating providers in or outside of Empire's operating area.

Here's an example of how costs compare for in-network and out-of-network care.

	IN-NETWORK	OUT-OF-NETWORK
Provider's Charge	$1,000	$1,000
Allowed Amount	$ 800	$ 800
Plan Pays Provider	$ 775 ($800 minus $25 co-payment = $775)	$ 360 ($800 x 70% = $560 minus $200 Deductible = $360)
You Pay Provider	$25 co-payment	$640 ($200 Deductible plus $240 Coinsurance plus $200 amount above Plan's allowed amount = $640)

The following chart shows you specific plan information.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	Individual $0 Family $0	Individual -- $200 Family ------ $500
Co-payment (For office visits and certain covered services)	$25 per visit	Deductible and Coinsurance
Co-payment (For hospital inpatient admissions)	Coinsurance	Deductible and Coinsurance
Co-payment (For emergency room)	$35 per visit; waived if admitted to hospital within 24 hours	$35 per visit; waived if admitted to hospital within 24 hours
Coinsurance	You pay 10% of allowed amount. Plan pays 90% of allowed amount.	You pay 30% of allowed amount. Plan pays 70% of allowed amount.
Annual out-of-pocket Coinsurance	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited

SUMMARY OF BENEFITS

The following table provides a summary of your benefits effective on or after January 1, 2013. Differences between in-network and out-of-network benefits are shown on the chart. The benefit amounts listed under the participating providers are all based on the PPO discounted allowances. For additional information about any benefit offered by the Plan, review the detailed description later in this booklet as well as the Exclusions and Limitations on pages 116-119. The Plan covers benefits that are Medically Necessary (See Definition on page 122). See pages 41-67 for a more detailed description of Medical Benefits.

MEDICAL BENEFITS (Physician Services)		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Physician Visits (Home/Office/Specialist)	$25 Co-payment	Deductible and Coinsurance
Chiropractic Care	$25 Co-payment	**Not Covered out-of-network**
Acupuncture Up to 15 treatments per calendar year	$25 Co-payment	**Not Covered out-of-network**
Allergy Testing	Coinsurance	Deductible and Coinsurance
Allergy Treatment	$0	Deductible and Coinsurance
Diagnostic Procedures X-Ray and All lab tests	$0	Deductible and Coinsurance
Diagnostic Procedures[4] MRI's/MRA's and other imaging	Coinsurance See Description for Pre-certification Requirements	Deductible and Coinsurance See Description for Pre-certification Requirements
Second Surgical Opinion[6]	$25 Co-payment	Deductible and Coinsurance
Pre-Surgical Testing	$0	Deductible and Coinsurance
Surgery (Inpatient and Outpatient)[4]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Surgical Assistant	Coinsurance	Deductible and Coinsurance
Chemotherapy	Coinsurance	Deductible and Coinsurance

MEDICAL BENEFITS (Preventive Care)		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Annual Physical Exam	Coinsurance	Deductible and Coinsurance
Diagnostic Screening Tests • Cholesterol, Diabetes, Colorectal cancer • Fecal occult blood test, Segmoidoscopy • Routine Prostate Specific Antigen (PSA) in asymptomatic males • Diagnostic PSA	Coinsurance	Deductible and Coinsurance
Well Woman Care • Office visits, Pap smears • Bone Density testing and treatment • Mammogram, Ages 35-39 – 1 baseline Ages 40+ - 1 per year	$25 Co-payment	Deductible and Coinsurance
Well Child Care (Covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits o Newborn: 2 in-hospital exams at birth following vaginal delivery o Newborn: 4 in-hospital exams at birth following c-section delivery • Office visits o From birth up to 1st birthday: 7 visits o Ages 1 through 4 years of age: 7 visits o Ages 5 through 11 years of age: 7 visits o Ages 12 through 17 years of age: 7 visits o Ages 18 to 19th birthday: 2 visits • Lab tests ordered at the well-child visits and performed in the office or in the laboratory Certain immunizations (office visits are not required)	$0	Deductible and Coinsurance
Immunization Benefit	$25 Co-payment	Deductible and Coinsurance

MEDICAL BENEFITS (Emergency Care)		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Emergency Room Facility Initial visit for Emergency Care	$35 Co-payment Waived if admitted within 24 hours	$35 Co-payment Waived if admitted within 24 hours
Emergency Room Physician Visit	$0	Deductible and Coinsurance
Ambulance Local professional ground transportation to the nearest hospital	Coinsurance Ground Transportation only	Deductible and Coinsurance Ground Transportation only. Air Ambulance services are limited to up to $7,500 for airlift charges resulting from emergency medical treatment. Annual Deductible waived if admitted within 24 hours.
World Wide Travel Emergency room facility	$35 Co-payment Waived if admitted within 24 hours	$35 Co-payment Waived if admitted within 24 hours

MEDICAL BENEFITS (Maternity Care)		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Maternity - Physician Charges	Coinsurance	Deductible and Coinsurance
Maternity Facility Charge[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Prenatal and Postnatal Care (In Physician's office)	$25	Deductible and Coinsurance
Lab Tests, Sonograms and Other Medically Necessary Diagnostic Procedures	Coinsurance	Deductible and Coinsurance
Routine Newborn Nursery Care (In hospital)	Coinsurance	Deductible and Coinsurance
Obstetrical Care[4] (In hospital)	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Obstetrical Care[4] (In birthing center)	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required

HOSPITAL BENEFITS		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Inpatient Medical Surgical[4]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Unlimited semi-private room & board[4]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Anesthesia	Coinsurance	Deductible and Coinsurance
Cardiac Rehabilitation	Coinsurance	Deductible and Coinsurance
<u>Outpatient</u> Surgery, Chemotherapy, Radiation Therapy, Mammography & Cervical Cancer Screening (In Hospital)	Coinsurance	Deductible and Coinsurance
Outpatient Kidney Dialysis	Coinsurance	Deductible and Coinsurance
Organ Transplant Benefits[4]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required

DURABLE MEDICAL EQUIPMENT AND SUPPLIES		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Durable Medical Equipment[4]	Coinsurance Network Supplier Must Pre-certify	Deductible and Coinsurance Pre-certification Required
Medical Supplies	Coinsurance	Deductible and Coinsurance
Orthotics	Coinsurance Network Supplier Must Pre-certify	Deductible and Coinsurance Pre-certification Required
Prosthetic Appliances[4]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required

DURABLE MEDICAL EQUIPMENT AND SUPPLIES		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Mastectomy Wear	Coinsurance	Deductible and Coinsurance
Hearing Aid Up to $500 maximum (once every 36 months)	**Not Covered In-network**	See Pg. 49 for covered services

SKILLED NURSING AND HOSPICE CARE		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Skilled Nursing Facility[4] Up to 60 days/calendar year in lieu of hospitalization	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Hospice	Coinsurance Limited to 210 days	Deductible and Coinsurance Limited to 210 days

HOME HEALTH CARE		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Home Health Care 200 Visits	Coinsurance	Coinsurance
Home Infusion Therapy	Coinsurance Network Supplier	Deductible and Coinsurance

PHYSICAL AND OTHER THERAPIES		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Inpatient Hospital Physical Therapy/ Medicine or Rehab[4] Up to 30 days per calendar year	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Outpatient Physical Therapy[4] Up to 30 visits per calendar year	$25 Co-payment Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Other Short Term Outpatient Rehabilitative Therapies[4] (Speech, vision) Up to 30 combined visits per calendar year	$25 Co-payment Pre-certification Required	Deductible and Coinsurance Pre-certification Required

BEHAVIORAL HEALTHCARE		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Inpatient Mental Health[5]	Coinsurance Pre-certification Required	Deductible and Coinsurance
Outpatient Mental Health[5]	$25 Co-payment	Deductible and Coinsurance

ALCOHOL OR SUBSTANCE ABUSE		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Inpatient Substance Abuse Treatment[5]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required

ALCOHOL OR SUBSTANCE ABUSE		1/1/2013
BENEFIT	***EMPIRE BC/BS[1]***	***OUT-OF-NETWORK[2,3]***
	EMPLOYEE PAYS	***EMPLOYEE PAYS***
Inpatient Detoxification[5]	Coinsurance Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Outpatient Substance Abuse Treatment[5]	Coinsurance	Deductible and Coinsurance Pre-certification Required

(1) Network provider delivers care.

(2) Out-of-Network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

(3) Out-of-network services are those from a provider who does not participate within your PPOs network. (This does not apply to emergency benefits). See (5) for Mental Health and Alcohol/Substance Abuse Services.

(4) Pre-certification by your PPO's Medical Management Program is required or benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure. For ambulatory surgery, pre-certification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Pre-certification is also required for cosmetic surgery, an excluded benefit except when Medically Necessary.

(5) Precertification for out-of-network services by your PPO's Behavioral Healthcare Management Program is required.

(6) Co-payment waived for Second Surgical Opinion, if arranged through Medical Management Program.

ADDITIONAL MEDICAL BENEFITS	1/1/2013
BENEFIT	***DESCRIPTION***
Prescription Drugs Generic – Lowest Co-Pay - A generic drug is the therapeutic equivalent of a brand name drug. (Offered through CVS/Caremark formerly Caremark)	Retail Pharmacy - $2 co-pay for up to a 30-day supply **(plus $15 for maintenance drugs after 3rd refill)** Mail-Order - $2 co-pay for up to a 30-day supply $3.50 co-pay for up to a 60-day supply $5 co-pay for up to a 90-day supply
Prescription Drugs Single Source – Mid Co-Pay - Drugs **do not** have a generic equivalent. (Offered through CVS/Caremark formerly Caremark)	Retail Pharmacy - $25 co-pay for up to a 30-day supply **(plus $20 for maintenance drugs after 3rd refill)** Mail-Order – $25 co-pay for up to a 30-day supply $43.75 co-pay for up to a 60-day supply $62.50 co-pay for up to a 90-day supply
Prescription Drugs Multi Source – Highest Co-Pay - Drugs **have** a generic equivalent. (Offered through CVS/Caremark formerly Caremark)	Retail Pharmacy - $50 co-pay for up to a 30-day supply **(plus $20 for maintenance drugs after 3rd refill)** Mail-Order – $50 co-pay for up to a 30-day supply $87.50 co-pay for up to a 60-day supply $125 co-pay for up to a 90-day supply
Prescription Drugs – Specialty Medication	CVS/Caremark Specialty Pharmacy Generic - $2 co-pay for up to a 30-day supply Single Source - $25 co-pay for up to a 30-day supply Multi Source - $50 co-pay for up to a 30-day supply

New Maintenance Medication Co-pays

Effective March 1, 2013, you and your eligible Dependent(s) can fill prescriptions for 84-90 day supplies of certain maintenance medications at CVS Pharmacies at the applicable mail order co-pay, which saves you money. See page 61.

ADDITIONAL MEDICAL BENEFITS	1/1/2013
BENEFIT	***DESCRIPTION***
Vision Care Benefits (Offered through Vision Screening)	Up to $100 payable once every 24 months No deductible Note: The Plan will pay for the cost of an eye examination and/or prescription eyeglasses for each Eligible Dependent Child until the child turns age 18. Please note that Eligible Dependent Child(ren) will only be reimbursed up to $100 for frames, the maximum amount payable for frames from a network vision vendor, once every 12 months.
Vascular Diagnostic Screening (Offered through Vascular Diagnostic, Inc.)	Up to 1 screening per year
D.J. O'Grady Consultants	Counseling for mental health in connection with alcohol and substance abuse treatment
Life Insurance	Active Eligible Employee: $50,000 Retired Employee: $10,000 Local 1 Represented Employee: $3,000
Accidental Death and Accidental Dismemberment Benefits	**Accidental Death:** An amount equal to the Life Insurance **Accidental Dismemberment:** 50% of Life Insurance amount is paid for loss of one foot, one hand or one eye; 100% of Life Insurance amount is paid for loss of two hands or feet or the loss of both eyes.

YOUR MEDICAL BENEFITS

The Plan provides Medical Benefits, Hospital Benefits and Other Benefits. The benefits may differ significantly depending on whether you use in-network or out-of-network providers. In some cases, benefits are only available in-network.

In-Network Claims

Effective July 1, 2014, there is no deductible for in-network services. If you have any questions about the deductible prior to July 1, 2014, please call the Fund Office. the annual deductible is $0

When you need to visit your Physician or a Specialist in-network, you are responsible only for a co-payment and coinsurance. There are no claim forms to fill out for X-rays, blood tests or other diagnostic procedures, as long as they are requested by the Physician and done in the Physician's office or a network facility. For in-network allergy testing, there is a co-payment and coinsurance. In-network visits for ongoing treatment are covered in full.

When you visit an out-of-network Physician or use an out-of-network facility for diagnostic procedures, including allergy testing and treatment visits, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

- When you make an appointment, confirm that the Physician is a network provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the Physician.
- If the Physician sends you to an outside lab or radiologist for tests or X-rays, call your PPOs Member's Services to confirm that the supplier participates in your network. This will ensure that you receive maximum benefits.

Ask about a second opinion anytime you are unsure about surgery or a cancer diagnosis. Second opinions for surgery are paid in full when arranged by your PPOs Medical Management Program. The Specialist who provides the second opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second opinions are paid at the in-network level, even if you use an out-of-network specialist.

Deductible for Out-of-Network Claims

In each calendar year that you or your Eligible Dependent has eligible out-of-network Medical Benefits and Hospital expenses, the eligible person must pay the deductible. The deductible is the amount that you or your Eligible Dependent pays before the Plan pays Medical Benefits. The deductible applies to each eligible person in each calendar year. The annual deductible is $500 per person but not more than $1,000 per family.

Carry Over Deductible

Any eligible expenses incurred during the last three months of a calendar year which were applied against that year's deductible will be carried over and also applied against the deductible in the next calendar year.

Covered Services

Medical Benefits cover expenses incurred for surgery, medical care, office and home Physician visits, laboratory and x-ray, medical consultation, anesthesia, physical and occupational therapy, medical supplies, annual physical and well woman care exams, well child care, allergy testing and treatment, chiropractic care, orthotics, cardiac rehabilitation, durable medical equipment, prosthetics, home health care, home infusion therapy, blood and ambulance.

Be sure to present your medical identification card any time you or your Dependent(s) receive medical care. If you need to replace your identification card, please call your PPO.

Empire BC/BS 1 (800) 553-9603 or visit www.empireblue.com

Vision Care Benefits, Cardiovascular Screening Benefits, Prescription Drug Benefits, Alcohol and Substance Abuse Benefits, and Life Insurance are not subject to the annual Deductible.

Pre-certification Requirements

Pre-certification is required for hospital admissions and for certain tests or procedures. The purpose of the pre-certification program is to protect your health and the financial integrity of the Plan by preventing unnecessary and potentially harmful treatment.

To receive the maximum available benefits, you or someone on your behalf MUST call the Medical Management Program in the following instances:

CALL TO PRE-CERTIFY	HOW COVERED	WHO CALLS TO PRE-CERTIFY
ALL HOSPITAL ADMISSIONS • At least two (2) weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission or as soon as reasonably possible • For illness or injury to newborns	In-Network and Out-of-Network	**YOU**
PREGNANCY • Within the first three (3) months of a pregnancy and again within 48 hours of the actual delivery date • Maternity facility • Obstetrical care	In-Network and Out-of-Network	**YOU**
BEFORE YOU RECEIVE • Inpatient physical therapy • Same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures • Diagnostic procedures, magnetic resonance imaging or magnetic resonance angiography scan (MRI or MRA)	In-Network and Out-of-Network	**YOU**
BEFORE YOU RECEIVE • Occupational or speech therapy • Outpatient physical therapy • Skilled nursing facility care	In-Network and Out-of-Network	**YOU**
BEFORE YOU RECEIVE • Inpatient Mental health • Inpatient detoxification	In-Network Only	**YOU**
BEFORE YOU • Rent, purchase or replace prosthetics, orthotics or durable medical equipment	In-Network Only	NETWORK SUPPLIER/**YOU**

If Services are NOT Pre-certified

If you call to pre-certify services as needed, you will receive maximum benefits. Otherwise, **benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure**. This benefit reduction also applies to same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not Medically Necessary, no benefits will be paid. To get the most out of your coverage, call your Medical Management Program:

EMPIRE BC/BS	Call 1 (800) 553-9603
D.J. O'Grady Consultants	Call 1 (212) 206-7898

DESCRIPTION OF BENEFITS

Medical Benefits (Physician Services)

Physician Visits

Eligible Employees and Eligible Dependent(s) are eligible for the following services by a licensed Physician:

- Office Visit
- Hospital Visit
- Specialist Visit
- Emergency Room Visit
- Maternity Care Visit
- Second Surgical Opinion

Chiropractic Care

In-network Chiropractic Care is paid in full subject to a $25 co-payment. Pre-certification is required. **Out-of-Network services are not covered under the Plan**.

Acupuncture

The Plan allows for fifteen (15) Acupuncture treatments per year when performed by a Physician or Certified Licensed Acupuncturist. In-network Acupuncture Services are paid in full subject to a $25 co-payment. **Out-of-network services are not covered under the Plan**.

Allergy Testing and Treatment

For in-network allergy testing, you are responsible for the coinsurance. For out-of-network allergy testing and treatment, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Diagnostic Procedures

- In-network x-ray and lab charges are paid in full.
- For out-of-network x-ray and lab charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Please note that using an in-network Physician does not insure that the lab is in-network. It is up to you to verify that the lab is in-network.

Other Diagnostic Procedures (Pre-certification Required)

- In-network MRI and MRA charges are paid in full.

- For out-of-network MRI and MRA services, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Second Surgical Opinion

Ask about a second opinion if you are unsure about your surgery or cancer diagnosis. The Plan covers a third surgical opinion if the second surgical opinion differs from the first. However, the Plan does not cover a second or third surgical opinion, if:

- It is with a Physician who is not certified as a Specialist in the medical field of the proposed surgery;

- It is with an associate of the Physician who performs the surgery or a Physician who has a financial interest in the outcome of the recommendation;

- It is in connection with the proposed surgery for which surgical benefits would not be payable under this Plan;

- The patient is examined in person by the Physician rendering the second opinion or it is obtained after the surgery is performed;

For an in-network second surgical opinion, there is a $25 co-payment. For an out-of-network second surgical opinion, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Pre-Surgical Testing

All in-network pre-surgical procedures performed within seven (7) days of the surgery are paid in full. For out-of-network surgery, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Surgical Benefits (Pre-certification Required)

- In-network surgical procedures are paid in full.
- For out-of-network surgical procedures, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Surgical Assistant

- In-network assistant surgeon charges are paid in full.
- For out-of-network assistant surgeon charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Voluntary Sterilization

The Plan covers voluntary sterilization.

Medical Benefits (Preventive Care)

Annual Physical Exam

For Active Eligible Employees and Eligible Dependent(s) of Active Eligible Employees, annual physical in-network charges are paid in full after a $25 co-payment. For out-of-network annual physical exams, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Well Woman Care

Benefits for an annual gynecological examination are payable once per calendar year. In-network charges are payable in full after a $25 co-payment. For out-of-network annual gynecological examinations, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. This coverage is for the examination only and does not include the cost of the mammography and other ancillary charges, which are covered under the x-ray/lab and medical portions of the Plan.

Important Information about the Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (the "Act") provides that any group health plan or health insurance that provides surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery following the mastectomy. Specifically, if you are receiving benefits in connection with a mastectomy, the Plan must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce symmetrical appearance, and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to all of the Plan's rules regarding benefits, including the Plan's annual deductible, co-pays or coinsurance and any amount above the Plan's amount.

Well Child Care

Eligible newborn Dependent(s) are entitled to benefits for well-baby care until the Eligible Dependent reaches two (2) years of age (*See* table on page 30). After age 2, see Annual Physical. Benefits for services of in-network Physicians are paid in full. For out-of-network services, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Immunizations

In-network immunizations are paid in full. For out-of-network immunizations, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. An immunization involves the administration of a preparation that contains all or part of an infectious agent to establish immune resistance to a disease. Immunizations may also be referred to as vaccinations, shots or boosters. Immunizations are medically necessary for the prevention of specific bacterial or viral diseases in both children and adults.

The Plan covers immunizations for those Employees and Dependent(s) enrolled in the PPO network. Coverage for adult immunization is available for hepatitis A vaccine, influenza vaccine, Lyme disease vaccine and pneumococcal vaccine. Immunizations and vaccines are administered according to the guidelines of the United States Center for Disease Control ("CDC").

Lyme Disease

The Plan allows for full treatment of three (3) injections to prevent Lyme disease. This vaccine is not part of the annual physical.

Screening for Volunteers at the World Trade Center Site

The Plan covers a $30 cost for a comprehensive medical evaluation program that provides free and confidential medical exams, referral for medical care and occupational health education for workers and volunteers who provided rescue, recovery, debris removal and sifting and restoration of vital support services at the World Trade Center and Staten Island landfill sites. The $30 payment is a per individual payment, payable to the World Trade Center Worker and Volunteer Medication Screening Program for any Eligible Employee who volunteered support and who would like additional medical screening. For more information about this program, contact the Welfare Department at (718) 835-2700.

Medical Benefits (Emergency Care)

Should you need emergency care, your Plan is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy;
- Cause serious problems with your body functions, organs or parts;
- Cause serious disfigurement;
- In the case of behavioral health, place yourself or others in serious jeopardy.

Emergency Room

Emergency Room Hospital charges for an accident or a sudden and serious illness will be paid in full after a $35 co-payment, if medically necessary. Charges are waived if you are admitted within 24 hours. If it is determined that the services provided are not considered an emergency, the deductible and coinsurance will apply. Fees for services by a non-participating Physician in connection with an Emergency Room visit are paid in full through your PPO.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of an in-network Hospital.

You are responsible only for a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the Hospital within 24 hours. If you make an emergency visit to your Physician's office, you are responsible for the same co-payment as for an office visit. Benefits for treatment in a Hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

Remember: You will need to show your I.D. card when you arrive at the emergency room.

If you are admitted to the Hospital, you or someone on your behalf must call your PPO network's Medical Management Program before services are rendered or within 48 hours after you are admitted or treated at the Hospital, or as soon as reasonably possible. If you do not obtain authorization from your PPO network's Medical Management Program within the required time, benefits may be reduced by 50% up to $2,500 for each admission, treatment or procedure.

Ambulance

The Plan covers professional ground only ambulance services when used to transport a patient from the place where an injury occurred or where the patient became incapacitated due to a disease, to the nearest Hospital where appropriate treatment can be provided.

Air Ambulance services are limited to allow up to $7,500 for airlift charges resulting from emergency medical treatment. An in-network and/or out-of-network provider may not accept the Plan's fee schedule as payment in full, so you may have out-of-pocket expenses. The annual deductible is waived if you are admitted within 24 hours.

Worldwide Travel

If you have an emergency outside the United States and visit a Hospital, simply show your I.D. card. If the Hospital does not participate with your PPO, you will need to file a claim.

Medicare does not pay for Hospital or other medical expenses outside the U.S. If you are on Medicare and plan to travel abroad, consider obtaining additional insurance.

Medical Benefits (Maternity Care)

Hospital charges for the mother and a newborn baby are paid in full for Eligible Employees, their Spouses and Dependent Children. There are no out-of-pocket expenses after the initial office visit co-payment for maternity and newborn care when you use in-network providers. That means you do not need to continue to pay a co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the Hospital or birthing center and routine newborn nursery care are all covered at 100% in-network subject to coinsurance.

For out-of-network maternity services, you are responsible for the annual deductible, coinsurance and any amount above the Plan's allowed amount. Reimbursements for the remaining balance may be consolidated in up to three installments, as follows:

- Two payments for prenatal care,
- One payment for delivery and post-natal care.

Maternity (Pre-certification Required)

Whether services are provided in-network or out-of-network, call your PPOs Medical Management Program within the first three (3) months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the Plan for the first 30 days. However, you must call the Fund Office within 30 days to add your newborn as a Dependent.

Newborns' and Mothers' Health Protection Act

In general, expenses related to pregnancy are treated in the same manner as expenses related to illness or injury. In addition, with respect to pregnancy, the word "Hospital" includes alternate birthing facilities under the supervision of a Physician or a licensed nurse-midwife.

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

Hospital Benefits

Hospital services are covered for most of the cost of your Medically Necessary care when you stay at a network hospital for surgery or treatment of illness or injury. When you use an out-of-network hospital or facility, you are responsible for the annual deductible and coinsurance, plus any amount above the in-network allowed amount.

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility,
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of same-day surgery program.

The following Hospital Benefits are provided when Medically Necessary:

Inpatient Medical and Surgical (Pre-certification Required)

The Plan covers up to 365 days of hospital care per calendar year. This coverage includes semi-private room and board and all services required and ordered by your Physician. Conditions that can be treated in a nursing home, long-term care facility or at home are not covered under Hospital care. Personal items such as TV and telephone are not covered.

Anesthesia Benefits

- In-network anesthesia charges are paid in full.
- For out-of-network anesthesia charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. However, fees for services by a non-participating anesthesiologist when the services are provided in a participating Hospital are paid in full.

Please note that using an in-network Hospital or in-network Physician does not insure that the anesthesiologist is in-network. It is your responsibility to verify that the anesthesiologist is in-network.

Cardiac Rehabilitation

- In-network cardiac rehabilitation charges are paid in full subject to a $25 co-payment.
- For out-of-network cardiac rehabilitation charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. The services must be provided following a Hospital discharge, and must be Medically Necessary. Services are limited to three (3) times per week with a 36 session maximum period of three (3) months.

Outpatient Ambulatory Surgery, Chemotherapy, Radiation Therapy, Mammography & Cervical Cancer Screening

If these services are performed in a network hospital, they are covered under the Hospital benefit which is payable in full. If these services are provided out-of-network, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Outpatient Kidney Dialysis

The Plan covers outpatient Kidney Dialysis Treatments in full when received from an in-network provider. For treatments received from an out-of-network provider, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Organ Transplant Benefits (Pre-certification Required)

Organ Transplant Benefits are covered under the Plan (for non-experimental organ transplants only). If you need an organ transplant, you must contact your PPOs Medical Management Program.

Durable Medical Equipment and Supplies

Your Plan covers the cost of Medically Necessary prosthetics, orthotics and durable medical equipment. The network supplier must pre-certify the rental or purchase by calling your PPOs Medical Management Program. When using a supplier outside your PPOs operating area, you are responsible for pre-certifying services. A PPOs network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact your PPOs Member Services. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

For prosthetics, orthotics and durable medical equipment, be sure the vendor knows the number to call for Medical Management pre-certification.

Covered services are listed in *Your Benefits Summary* section. The following are additional covered services and limitations:

Durable Medical Equipment (Pre-certification Required)

In-network charges for purchase or rental of Durable Medical Equipment such as wheelchairs, walkers, hospital beds, oxygen, and charges for purchase or rental of equipment for the administration of oxygen when Medically Necessary as prescribed by an attending Physician, depending on which option is more cost-effective and available, are covered in full. In the case of charges for equipment purchased through an out-of-network provider, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a Physician and approved by your PPOs Medical Management Program, including:

  (1) Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses;

  (2) Prescription lenses, if organic lens is lacking;

  (3) Supportive devices essential to the use of an artificial limb;

  (4) Corrective braces;

  (5) Wheelchairs, hospital-type beds, oxygen equipment and sleep apnea monitors.

- Rental (or purchase when more economical) of Medically Necessary Durable Medical Equipment.
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a Physician.
- Reasonable cost of repairs and maintenance for covered medical equipment.

Limitations

Covered expenses include Durable Medical Equipment when it is prescribed by a Physician who documents the necessity of the item, it is necessary for the treatment of a disease or injury to improve body function lost as the result of a disease, injury or congenital abnormality or is Medically Necessary to enable the patient to perform essential activities of daily living. Examples of these activities include eating, toileting, bathing, walking, transferring from bed to chair and bed to wheelchair or walker. However, it does not include equipment to enable someone to drive a vehicle or equipment solely for the convenience of the patient's caretaker.
Expenses for Durable Medical Equipment are not covered unless the equipment:

1. Is of strong construction for repeated use;

2. Is appropriate for home use and is safe and effective without medical supervision;

3. Is used to serve a medical purpose and is not normally of use to individuals who do not have a disease or injury;

4. Is not aesthetic in nature;

5. Is less expensive than alternative equipment;

6. Is not used to enhance the home or environment, to change temperature or humidity or air quality;

7. Is not for exercise or training.

Orthotics (Pre-certification Required)

The Plan covers orthotics when pre-certified. In-network orthotics are covered in full. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Prosthetic Appliances (Pre-certification Required)

Prosthetic Appliances when Medically Necessary as prescribed by an attending Physician are covered in full when purchased through an in-network provider. For Prosthetic Appliances purchased through an out-of-network provider, you are responsible for the deductible and coinsurance, plus any amount above the Plan's allowed amount.

Mastectomy Wear

The Plan allows for the initial prosthesis and mastectomy wear following a mastectomy. The Plan also allows an additional $750 per calendar year for additional mastectomy wear (this can be used for bras, camisoles or additional prosthesis). For additional benefits, please contact the Fund Office.

Hearing Aid

Hearing Aids are not covered in-network. For out-of-network, the Plan pays Hearing Aid Benefits, ***including repairs to hearing aid devices***, in full up to a maximum of $500, payable one time in a thirty-six (36) month period. Claims must be submitted to your PPO.

Skilled Nursing and Hospice Care

In order to receive maximum benefits, please call to pre-certify skilled nursing with your PPOs Medical Management Program.

Skilled Nursing Facility (Pre-certification Required)

Charges for admission to a skilled nursing facility in lieu of hospitalization are paid in full for up to 60 days. You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. Prior hospitalization is not required in order to be eligible for benefits. In an out-of-network facility, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. Services are covered if the Physician provides:

- A referral and written treatment plan;
- A projected length of stay;
- An explanation of the services the patient needs;
- The intended benefits of care; or
- Care that is under the direct supervision of a Physician, registered nurse (RN), physical therapist or other healthcare professional.

Hospice Care Benefits

Your Plan covers up to 210 days of hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their Physician as having a life expectancy of six (6) months or less. Hospice care can be provided in a hospice, in the hospice area of a network Hospital or at home, as long as it is provided by a network hospice agency.

Covered services are listed in *Your Benefits Summary* section. Following are additional covered services and limitations:

Hospice care services, including:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN);
- Medical care given by the hospice Physician;
- Drugs and medications prescribed by the patient's Physician that are not experimental and are approved for use by the most recent Physicians' Desk Reference;
- Physical, occupational, speech and respiratory therapy when required for control of symptoms;

- Laboratory tests, X-rays, chemotherapy and radiation therapy;
- Social and counseling services for the patient's family, including bereavement counseling visits until one (1) year after death;
- Transportation between home and hospital or hospice when medically necessary;
- Medical supplies and rental of Durable Medical Equipment; and
- Up to 14 hours of respite care in any week.

Home Health Care

Home health care can be an alternative to an extended stay in a hospital or a skilled nursing facility. In-network Home Health Care is paid in full as set out below. For out-of-network home health care, you are responsible for coinsurance only (the deductible does not apply). Out-of-network agencies must be certified by New York State or have comparable certification from another state.

Charges for up to 200 visits (1 visit equals a 4 hour shift) annually of Home Health Care provided by an approved agency are covered when:

- The attending Physician has established a home health care program and certifies that proper treatment would require continued hospitalization in the absence of the home health care program;
- The home health care program has been approved by the Plan prior to the patient's discharge from the hospital; and
- The number of days for which home health care benefits are payable is subject to re-certification and approval by the Plan prior to the expiration of the original approval.

An in-network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services. Home health care services include:

1. Part-time services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Part-time home health aide services (skilled nursing care);
3. Physical, speech or occupational therapy, if restorative;
4. Medications, medical equipment and supplies prescribed by a Physician; and
5. Laboratory tests.

Home Infusion Therapy Benefits

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network.

Infusion Therapy Benefits

The Plan covers infusion therapy administered in a Physician's office. Covered benefits include:

- Antibiotic Therapy;
- Hydration Therapy;
- Pain Management;
- Chemotherapy;
- Total Parental Nutrition (TPN); and
- Aerosolized Pentamidine.

Physical and Other Therapies

You receive benefits through the Plan for physical, occupational, speech and vision therapy. In-network outpatient physical, occupational, speech and vision therapy services charges are paid in full after a $25 co-payment. For out-of-network benefits, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount. Inpatient physical therapy can be in-network or out-of-network.

Please call your PPO's Medical Management Program to pre-certify all physical, occupational, speech and vision therapy. This will ensure that you receive maximum benefits. Ask for exercises you can do at home that will help you get better faster.

Inpatient Hospital Physical Therapy/ Medicine or Rehabilitation (Pre-certification Required)

Regular Hospital benefits are provided for up to 30 days per calendar year for stays or portions of stays primarily for physical therapy, medicine or rehabilitation. In-network charges are paid in full. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Outpatient Physical Therapy (Pre-certification Required)

In-network Outpatient Physical Therapy benefits are provided for up to 30 days per calendar year. They are paid in full after a $25 co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Other Short-Term Outpatient Rehabilitative Therapies, Speech and Vision Therapy (Pre-certification Required)

Charges are eligible for coverage when provided by a licensed or registered therapist as prescribed by an attending Physician on an outpatient basis. Physical therapy does not include chiropractic care. There is a maximum of 30 combined visits payable per family member per calendar year. Charges for in-network services are paid in full after a $25 co-payment. For out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Behavioral Healthcare

Your behavioral healthcare benefits cover in-network and out-of-network mental healthcare on an inpatient and outpatient basis.

To help ensure that you receive appropriate care, you need to pre-certify all inpatient services (whether in-network or out-of-network) by calling the Behavioral Healthcare Management Program. A counselor will refer you to an appropriate Hospital, facility or provider and send written confirmation of the authorized services.

If you do not call to pre-certify the above-stated behavioral healthcare, covered benefits may be reduced as follows:

- 50% up to $2,500 per inpatient admission for mental health; or
- 50% for each professional mental health care visit made during an inpatient stay.

Inpatient Mental Health Benefits (Precertification Required)

In-network charges for mental health admissions (other than for treatment of substance abuse) in a Hospital are paid in full; there is no co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Outpatient Mental Health Benefits

In-network charges for outpatient mental health visits are paid in full, after a $25 co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

In addition to the services listed in *Your Benefits Summary* section, the following mental health care services are covered:

- Care from psychiatrists, psychologists or certified social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be certified by the New York State Education Department or a comparable organization in another state and have three years of post-degree supervised experience in psychotherapy; and

- Electroconvulsive therapy for treatment of mental or behavioral disorders.

Alcohol or Substance Abuse

Your healthcare benefits cover outpatient treatment for alcohol or substance abuse, and inpatient detoxification both in-network and out-of-network. Inpatient alcohol and substance abuse rehabilitation in a facility is covered in-network and out-of-network.

To help ensure that you receive appropriate care, you need to pre-certify inpatient detoxification and treatment for alcohol and substance abuse services in advance. When you call the Behavior Healthcare Management Program to pre-certify, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services. If you do not call to pre-certify in-patient detoxification or treatment for alcohol and substance abuse, covered benefits may be reduced as follows:

- 50% up to $2,500 per inpatient admission for alcohol/substance abuse detoxification; or

- 50% for each outpatient alcohol and substance abuse facility or provider visit

Remember: When you are admitted in an emergency to a hospital or inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program within 48 hours or as soon as reasonably possible. To do so, you can call the Behavioral Healthcare Management Program through:

EMPIRE BC/BS 1 (800) 553-9603

In addition, D.J. O'Grady Consultants Ltd. ("D.J. O'Grady") provides counseling and referral for alcohol or substance abuse treatment. The telephone number to call is 212-206-7898. Please note that the use of counseling and referral services provided by D.J. O'Grady is voluntary and is not a pre-requisite to obtaining benefits for substance abuse treatment.

When you call either Empire Blue Cross/Blue Shield or D.J. O'Grady to pre-certify inpatient in-network services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

Inpatient Substance Abuse Treatment (Pre-certification Required)

In-network charges for admissions for treatment of substance abuse are paid in full; there is no co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Inpatient Substance Abuse Detoxification Treatment (Pre-certification Required)

In-network charges for admissions for treatment of substance abuse detoxification are paid in full; there is no co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

Outpatient Substance Abuse Benefits

In-network charges for outpatient substance abuse visits are paid in full; there is no co-payment. In the case of out-of-network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Plan's allowed amount.

In addition to the services listed in *Your Benefits Summary* section, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive one (1) counseling visit per day;

- Out-of-network outpatient treatment at a facility that:

    1. Has New York State certification from the Office of Alcoholism and Substance Abuse Services.

    2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations, if out of state. The program must offer services appropriate to the patient's diagnosis.

VISION CARE BENEFITS

The Plan pays up to $100 for an eye examination and/or prescription eyeglasses for each Eligible Employee, Spouse and Eligible Dependent Children (age 18 to the end of the month in which the child turns age 26), once every 24 months. If you receive benefits through the Plan's PPO provider, Vision Screening, you will receive an exam and glasses from selected frames.

The Plan will pay for the cost of an eye examination and/or prescription eyeglasses for each Eligible Dependent Child under age 18. Eligible Child(ren) will only be reimbursed up to $100 for frames, the maximum amount payable for frames from an in-network vision vendor, once every 12 months.

If you receive benefits through an out-of-network provider, you must purchase your frames and lenses or contacts within 90 days of the exam for them to be covered. All expenses associated with the exam, frames, lenses or contacts must be submitted on the same claim form no later than eighteen (18) months from the latest date of service.

Description	Price
Bifocal Lenses	$100
Contact Lenses	$100
Exam (Maximum Benefit Allowance)	$ 20
Exam & Bifocal Lenses	$100
Exam & Contact Lenses	$100
Exam & Frame	$100
Exam & Single Vision Lenses	$100
Exam & Trifocal Lenses	$100
Exam, Frame & Bifocal Lenses	$100
Exam, Frame & Single Vision Lenses	$100
Exam, Frame & Trifocal Lenses	$100
Frame	$100
Frame & Bifocal Lenses	$100
Frame & Single Vision Lenses	$100
Frame &Trifocal Lenses	$100
Single Vision Lenses	$100

Eligible Employee, Spouse and Eligible Dependent Children (age 18 to the end of the month in which the child turns age 26) – There is a 24-month waiting period between services. For example, if you receive an eye exam on January 15, 2013, you will have to wait until January 15, 2015 before you may receive another exam. If the cost of the exam is $75, the cost of the frame is $110, and the cost of trifocal lenses is $150, **the Plan will pay $100 ($20 for the exam, and $80 for the frame and trifocal lenses).**

Eligible Dependent Children under age 18 – There is a 12-month waiting period between services. For example, if you receive an eye exam on January 15, 2013, you will have to wait until January 15, 2014 before you may receive another exam. If the cost of the exam is $75, the cost of the frame is $110, and the cost of the trifocal lenses is $150, the Plan will reimburse an in-network provider $100 and there is no cost to the patient**. For out-of-network services, the Plan will pay $325 ($75 for the exam, $100 for frame and $150 for trifocal lenses).**

CARDIO VASCULAR SCREENING BENEFITS

There are a number of “early warning signs” that can indicate a person’s risk for cardiovascular disease (such as heart attacks and strokes). These include high blood pressure, chest pains, tightness or discomfort, shortness of breath, and heart palpitations. If you are experiencing these or any other cardiovascular symptoms, you can schedule an appointment with Vascular Diagnostic Associates, P.C., (“Vascular Diagnostic”) for non-invasive cardiac and vascular testing.

Vascular Diagnostic provides cardiovascular diagnostic screening. Use of their services will provide 100% coverage for covered tests up to the limits of the Plan including: (1) Cardiac Stress Test, (2) Ultrasound & Blood Flow (Doppler) of Carotid Arteries, (3) Extremity (legs) Arteries with or without Doppler, (4) Abdominal Aorta Ultrasound Scan for Aneurysm, (5) Blood Analysis (Cardiovascular Risk Profile with recommendations), (6) Body Weight Composition with recommendations and Exercise Program and (7) Pulmonary Function Study – if symptoms are shortness of breath.

Vascular Diagnostic Associates, P.C.
41-61 Kissena Blvd., Suite #4
Flushing, NY 11355
(718) 886-0600

Covered Expenses

The Plan pays the cost of the above-stated tests performed at Vascular Diagnostic. The nature and number of tests performed will vary according to your symptoms and medical history.

PRESCRIPTION DRUG BENEFITS

Using the CVS/Caremark Retail Pharmacy Network

When you fill your prescriptions, simply present your CVS/Caremark ID card to the pharmacist. Your card contains important information to help the pharmacist process your order correctly.

Up to 30-day supply through CVS/Caremark network pharmacies	$ 2.00 co-pay for generic $25.00 co-pay for single-source $50.00 co-pay for multi-source

New Maintenance Medication Co-pays

Effective March 1, 2013, you and your eligible Dependent(s) can fill prescriptions for 84-90 day supplies of certain maintenance medications at CVS Pharmacies and pay the applicable mail order co-pay, which saves you money.

Participants are allowed to fill their prescriptions for 30-day supplies of their maintenance medications at any in-network retail pharmacy up to three times at the applicable retail co-pay. However, starting with the fourth fill, you will pay the applicable retail co-pay ***plus*** a surcharge if you continue to fill prescriptions for 30-day supplies of maintenance medications.

Here's how the co-payments for maintenance medications work:

For Prescriptions Filled at Retail CVS Pharmacies			
	30-Day Supply (First three fills)	**30-Day Supply** (Fourth Fill and After)	**84-90-Day Supply** (First Fill and After)
Generic Medication	$2	$17 ($2 co-pay + $15 surcharge)	$5
Single-Source	$25	$45 ($25 co-pay + $20 surcharge)	$62.50
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	$125

For Prescriptions Filled at Other Network Retail Pharmacies			
	30-Day Supply (First three fills)	**30-Day Supply** (Fourth Fill and After)	**84-90-Day Supply** (First Fill and After)
Generic Medication	$2	$17 ($2 co-pay + $15 surcharge)	Not Covered
Single-Source	$25	$45 ($25 co-pay + $20 surcharge)	Not Covered
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	Not Covered

For a list of covered maintenance medications or for more information, visit CVS/Caremark online at www.caremark.com. You can also call CVS/Caremark toll-free at 1-866-831-4336.

Effect of Filling Maintenance Drugs at Other Network Retail Pharmacies
For maintenance drugs, which are those for which you have a continuing, long-term prescription, supplies purchased through network pharmacies instead of CVS Pharmacies or the mail service described below will be charged a $15 surcharge for generic and a $20 surcharge for single source or multi source after three (3) prescription fills at retail.

Using the CVS/Caremark Mail Service

You will need to complete a mail order form for you and your family member who will be utilizing the Caremark mail program. This will set up each member's profile in the mail order system with valuable information. Then simply mail the completed form, along with an original prescription written for a 90-day supply and payment. It will take approximately 14 days to receive your mail order prescription. ***It may be necessary to obtain two prescriptions from your Physician, one for a 30-day supply so you can start or continue your medication without interruption and one for the 90-day mail order supply.*** After your script has been filled the first time and you have available refills, you can re-order your mail script online at www.caremark.com, by calling Caremark Member Services or by mailing in your re-order form that you received with your prescription.

Members are encouraged to use the Caremark Mail Service to order maintenance drugs.

Up to 30-day supply through CVS/Caremark mail order	$ 2.00 co-pay for up to 30-day generic $ 25.00 co-pay for up to 30-day single-source $50.00 co-pay for up to 30-day multi-source
Up to 60-day supply through CVS/Caremark mail order	$ 3.50 co-pay for up to 60-day generic $ 43.75 co-pay for up to 60-day single-source $ 87.50 co-pay for up to 60-day multi-source
Up to 90-day supply through CVS/Caremark mail order	$ 5.00 co-pay for up to 90-day generic $ 62.50 co-pay for up to 90-day single-source $125.00 co-pay for up to 90-day multi-source

Pro-Rated Co-pays for Prescriptions Filled by Mail Order

The mail order pharmacy program is designed to provide convenience and cost savings to you and your eligible Dependent(s). You can fill a 90-day prescription and have the prescription mailed to your home for less than the cost of filling three (3) 30-day prescriptions at a retail pharmacy.

To use the mail-order program, you need a prescription written for a 90-day supply. When you make the switch from retail pharmacy to mail order, make sure to get a new prescription from your doctor for a 90-day supply. If you forget and send a prescription to CVS/Caremark's mail order pharmacy for a 30-day supply, you will only pay a pro-rated copayment—and not the full 90-day supply copayment. The chart above shows how the pro-rated copayments work.

The Plan has a **3-Tier Prescription Program which is described below**. Mail Order is available to members who choose to obtain up to a 90-day supply through CVS/Caremark mail order.

Most injectables are covered under a separate specialty drug program provided by Caremark's SpecialtyRx Pharmacy. A complete list of injectables covered through this program is available through Caremark upon request. You can receive up to a 30-day supply of specialty medications at a time. The CVS/Caremark Specialty Guideline Management program helps manage Biotech/Specialty injectables and oral medicines. While all specialty injectable and oral medicines are reviewed for safe and appropriate use, these medicines will require an additional review.

The Specialty Guideline Management Program requires approval of treatment for select medicines. There is a review of clinical information for approval of treatment with these medicines. Decisions are based on guidelines and are administered by a Caremark clinical specialist.

Formulary Program (Effective July 1, 2013)

The Fund is committed to providing you with quality prescription drug benefits coverage. As prescription drug prices increase, both you and the Fund may pay higher costs. In order to continue offering you comprehensive prescription drug benefits, while keeping the costs of those prescription drugs affordable, CVS/Caremark frequently reviews the list of covered medications (also known as the formulary). CVS/Caremark makes the determinations about which tier (Generic, Preferred or Non-Preferred) medications fall under. It also decides which medications are on the formulary at all. Each year, CVS/Caremark will review the list and decide which medications to exclude from Fund coverage. For a current list of covered medications, please contact CVS/Caremark at 1-866-831-4336 or www.caremark.com.

Prior Authorization - If you or your eligible dependent's doctor wants you to take a medication which is not on the CVS/Caremark formulary list of covered prescription drugs, the Prior Authorization program can help. Through this program, participants and doctors can have certain prescription medications which are not covered by the Fund approved by CVS/Caremark under certain clinical protocols. If so approved, they will be considered as if the prescription medications were in the formulary. You or your doctor should contact CVS/Caremark at 1-855-240-0536 to initiate the Prior Authorization process. Please visit CVS/Caremark's website, www.caremark.com, to view the most current version of the formulary.

3-Tier Plan Design

Tier 1	Generic Drugs
Tier 2	Single-Source Drugs
Tier 3	Multi-Source Drugs

Step Therapy Program (Effective March 1, 2013)

Step Therapy programs require participants to try generic or preferred brand medications before receiving Fund coverage for certain non-preferred brand medications. This requirement encourages you to try safe, effective and less expensive drugs first before the Fund covers another drug.

For example, if **Drug A** (generic) and **Drug B** (non-preferred brand) treat the same medical condition, the Fund may require you to try **Drug A** first. If **Drug A** does not work for you and your doctor believes you should use a non-preferred medication, you or your doctor can request a coverage review by calling CVS/Caremark's Prior Authorization line toll-free at 877-203-0003. If, after review with your doctor, it is deemed appropriate, the Fund will then cover the non-preferred brand medication, **Drug B.**

If you fill a prescription for certain non-preferred brand medications without first trying a generic or preferred brand alternative—or receiving prior approval for the non-preferred brand medication—you will be responsible for the entire cost of the medication.

The non-preferred brand medications covered by the Step Therapy Program include drugs in the following classes:

- Bisphosphonates
- Sleep Agents
- NSAIDS (Non-Steroidal Anti-Inflammatory Drugs)
- Nasal Steroids
- Urinary Antispasmodics

For a list of non-preferred brand medications that fall under the Step Therapy Program, as well as their generic and preferred brand alternatives, or for more information, visit CVS/Caremark online at www.caremark.com. You can also call CVS/Caremark toll-free at 1-866-831-4336.

Prior Authorization for Oral Fentanyl Agents (Effective March 1, 2013)

If you or your eligible dependent's doctor prescribes an Oral Fentanyl agent such as Actiq™, Fentora™, Onsolis™ or other Preferred or Non-Preferred Brand prescription medication that may be considered an Oral Fentanyl agent, the Fund requires prior authorization from CVS/Caremark to determine whether the prescribed medication is acceptable under CVS/Caremark's clinical protocols. To initiate the Prior Authorization process, you or your doctor should contact CVS/Caremark at 855-240-0536.

Prescription Drug Benefit Exclusions, Limitations and Restrictions

In addition to the general exclusions, limitations and restrictions contained on pages 116-119, the following exclusions, limitations and restrictions apply to Prescription Drug Benefits:

1. Prescription drug co-payments may be covered by your Health Reimbursement Arrangement (HRA) if the requirements of the HRA are satisfied;
2. Prescriptions may not exceed the maximum supply permitted under Food and Drug Administration ("FDA") guidelines.
3. For maintenance drugs, which are those you use continuously for a long term, the Plan encourages you to purchase a 90-day supply of maintenance drugs through CVS/Caremark mail order program or at a CVS Retail Pharmacy. After 3 refills of a 30 day supply through a retail pharmacy, maintenance prescriptions that are not obtained at a 90 day supply at CVS/Caremark mail-order r at a CVS Retail pharmacy will be charged a $15 penalty on generics and a $20 penalty on brands;
4. The number of refills that may be dispensed is subject to FDA guidelines. Refills must be obtained within a reasonable time after the exhaustion of the previous supply;
5. The following drugs, medicines and devices are not covered by the Plan:
    - Drugs or medicines that can be purchased without a prescription, even if a prescription is written for them;
    - Devices such as, but not limited to, artificial appliances, therapeutic devices, diaphragms or similar items, even if a prescription is written for them;
    - For medicines dispensed and charged for by a Physician or by any person other than a registered pharmacist employed by a licensed pharmacy;
    - Drugs or medicines that cannot legally be dispensed under Federal or State law at a registered pharmacy (e.g., methadone, experimental or investigational drugs) and drugs not within the purview of FDA regulations (e.g., certain foreign drugs); and
    - Viagra and related medications.

Administrative Overrides

There may be instances when you or your eligible dependent attempt to fill a prescription either through a retail pharmacy or through the CVS/Caremark Mail Order Program, and it is denied either because it is not a covered service or for other administrative reasons. The Fund has authorized CVS/Caremark to grant administrative overrides under the following limited circumstances:

- If your medication has been lost, stolen or damaged, the Fund has authorized CVS/Caremark to allow a replacement prescription to be filled. You or your eligible dependent may ask your doctor or pharmacist to request such a replacement prescription for any medication you are taking only one time every 365 days up to a maximum cost of $500. Please note that CVS/Caremark is prohibited from approving a replacement prescription for controlled substances.

- If you submit a prescription for a 90-day supply through the CVS/Caremark mail-order program, and it is delayed by CVS/Caremark through no fault of your own either due to a raw material shortage or manufacturer supply of the drug, or if there is a shipment delay by CVS/Caremark, your doctor or pharmacist should call CVS/Caremark and request approval for a thirty-day supply of the prescription drug to be filled at a retail pharmacy. Such a request for an administrative override may be granted based on the professional judgment of a CVS/Caremark pharmacist.

- If your doctor has prescribed a drug for you or your eligible dependent that is new to the market and may have limited or exclusive distribution, he/she should call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- If your doctor prescribes a drug to you or your eligible dependent at a dose that is either higher or lower than the one you currently are taking, he/she should call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- If your doctor prescribes a drug to you or your eligible dependent that either decreases or increases the amount of a medication so that you only would have to take it once a day, instead of taking a lower dose two times each day, he/she should call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- In the event the retail pharmacy where you or your eligible dependent filled a 30-day prescription made a mistake entering the days' supply information for the prescription, for example, the pharmacist incorrectly calculated the number of doses you would receive from an asthma inhaler, have the pharmacist call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- In the event you run out of a medication that you are currently taking before the 90-day supply of that same medication you ordered through the CVS/Caremark mail-order service arrives, your doctor or pharmacist should call CVS/Caremark to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist. Please note you and/or your eligible dependent may only make such a request once in a 365 consecutive day period. Prescriptions for controlled substances are excluded from this type of request.

- In the event you run out of a medication that you are currently taking before the 90-day supply of that same medication you ordered through the CVS Caremark mail-order service, and it is determined that the reason for the delay of the delivery of the 90-day supply from CVS/Caremark's mail-order service is due to your late submission of that prescription, your doctor or pharmacist should call CVS/Caremark to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist. Please note you and/or your eligible dependent may only make such a request once in a 365 consecutive day period. Prescriptions for controlled substances are excluded from this type of request.

- If your doctor prescribes a drug to you or your eligible dependent that is considered a "duplicate drug therapy", or a prescribed medication that duplicates a particular effect another drug you are taking may have on you, your doctor or pharmacist should call CVS/Caremark to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- If your doctor has prescribed a new medication for you or your eligible dependent and requires that you start taking that medication on that same day, if you are unable to have the prescription filled through the mail-order program or CVS/Caremark's Specialty Drug Pharmacy, the pharmacist should call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- If you or your eligible dependent is a patient in a Nursing Home, Skilled Nursing Facility ("SNF"), or Long Term Care ("LTC") Facility that prohibits any medication that has not been prescribed and dispensed by the facility, have your doctor call CVS/Caremark and request that a coverage determination be made and to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

- In the event of an emergency resulting from a non-standard occurrence that includes a facility disaster, systems disruption, a disruption of a supply chain, bioterrorism, natural disaster, or epidemic, if you require an immediate prescription, your doctor or pharmacist should call CVS/Caremark to receive a determination whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist.

LIFE INSURANCE

The following Life Insurance is provided for Employees only under the Plan:

Active Eligible Employees:	$50,000.00
Retired Employees:	$10,000.00
Local 1 Represented Employees*:	$ 3,000.00

*(*Employees represented by Local Union No. 1 who are employed under the terms of an agreement between Local Union No. 1 and an Employer and who are not currently eligible as an Active Eligible Employee or a Retired Employee who previously had contributions made to the Plan on his/her behalf).*

Normally, your Life Insurance Benefit will be paid in a lump sum to your designated beneficiary. The Life Insurance Benefit is paid based on the last Beneficiary designation received in the Fund Office before your death. If more than one Beneficiary is designated, they will share equally unless you specify otherwise.

Designating a Beneficiary

You should have a beneficiary designation form on file with the Plan. This form is available by calling the Fund Office.

You may designate one or more beneficiaries on the "Beneficiary Designation Form" provided by the Plan. You may change your beneficiary at any time by filing with the Fund Office a written change of beneficiary. A designation of beneficiary will become effective only upon the receipt by the Plan of the written designation. The last effective designation received by the Plan prior to your death will supersede all prior designations. A designation of beneficiary will not be effective if the designated beneficiary dies before you.

You must complete the actual form provided by the Plan. No other form of designation may be used. A common form is used for designating your primary and contingent beneficiaries for this Plan and the Additional Security Benefit Plan. Forms for the 401(k) Savings Plan and Plumbers & Pipefitters National Pension Plan or the United Association Burial Expense Benefit are separate.

If you have not provided a designation of beneficiary form to this Plan, you should do so without delay.

IMPORTANT: A divorce does not change your beneficiary or invalidate your prior designation of your former spouse as beneficiary. If you are divorced and wish to change your beneficiary, you must submit a new form to the Fund Office.

If there is no Beneficiary

If you have not designated a beneficiary or your beneficiary is not living at the time of your death, your Life Insurance Benefits will be paid as described below.

ACCIDENTAL DEATH AND ACCIDENTAL DISMEMBERMENT BENEFITS

The following Accidental Death and Accidental Dismemberment Benefits are provided to Employees only under the Plan:

Accidental Death:	An amount equal to the Life Insurance payable in addition to the Life Insurance.
Dismemberment:	For the loss of one hand, one foot or the sight of one eye, or a combination of any two or more such losses, an amount equal to 50% of the Life Insurance is payable. For the loss of two hands or feet or sight in both eyes, or a combination of any two or more losses, an amount equal to 100% of the Life Insurance is payable.

Accidental Dismemberment means the loss of sight in one or both eyes or the loss of one or both hands or feet by severance at or above the wrist or ankle joint.

If you die:

1. The Accidental Death Benefit is paid based on the last Beneficiary designation received in the Fund Office before your death. If more than one Beneficiary is designated, they will share equally unless you specify otherwise. If your Beneficiary should die while receiving benefits and further payments are due for periods after his/her death, such payments shall be made to your Beneficiary's designated Beneficiary(ies).

2. If you fail to designate a beneficiary or if all designated Beneficiaries die or are invalidated, the benefit will be distributed in the following order:

    i. your surviving spouse (or the surviving spouse of your Beneficiary if your Beneficiary is receiving benefits);

    ii. your children (or the children of your Beneficiary if your Beneficiary is receiving benefits);

    iii. your parents (or the parents of your Beneficiary if your Beneficiary is receiving benefits);

iv. your brothers and sisters (or the brothers and sisters of your Beneficiary if your Beneficiary is receiving benefits); or

v. the personal representative of your estate (or the personal representative of your Beneficiary's estate if your Beneficiary is receiving benefits).

If there is more than one individual in a category, the benefit will be divided equally among them unless you state otherwise in your beneficiary designation. If all Beneficiaries in a category determined according to the procedures in this paragraph die before all the payments are made, the remaining payments will be made to the next category stated above.

3. In accordance with New York State Insurance Department ("NYSID") regulations ***governing*** payment of death benefits to a minor, the Plan requires duly signed and notarized guardianship papers for the property of the minor from the Surrogate Court in the county where the minor resides.

4. Benefits will be paid within a reasonable time following notification to the Plan of the death of the Employee.

Accidental Death and Dismemberment Benefits - Exclusions

No benefits will be paid for losses resulting from or caused directly or indirectly by:

1. War or any act of war.
2. Bodily or any mental infirmity.
3. Disease or illness of any kind.
4. Medical or surgical treatment (except medical or surgical treatment made necessary solely by injury).
5. Bacterial infection (except pyrogenic infections resulting solely from injury).
6. Intentionally self-inflicted injury.
7. Suicide or any attempt thereat.
8. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft, except while a fare-paying passenger, in any aircraft then licensed to carry passengers.
9. Commission of or participation in a crime.

BENEFITS FOR RETIRED EMPLOYEES

Retired Employee Benefits Up to Age 65 (Medicare Eligibility)

Non-Medicare eligible Retired Employee Benefits are the same as the coverage for an Active Employee described in this booklet with the following exceptions:

1. There are no Weekly Disability Benefits; and

2. Life Insurance Benefits are $10,000.

Upon your death, your Spouse will be offered the choice to continue the same coverage. The cost of the coverage will be based on your Spouse's age and will be revised annually to reflect changing benefit costs. Your Spouse may continue this coverage until he/she becomes eligible for Medicare or remarries, if earlier. However, if your Spouse remarries after your death and within 18 months of your retirement, your Spouse will be offered the right to purchase COBRA Continuation Coverage for the remainder of the 18 months.

Retired Age 65 and Over Medicare-Eligible Employee Benefits

The Plan provides the following benefits to all Medicare-eligible retirees and their Medicare-eligible Spouses. The eligibility rules for Retired Employees stated on pages 16–19 of this booklet apply. If your Spouse is also Medicare- eligible, then the following benefits apply to both you and your Spouse at no cost to you or your Spouse. If your Spouse is not Medicare-eligible, then your Spouse will be covered by the Plan benefits applicable to Retired Employees who are not Medicare-eligible. Your Eligible Dependent Children will be covered by the Plan benefits applicable to Dependent(s).

In addition, if you and your Spouse are covered through this program, upon your death, your Spouse will be offered the option to continue this coverage for the remainder of his or her life. A monthly premium will be charged based upon the cost of the program. Upon your death, if your Spouse is not Medicare-eligible, your Spouse will be offered COBRA coverage, which is available for 36 months.

Important Reminder

You must elect Retiree Continuation of Coverage at time of retirement. Failure to elect Retiree Continuation of Coverage at time of retirement will result in forfeiture of eligibility for Retiree coverage. Retiree coverage cannot be elected after your retirement.

Medicare Wrap-Around Plan Schedule

NOTE: ALL PLAN PAYMENTS ARE BASED UPON MEDICARE-APPROVED AMOUNTS AND ARE MADE IN ACCORDANCE WITH THE TERMS AND LIMITATIONS OF THE PLAN. PAYMENTS BY MEDICARE ARE MADE AFTER SATISFACTION OF THE $147.00 ANNUAL DEDUCTIBLE WHERE APPLICABLE. **(Note: Medicare Coverage based on Medicare Premium, and Deductibles for 2014 which are subject to change annually based on Medicare regulations)**

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Physician Visits (Primary or Specialist)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Chiropractic Care	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Allergy Testing and Treatment	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
X-Ray and Lab	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Second Surgical Opinion	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Surgical Benefits	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Surgical Assistant	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Chemotherapy	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Routine Physical Exam	Not covered if routine	Not covered if routine	You pay 100% for routine physical exam
Immunization Benefit	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Emergency Room (initial visit for emergency care)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Hospital Care	Hospital Day 1-60: all but $1,216 Day 61-90: all but $304/day Day 91-150: all but $608/day 150 day limit Surgical: 80% of approved amount	Hospital Day 1-60: $1,216 Day 61-90: $304/day Day 91-150: $608/day 150 day limit Surgical: 20% of approved amount	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-150: $0 Over 150 days: You pay 100% beyond 150 days Surgical: $0 (1)* (2)** See notes 1 & 2 below
Outpatient Surgery, Therapy (in-hospital)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Anesthesia	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Organ Transplant	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Durable Medical Equipment & Supplies	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Prosthetic Appliances	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Skilled Nursing Facility(3)*** See note 3 below	Day 1-20: 100% of approved amount Day 21-100:all but $152/day 100 day limit/benefit period	Day 1-20: $0 (Medicare) Day 21-100: $152/day Over 100 days: $0	Day 1-20: $0 Day 21-100: $0 Over 100 days: You pay 100%
Home Health Care	100% limit of 21 consecutive days	Day 1-21: $0 (Medicare) Over 21 days – not covered	Day 1-21: $0 Over 21 days – You pay 100%
Inpatient Physical Therapy	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Outpatient Physical Therapy	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Other Outpatient Therapies	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Cardiac Rehabilitation	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Inpatient Mental Health	Hospital Day 1-60: all but $1,216 Day 61-90: all but $304/day Day 91-150: all but $608/day 190 day lifetime limit	Hospital Day 1-60: $1,216 Day 61-90: $304/day Day 91-150: $608/day 190 day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%
Outpatient Mental Health	50% of approved amount	50% of approved amount (limit of 40 visits per year)	50% of approved amount, over 40 visits/year you pay 100%

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Inpatient Substance Abuse	Hospital Day 1-60: all but $1,216 Day 61-90: all but $304/day Day 91-150: all but $608/day 190 day lifetime limit	Hospital Day 1-60: $1,216 Day 61-90: $304/day Day 91-150: $608/day 190 day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100%
Outpatient Substance Abuse (Physician Charges)	80% of approved amount	20% of approved amount	$0 (1)* (2)** See notes 1 & 2 below
Lifetime Limit	None except as result of individual benefit max	Effective January 1, 2011, the $1-million per person lifetime limit on the dollar value of benefits no longer applies.	N/A

*(1) In 2014, you must pay an annual $147 deductible for Part B services and supplies before Medicare begins to pay its share. These deductibles are not paid by the Plan and are subject to change annually based on Medicare regulations.
**(2) Actual amounts you must pay may be higher if Physicians, health care providers or suppliers don't accept assignment.
***(3) Medicare will cover skilled care only if you have Medicare Part A (Hospital Insurance) AND you have days left in your benefit period available to use AND you have a qualified hospital stay, which is an inpatient hospital stay of three (3) consecutive days or more, not including the day you leave the hospital. You must enter the skilled nursing facility within 30 days of leaving the hospital. In the event you are discharged from an inpatient hospital and admitted to a skilled nursing facility one day prior to becoming eligible for Medicare, the Plan will pay up to a maximum charge of $41,000.

Additional Retiree Benefits

Vision Care Benefit (Offered through PPO: Vision Screening, Inc.)	Up to $100 payable once every 24 months No deductible
Hearing Aids	Limit $500 every 3 years
Life Insurance	$10,000 Retired Employee
Prescription Drug Benefits Retail – When the prescription is filled at a participating Pharmacy (Offered through CVS/Caremark)	$2 Co-payment for Generic. $25 Co-payment for single source. $50 Co-payment for multi source.

Prescription Drug Benefits Maintenance – Effective March 1, 2013 - You and your eligible Dependent(s) can fill prescriptions for 84-90 day supplies of certain maintenance medications at CVS Pharmacies and pay the applicable mail order co-pay, which saves you money.

Participants are allowed to fill their prescriptions for 30-day supplies of their maintenance medications at any in-network retail pharmacy up to three times at the applicable retail co-pay. Starting with the fourth fill, you will pay the applicable retail co-pay plus a surcharge if you continue to fill prescriptions for 30-day supplies of maintenance medications. See table below.

For Prescriptions Filled at Retail CVS Pharmacies			
	30-Day Supply (First three fills)	**30-Day Supply (Fourth Fill and After)**	**84-90-Day Supply (First Fill and After)**
Generic Medication	$2	$17 ($2 co-pay + $15 surcharge)	$5
Single-Source	$25	$45 ($25 co-pay + $20 surcharge)	$62.50
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	$125

For Prescriptions Filled at Other Network Retail Pharmacies			
	30-Day Supply (First three fills)	**30-Day Supply (Fourth Fill and After)**	**84-90-Day Supply (First Fill and After)**
Generic Medication	$2	$17 ($2 co-pay + $15 surcharge)	Not Covered
Single-Source	$25	$45 ($25 co-pay + $20 surcharge)	Not Covered
Multi-Source	$50	$70 ($50 co-pay + $20 surcharge)	Not Covered

PLEASE NOTE: There are no dental benefits for Medicare-Eligible Retired Employees.

IMPORTANT NOTICE:

IN ORDER TO RECEIVE THE MAXIMUM BENEFITS POSSIBLE, YOU AND YOUR SPOUSE MUST ENROLL IN BOTH MEDICARE (PART A) AND MEDICARE (PART B) WHEN ELIGIBLE.

YOUR BENEFITS FROM THIS PLAN WILL BE CALCULATED AS IF YOU HAVE BOTH MEDICARE PART A AND MEDICARE PART B BENEFITS, WHETHER YOU HAVE SIGNED UP FOR THEM OR NOT. THIS MEANS THAT IF YOU HAVE NOT SIGNED UP FOR MEDICARE, YOUR BENEFIT PAYMENTS FROM THIS PLAN WILL BE REDUCED BY THE AMOUNT THAT MEDICARE WOULD HAVE PAID.

Social Security Administration 1 (800) 772-1213 or www.ssa.gov
Medicare 1 (800) 633-4227 or www.medicare.gov

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A Health Reimbursement Arrangement ("HRA") is an individual account under the Plan that uses pretax dollars in the account to pay for eligible out-of-pocket health care expenses incurred by you and your Qualified Relatives, as defined below. The IRS allows you to deduct medical expenses on your income tax return if they exceed 7.5% of your adjusted gross income. Most people do not reach this threshold. With an HRA you can save money in taxes on your health care expenses even if they are not significant enough to deduct on your federal income tax return. If your medical expenses exceed 7.5% of your adjusted gross income for federal purposes, you can still use an HRA but you must subtract the amount you contribute to such an account from the amount you can deduct on your federal tax return. You will need to satisfy the eligibility requirements of the Plan to participate in the HRA.

Eligibility

The eligibility requirements for participation in the HRA are the same for participation in the Plan as previously described (see page 2). An Active Employee will be eligible on the first day of the calendar month after he or she has been credited with at least 270 hours in Covered Employment under the Plan within a period of three (3) consecutive months, provided the Plan actually receives the contributions for those hours.

Once an active Eligible Employee meets the general eligibility requirements, the Eligible Employee and his or her Qualified Relatives will remain eligible for benefits from the HRA as long as he/she maintains an account balance of greater than $0, even if he/she has stopped working in Covered Employment and fails to meet the continuing eligibility requirements for other benefits from the Plan. A special provision where there is a COBRA Qualifying Event under the Plan is discussed below.

If an Eligible Employee loses eligibility for benefits from the HRA because his or her HRA account has been completely distributed after he or she has stopped working in Covered Employment, the Employee may re-establish eligibility by satisfying the initial eligibility requirements.

In the event an Eligible Employee dies before his or her HRA has been completely distributed, your Qualified Relatives as defined below for purposes of the HRA will be eligible to continue to receive reimbursement from the HRA as long as the account balance is sufficient to cover their claims.

Retiree Eligibility

Retirees who have a balance in their HRA at retirement may continue to receive reimbursement from the HRA as long as the account balance is sufficient to cover their claims.

Contribution Amounts

The following amount has been allocated to the HRA for the Mechanical Equipment Service Division :

Mechanical Equipment Service Division

MES Helper	$0.15/hour

The amount that an Employee can accumulate in his or her individual HRA account is not subject to any maximums, and the Employee will be allowed to carry over his or her entire account balance from Plan Year to Plan Year.

Enrollment

Enrollment information must be provided for all Employees, Dependent(s) and Qualified Relatives. If you do not notify the Fund Office of a Qualified Relative, the individual cannot be enrolled. Dependent(s) enrolled for purposes of other benefits provided by this Plan are also enrolled for purposes of the HRA. Some individuals who may be enrolled as Qualified Relatives for purposes of the HRA may not be Dependent(s) for purposes of other benefits provided by this Plan. See page 11 for the definitions of Dependent(s) for purposes of other benefits provided by this Plan.

"Qualified Relatives" may be enrolled as Dependent(s) for purposes of the HRA. A "Qualified Relative" is an individual who qualifies as a dependent under Section 152 of the Internal Revenue Code including child, foster child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, stepparent, grandparent, niece, nephew, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or an individual who for more than one half of the year resides with the Eligible Employee and is a member of the Eligible Employee's household or in the case, of a child, the child lives with his/her other parent. Qualified Relatives must meet all the requirements under Section 152(b) and (d) of the Internal Revenue Code.

Reimbursable Expenses

The HRA will reimburse Eligible Health Care Expenses incurred by you and Your Qualified Relatives, during your period of coverage. "Eligible Health Care Expenses" are generally those expenses that would be an eligible deduction on your tax return (but without regard to the requirement that such expenses exceed a specified amount of your income) and in accordance with IRS rules. These expenses cannot be covered by any other benefit plan. Following is a list of some examples of expenses which are reimbursable if they are not covered by a health care plan:

- Prescription Drug co-payments;
- Medical co-payments and annual deductibles;
- Medicare Part "B" monthly premiums;
- COBRA monthly premiums;
- Unemployment Continuation of Coverage premiums;
- Long-term care insurance premiums (For taxable years beginning in 2013, limits specified under Section 213(d) and 7702B(b) of the Internal Revenue Code);

Age 40 or younger	$ 360 per taxable yr.
Older than 40, younger than 50	$ 680 per taxable yr.
Older than 50, younger than 60	$1,360 per taxable yr.
Older than 60, younger than 70	$3,640 per taxable yr.
Older than 70	$4,550 per taxable yr

- The portion of medical, dental and/or vision expenses that exceeds the reasonable and customary limits or plan maximums; and
- Laser eye surgery, contact lenses and solutions.

You may also request a tax-free reimbursement for medicines and/or drugs you purchase Over-the-Counter with a Physician's prescription. These Over-the-Counter drugs not otherwise covered by the Plan must be for the treatment of illness or injury (as defined by the Internal Revenue Code), not merely to advance your general good health and must be prescribed by a Physician even though a prescription is not otherwise required.

Following are some examples of Over-the-Counter expenses which are reimbursable if they are **not** covered by a health care plan:

Bandages	Band-Aids	Blood Pressure Kit	Cold/hot packs for injuries	Condoms
Contact Lens Solution	Contraceptive Creams	Crutches	Eye Lubricant Drops	Eye Patches
First aid kits	Gauze pads	Home Diagnostic Tests/Kits	Incontinence Products	Joint support bandages & hosiery
Liquid adhesive for small cuts	Ovulation Kits	Pregnancy test kits	Reading glasses	Thermometers

NOTE: To be reimbursed for the above products, you must provide a computerized receipt clearly showing the name and cost of the item purchased.

Over-the-Counter expenses which are reimbursable if they are required and recommended by a physician that specializes in the field of your diagnosis:

Feminine hygiene products for specific medical condition	Fiber supplements for specific medical condition	Glucosamine/ Chondrotin for arthritis	Hydrogen peroxide	Massage Therapy
Medical Alert device	Medicated shampoo	Medicated soap	Menopause therapy	Nasal sprays for snoring
Nicotine gum / patches	OTC hormone therapy	Prenatal vitamins	Rubbing alcohol	Special toothbrushes
St. John Wort – for depression	Sunglasses	Sunscreens	Supplements or herbal meds	Weight loss drugs

NOTE: To be reimbursed for the above over-the-counter products, you must provide a computerized receipt clearly showing the name and cost of the item purchased and a signed statement from your physician confirming the medical necessity of this item.

Expenses for Over-the-Counter medicines or drugs purchased with a Physician's prescription may also be reimbursed. These Over-the-Counter medicines or drugs not otherwise covered by the Plan must be for the treatment of illness or injury (as defined by the Internal Revenue Code), not merely to advance your general good health and must be prescribed by a Physician (for reimbursement) even though a prescription is not otherwise required. Following are some examples of Over-the-Counter expenses which are reimbursable if they are not covered by a health care plan:

Allergy Medicine	Antacids	Anti-diarrhea medicine	Bactine	Ben Gay or similar products
Bug bite medication	Calamine lotion	Cold medicine	Cough drops	Cough syrups
Diaper rash ointment	First aid cream	Hemorrhoidal cream	Lactose Intolerance supplies	Laxatives
Motion sickness pills	Nasal sinus sprays	Nasal strips	Pain relievers	Pedialyte
Sinus medication	Sleeping aids	Special creams for sunburn	Throat lozenges	Wart removal treatments

NOTE: To be reimbursed for the above products, you must provide a computerized receipt and prescription clearly showing the name and cost of the item purchased.

EXAMPLE: Your Physician recommends that you take OTC Claritin (Allergy Medicine) to treat your allergies and he/she fills out a prescription for this medicine. You may submit your claim for reimbursement up to 18 months from the date of this purchase but you must attach the Physician's prescription for the OTC Claritin and the receipt of purchase on your claim form.

Over the-counter supplies and devices continue to be covered without a prescription.

Ineligible Expenses

Expenses that do not meet the definition of "medical care" under Section 213 (d) of the Internal Revenue Code are excluded from reimbursement. The following expenses are not eligible for reimbursement:

- Cosmetic Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease;
- Long-term care services (excluding premiums);
- Funeral and burial expenses;
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity;
- Marijuana and other controlled substances, the possession of which are in violation of federal laws, even if prescribed by a physician;
- Maternity clothes, diaper service or diapers, salary of nurse to care for healthy newborn at home, babysitting, formula or childcare;
- Home improvements, household and domestic help;
- Death Benefits or life insurance benefits including the portion of the Plan's COBRA premium that pays for life insurance; or
- Any item that does not constitute "medical care" as defined under Section 213 of the Internal Revenue Code.

For example, you cannot be reimbursed for the following products:

Chap stick/ Lip balm	Cosmetics	Denture adhesive products	Deodorant	Face creams
Hand lotion	Moisturizers	Suntan lotion	Toothpaste/ Mouthwash	

IMPORTANT:
FEDERAL LAW RESTRICTS THE TYPES OF EXPENSES THAT MAY BE PAID FROM YOUR HRA. THE TRUSTEES CANNOT CHANGE THESE RULES.

How to File a Claim for Reimbursement

A claim can be filed up to eighteen (18) months from the date the reimbursable expense was incurred.

You or your provider must first submit a claim for the expense to any benefit plan in which you are covered for the same services. For a list of HRA expenses which may be submitted, see the Eligible Expenses section above. You must have itemized bills with the name of the patient and provider or the date(s) of service or supply and the type of service or supply for each expense. Canceled checks and balance forward statements cannot be used for claim purposes. You can submit a claim as often as necessary. The minimum claim payment is $25.00. Reimbursement for Eligible Expenses is not made until you have submitted at least $25.00 in reimbursable expenses and at least $25.00 is available in your HRA account. Claims submitted or awaiting payment that are less than $25.00 will be reimbursed quarterly. All reimbursements will be made payable to the Employee.

Claims for reimbursement are processed monthly.

Employees will receive an Explanation of Benefits for each claim. Account balance statements will be mailed to Eligible Employees at the end of each Plan Year.

COBRA Continuation of Coverage - HRA

Qualified Beneficiaries have the opportunity to continue to add money to the HRA after a Qualifying Event with additional amounts paid under COBRA from personal monies The rules for access to the HRA after a Qualifying Event are described below.

If You Are No Longer Eligible For Coverage

You and your Dependent(s)' loss of eligibility because of your termination of Covered Employment or a reduction in hours of Covered Employment is a Qualifying Event. If eligibility is not extended under one of the Plan rules, you and your Dependent(s) will be offered the opportunity to extend eligibility by electing COBRA Continuation Coverage and paying COBRA premiums.

You are NOT required to elect COBRA Continuation Coverage or pay COBRA premiums to continue to receive reimbursements from your HRA. The COBRA HRA premium is separate from the COBRA premium for other Welfare Plan Benefits. You will continue to have access to your HRA and to receive reimbursements from your HRA so long as the account balance is sufficient to cover your claims. You may even use your HRA to pay the required COBRA premiums for other Welfare Plan benefits.

However, you do have the opportunity to continue contributing to your HRA on an after-tax basis after a Qualifying Event with additional COBRA amounts paid from your personal monies. If you elect to contribute to your HRA through COBRA, those amounts are subject to HRA rules and may only be paid to you as described in this section.

If You Lose Eligibility Because of Death of the Employee

If you lose eligibility for benefits because of the death of the Employee, you have a Qualifying Event. If eligibility is not extended under one of the Plan rules, you will be offered the opportunity to add to the Employee's HRA account by electing COBRA Continuation Coverage and paying COBRA premiums.

You are NOT required to elect COBRA Continuation Coverage or pay COBRA premiums to continue to receive reimbursements from the HRA. The COBRA HRA premium is separate from the COBRA premium for other Welfare Plan Benefits. You will continue to have access to the HRA and to receive reimbursements from the HRA so long as the account balance is sufficient to cover your claims. You may even use the HRA to pay the required COBRA premiums for other Welfare Plan benefits.

However, you do have the opportunity to continue to add to the Employee's HRA on an after-tax basis after a Qualifying Event through additional COBRA amounts paid from your personal monies. If you make HRA contributions through COBRA, those amounts are subject to HRA rules and may only be paid to you as described in this section.

If You Lose Eligibility Because of Divorce or Because You No Longer Meet the Definition of "Dependent" under the Plan

If you lose eligibility because of your divorce from the Employee or because you no longer meet the definition of "Dependent" under the Plan, you have a Qualifying Event. If eligibility is not extended under one of the Welfare Plan rules, you will be offered the opportunity to extend eligibility for benefits by electing COBRA Continuation Coverage and paying COBRA premiums.

In order to have access to the HRA and to receive reimbursements from the HRA, you are required to elect COBRA Continuation Coverage and to pay COBRA premiums to the HRA and the account balance must be sufficient to cover your claims.

Forfeiting Unused Contributions

Upon your death, your eligible Dependent(s) will continue to have access to the HRA and receive reimbursements from the HRA so long as the account balance is sufficient to cover their claims. However, under IRS requirements, if you have no eligible Dependent(s) or if your eligible Dependent(s) die without using all of the amounts in your HRA, any unused balances in your HRA will be forfeited. Any amount forfeited will be used to offset the administrative costs of the Plan's HRA. The Trustees cannot change the IRS requirement for forfeiture of unused HRA balances.

COORDINATION OF BENEFITS

Coordination of Benefits with Other Plans

Family members may be covered under more than one plan of health benefits. In order to avoid duplication of benefits (i.e., two plans paying benefits for the same dollar of medical expense), the Plan has a Coordination of Benefits provision for all covered benefits except Life Insurance and Accidental Death & Accidental Dismemberment.

"*Coordination"* means that benefits from this Plan plus benefits received from other health plans can total, but not exceed, 100% of the Allowable Expenses for each covered person in each calendar year. This is intended to permit full payment of Allowable Expenses but not duplicate payments.

"Allowable Expenses" are any Medically Necessary charges for Hospital, Medical, Dental and Vision benefits and services covered in whole or in part by this Plan (except Life Insurance and Accidental Death & Accidental Dismemberment) and any other plan covering the person making the claim. Expenses not covered by any plan which covers a person are not Allowable Expenses, for example, charges for personal comfort items, such as television rental in the Hospital.

"Other health plans" include group plans (either insured or self-insured) such as health plans available from your Spouse's employer and Medicare.

How Coordination Works with another Group Health Plan

This Plan always pays Allowable Expenses after a plan that does not have a Coordination of Benefits provision. In addition, the following rules apply:

- A plan covering an individual as an employee pays benefits before a plan covering an individual as a dependent.

- If someone is covered as a dependent under the plan of both parents, the plan of the parent whose birthday falls earlier in the calendar year (regardless of age) will pay benefits before the plan of the other parent. This Birthday Rule applies only if both plans include the same rule. If the other plan has a gender rule, then the plan covering the male head of household pays benefits first. If the order of payment is not specified, the plan of the parent that has covered the dependent for the longer period of time pays benefits first unless this Plan covers that parent as a laid off or Retired Employee and the other parent is covered as an Active Employee. In this case, the plan of the parent who is an Active Employee pays benefits first.

- If a member and Spouse are both Eligible Employees under this Plan, benefits will be paid first as if this Plan was the primary plan and then as if this Plan was the secondary plan. This will provide the same coverage as if the Spouses had been covered by two separate plans.

- The following special rules apply for dependent coverage in the case of legal separation or divorce:

    - If the parent with custody has not remarried, the plan covering the parent with custody pays benefits first. The plan covering the parent without custody pays benefits second.

    - If the parent with custody has remarried, the plan covering the parent pays first, the plan of the step-parent with whom the dependent resides pays second and the plan of the parent without custody pays third.

How Coordination Works with Medicare

Medicare Coordination for Active Employees who are Eligible for Medicare

At age 65, you become eligible for Medicare benefits. In addition, anyone under age 65 who is entitled to Social Security Disability is also entitled to Medicare coverage (usually after a waiting period). You may also be entitled to Medicare if you have End-Stage Renal Disease (ESRD). As long as you continue to work and have enough hours or make the required self-payments, you continue to be covered by the Plan's medical benefits as an Active Employee. Medical benefits provided by the Plan will be your primary coverage (and your Spouse's, if he or she is also eligible for Medicare), and Medicare benefits will be secondary. You will have the benefit of two coverages. As long as you remain eligible under this Plan, due to hours worked or employee self-payments, you should continue to submit your claims to the Plan. After payment by the Plan, you can submit any remaining expenses to Medicare for possible payment.

Active disabled employees (as defined in Federal Regulations) also receive primary coverage from the Plan and secondary coverage from Medicare as described above.

In deciding whether to enroll in Medicare, the following points should be kept in mind:

- Having coverage under this Plan and Medicare provides the greatest protection;

- You are responsible for enrolling in Medicare; and

- Consider how long you expect to work and what will happen to your coverage when you stop working. You may not be able to enroll in Medicare at the same time that coverage under this Plan stops.

The Plan recommends but does not require that Active Employees age 65 or over and Spouses of Active Employees age 65 or over enroll in Medicare Parts A and B when first eligible.

Medicare Coordination for End-Stage Renal Disease

If you are an Active Employee and are entitled to Medicare because of End-Stage Renal Disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Medicare Coordination for COBRA Qualified Beneficiaries

If you are age 65 or over **OR** are disabled and covered by both Medicare and COBRA continuation coverage from this Plan, Medicare will pay first and your COBRA continuation coverage under this Plan will pay second.

If you have ESRD and are covered by Medicare (as a result of ESRD) and are, or become covered by COBRA continuation coverage from this Plan, this Plan will pay first during the first 30 months of eligibility/entitlement to Medicare and Medicare will pay second. After the 31st month after the start of Medicare coverage, if you are or become covered under COBRA Continuation Coverage, Medicare pays first and your COBRA continuation coverage under this Plan pays second. Note that this provision does not extend the maximum periods of COBRA Continuation Coverage and that once you exhaust the maximum COBRA period, your coverage under this Plan will end.

Medicare Coordination for Retired Employees

If you are a retiree or an inactive disabled Employee and become eligible for Medicare, Medicare will be your primary coverage. After Medicare has covered the expense, the Plan will pay benefits. You will have to satisfy any applicable Deductible whether or not the medical services are covered by Medicare.

Medicare has two parts, Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers inpatient Hospital care and generally is available to all individuals age 65 and over at no cost. Part B, which is optional, covers Physician services, outpatient Hospital services and other medical supplies and. You must pay a monthly premium for Part B. To have adequate coverage, you and your Spouse must sign up for both Medicare Part A and Part B when eligible.

All medical claims after your enrollment in Medicare must be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare Explanation of Benefits to the Plan.

The Plan's medical payment will coordinate with Medicare's payment. For covered expenses, the Plan will determine its benefit based on the Medicare-approved amount and then subtract the Medicare benefit and consider the balance under the provisions of the Plan. For these expenses, the Plan carves out Medicare payments. However, Federal law limits the amount a provider (Hospital, Physician, etc.) can charge above the Medicare payment. The Plan cannot pay the provider more than that amount and the provider cannot legally bill you more than that amount.

Enrolling in Medicare

It is important that you or your Eligible Dependent visit an office of the Social Security Administration during the three-month period prior to your 65th birthday or earlier if you are disabled or have ESRD, to learn all about Medicare. If you have questions about this Plan's coverage or would like help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office. Keep in mind that the Plan will pay benefits as if you have both Medicare Part A and Part B benefits irrespective of whether you enroll in Medicare Part A and Part B.

If you are retired, you and your Eligible Dependent(s) will lose active eligibility for benefits upon your 65th birthday or earlier if you are disabled. Pursuant to the Plan's Active Eligibility Rule – i.e., the Plan provision that an Active Eligible Employee and his or her Eligible Dependent(s) will lose eligibility for benefits on the last day of the sixth month following the most recent period of three consecutive months in which the Employee worked at least 270 hours in Covered Employment - does not apply after you reach age 65.

In addition, if an individual who is eligible for benefits under this Plan becomes covered by Medicare, whether because of age, disability or ESRD, that individual may either retain or cancel coverage under this Plan. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the Employee. Neither this Plan nor the Employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

HOW TO FILE A CLAIM

General Rules - IMPORTANT

In order to receive benefits from the Plan, a claim must be filed as described in these procedures. You may file claims directly or through a provider, subject to the limitations on assignments. There are special procedures for some claims as explained below. There are different addresses for different types of claims and for In-Network and Out-of-Network claims. Please review the following procedures carefully.

A claim is considered filed as soon as a written claim form is received at the correct address stated on page 97 by mail, personal delivery or fax. Telephone calls and e-mails are not acceptable. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by billings from the provider and such other proof as may be required by the Plan.

Some types of requests to the Plan are not considered claims. For example, requests for a determination as to whether you are eligible for benefits or whether a particular benefit that does not require pre-approval will be paid are not claims. Casual inquiries about benefits or the circumstances under which benefits might be paid are also not claims. Although the Plan may respond to such inquiries, these rules and the appeal procedures discussed below do not apply.

Some, but not all, benefits require pre-certification or pre-approval (see page 40-65). Pre-approval must be obtained when it is required and your failure to do so may result in a reduction of benefits, up to 50% or a maximum of $2,500. To get the most out of your coverage, call:

Empire BC/BS 1 (800) 553-9603

Claims must be filed as soon as reasonably possible after the expense is incurred. We recommend that you submit a claim for benefits to the Plan within 90 days from the date of service. **Any claims submitted after eighteen (18) months from the date of service will not be considered unless you were eligible at the time of service and the medical service provider failed to bill you or the applicable PPO within eighteen (18) months of the date of service**. However, the 18 month claims limitation does not apply when eligibility is established retroactively due to the payment of delinquent contributions.

In order for any claims to be paid, you and your Eligible Dependent(s) must have a completed Enrollment Form on file at the Fund Office.

In determining eligibility for any benefit, the Plan has the right to have the person for whom the benefits are claimed, examined by a professionally qualified practitioner, designated and paid for by the Plan (e.g., Physician, Dentist, etc.). Such examination may be repeated as often as may be reasonably required while the claim is pending.

You may designate a representative to act on your behalf in filing a claim or an appeal of a denial of a claim or other adverse determination. If the Fund Office or claims processor, as applicable, is uncertain whether you have designated a representative, you may be required to submit such designation in writing before the Fund Office or claims processor will communicate with a third party claiming to be your representative.

Initial claims and appeals will be determined in accordance with this Plan document, PPO contract, policies and rules, and such provisions will be applied consistently, to the extent reasonable, with respect to similarly situated claimants.

There are several time limits governing your filing of a claim or appeal and the claims processor's or the reviewer's decision on such claim or appeal. Any agreement to extend these time limits must be knowing, explicit and confirmed in writing before the time period in question expires.

Types of Claims - Definitions

Claims procedures differ depending on whether your claim involves "urgent care," is a "pre-service claim" or is a "post-service claim." These and other important terms are defined in this subsection.

"*Urgent Care Claim*" - A pre-service claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health or ability to regain maximum function; or (2) in the opinion of a Physician, with knowledge of your medical condition, would subject you to severe pain if your claim were not decided within the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim. Post-service claims are not urgent care claims because pre-approval is not required before you can receive treatment.

"Pre-service Claim" - Any claim for which the receipt of the benefit, in whole or part, is conditioned on approval of the benefit in advance of obtaining medical care. See pages 40-65 for information concerning which benefits require pre-approval.

"Post-service Claim" - Any claim for a benefit that is not a pre-service claim and in which you request reimbursement after medical care has already been provided.

"Concurrent Care Claim" - Any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

Disability Claims (Weekly Disability and Accidental Dismemberment Claims)

"Disability Claims," which include Weekly Disability and Accidental Dismemberment Claims, will generally be handled as Post-Service Medical Claims. However, there are some special time periods that apply to processing Disability Claims.

"Incomplete Claim" - A claim is incomplete if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Plan, your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.

Filing Claims for Hospital and Medical Benefits (For Employees and Dependent(s) enrolled in Empire BC/BS)

The Plan makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the PPO's network, you generally do not have to file a claim. However, you do have to file a claim for reimbursement for out-of-network covered services from non-participating providers or if you have a medical emergency out of the PPO's service area. To obtain a claim form, call the PPO's customer service listed on page 134.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL	Provider files claim directly with PPO*	Provider files claim directly with PPO*
MEDICAL	Provider files claim directly with PPO*	**You file claim with PPO**
AMBULANCE CHARGES	Provider files claim directly with PPO*	**You file claim with PPO**

*Note: The provider files claim directly with Empire BC/BS or local BC/BS plan.

In-Network Hospital and Medical Benefit Claims

If you or one of your Eligible Dependent(s) receives medical care and/or are admitted to a Hospital as an inpatient, present your Identification Card to the admitting office. Present this card to the Hospital emergency room for treatment due to an accident. The Plan will pay the Hospital directly for covered services. You are responsible for all personal items, such as telephone, television, etc. The participating provider or hospital will accept PPO in-network allowance as full payment, less any applicable co-payment. Some services require pre-certification. Refer to the chart on page 40.

Out-of-Network Hospital and Medical Benefit Claims

You should send any Out-of-Network claim for benefits to the PPO in which you are enrolled, at the address stated below, within 90 days of the date of service. **Any claims submitted more than eighteen (18) months from the date of service will not be considered unless you were eligible at the time of service and the provider failed to bill you or the applicable PPO within 18 months from the date of service.** However, the 18 month claims limitation does not apply when eligibility is established retroactively due to the payment of delinquent contributions.

For Employees enrolled with Empire BC/BS

Hospital Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Dept.

Medical Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Dept.

Empire BC/BS Out-of-Network claims – You should send any Out-of-Network claim for benefits to the PPO in which you are enrolled, at the address stated above, within 90 days of the date of service. Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits ("EOB") will be sent directly to you if you have any responsibility on the claim, other than your co-payment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or EOB citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for denial;
- References to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary; and
- An explanation of claim review procedures and any time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse determination on review:

- If an internal rule, guideline or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline or other similar criterion; or a statement that such a rule, guideline, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline or other similar criterion will be provided free of charge to you upon request;

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- In the case of an adverse benefit determination involving urgent care, a description of the expedited review process applicable to such claims.

If you have any questions about your claim, you may contact Empire Member Services at 1-800-553-9603, www.empireblue.com or in writing. When you call, be sure to have your Empire Blue Cross/Blue Shield I.D. Card number handy, along with any information about your claim. Send written inquiries to the address listed above.

You can also check the status of your claim, view and print EOBs, correct certain claim information and more at any time of day or night just by visiting www.empireblue.com.

Assignment – You authorize Empire, on behalf of the Employer, to make payments directly to participating in-network providers for covered services. Empire also reserves the right to make payments directly to you. Except where Empire expressly indicates otherwise, payments will always be made directly to you for services provided by an out-of-network provider. Payments and notices regarding claims may be sent to an Alternate Recipient, or a person's custodial parent or designated representative. Any payments made by Empire will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or other applicable law. See page 15. Coverage and benefits under the Plan are not assignable without the written consent of the Plan, except as provided above.

Once a provider performs a covered service, Empire will not honor a request to withhold payment of the claims submitted.

Out-of-Network Secondary Claims/Coordination of Benefits

There may be times when your Spouse has medical coverage under another plan (usually through his or her employer). Other times there may be other coverage that is primary for your Spouse and/or dependent children (such as in cases of a divorce). In order to determine which plan is primary coverage, please refer to pages 84-86. As a reminder, this Plan uses the "Birthday Rule" in determining which plan is primary for Dependent Children.

In cases where this Plan is the secondary coverage, the claims submission procedure is as follows:

1. You receive "covered" services from a provider;
2. The claim is submitted to the primary plan for processing;
3. You receive an EOB from the primary plan;
4. You file a claim for benefits with this Plan by sending a completed claim form, an EOB from the primary plan and an Itemized Bill from the provider to your PPO at the address stated above; then
5. Your PPO will process the secondary claim; the benefits will be reduced so that the total benefits paid by both plans will not be greater than the allowable expenses. Also, the Plan will not pay more than the amount the Plan would normally pay if the Plan were primary.

Medicare Wrap-Around Claims/Coordination of Benefits

For Medicare-Eligible Claims, the Plan is secondary provided the member is not an Active Eligible Employee. Because the Plan is secondary, the Plan will make payment on a claim only after Medicare has processed the claim for payment.

In cases where this Plan is secondary and Medicare is primary, the claims submission procedure is as follows:

1. You receive "covered" services from a provider;
2. The claim is submitted to Medicare;
3. You receive an EOB from Medicare, your primary insurance;
4. You must submit a claim for benefits with this Plan by sending a completed claim form, an EOB from Medicare and an Itemized Bill from the provider to the Plan's third party claims processor "**Administrative Services Only, Inc.**" at the following address:

   Plumbers Local Union No. 1 Welfare Fund
   c/o Administrative Services Only, Inc.
   303 Merrick Road
   Lynbrook, NY 11563-9010
   Phone: (516) 394-9492
5. The Plan will process the secondary claim for payment to you, the member or to the provider, if the member requests an assignment of benefits.

If a provider submits the claim directly to "*Administrative Services Only, Inc.**" *without a claim form, an EOB from the primary plan must also be submitted. If the claim is submitted directly from the provider without the EOB, you will be notified of the incomplete claim.*

Electronic Submission of Medicare Wrap-Around Claims

Your provider may submit a HIPAA-compliant electronic claims submission to **Administrative Services Only, Inc**. The Plan is committed to reasonably and appropriately protecting the confidentiality, integrity, and availability of electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of the Plan.

Although claims may be filed electronically, the Plan strongly encourages you to continue to submit the paper claim form, a copy of the EOB, and an itemized bill from the provider for payment of Medicare Wrap-Around claims. You can download additional claim forms and related documents via our web site at www.ualocal1funds.org.

Prescription Drug Benefit Claims / Mail Order Drug Benefit Claims

There are special procedures for making claims for the Prescription Drug Benefit. If you fill the prescription at a participating pharmacy (in-network), you do not have to complete a written claim form; you just present the card to the participating pharmacy. See pages 61-62 for co-payment information

You may also get your prescription filled at an out-of-network pharmacy but you must then submit a claim to the Prescription Drug Administrator, noted below, for reimbursement. This only applies to prescriptions filled by out-of-network pharmacies. Over-the-counter medications for which a prescription is not legally required are not covered by the Plan although you may be able to obtain reimbursement through the HRA (with a prescription).

CVS/Caremark
P.O. Box 853901
Richardson, TX 75085-3901
Phone: (866) 831-4336

The Plan employs certain constant cost containment programs and certain drugs are subject to pre-approval/pre-authorization as well as the terms of formularies or preferred drug lists (referred to as single source and multi-source drugs). See the Prescription Drug benefit section for details on the CVS/Caremark Specialty Guideline Management program to help manage Biotech/Specialty injectable and oral medicines and for cost differentials for single source and multi-source drugs. You may also contact CVS/Caremark directly if you have questions or want to check if a certain drug requires pre-approval or is considered a single source or multi-source drug.

If CVS/Caremark determines the request for pre-approval/authorization cannot be approved, the determination will constitute a denial. If CVS/Caremark determines that a request for a drug or benefit cannot be approved based on the terms of the Plan, including the single source/multi-source drugs selected by the Board of Trustees, that will constitute an Administrative Denial.

To order prescription drugs through the Mail Order Drug Program, you must submit a claim form to:

CVS/Caremark
P.O. Box 3223
Wilkes-Barre, PA 18773-3223
Phone: (866) 831-4336

For refills, a claim must be submitted at least 14 days before you need the prescription to allow sufficient time to process your claim.

If CVS/Caremark denies any claim for prescription drugs in whole or in part, you have the right to seek a review by CVS/Caremark in accordance with the procedures described in the next section entitled "Right to Review Denied Claims/Appeals Procedure".

Vision Care Benefit Claims

If you use Vision Screening, Inc., there is no claim form to submit. If you receive benefits through an out-of-network provider, you must purchase your frames and lenses or contacts within 90 days of the exam for them to be covered. All expenses associated with the exam, frames, lenses or contacts must be submitted on the same claim form no later than eighteen (18) months from the latest date of service. You must submit a Claim Form with the completed Member Statement to the Claims Processor, noted below, with the original paid bills (photocopies are not accepted).

Vision Screening, Inc.
1919 Middle Country Road, Suite 304
Centereach, NY 11720
Phone: (800) 652-0063

If Vision Screening, Inc. denies any claim for vision services in whole or in part, you have the right to seek a review by the Trustees in accordance with the procedures described in the next section entitled "Right to Review Denied Claims/Appeals Procedure".

Cardiovascular Screening Benefit Claims

There are no claims to submit when you use this service.

Life Insurance and Accidental Death & Accidental Dismemberment

An Accidental Death and Dismemberment (AD&D) claim is any claim for loss of life, limb(s), or sight of eye(s) caused directly and independently by an accident. For benefits to be payable, the loss must occur within 90 days of such accident, the loss be listed in the schedule of benefits and it must be the result of the injuries, directly and independently of all other causes.

A Life Insurance Claim is any claim made by your beneficiary on the occasion of your death.

Please call the Fund Office to notify us of a death at the time of death. Upon notification, the Plan will provide the necessary forms to be completed by the Beneficiary. Claim forms for Active Eligible Employees and Retired Employees should be submitted to:

Amalgamated Life Insurance Company
Life Claims Department 1st floor
333 Westchester Avenue
White Plains, NY 10604
(914) 367-5984 (phone)
(914) 367-4115 (fax)

Claim forms for Local 1 Represented Employees should be submitted to:

Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700 (phone)
(718) 641-8155 (fax)

Claims must be filed as soon as reasonably possible after the death of an Eligible Employee or Retired Employee. We recommend that you send a claim for benefits to the Plan within 90 days of the date of death. **Claims may be filed with the Fund Office up to five (5) years after the death of the Eligible Employee or Retired Employee. Any claims submitted after five (5) years of the Eligible Employee's or Retired Employee's death will not be considered.**

If your claim for life, accidental death or accidental dismemberment benefits is denied in whole or in part, you have the right to seek a review by the Trustees in accordance with the procedures for claims for Represented Employees and Amalgamated Life Insurance Company for all other Life or AD&D claims, in accordance with the procedures described in the next section entitled "Right to Review Denied Claims/Appeals Procedure".

Notice of Initial Benefit Determination

Urgent Care Claims - The Plan or its claims processor will decide your claim and notify you of the decision as soon as possible but no later than 72 hours after your claim is received at the proper address, unless your claim is incomplete. The Plan or its claims processor will notify you as soon as possible if your claim is incomplete but no more than 24 hours after receiving your claim. The Plan may notify you verbally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Plan or its claims processor will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

Urgent Pre-certification Requests for Hospital and Medical Claims Administered by Empire - If the need for the service is urgent, Empire will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and requires further information to make a decision, Empire will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. Empire will make a decision within 48 hours of receipt of the requested information or, if no response is received, within 48 hours after the deadline for a response.

Pre-service Claims - The Plan or its claims processor will decide your claim and notify you of the decision within a reasonable time but no later than 15 days after receipt of your claim at the proper address. This period may be extended by one 15-day period, if circumstances beyond the control of the Plan require that additional time is needed to process your claim. If an extension is needed, the Plan or its claims processor will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Plan or its claims processor expects to reach a decision. If the Plan or its claims processor needs an extension because you have submitted an incomplete claim, the Plan will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Plan or its claims processor may notify you verbally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan or its claims processor to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan or its claims processor sends you the notification of the extension until the date you respond to the request for additional information.

Pre-certification Requests for Hospital and Medical Claims Administered by Empire -Pre-certification means that you must contact Empire's Medical Management Program for approval before you receive certain health care services. Empire will review all requests for pre-certification within three (3) business days of receipt of the necessary information but not to exceed 15 calendar days from the receipt of the request. If Empire does not have enough information to make a decision within three (3) business days, it will notify you in writing of the additional information it needs, and you and your provider will have 45 calendar days to respond. Empire will make a decision within three (3) business days of its receipt of the requested information or if no response is received, within three (3) business days after the deadline for a response.

Post-service Claims - The Plan or its claims processor will decide your claim and notify you of the decision within a reasonable time but no later than 30 days after receipt of your claim at the proper address. This period may be extended by one 15-day period, if circumstances beyond the control of the Plan or its claims processor require additional time to process your claim. If an extension is needed, the Plan or its claims processor will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Plan or its claims processor expects to reach a decision. If the Plan or its claims processor needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan or its claims processor to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan or its claims processor sends you the notification of the extension until the date you respond to the request for additional information.

Retrospective (Post-Service) Requests for Hospital and Medical Claims Administered by Empire - Retrospective review is conducted after you receive medical services. Empire will complete all retrospective reviews of services already provided within 30 calendar days of its receipt of the claim. If Empire does not have enough information to make a decision within 30 calendar days, it will notify you in writing of the additional information it needs and you and your provider will have 45 calendar days to respond. Empire will make a decision within 15 calendar days of its receipt of the requested information or if no response is received, within 15 calendar days after the deadline for a response.

Concurrent Care Claims - If the Plan or its claims processor has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment and that claim involves urgent care, the Plan or its claims processor will notify you of its determination within 24 hours after receiving your claim, provided that the Plan or its claims processor receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

Concurrent Requests for Hospital and Medical Claims Administered by Empire - Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. Empire will complete all concurrent reviews of services within 24 hours of its receipt of the request.

Weekly Disability and Accidental Dismemberment Claims - The Plan or its Insurer will decide your disability or dismemberment claim and notify you of the decision within a reasonable time but no later than 45 days after receipt of your claim at the proper address. This period may be extended by up to two additional 30-day periods, if circumstances beyond the control of the Plan or its Insurer require additional time to process your claim. If an extension is needed, the Plan or its Insurer will notify you prior to the expiration of the initial 45-day period or the first 30-day extension period of the circumstances requiring an extension and the date by which the Plan or its Insurer expects to reach a decision. If the Plan or its Insurer needs an extension because you have not submitted information

necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Plan or its Insurer to decide a claim, the period for making the benefit determination will be tolled or frozen from the date on which the Plan or its Insurer sends you the notification of the extension until the date you respond to the request for additional information.

Accidental Death and Dismemberment and Life Insurance Claims - For Accidental Death and Dismemberment (AD&D) and Life Insurance Claims, Amalgamated Life Insurance Company will make a decision on the claim and notify you and or your beneficiary of the decision within 90 days. If Amalgamated Life requires an extension of time due to matters beyond its control, Amalgamated Life will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time that Amalgamated Life notifies you of the delay.

Notice of Denial of Claim

If a claim for hospital, medical, prescription drug, dental, vision, cardiovascular, life, accidental death or dismemberment benefits is denied, in whole or in part, the Plan or the applicable PPO or claims processor will provide you with a written notice that provides:

- the specific reasons for the denial,
- references to the specific Plan provisions on which the denial is based,
- a description of any additional material or information needed to decide the claim and an explanation why this information is necessary,
- an explanation of the Plan's review procedures and any time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on review;.
- If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, you will be provided either with the specific rule, guideline, protocol or similar criterion, or will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you upon request.
- If the adverse determination is based on a Medical Necessity determination or experimental treatment or similar exclusion or limitation, you will be provided either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- In the case of an adverse benefit determination concerning an urgent care claim, the notice will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim, the notice may be provided to you verbally, within the time frames described above. You will be provided with a written notice within 3 days of verbal notification.

Right to Review Denied Claims/Appeals Procedure

If a claim for benefits is denied, in whole or in part, you may request a review of the benefit denial. Different procedures apply depending on the type of benefit involved. All appeals must be in writing and must be received at the appropriate address within 180 days after you receive the claim denial notice from the claims processor. Failure to file a timely written appeal will result in a complete waiver of your right to appeal and the decision of the claims processor will be final and binding.

In presenting an appeal, you have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. You are also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Personal appearances on appeals are not permitted.

The review will take into account all comments, documents, records and other information that you submit, without regard to whether such information was submitted to or considered by the claims processor in its determination. The review will also not afford deference to the initial determination by the claims processor.

In deciding an appeal of a determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate), the reviewer will consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the claims processor in connection with its initial determination. The identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process without regard to whether that advice was relied on will be provided upon request.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the claims processor did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make “legal” arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Plan policy, determination or action. The reviewer can best consider your position if your claims, reasons and/or objections are clearly stated.

Requests for review of denied Hospital and Medical benefit claims should be sent to the following address:

The review on appeal for all claims will be made by Empire Blue Cross/Blue Shield. See pages 103-106.

Empire Blue Cross/Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008

You may submit an urgent care request by calling (800) 553-9603

Requests for review of denied Prescription Drug Claims should be sent to the following address:

CVS/Caremark
Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.

Requests for review of denied Medicare Wrap-Around Claims, Dental Claims, Vision Claims, Cardiovascular Claims, Health Reimbursement Arrangement (HRA) Claims, and Life Insurance Claims for Represented Employees should be sent to the following address:

Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700

The review on appeal will be made by the Trustees of the Plan or a designated Committee of the Trustees.

The decision on each review will be made by individuals, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The reviewer deciding the appeal will give no deference to the initial denial or adverse determination.

In the case of an Urgent Care Claim, you may request review verbally or in writing, and communications between you and the reviewer (Empire Blue Cross/Blue Shield or CVS/Caremark) may be made by telephone, facsimile or other similar means.

Empire Blue Cross Blue Shield Appeal Process

If a request is denied - All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will send a notice to you and your Physician with the reasons for the denial. You will have the right to appeal. See the section in this booklet titled "Complaints, Appeals and Grievances" for more information.

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your Physician, your Physician is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one (1) business day of making the decision.

An appeal is a request to review and change an adverse determination (i.e., denied authorization for a service) made by Empire's Medical Management Program or Behavioral Health Management Program that a service is not medically necessary or is excluded from coverage because it is considered experimental or investigational. Appeals may be filed by telephone or in writing.

Level 1 Appeals - A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date. Qualified clinical professionals who did not participate in the original decision will review your appeal. Empire will make a decision within the following timeframes for 1st Level Appeals:

- **Pre-certification** - Empire will complete its review of a pre-certification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.

- **Concurrent** - Empire will complete its review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.

- **Retrospective** - Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Empire will provide a written notice of its determination to you or your representative, and your provider, within two (2) business days of reaching a decision. If Empire's Medical Management Program does not make a decision within 60 calendar days of receiving all necessary information to review your appeal, Empire will approve the service. If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal.
Remember - A Level 1 Appeal submitted beyond the 180-calendar-day limit will not be accepted for review. A Level 2 Appeal submitted beyond the 60-business-day limit will not be accepted for review.

Expedited Level 1 Appeals - You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue healthcare services, procedures or treatments that have already started;

- You need additional care during an ongoing course of treatment; or

- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

- You or your provider will have reasonable access to Empire's clinical reviewer within one business day of Empire's receipt of the request;

- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal; or

- Empire will notify you immediately of the decision by telephone and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options. If Empire's Medical Management Program does not make a decision within the appropriate time frames listed above, Empire will approve the service.

Level 2 Appeals and Timeframes - If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If the appeal is not submitted within that timeframe, Empire will not review it and its decision on the Level 1 Appeal will stand. Appeals may be filed by telephone and in writing.

Empire will make a decision within the following timeframes for 2nd Level Appeals:

- **Pre-certification** - Empire will complete its review of a pre-certification appeal within 15 calendar days of receipt of the appeal.

- **Concurrent** - Empire will complete its review of a concurrent appeal within 15 calendar days of receipt of the appeal.

- **Retrospective** - Empire will complete its review of a retrospective appeal within 30 calendar days of receipt of the appeal.

Level 1 Grievances - A grievance is a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity, such as a claim denial for failure to obtain pre-certification for services.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 180-calendar-day limit will not be accepted for review. If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address and telephone number of the department that will respond to the grievance and a description of any additional information required to complete the review.

Empire will make a decision within the following timeframes for 1st Level Grievances:

- **Pre-service** *(services have not yet been rendered)* - Empire will complete its review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.

- **Post-service** *(services have already been rendered)* - Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Level 2 Grievances - If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire within 60 business days from receipt of the notice of the letter denying your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, Empire will not review it and the decision on the Level 1 Grievance will stand. Empire will acknowledge receipt of the 2nd Level Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone number of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

Empire will make a decision within the following timeframes for 2nd Level Grievances:

- **Pre-service** - Empire will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.

- **Post-service** - Empire will complete its review of a post-service grievance within 30 calendar days of receipt of the grievance.

Expedited Grievances - You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information but in any event within 72 hours of receipt of the grievance; or

- Empire will notify you immediately of the decision by telephone and within two business days in writing.

Decision on Grievances - Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision,

- The clinical rationale, if appropriate, and

- For Level 1 Grievances, instructions on how to file a Level 2 Grievance, if you are not satisfied with the decision.

How to File an Appeal or Grievance - To submit an appeal or grievance, call Member Services at 1-800-342-9816 or write to the following address with the reason why you believe the administrative decision was wrong. Please submit any data to support your request and include your member ID number and if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire Blue Cross/Blue Shield
Appeals and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

CVS/Caremark Appeal Process

If a claim is denied in whole or part, you may file an appeal of that determination. The appeal of the denial must be made in writing and submitted to CVS/Caremark within 180 days after you receive notice of the Adverse Benefit Determination.

If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, you and/or your attending physician may submit an appeal by calling CVS/Caremark.

The appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS/Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and

Written comments, documents, records or other information relating to the Claim
The appeal and supporting documentation may be mailed or faxed to CVS/Caremark:

CVS/Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Physicians may submit an urgent appeal requests by calling the physician-only toll-free number: 1-866-443-1183.

CVS/Caremark's Review Process

Review of Denial of Pre-Service Clinical Claims. CVS/Caremark will provide the first-level review of appeals of Pre-Service Clinical Claims. Such Claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If the first-level appeal is denied, you may appeal CVS/Caremark's decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization ("IRO").

For purposes of Prescription Drug Claims and Appeals, the definition of Medical Necessity is:

Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;

- Use of the medication, service or product is based on recognized standards for the health care specialty involved;

- Use of the medication, service, or product represents the most appropriate level of care, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are preformed and

  Use of medication, service or product is not solely for the convenience of the patient, patient's family, or provider.

Review of Administrative Denials. If CVS/Caremark determines that the request for a drug or benefit cannot be approved based on the terms of the Plan, including single source and/or multi-source drugs selected by the Board of Trustees, the determination will constitute an Administrative Denial. CVS/Caremark provides a single level of appeal for Administrative Denials. Upon receipt of such an appeal, CVS Caremark will review the request for a particular drug or benefit against the terms of the Plan, including the single source or multi-source drugs selected by the Board of Trustees.

Timing of Review:

Pre-Authorization Review – CVS/Caremark will make a decision on a Pre- Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS/Caremark will make a decision on the Claim within 72 hours.

Pre-Service Clinical Claim Appeal – CVS/Caremark will make a decision on a first-level appeal of a claim denial rendered on a Pre-Service Clinical Claim within 15 days after it receives the appeal. If CVS/Caremark renders an Adverse Benefit Determination (upholds the denial) on the first-level appeal of the Pre-Service Claim, you may appeal that decision by providing the information described above. A decision on the second-level appeal will be made (by the IRO) within 15 days after the new appeal is received. If you are appealing a denial of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first- and second-level appeals, combined).

Administrative Denial or Post-Service Claim Appeal – CVS/Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim or on an Administrative Denial within 60 days after it receives such appeal.

Scope of Review:
If you appeal CVS/Caremark's denial of a Pre-Service clinical Claim, and request an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained onbehalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination:
Following the review of a Claim, CVS/Caremark will notify you of any denial of an appeal in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the denial;
- Reference to the pertinent Plan provision on which the denial was based;
- A statement that you are entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial/determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the denial is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary:

CVS/Caremark shall serve as the claims fiduciary with respect to preauthorization review of prescription drug benefit Claims, first-level review of appeals of Pre-Service clinical Claims, and review of Post-Service Claims and Administrative Denials. CVS/Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties.

Appeal Process for Medicare Wrap-Around Claims, Dental Claims, Vision Claims, Cardiovascular Claims, Health Reimbursement Arrangement (HRA) Claims

The Plan maintains a one-level appeal for post-service Medicare Wrap-Around Claims, Dental Claims, Vision Claims, Cardiovascular Claims and Health Reimbursement Arrangement (HRA) Claims. Appeals must be submitted in writing to the:

Appeals Committee/Board of Trustees
Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700 (phone)

The Appeals Committee of the Board of Trustees will make a determination on the appeal no later than 90 calendar days from receipt of the appeal. You will receive a notice of decision on review within 5 days of the Appeals Committee making the benefit determination.

Appeal Process for Life and AD&D Benefits

Amalgamated Life Insurance Company will make a decision within 90-days of its receipt of your request for review. Under special circumstances, an extension of time, not exceeding 60 days, may be required. If such an extension is needed, you or your beneficiary will be notified in writing before the initial 90-day period expires of the special circumstances and the date when a decision will be made. You will receive a written notice of the decision from Amalgamated Life.

Content of Notification of Decision on Review

You will receive a written or electronic notice of the determination on review. If the appeal is denied in whole or in part, the written notice will include:

- The specific reason(s) for the denial;
- Reference to the specific Plan provisions on which the benefit determination is based;
- a statement that you are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to your claim for benefits;

- if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request; and

- If the adverse determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Reviewer's Decision on Appeal is Final and Binding

The decision of each reviewer is final and binding on all parties, including anyone claiming a benefit on behalf of the claimant. Each reviewer has full discretion and authority to determine all matters relating to the benefits provided under the portion of the Plan for which the reviewer has responsibility including, but not limited to, questions of coverage, eligibility, and methods of providing or arranging for benefits. Each reviewer also has full discretion and authority over the standard of proof required for any claim and over the application and interpretation of the portion of the Plan for which the reviewer has responsibility. In the case of reviews conducted by the Trustees of the Plan, the Fund Office will maintain records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

If a reviewer denies an appeal and the claimant decides to seek judicial review, the reviewer's decision will typically be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No lawsuit may be brought without first exhausting the above claims and appeals procedure. Nor may any evidence be used in court unless it was first submitted to the appropriate reviewer prior to the decision on appeal.

The time period for filing suit to seek judicial review of denial of claim is the one-year period measured from the date of the notification that the Fund or a reviewer denied your last appeal.

REIMBURSEMENT AND SUBROGATION

Cases Involving a Third Party

This Plan is not required to pay benefits for you or your dependent for an injury (including an illness) for which another party may be liable. The Plan may, however, advance benefits to the injured party (you or your dependent) while a third party's liability is being determined. You must notify the Plan in writing as soon as the injured party institutes a claim against another person or entity, and the Fund Office will require the injured party to sign a Reimbursement/Subrogation acknowledgement form before any benefits are paid. If you, your dependent, if applicable, or your attorney refuse to sign a Reimbursement/Subrogation acknowledgement form, the Plan may withhold payment of any benefits as a result of the injury or illness caused by a third-party, and may recoup by offset or lawsuit any amount already paid.

Reimbursement

If you or your dependent should recover damages from an insurance company or from the other party (for example, in a lawsuit), then you must reimburse the Plan for the payments it has made or will make in connection with the injury. If you are injured by another party, you are required as a condition of receiving benefits from the Plan to sign a form acknowledging the Plan's right to recover under the terms of the Plan. However, the Plan's right or subrogation/reimbursement is established by the Plan and not by the acknowledgement form. In the event you receive benefits in such a case, the Plan's interest in your recovery is governed by the terms of the Plan irrespective of whether you have signed the acknowledgement form.

Under the terms of the Plan, the acceptance of benefits by an Employee or beneficiary (or someone acting on his or her behalf) who has been injured by another party constitutes an agreement by the injured party to reimburse the Plan for benefits paid up to the full amount of the recovery due to the injury. The Plan has a right to first reimbursement out of any recovery whether or not the amounts recovered are designated to cover medical expenses. By accepting benefits from the Plan, the injured person agrees that any amount recovered by the injured person by judgment, settlement or compromise, will be applied first to reimburse the Plan, without reduction for attorneys' fees or costs, even if the injured person is not made whole. Amounts recovered by the injured person in excess of benefits paid by the Plan are the separate property of the injured person. In addition, amounts received from an individual health insurance policy for which the injured person or a member of the injured person's family has paid premiums are also the separate property of the injured person.

By accepting benefits from the Plan, the injured party agrees to notify the Plan promptly of efforts made to recover from a third party, including filing a suit to recover amounts in connection with the injury or illness. Furthermore, in the event the injured party or someone acting on his or her behalf receives payment from any source for claims related to the injury, the injured person agrees to notify the Plan promptly. By accepting benefits from the Plan, the injured person agrees that neither the injured person nor anyone acting on behalf of the injured person will settle any claim relating to the accident or illness without the written consent of the Plan.

In the event an injured party accepts benefits from the Plan and amounts are recovered from claims arising from the injury or illness, the amounts recovered, up to the amount paid on behalf of the injured person by the Plan, are assets of the Plan by virtue of the Plan's reimbursement interest. Such Plan assets may not be distributed without a release from the Plan. Furthermore, by accepting benefits from the Plan, the injured person specifically agrees that any payments, up to the amount paid on behalf of the injured person by the Plan, must remain in the possession of the injured person or his or her authorized agent and placed in a specifically identifiable segregated account. The injured person also acknowledges that, under the terms of the Plan, any payments so held constitute assets of the Plan until and unless the Trustees waive or release the Plan's right to reimbursement.

In the event monies are recovered and the Plan is not reimbursed to the extent of its interest in accordance with Plan provisions, the Plan may bring suit against the injured party, insurers and any recipients of the Plan assets improperly distributed without the consent of the Plan. The Plan may recover benefits paid on behalf of the injured person by treating such benefits as an advance and deducting such amounts from benefits which become due to the injured person and his or her immediate family until the Plan's interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have provided to such providers.

Subrogation

The Plan is not required to participate in an injured person's claims to demand reimbursement from an injured person or to invoke its subrogation rights. The Plan may request that the injured person assign or subrogate his or her claim or any other right of recovery to the Plan so that the Plan can enforce its right to recovery. The injured person must cooperate fully with the Plan in connection with any claim brought by the Plan to recover its assigned or subrogated interest. By accepting benefits from the Plan, the injured person authorizes the Plan to elect to pursue any claims arising from the injury in the name of the injured person and/or the Plan's name and to sue, compromise or settle such claims without the approval of the injured person to the extent of benefits paid and/or to be paid. If the injured person does not cooperate or if the injured person or anyone acting on the injured person's behalf takes any action which harms the Plan's subrogated interest, the Plan is entitled to cease payment of any benefits connected to the third-party-caused injury, and recover from the injured person the amount of plan benefits paid. The Plan may bring a lawsuit against the injured person to collect payments already made or may collect these amounts by offset, against any future benefit payments otherwise due to the injured person and their immediate family. If legal proceedings are instituted, the Plan may recover the costs and attorney's fees incurred.

Cases Involving Work-Related Claims

In general, the Plan does not cover expenses for an illness or injury that arises out of the course of employment. However, an exception exists if you have a work related injury or illness for which a claim has been filed with a worker's compensation insurance carrier or with a federal or state court or agency. In the event that the claim has been initially denied, then the Plan, upon request, may pay benefits arising from the work-related injury or illness.

By accepting these benefits from the Plan, you agree to actively pursue your work-related claim and also agree that the Plan has the power to institute, compromise or settle such a claim in your name, to the extent of benefits paid. By accepting these benefits, you also agree that any amounts recovered by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, are assets of the Plan and will be applied first to reimburse the Plan, in full and without any reduction for attorney's fees or costs, for benefits paid due to the work related claim. The Plan must be reimbursed first, even if you are not made whole. Once benefits are paid under this provision, you may not settle your work related claim without the written consent of the Plan.

As a condition of receiving benefits from the Plan, you are required to sign a form acknowledging the Plan's right to reimbursement under the Plan. However, the Plan's right to reimbursement is established by the Plan and not by the form. The Plan's interest in your recovery is governed by the terms of the Plan irrespective of whether you have signed the acknowledgment form. Therefore, the Plan has the rights described in this section even if you have not notified the Plan or signed the acknowledgment form.

If monies are recovered and the Plan is not reimbursed to the extent of its subrogation interest in accordance with Plan provisions, the Plan may bring suit against you, any insurers and any recipients of the Plan assets improperly distributed without the consent of the Plan. The Plan may recover benefits paid on your behalf by treating such benefits as an advance and deducting such amounts from benefits, which become due to you and your family until the Plan's interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have provided to such providers.

Fraudulent and Erroneous Claims

If a fraudulent claim is submitted, benefits will be denied. However, if any benefits are paid on a fraudulent claim, the amounts due to the Plan may be deducted from any benefits due to the Eligible Employee and his or her Dependent(s) until the Plan is reimbursed for the benefits improperly paid.

If any claim is paid because of a mistake of law or fact not due to fraud, the Plan will make a written demand upon the Eligible Employee for repayment. If repayment is not promptly made, the Trustees may determine to deduct the amounts due the Plan from any benefits due to the Eligible Employee and his/her Dependent(s) until the Plan is fully reimbursed for the benefits improperly paid.

You must reimburse the Plan for any claim paid in error by the Fund Office because you have failed to update your enrollment status. Important events that must be reported include your divorce, legal separation, loss of custody, and the marriage or gainful employment of a child. If reimbursement is not promptly made, the amounts due the Plan may be deducted from any benefits due to the Eligible Employee and his or her Dependent(s) until the Plan is reimbursed for the benefits improperly paid.

Payment to Third Parties

Generally, benefits payable under the Plan cannot be alienated, transferred, assigned, or otherwise promised to a person or party other than the employee. However, there are some exceptions to this rule. You may direct that benefits payable to you be paid to an institution or provider of medical care that provided medical care for which benefits are payable under this Plan. However, the Plan is not obligated to accept such direction from you, and no payment by the Plan pursuant to your direction shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical care except to the extent to which the Plan actually chooses to do so. If there has been a benefit overpayment, or you otherwise owe money to the Plan, the Plan may choose to offset the overpayment against future benefits even if you have assigned those benefits to your Hospital or Physician. This is true even if the Plan has pre-certified coverage.

EXCLUSIONS AND LIMITATIONS

Services and supplies covered by this Plan are subject to the following exclusions and limitations. Please read this section carefully.

Benefits will be reduced or not payable under the following circumstances:

- You are covered by another plan and pursuant to the Coordination of Benefits rules, your benefits payable from this Plan are reduced;
- You incur expenses which are not covered by this Plan;
- You and/or your Dependent fail to refund a benefit paid by the Plan to which you and/or your Dependent were not entitled. In this case, the amount you owe the Plan will be deducted from any benefits to you or any of your Dependent(s) until the amount you owe the Plan is paid in full. The Plan may also file suit against you, your Eligible Dependents or your former Eligible Dependent(s), such as a former Spouse, to collect the amount due the Plan;
- You and/or your Dependent fail to furnish the Plan with any information or document required by the Plan to determine or process a claim; or
- The Plan is amended, modified or terminated by the Trustees.

Exclusions and Limitations

The Plan does not pay benefits unless the charge is for services or supplies covered by the Plan. In addition, the Plan does not pay for or limits the following charges; the amount of any such charges or charges in excess of the Plan's limit will be deducted from the individual's expenses before benefits of this Plan are determined:

- Injuries arising out of (or in the course of) any employment for wage or profit, or diseases that are covered by any worker's compensation law, occupational disease law or similar legislation. However, under specific circumstances, the Plan may advance benefits where the work relatedness of the illness or injury is questioned, subject to full reimbursement if the illness or injury is later determined to be work-related. See page 112;
- Services or supplies not Medically Necessary for the care of the patient's illness or injury or not certified as Medically Necessary by the attending Physician;
- Surgery and related services intended solely to improve appearance. However, surgery and related services which are Medically Necessary to restore bodily function or to correct deformity resulting from disease, accidental injury, congenital anomaly or previous therapeutic process are covered subject to all Plan terms and limits;
- Illnesses or injuries due to war or any act of war, declared or undeclared (including resistance to armed insurrection);

- Charges for services or supplies furnished by or on the behalf of a federal, state or local government, agency or program, unless payment of the charge is legally required;

- Check-ups not reasonably necessary for the treatment of an illness or injury (except for Annual Physical Benefits, Well Child Care and Well Woman Care);

- Treatment of the teeth or gums, except:

    1. For the repair of non-occupational injuries to natural teeth, or

    2. Specifically provided dental benefits.

- Medication, services or supplies not prescribed by a Physician or Dentist;

- Services for which no charge is made or for which no charge would be made if no coverage existed;

- Charges that neither the Eligible Employee nor the Eligible Dependent is personally liable to pay;

- Amounts in excess of actual charges, except when required by contract;

- Charges in excess of the Plan's limitations;

- Charges for services or supplies which are furnished, paid for or otherwise provided by reason of the past or present service of any person in the armed forces;

- Benefits, services, equipment and supplies that are required as a condition of employment;

- Benefits, services, equipment and supplies promised by an Employer as a result of an agreement (other than an agreement to contribute to the Plan);

- Charges for services provided by an immediate family member related by blood or marriage, or an individual who customarily resides in the Eligible Employee's or Eligible Dependent's home;

- Hospitalization primarily for diagnostic studies and evaluations, x-ray examinations, laboratory examinations or electrocardiograms except where appropriate by virtue of medical necessity;
- Services or supplies provided before the Eligible Employee or his or her Eligible Dependent became eligible for coverage. Services or supplies provided after the eligibility of the Employee or his or her Dependent has terminated. To be covered, all treatments must be completed while the Employee or Dependent is eligible even if the treatment has been pre-approved;

- Treatment that is experimental, investigational or part of a research program. Experimental or investigational include:

    - any treatment not proven in an objective manner to have benefits for the patient;

    - any treatment that is restricted to use at a medical facility engaged primarily in carrying out scientific studies;

    - any treatment, drug or supply which is not recognized as acceptable medical practice in the United States;

    - any items requiring governmental approval which was not granted at the time the services were rendered;

    - any service or supply that is available only on approval of an Institutional Review Board (as required by Federal statute), including ones that require completion of an informed consent for experimentation on human subjects (as required by Federal regulations);

    - any treatment that involves drugs not approved by the Food and Drug Administration (FDA), including dosages, combinations and uses that are not approved;

    - any new drug or device for which an investigational application has been filed with the FDA;

    - any treatment that is available only through participation in FDA Phase I or Phase II clinical trials or Phase III experimental or research clinical trials sponsored by the National Cancer Institute; and/or

    - any services or supplies that have protocols or consent documents describing them as an alternative to more conventional therapies.

- Services or supplies provided by an institution that is principally a rest or nursing facility, a facility for the aged, chronically ill or convalescents, or a facility providing custodial, educational or rest cures, or mere maintenance;

- Any treatment leading to or in connection with transsexual surgery;

- Any claim submitted more than 18 months after the date of treatment or service, except as otherwise approved by the Plan;

- Charges for or related to in-vitro fertilization or artificial insemination. However, prescription drugs in connection with such treatment are covered;

- Charges for broken or missed appointments;

- Treatment to reverse voluntary surgically induced infertility;

- Charges for treatment for which the Eligible Employee or Eligible Dependent has failed to comply with the Plan's request to be examined by a practitioner designated and paid for by the Plan. See page 88;

- Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition;

- Confinement to an institution that is not a Hospital;

- Charges resulting from the participation in one of the following crimes for which the individual is convicted or pleads guilty or no contest: murder, rape, robbery, burglary, kidnapping, arson, possession and use of illegal explosives or drug trafficking;

- The Plan will not pay for co-payments of any kind;

- Charges for Shock Treatment;

- Charges for Immunization required for travel outside the United States;

- Charges for Hypnosis;

- Charges for LASIK Eye Surgery/Radial Keratotomy;

- Treatment for temporomandibular joint ("TMJ"), including all related expenses. Treatment for TMJ shall be covered only as a dental expense;

- Charges for Biofeedback; or

- Charges for or related to weight loss treatment. (Prescription drugs and medically necessary procedures in connection with weight loss however, are covered).

DEFINITIONS

Some terms have special meanings when used in this booklet. Some of these terms are defined in the text of the Plan, generally in the section in which they are first used. Other terms are defined below. All defined terms apply throughout the booklet unless indicated otherwise.

Accident or Accidental means an unexpected event causing injury, dismemberment or death which is not due to any fault or misconduct on the part of the person injured and which does not arise from and is not related in any way to the person's employment or place of employment.

Active Eligible Employee is an Employee whose eligibility for benefits is based on hours worked for which his or her Employer must make contributions. Therefore, Employees who are eligible under the Plan based completely on payment of COBRA premiums and Employees who are eligible because hours are credited during periods of disability are Eligible Employees but are not Active Eligible Employees.

Allowed Amount is the maximum amount the PPO will pay for covered services. See page 28.

Allowable Expenses are any Medically Necessary charges for Hospital, Medical, Dental and Vision benefits and services covered in whole or in part by this Plan (except Life Insurance and Accidental Death & Accidental Dismemberment) and any other plan covering the person making the claim.

Alternate Recipient is an individual who may be authorized to receive notices of the receipt or adjudication of claims or payment of benefits when authorized by the Trustees or pursuant to a valid legal order.

Apprentice is a job classification of Employee of an Employer under the Local 1 Collective Bargaining Agreement for a participant in the Apprenticeship program of the Plumbers Local No. 1 Trade Education Fund.

Behavioral Healthcare Management Program - see page 55.

Beneficiary Designation Form - see page 68.

Certificate of Creditable Coverage - see page 24.

Collective Bargaining Agreement is an agreement between an Employer and Plumbers Local Union No. 1 that requires the Employer to make contributions to this Plan.

Concurrent Care Claim - This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

Coordination means that benefits from this Plan plus benefits received from other health plans can total, but not exceed, 100% of the allowable expenses for each covered person in each calendar year. This is intended to permit full payment of Allowable Expenses but not duplicate payments.

Covered Employment is work under a Collective Bargaining Agreement or Participation Agreement for which contributions must be paid to this Plan.

Deductible is the amount an Eligible Employee or Eligible Dependent pays before the Plan pays Medical Benefits. See page 38.

Delinquent Employer is an Employer who is required to contribute to this Plan on your behalf but who has not paid the required contributions.

Dependent Child - see page 11.

Disabled Dependent Child - see page 11.

Disability Claims (Weekly Disability and Accidental Dismemberment Claims) include Weekly Disability and Accidental Dismemberment Claims and are generally handled as Post-Service Medical Claims.

Eligible Employee is an Employee who has satisfied the requirements for eligibility for benefits from this Plan and who is currently eligible for benefits.

Eligibility Period – Generally, when an Employee terminates employment with a Contributing Employer, the Employee's coverage under the Plan continues through the end of the sixth month following the most recent period of three (3) consecutive months in which the Employee works at least 270 hours in Covered Employment.

Eligible Health Care Expenses are generally those expenses that would be an eligible deduction on your tax return (but without regard to the requirement that such expenses exceed a specified amount of your income) and in accordance with IRS rules. These expenses cannot be covered by any other benefit plan. See page 78.

Employee is an individual who is covered by a Collective Bargaining Agreement or a Participation Agreement that requires his or her Employer to make contributions to this Plan on his or her behalf. Contributions on an Employee's behalf are made for hours worked in accordance with the applicable Agreement.

Employer or Contributing Employer is a company, corporation or other entity that has an obligation to make contributions to the Plan.

Health Reimbursement Account ("HRA") - see page 76.

Helper is a job classification of an Employee of an Employer signatory to the Local 1 Mechanical Equipment and Service Agreement (MES Agreement).

Hospital means a legally constituted general acute care non-governmental institution duly accredited by the Joint Commission on Accreditation of Hospitals or any similar Hospital in a foreign country and operated for the treatment of acute illness or injured person with facilities for surgery and having 24-hour nursing and full medical services. An institution for the aged, chronically ill, a convalescent, rest or nursing home is not a Hospital. No benefits are payable to an institution that is not a Hospital unless otherwise stated in the Plan. In addition, with respect to pregnancy, the word "Hospital" includes alternate birthing facilities under the supervision of a Physician or a licensed nurse-midwife. See page 48.

Incomplete Claim - A claim is incomplete if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Plan, your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.

Independent Medical Examination - The Plan has the right to have the person for whom benefits are claimed examined by a professionally qualified practitioner, designated and paid for by the Plan (e.g., Physician, Dentist, etc.).

Local 1 is Plumbers Local Union No. 1, affiliated with United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada AFL-CIO.

Local One Represented Employee is an Employee whose wages, hours and working conditions are covered by a Collective Bargaining Agreement or other agreement between an Employer and Local 1.

Medical Management Program is the program that provides Pre-Certification services for hospital admissions and certain tests and procedures. See page 40.

Medically Necessary means services or supplies when prescribed as necessary by a Physician legally licensed to practice medicine while prescribing within the scope of his/her expertise when furnished under the laws of the United States. The Plan uses the following criteria for determining Medical Necessity:

1. The treatment is consistent with the symptoms and diagnosis of the patient's condition;

2. The treatment is in accordance with standards of good medical practice;

3. The treatment is not strictly for the convenience of the patient and his or her family;

4. The treatment is not primarily custodial; and

5. The treatment is the most appropriate level of the service or supply.

Medicare Wrap Around Program see page 18.

Other Health Plans include group plans (either insured or self-insured) such as health plans available from your Spouse's employer and Medicare.

Participating Providers see page 26.

Participation Agreement is an agreement between the Plan and an Employer which obligates the employer to report and pay contributions to this Plan on behalf of the Employees covered by the Participation Agreement.

Physician means a person who is licensed to practice medicine or to perform surgery in the state in which he/she practices, who is practicing within the scope of his/her license and who is providing a service covered by the Plan. Physician includes a Physician of medicine, osteopathy, dental surgery or podiatry. Physician charges also include the services of a qualified professional chiropractor, acupuncturist, physiotherapist, psychologist, optometrist, nurse-midwife and nurse anesthetist.

Post-service Claim is any claim for a benefit that is not a pre-service claim. In the case of this type of claim, you request reimbursement after medical care has already been provided. Most of the benefits provided by the Plan are post-service claims.

Pre-service Claim is any claim for which the Plan conditions receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care. See pages 40-65 for information concerning which benefits require pre-approval.

Preferred Provider Organization (PPO) means a network of medical care providers, including hospitals, physicians, laboratories and radiology facilities, with which the Plan has contracted and who have agreed to reduce their fees for medical services and supplies that may be required by Eligible Employees and Eligible Dependent(s). See page 25.

Prescription Drug means a drug dispensed pursuant to a Physician's or Dentist's written prescription that meets at least one of the following criteria:

(1) It is a legend drug for which Federal Law requires a prescription;

(2) It is a prescription requiring compounding; or

(3) It is insulin that has been prescribed.

Prior Plans mean the health and welfare plans of former Local Unions 1, 2 and 371, which were merged into this Plan on June 1, 1998.

Probationary Period is the time period before an Apprentice or a Helper becomes a second grade Apprentice or a second term Helper during which period the Apprentice or Helper is not eligible for benefits. See page 2.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Plan which relates to your past, present or future physical or mental health, health care or payment for health care, and either identifies you or provides a reasonable basis for identifying you.

Qualifying Events are events that would permit you or your Dependent(s) to elect COBRA Continuation Coverage. See page 21.

Qualified Relative is an individual who qualifies as a dependent under Section 152 of the Internal Revenue Code including child, foster child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, stepparent, grandparent, niece, nephew, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or an individual who for more than one half of the year resides with the Eligible Employee and is a member of the Eligible Employee's household or in the case of a child, the child lives with his/her other parent. Qualified Relatives must meet all the requirements as stated under Section 152(b) and (d) of the Internal Revenue Code. See page 77.

Retired Employee is an Employee who has qualified for and is receiving Retiree Benefits from this Plan. An Employee is a Retired Employee on the effective date of his Pension. See beginning on page 1.

Specialty Guideline Management Program - see page 63.

Specialist means a Physician whose practice is limited to a particular branch of medicine or surgery and who is board certified in such branch of medicine or surgery by one of the American boards of medical specialties, the government or other recognized standard-setting health agency that defines standards for specialists.

Temporarily Disabled Employee is an Active Eligible Employee who is receiving State Disability Benefits or Workers' Compensation Benefits, or an Active Eligible Employee who is disabled but who is not receiving State Disability or Workers' Compensation Benefits. In order to be Temporarily Disabled, the Employee is temporarily unable to engage in the following types of employment due to an illness or injury: (1) Employment with any Contributing Employer; (2) Employment with any Employer in the same or related business as a Contributing Employer; (3) Self-employment in the same or related business as a Contributing Employer; or (4) Employment or self-employment in any business which is under the jurisdiction of the Union.

Totally and Permanently Disabled see page 16.

Union or Local Union is Plumbers Local Union No. 1, affiliated with United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada AFL-CIO.

Uniformed Services - see page 9.

Urgent Care Claim is a pre-service claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health or ability to regain maximum function; or (2) in the opinion of a Physician, with knowledge of your medical condition, would subject you to severe pain if your claim was not decided within the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim. Post-service claims are not urgent care claims because pre-approval is not required before you can receive treatment.

IMPORTANT INFORMATION ABOUT THE HIPAA PRIVACY REGULATIONS

The U.S. Department of Health and Human Services has issued regulations establishing strict standards on how health plans, like this Plan, may use and disclose individual medical records (known as "Protected Health Information" or "PHI"). These regulations affect some of your dealings with the Fund Office and with your PPOs and claims payers. In some instances, the requirements of the Privacy Rules may be an inconvenience to you. However, we are doing everything possible to minimize the burden on you.

The Privacy Rules are detailed. The following questions and answers explain the Rules in more detail and give some important information on how the Privacy Rules affect you directly.

What do the privacy regulations require?

In general, the regulations require the Plan to secure all medical information so that it is not readily accessible or available to those who do not need access to it. If your spouse or Business Agent calls the Fund Office with a question about you or your family's benefits from the Plan, then, in the absence of a written authorization (described below), the law will prohibit us from disclosing any information to them. It does not matter that your spouse or Business Agent may already know all the details directly from you. (There is an exception in the Rules allowing parents to obtain information from us concerning their minor children).

The Rules permit us to discuss your medical information with you directly, *but we are not able to discuss with or disclose your information to third parties, such as your spouse or your union officials, unless you specifically authorize the Plan to do so and subject to certain other exceptions.*

How do I authorize my spouse or Business Agent to assist me in dealing with the Plan Office?

If you are not present, your spouse or Business Agent cannot get specific information from the Fund Office about you unless you first submit a written authorization to the Fund Office. You may request an Authorization Form by calling the Fund Office at (718) 835-2700 or visiting our web site at www.ualocal1funds.org.

Once properly authorized by you, the Fund Office is permitted to disclose necessary information about you to whomever you have designated.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION FOR THE PLUMBERS LOCAL UNION NO. 1 WELFARE PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by the Standards for the Privacy of Individually Identifiable Health Information ("Privacy Rules") issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996. It describes how the Plan can use and disclose your Protected Health Information. Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Plan which relates to your past, present or future physical or mental health, health care or payment for health care, and either identifies you or provides a reasonable basis for identifying you. In general, the Plan may not use or disclose your PHI unless you consent to or authorize the use or disclosure, or if the Privacy Rules specifically allow the use or disclosure.

Use or Disclosure of PHI

1. The Plan may use or disclose your PHI for treatment, payment or health care operations without your written authorization:

"Payment" generally means the activities of a Plan to collect premiums, to fulfill its coverage responsibilities and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing, and collection, making claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Plan will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

"Health Care operations" are certain administrative, financial, legal and quality improvement activities of the Plan that are necessary to run its business and to support the core functions of treatment and payment. For example, the Plan may disclose the minimum necessary PHI to the Plan's attorney, auditor, actuary and consultant(s) when these professionals perform services for the Plan that requires them to use PHI.

Persons who perform services for the Plan are called "business associates." Federal law requires the Plan to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Plan's contract with them. Other examples of business associates are the Plan's stop-loss insurance carrier, claims re-pricing services, utilization review companies, prescription benefit managers, PPOs and HMOs.

"Treatment" means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party, consultation between health care providers relating to a patient, or the referral of a patient for health care from one health care provider to another. The Plan is not typically involved in treatment activities.

2. The Plan is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:

The Plan will use or disclose your PHI to the extent it is required by law to do so.

The Plan may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths; (2) conducting public health surveillance, investigations or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA) or State law requirements having a similar purpose.

The Plan may disclose your PHI to the appropriate government authority if the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence.

The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law, including: (1) audits; (2) civil, administrative or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative or criminal proceedings or actions; and (6) other activities.

The Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal, or in response to a subpoena, discovery request or other lawful process.

The Plan may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena or administrative request.

The Plan may disclose your PHI in response to a law enforcement official's request for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

The Plan may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Plan is unable to obtain your consent because of incapacity or emergency and law enforcement demonstrates a need for the disclosure and/or the Plan determines in its professional judgment that such disclosure is in your best interest.
The Plan may disclose your PHI to law enforcement officials to inform them of your death, if the Plan believes your death may have resulted from criminal conduct.
The Plan may disclose your PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Plan.

The Plan may disclose your PHI to a coroner or medical examiner for identification purposes. The Plan may disclose your PHI to a funeral director to carry out his or her duties upon your death or before and in reasonable anticipation of your death.

The Plan may disclose your PHI to organ procurement organizations for cadaveric organ, eye or tissue donation purposes.

The Plan may use or disclose your PHI for research purposes, if the Plan obtains one of the following: (a) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.

The Plan may use or disclose your PHI to avoid a serious threat to the health or safety to you or others.

The Plan may disclose your PHI if you are in the Armed Forces and your PHI is needed by military command authorities. The Plan may also disclose your PHI for the conduct of national security and intelligence activities.

The Plan may disclose your PHI to a correctional institution where you are being held.

The Plan may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.

The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

3. The Plan may use or disclose your PHI to you, your Personal Representative, a third party (such as your spouse) pursuant to an Authorization Form, and to the Board of Trustees of the Plan but only for the purposes and to the extent specified in the Plan:

The Plan will provide you with access to your PHI.

The Plan may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or lawyer has authority under applicable law to act on your behalf.

Unless otherwise permitted by law, the Plan will not use or disclose your PHI to someone other than you unless you sign and execute an "Authorization Form." You can revoke an Authorization Form at any time by submitting a "Cancellation of Authorization Form" to the Plan. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Plan.

The Plan will disclose your PHI to the Plan's Board of Trustees only in accordance with the provisions of the Plan's Privacy Policy and the provisions of the Plan.

Individual Rights

You have certain important Rights with respect to your PHI. You should contact the Plan's Privacy Officer, identified below, to exercise these rights.

You have the right to request that the Plan restrict use or disclosure of your PHI to carry out payment or health care operations. The Plan is not required to agree to a requested restriction.

You have a right to receive confidential communications about your PHI from the Plan by alternative means or at alternative locations, if you submit a written request to the Plan in which you clearly state that the disclosure of all or part of that information could endanger you.

You have the right of access to inspect and copy your PHI that is maintained by the Plan in a "designated record set." A designated record set consists of records or other information containing your PHI that is maintained, collected, used or disseminated by or for the Plan in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Plan, or (2) decisions that the Plan makes about you.

You have the right to amend your PHI that was created by the Plan and that is maintained by the Plan in a designated record set, if you submit a written request to the Plan in which you provide reasons for the amendment.

You have the right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Plan. The Plan need not account for disclosures that were made more than six years before the date on which you submit your request or any disclosures that were made for treatment, payment or health care operations.

Duties of the Plan

The Plan has the following obligations:

The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Plan's entire Privacy Policy, you should contact the Plan's Privacy Officer, identified below.

The Plan is required to abide by the terms of the notice that is currently in effect.

The Plan will provide a paper copy of this Notice to you upon request.

Changes to Notice

The Plan reserves the right to change the terms of this Notice and to make the new Notice provision effective for all PHI it maintains, regardless of whether the PHI was created or received by the Plan prior to issuing the revised Notice.

Whenever there is a material change to the Plan's uses and disclosures of PHI, individual rights, the duties of the Plan or other privacy practices stated in this Notice, the Plan will promptly revise and distribute the new Notice to Eligible Employees and beneficiaries.

Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Plan's Privacy Officer at the following address:

Walter Saraceni
Plumbers Local Union No. 1 Welfare Fund
158-29 George Meany Boulevard
Howard Beach, NY 11414
(718) 835-2700

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. The Plan will not intimidate, threaten, coerce, discriminate against or take other retaliatory action against any person for filing a complaint.

For More Information About Privacy

If you want more information about the Plan's policies and procedures regarding privacy or PHI, contact the Plan's Privacy Officer at the address above or access our website at www.ualocal1funds.org.

GENERAL INFORMATION & ERISA RIGHTS

The following information is provided as specified in Section 102(b) of the Employee Retirement Income Security Act of 1974 (ERISA).

Official Name of Plan:

Plumbers Local Union No. 1 Welfare Fund

Type of Administration:

Collectively bargained, joint-trusteed labor management trust; self-administered.

Type of Plan:

Hospitalization, Medical, Disability, Dental, Vision, Cardiovascular, Prescription, Life and Accidental Death & Accidental Dismemberment.

Name and Address of the Administrator, the Plan Office and the Agent for the Service of Legal Process:

The Board of Trustees
Plumbers Local Union No. 1 Welfare Plan
158-29 George Meany Blvd.
Howard Beach, NY 11414
(718) 835-2700

In addition, service of legal process may be made on any Plan Trustee.

Names, Titles and Addresses of the Plan Trustees:

Union Trustees

John J. Murphy, Co-Chairman
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

Michael Apuzzo
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

Donald T. Doherty
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

Daniel Lucarelli
Plumbers Local Union No. 1
158-29 George Meany Blvd.
Howard Beach, NY 11414

Alternate Union Trustees

Employer Trustees

Eugene S. Boccieri, Co-Chairman
Duo Plumbing & Heating Corp.
88 Kreischer Street
Staten Island, NY 10309

Louis J. Buttermark
Louis Buttermark & Sons, Inc.
16 New Dorp Lane
Staten Island, NY 10306

Vito Giachetti
Taggart Associates Corp.
3318 Delavall Avenue
Bronx, NY 10475

Thomas Maniuszko
Total Service Ltd.
116-04 Atlantic Avenue
Richmond Hill, NY 11419

Alternate Employer Trustee

Stewart O'Brien
Association of Contracting Plumbers
44 West 24th Street, 12th Floor
New York, NY 10001

Source of Financing of the Plan and Identity of Any Organization through Which Benefits are Provided:

Payments are made to the trust by individual Employers under the provisions of Collective Bargaining Agreements between Plumbers Local Union No. 1 and Employers, by individuals through self-payments, and from any income earned from investments of contributions. All monies are used exclusively for providing benefits to Eligible Employees or their Eligible Dependent(s), and for expenses incurred with respect to the operation of the Plan. The Trustees annually review the funding status of the Plan with the assistance of their professional advisors.

The Plan will provide you, upon written request, information as to whether an Employer is contributing to this Plan on behalf of Employees working under a Collective Bargaining Agreement.

The Plan has arrangements with various Preferred Provider Organizations and claims payers to provide the benefits of the Plan. The following is a list of those providers:

Mail Order Maintenance Drugs
CVS/Caremark P.O. Box 3223
Wilkes-Barre, PA 18773-3223
Phone: (866) 831-4336
Website: www.caremark.com

Prescription Drug Card
CVS/Caremark
P.O. Box 853901
Richardson, TX 75085-3901
Phone: (866) 831-4336
Website: www.caremark.com

Physician & Hospital Network
Empire Blue Cross & Blue Shield
P.O. Box 1407
New York, NY 10008
Phone: (800) 553-9603
Website: www.empireblue.com

Vision Benefits
Vision Screening
1919 Middle Country Road, Suite 304
Centereach, NY 11720
Phone: (800) 652-0063
Website: www.vscreening.com

Medicare Wrap-Around Claims Processor
Administrative Services Only, Inc.
303 Merrick Road
Lynbrook, NY 11563-9010
Phone: (516) 394-9492

Cardiovascular Screening Benefits
Vascular Diagnostic Associates, PC
41-61 Kissena Blvd. – Suite #4
Flushing, NY 11355
Phone: (718) 886-0600
Website: www.vasculardiagnostic.com

Alcohol & Substance Abuse
D.J. O'Grady Consultants Ltd.
90 John Street, Suite 305
New York, NY 10038
Phone: (212) 206-7898

Date of the End of the Plan Year:
December 31

Internal Revenue Service Plan Identification Number:
11-1538293

The Plan Number is:
501

Plan Termination, Amendment or Elimination of Benefits:
The Welfare Plan may be terminated by a document in writing, adopted by a majority of the Union Trustees and a majority of the Employer Trustees. The Plan may be terminated if, in the opinion of the Trustees, the Trust Plan is not adequate to carry out the intent and purpose of the Plan as stated in its Trust Agreement, or is not adequate to meet the payments due or which may become due under the Plan of Benefits. The Plan may also be terminated if there are no individuals living who can qualify as Employees or Beneficiaries under the Plan. Finally, the Plan may be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Plan. The Trustees have complete discretion to determine when and if the Plan should be terminated.

If the Plan is terminated, the Trustees will: (a) pay the expenses of the Plan incurred up to the date of termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Plan; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Plan in accordance with the Plan of Benefits, including amendments adopted as part of the termination until the assets of the Plan are distributed.

No part of the assets or income of the Plan will be used for purposes other than for the exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of the Plan. Under no circumstances will any portion of the Plan revert or inure to the benefit of any contributing Employer, the Association or the Union either directly or indirectly.

Upon termination of the Plan, the Trustees will promptly notify the Union, the Association of Contracting Plumbers, Employers and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Plan.

In addition, the Trustees have complete discretion to amend or modify the Plan and any of its provisions, in whole or in part, at any time. This means that the Trustees can reduce, eliminate or modify benefits as well as improve benefits. The Trustees may also modify length of coverage for all employees' Dependent(s) and retirees, and eligibility requirements for coverage.

ERISA Rights Statement

As an Employee in Plumbers Local Union No. 1 Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Employees shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Pan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contacts 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 Benefits 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 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 annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependent(s) if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependent(s) 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.

There will be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a subsequent group health plan, if you have creditable coverage from this Plan. You should be provided a certificate or 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 pre-existing condition exclusions under a subsequent plan for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participation, 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 the duty to do so prudently and in the interest of you and other Plan Employees and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file a suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medial 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 Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

NOTES