WELFARE FUND

PLAN AND SUMMARY PLAN DESCRIPTION

PLUMBERS LOCAL UNION No.1 FUND OFFICE

50-02 FIFTH STREET, LONG ISLAND CITY, NEW YORK 11101

www.ualocal1funds.org

2020

June 2020

Introduction

A Message from the Board of Trustees

To all Eligible Employees:

Throughout your career in the Plumbing Industry, the Plumbers Local Union No. 1 and signatory employers make every effort to provide you with the tools you need to do your job safely and efficiently. The Plumbers Local Union No. 1 Welfare Fund (Fund) is a tool developed by the Union with signatory employers to provide hospital, medical, prescription drug, dental, optical, weekly unemployment and disability, life insurance, accidental death and dismemberment and Health Reimbursement Account benefits for you and/or your eligible dependents.

This updated Summary Plan Description (SPD) has been designed to be easy to read and to understand. It outlines the eligibility rules, describes the conditions governing the payment of benefits, and explains the procedures you should follow in filing a claim and appealing a claim denial should your claim be denied. You should share this SPD with your spouse, dependent or beneficiary because it contains important information about benefits that may be available to them.

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 protect your benefits. In these days of escalating medical costs, it is important to assure that benefit funds are neither wasted nor misused, so benefits can be available to safeguard the health and security of members and their families.

If you have questions concerning the Fund's benefits or your eligibility to participate, please contact the Fund Office, Welfare Department at (718) 835 – 2700.

Sincerely,

Plumbers Local Union No.1 Welfare Fund
The Board of Trustees

This booklet provides a summary of the benefits for participants in the Plumbers Local Union No. 1 Welfare Fund (as amended through April 2020) as well as information that must be included to comply with the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Plan is a group health plan that provides hospital, medical, prescription drug, dental, optical and other benefits for you and your eligible dependents. This booklet serves as both the Plan Document and the SPD. It supersedes all prior SPD, 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.

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HOW DOES THE FUND WORK?

Administration of the Fund

The Fund is administered by a Board of Trustees with an equal number of representatives from the Union and Contributing Employers. The Fund was created pursuant to a Trust Agreement that establishes the Plan. The Trustees have the duty and authority to administer the Fund. Pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), the Trustees are the "Plan Administrator", the "Plan Sponsor", and the "Named Fiduciaries" of the Fund. The names and business address of each of the current Trustees are as follows:

The Board of Trustees

UNION TRUSTEES	EMPLOYER TRUSTEES
Michael Apuzzo, Co-Chairman Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Eugene Boccieri,** Co-Chairman Duo Plumbing & Heating Company 88 Kreischer Street Staten Island, NY 11309
Freddy Delligatti Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Louis J. Buttermark** Louis Buttermark & Sons, Inc. 16 New Dorp Lane Staten Island, NY 10306
Daniel Lucarelli Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Marie Cardoza** Cardoza Plumbing Corp. 514 Grand Blvd. Westbury, NY 11590
Paul O'Connor Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Jeffrey M. Levine** The Par Group 60 North Prospect Avenue Lynbrook, NY 11563
ALTERNATE UNION TRUSTEES	**ALTERNATE EMPLOYER TRUSTEES**
None	**Terence O'Brien** The Association of Contracting Plumbers of the City of New York, Inc. 535 8th Avenue, 17th Floor New York, NY 10018

The full Board of Trustees is authorized to interpret this Plan Document/Summary Plan Description ("SPD") and the Trust Agreement. The Board has discretion to decide all questions about the Fund or Trust, including questions about your eligibility for participation, benefits and the definition of any Fund terms. No individual Trustee, Employer, Union representative, or Fund employee has the authority to interpret this Plan Document/SPD on behalf of the Board or to act as an agent of the Board. The Board also has the discretion to make factual determinations regarding any claim you make for benefits.

The day-to-day operations of the Fund are conducted by the Fund Office at the following address:

FUND OFFICE

Plumbers Local Union No. 1 Trust Funds ("Fund Office")
50-02 Fifth Street, 2nd Floor
Long Island City, NY 11101
1-718-835-2700

Normal Business Hours:
8:00 am to 4:30 pm Monday – Friday

Fund Office Website:
UAlocal1funds.org

Did you know that you can access your benefits information 24x7?

In addition to calling or visiting the Fund Office on Monday through Friday between 8:00 am and 4:30 pm, you can also access benefits information by logging into the Fund Office's online secure portal at **MyBenefits.nypl1f.org**.

Through MyBenefits.nypl1f.org, you can review all your benefit accounts in one place, contribution history, eligibility, beneficiary and dependent information, account balances, transaction history, and certain claims status. This portal provides:

- At-a-glance online account information dashboard
- Real-time account balances and claims activity
- Work Hour reporting capabilities
- State-of-the-art system security
- 24 x 7 access

To access your account, you must first register with the site and create a password. Contact the Fund Office for your login information and temporary password.

You can also access this SPD and any modifications at UALocal1funds.org.

WHO CAN BECOME ELIGIBLE?

Eligibility for benefits from the Plumbers Local Union No. 1 Welfare Fund (the "Plan") is based upon hours worked under Collective Bargaining Agreements between Employers and Plumbers Local Union No. 1 ("Local 1" or the "Union") affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting 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 eligibility requirements described on pages 3-9 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 a Journeyman and any other skill level except for 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 pages 113 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 "Active Eligible Employee" is an Employee whose eligibility for benefits is based on hours worked for which his or her Employer must make contributions. In addition, Employees who are eligible under Unemployment Continuation of Coverage, Workers' Comp Continuation of Coverage, Disability Continuation of Coverage, or Weekly Unemployment Benefit are also Active Eligible Employees.

An "Eligible Employee" is an Employee who is eligible under the Plan based solely on payment of COBRA premiums. While such Employees are considered Eligible Employees, they are not considered 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 290 hours in Covered Employment under this Plan. For example, if you first work in Covered Employment in October and you are credited with at least 290 hours between October and December, you will be eligible for benefits on January 1.

The Plan allows you to purchase up to 16 hours to apply to a period of three consecutive months in order to attain eligibility. The cost to purchase hours is an hourly rate to be determined by the Trustees annually. Also, in certain circumstances 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 of Coverage." on pages 19-21.

Reciprocal Plans - This Plan has reciprocal agreements with certain other welfare plans of Local Unions affiliated with the UA. You can continue eligibility if you provide the Fund Office 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. If the reciprocal Plan contributions are at a rate that is less than this Plan's contribution rate, your credited hours will be prorated. If the reciprocal Plan contributions are 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 the prorated hours from a reciprocal Plan are not sufficient to maintain eligibility, you may continue to be eligible under this Plan for up to twelve (12) months of coverage at no cost from the date your eligibility would otherwise terminate. 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 your date of travel to the outside local. 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 40 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. You also will not be credited with coverage if Local 1 notifies you that you are working for a delinquent or non-compliant contractor on a PLA job even if Local 1 does not direct you to stop working on such PLA job.

Termination of Eligibility for Employees

You and your Eligible Dependent(s) will lose eligibility for benefits on the last day of the fourth month following the most recent period of three (3) consecutive months in which you work at least 290 hours in Covered Employment. This period is called the "Eligibility Period". For example, if you are credited with at least 290 hours in Covered Employment between January and March and you are not credited with any hours after March, you will lose eligibility on July 31st (four (4) months after March).

If you work less than 290 hours during the Eligibility Period, you may purchase up to 16 hours to apply to a period of three consecutive months in order to attain eligibility. The cost to purchase hours is an hourly rate determined by the Trustees annually. For example, if you work in Covered Employment and you are credited with 274 hours between May and July, you can buy-up 16 hours (so that you have a total of 290 hours) and you will be eligible for benefits through November 30th.

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 and a Weekly Unemployment Benefit described on pages 7-8 and page 65.

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 of 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 Hour 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 eighteen (18) 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. 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 will be at a monthly rate to be determined by the Trustees annually. If you elect COBRA Continuation of Coverage, you are not eligible for the Temporary Disability Extension.

Examples of Eligibility Scenarios effective January 1, 2020:

- 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 a monthly rate to be determined by the Trustees annually.

- 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 at a monthly rate to be determined by the Trustees annually.

- If you had been eligible for benefits for 36 months or more prior to becoming disabled and you reject COBRA upon termination of coverage, you would be eligible for a maximum of 18 months of the Disability Continuation of Coverage at no cost plus, an additional 18 months of coverage at a monthly rate to be determined by the Trustees annually.

DISABILITY CONTINUATION OF COVERAGE MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
First 18 months	$0 per month	$0 per month
Additional 18 months	$839 per month	$2,254 per month

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 a description of the illness or injury, the date of onset of the illness or injury, proof of State Disability Benefits or a Workers' Compensation claim number, if applicable, and any other information requested by the Fund Office or the Trustees. 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, (ii) submit additional evidence of your disability status, or (iii) submit to an evaluation by an Independent Medical Examination ("IME") periodically during the period of extended coverage. The Trustees may rely on the results of the IME in determining whether to continue the Temporary Disability Extension, and they may terminate the Temporary Disability Extension if the result of the IME indicates that you are not disabled. Your Temporary Disability Extension may also be terminated if you (i) fail to appear before the Trustees 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 106-108.

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 Social Security Disability Award, you are no longer Temporarily Disabled. You must notify the Fund Office within 30-days of becoming eligible for a Social Security Disability Award. If you receive a Social Security Disability Award and fail to notify the Fund Office, the Plan will seek reimbursement of the lesser of (a) the amount you would have paid in retroactive COBRA premiums (if COBRA had been elected instead of the Temporary Disability Extension) or (b) the amount of actual claims paid after you received the Social Security Disability Award.

For Social Security Permanent Disability Awards granted on or after January 1, 2017 the Plan will not seek reimbursement.

Effect of Retirement on Eligibility for Temporary Disability Extension: Eligibility under this extension will terminate for a Retired Employee on the 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 six (6) months of coverage at a monthly rate to be determined by the Trustees annually.

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. If you reject COBRA and elect the Unemployment Extension, an additional 18-month extension is available once the Unemployment Extension of up to 12 months is exhausted. The cost for the additional 18-month extension will be at a monthly rate to be determined by the Trustees annually. If you elect COBRA Continuation of Coverage, you are not eligible for the Unemployment Extension.

Examples of Eligibility Scenarios effective January 1, 2020:

- 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 a monthly rate to be determined by the Trustees annually.

- If you had been eligible for benefits for 18 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 9 months of the Unemployment Extension. The first six (6) months of the Unemployment Extension would be at no cost and the next three (3) months would be at a monthly rate to be determined by the Trustees annually. Following the Unemployment Extension, you are also eligible for an additional 18 months at a monthly rate to be determined by the Trustees annually.

- If you had been eligible for benefits for 24 months or more 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 12 months of the Unemployment Extension. The first six (6) months of the Unemployment Extension would be at no cost and the second six (6) months would be at a monthly rate to be determined by the Trustees annually. Following the Unemployment Extension, you are also eligible for an additional 18 months of coverage at a monthly rate to be determined by the Trustees annually.

UNEMPLOYMENT CONTINUATION OF COVERAGE MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
First 6 months (Month 1 to Month 6)	$0 per month	$0 per month
Following 6 months (Month 7 to Month 12) _	$210 per month	$564 per month
Additional 18 months (Month 13 to Month 30)	$839 per month	$2,254 per month

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.

Effect of Retirement on Eligibility for Unemployment Continuation of Coverage: Eligibility under this extension will terminate for a Retired Employee on the effective date of your pension.

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 four (4) months following the most recent period of three (3) consecutive months in which you worked at least 290 hours in Covered Employment.
- If March is the end of the period in which you worked at least 290 hours in Covered Employment, your Eligibility Period is four-month period from April through July. Evidence that you are unemployed and collecting or have collected or are unable to collect unemployment will be required for April through July 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 of Information to the Fund Office:

- If you are claiming an extension for August Benefits, a notarized statement is due no earlier than July 20th and no later than September 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 twelve (12) 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 Temporary or Seasonal employee by the city, state or federal government during periods of unemployment, you may be covered by this Plan while employed. If 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 twelve (12) 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 (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 when requested, (iii) 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) 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.

Reinstatement of Eligibility for Employees

If your eligibility has terminated, you may become eligible again by satisfying the Initial Eligibility requirements described on pages 3-4. A Retired Employee who returns to work must re-establish eligibility as an Active Employee by satisfying the Initial Eligibility requirements described on pages 3-4.

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 fourth month following the most recent period of three (3) consecutive months in which you work at least 290 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 your return to Covered Employment.

When you leave Covered Employment: If you leave Covered Employment to enter the Uniformed Services as defined in USERRA, your eligibility and your Dependent(s)' eligibility 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 of Coverage.

When you return to Covered Employment: 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 Covered Employment. Your eligibility (and that of your Eligible Dependents) will continue through the end of the Eligibility Period as it existed on the date that you left 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 qualify for Continuing Eligibility, you may then self-pay for continuation coverage under the procedures set forth below for COBRA Continuation of Coverage until you again qualify for Continuing Eligibility or until the maximum period of COBRA Continuation of Coverage is reached, whichever first occurs.

Notwithstanding the above, the Plan provides continuous eligibility through December 31, 2020 for a covered Employee who enters the Uniformed Services and provides the Fund Office 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: You must meet the following requirements of USERRA to be covered by this section:

- 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 DEPENDENTS

Upon becoming eligible for benefits, certain of your Dependents may also become eligible for benefits from this Plan. "Eligible Dependents" are:

- Your "Spouse" to whom you are legally married. 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. Your children will qualify as Eligible Dependents 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 such Dependent. However, you must file with the Fund Office an enrollment form within 180-days after the marriage, birth, adoption or placement for adoption. Eligibility for enrollment received following this 180-day period may be accepted by the Fund. However, eligibility will be effective from the first day of 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.

Effect of Change in Marital Status on Eligibility

If your marital status changes due to 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 are the financial responsibility of the Employee or 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 Dependents 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 Dependents in this Plan if you or your Dependents 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 Dependents. However, you must request an enrollment form within 30 days after the marriage, birth, adoption or placement for adoption.

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

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

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

Dependent Eligibility Following the Death of An Active Eligible Employee

Dependents who are eligible for benefits at the time of the death of the Active 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, Dependents may elect to purchase COBRA Continuation as described on page 19.

The Spouse of a deceased Eligible Employee may continue to purchase Plan coverage after the 36 months of COBRA Continuation of Coverage until the Spouse becomes eligible for Medicare or until the Spouse remarries, if earlier. The Trustees will determine the rate for Surviving Spouse Continuation of Coverage annually.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
SURVIVING SPOUSE CONTINUATION OF COVERAGE	$545 per month	$1,465 per month

Termination of Dependent Coverage

Benefits for Eligible Dependents end on the earliest of the following:

- The date the Employee's eligibility terminates (see page 4);
- For the Employee's Spouse and any step-children, the first day of the month following the date the Employee and the step-children's parent are divorced;
- The date a Dependent becomes an Active Eligible Employee under this Plan, except that Dependents under age 26 will maintain eligibility both as an Active Eligible Employee and a Dependent until the end of the month in which the Dependent reaches age 26 and will be subject to the coordination of benefits rules described on page 77;
- Upon the Dependent's entry into military service;
- Upon the Dependent's eligibility and enrollment in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan;
- Six (6) months after the date of death of an Eligible Employee. 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 can remove your Spouse and any dependent children who have reached age 18 from your coverage under the Fund by submitting a written request to the Fund Office and providing any additional information that may be required by the Fund. A removal request may be rescinded within 10 days from the date of disenrollment of the Dependent upon written notice to the Fund Office.

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.

If you remove your spouse or dependent children (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 children (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, 2019, in the absence of eligibility for Special Enrollment, you will not be able to reenroll your spouse for coverage until December 1, 2020. 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, 2019 to apply for re-enrollment. If you do not reenroll your spouse for coverage beginning December 1, 2020, then you will have to wait until December 1, 2021 (with 30 days' advance notice required). Such coverage will be prospective only; retroactive coverage will not be provided. 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.

Qualified Medical Child Support Orders

Qualified Medical Child Support Orders ("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 Dependents can obtain a copy of the QMCSO 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.

RETIREE CONTINUATION OF COVERAGE

The Fund provides optional continuation of coverage to eligible retirees, their spouses and their eligible dependents. Your eligibility and cost for retiree health coverage depends on several factors, including when you began working in Covered Employment, the length of your service and your age at retirement. For details, please review our Retiree Continuation of Coverage Eligibility overview. For a projected date when you may qualify for retiree continuation of coverage, please contact the Fund Office, Welfare Department.

Important Reminder - You must elect Retiree Continuation of Coverage at the time of your retirement. Failure to elect Retiree Continuation of Coverage at time of retirement will result in the permanent forfeiture of your opportunity to elect Retiree coverage. Retiree coverage cannot be elected after your retirement.

Retiree Continuation of Coverage Eligibility Overview

Eligibility for the different levels of Retiree Continuation of Coverage is determined by Age and Service. If you qualify for Retiree Continuation of Coverage, your level of benefits and your monthly cost may change over time as you and or your dependents become Medicare eligible or if the Trustees make any changes to the Fund's rules.

- **Early Continuation of Coverage for Retirees/Dependents:**
  If you retired between ages 55 and 59 and met the service requirements.
- **Non-Medicare Continuation of Coverage for Retirees/Dependents:**
  If you retired between ages 60 and 64 or at age 55 or older with Social Security Disability, met the service requirements, and you are **not** currently Medicare-eligible.
- **Medicare Wrap Around Continuation of Coverage for Retirees/Dependents:**
  If you retired between ages 60 and 64 or at age 55 or older with Social Security Disability, and you are currently Medicare-eligible.
- **Early Continuation of Coverage under Age 55 for Retirees and Dependents:**
  If you retired with Social Security Disability, did not meet the service requirements or retired under age 55.

Retiree Continuation of Coverage Eligibility Rules

An Employee is a Retired Employee on the effective date of his Pension. If you retire and you are receiving a pension from the Plumbers and Pipefitters National Pension Fund (the "PPNPF"), you may be eligible for Retiree Benefits from this Plan if you meet the following requirements. You must satisfy both the applicable age and service requirements. In addition, you must elect Retiree coverage at the time of your retirement. Failure to elect Retiree Continuation of Coverage at the time of your retirement will result in the permanent 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.

- **Age** – The level of Retiree Continuation of Coverage that may be available to you is determined by Age. See above Eligibility Overview for the different age groups.
- **Service -** The level of Retiree Continuation of Coverage that may be available to you is determined **based on how long you worked in** Covered Employment, i.e., the length of your service.
  1. You must have been eligible for benefits from this Plan for at least ten (10) years and for at least 84 out of the last 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. In addition to satisfying requirement 1 above, you must have at least 500 hours of work reported to the Welfare Fund for the last three (3) years prior to the year of retirement. If disabled, you must have had 500 hours reported during the 36-month period prior to the commencement of your disability.
  3. In addition to satisfying requirements 1 and 2 above, you must have 20-years of Pension Credit with the PPNPF, or one of the prior plans.

REMEMBER – You are not automatically eligible for Retiree Continuation of Coverage just because you are receiving a pension from the PPNPF, or have reached a certain age, or have earned a certain amount of Pension Credit with the PPNPF. As explained above, 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 Covered Employment 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 Eligible 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.

Retiree Continuation of Coverage Cost & Benefits Overview

Following is an overview of the benefits and cost for the optional continuation of coverage for eligible retirees, their spouses and their eligible dependents. Medicare eligibility has a direct impact on coordination of benefits and cost to you.

If you retire before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the PPNPF, you will be able to continue eligibility under Extension of Eligibility During Periods of Temporary Disability and you will not be required to elect COBRA or make self-payments if you qualify for this extension. See pages 5-6 for more information about Extension of Eligibility During Periods of Temporary Disability. 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 you receive a Social Security Disability Award, your eligibility for Retiree benefits and cost are determined in accordance with the Retiree Continuation of Coverage Eligibility Rules described above.

If you are eligible for benefits from the Welfare Fund based on the receipt of Workers' Compensation Benefits, your coverage will continue as described on pages 4-6 of the SPD, regardless of whether you have elected to commence a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the PPNPF. If you receive a Social Security Disability Award, you will qualify for Retiree Coverage. If you are denied a Social Security Disability Award, your eligibility for Retiree Coverage and payments will be determined in accordance with the Retiree Continuation of Coverage Eligibility Rules described 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 Medicare 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 Dependents will have retiree Medicare Wrap Around benefits under the Welfare Fund. Medicare Wrap Around benefits do not cover expenses which would be covered by Medicare Part B. See pages 66 - 68 for a description of this benefit.

Effect of Enrolling in Another Medicare Part D Prescription Drug Plan

If you decide not to enroll in the SilverScript Prescription Drug Plan, and instead enroll in a different Medicare Part D prescription drug plan, **you and your Spouse and Dependents will lose Welfare Fund coverage (Medicare Wrap-Around Plan or Empire BCBS for medical and hospital coverage, Prescription Drug Plan SiverScript or CVS Caremark, Vision and Life Insurance Benefits**).

Your Retiree Benefits

See the "Benefits For Retired Employees" section on pages 66 -71 for a description of retiree benefits. If you and your Spouse have retiree benefits, your Spouse will be offered the option to continue retiree benefits upon your death subject to payment of a monthly premium based on the cost of the program. Upon your death, if your Spouse is not Medicare-eligible, your Spouse will be offered COBRA and or Surviving Spouse Continuation of Coverage.

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 3 of the SPD.

Early Continuation of Coverage for Retirees/Dependents

If you retired between ages 55 and 59 and met the service requirements, benefits for you and your spouse and your eligible dependents may be continued until the last day of the month before your 65th birthday or until you become Medicare eligible. This continuation allows you to retire early and continue medical coverage until you become Medicare eligible. You are not eligible for the Medicare Wrap Around Program or any other coverage from the Welfare Fund at or after age 65 once Medicare eligible. Nor are you eligible for COBRA Continuation of Coverage upon reaching age 65 (unless you are within the 18-month COBRA period measured from the date of retirement).

Benefits are the same as Active Coverage, except that there is no Disability Continuation of Coverage, Unemployment Continuation of Coverage, Weekly Disability Benefit, Weekly Unemployment Benefit, or Accidental Death and Accidental Dismemberment Benefit and the Life insurance Benefit for an Eligible Retired Employee is $10,000. In addition, if your Spouse or Dependent is or becomes Medicare eligible, Medicare will be their primary coverage and the Fund will be secondary to Medicare.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Early Continuation of Coverage	$545 per month	$1,465 per month

Dependent Eligibility Following Death of Early Continuation of Coverage Retiree - Dependents who are eligible for benefits at the time of the death of the Eligible Retiree will continue to be covered by the Plan at no cost for three (3) months following the date of death of the Employee. Thereafter, Dependents may elect to purchase COBRA, as described on page 19 of this SPD.

Following COBRA, Spouses and Overage Dependents (Dependents older than age 26 and incapable of self-support) may elect to purchase Surviving Spouse Continuation of Coverage until the last day of the month before the retired member's 65th birthday or until the retired member would have become Medicare eligible.

The Spouse and Overage Dependent (as defined above) of a deceased Eligible Employee may purchase Plan coverage after the 36 months of COBRA Continuation of Coverage until the last day of the month before the retired member's 65th birthday or until the retired member would have become Medicare eligible, or until the Spouse remarries, if earlier. However, if your Spouse remarries within 18 months of your retirement, your Spouse and Overage Dependent (as defined above) will be offered the right to purchase COBRA Continuation of Coverage for the remainder of the 18 months. The Trustees will determine the rate for Surviving Spouse Continuation of Coverage annually.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Surviving Spouse / Overage Dependent Continuation of Coverage	$545 per month	$1,465 per month

Non-Medicare Continuation of Coverage for Retirees/Dependents

If you retired between ages 60 and 64 or at age 55 or older with Social Security Disability, met the service requirements, and are **not** currently Medicare-eligible, benefits for you, for your spouse and your eligible dependents may be continued until you become Medicare eligible. This continuation allows you to retire and continue medical coverage until you become Medicare eligible. Once you become Medicare eligible your coverage may continue under Medicare Wrap Around Continuation of Coverage for Retirees/Dependents as described below. See also the section below of this SPD entitled "Effect of Becoming Eligible for Medicare."

Benefits are the same as Active Coverage, except that there is no Disability Continuation of Coverage, Unemployment Continuation of Coverage, Weekly Disability Benefit, Weekly Unemployment Benefit, or Accidental Death and Accidental Dismemberment Benefit and the Life insurance Benefit for an Eligible Retired Employee is $10,000. In addition, if your Spouse or Dependent is or becomes Medicare eligible, Medicare will be their primary coverage and the Fund will be secondary to Medicare.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Non-Medicare Continuation of Coverage	$59 per month	$158 per month

Dependent Eligibility Following Death of Non-Medicare Continuation of Coverage Retiree - Dependents who are eligible for benefits at the time of the death of the Eligible Retiree will continue to be covered by the Plan at no cost for three (3) months following the date of death of the Retiree. Thereafter, Dependents may elect to purchase COBRA, as described on page 19 of this SPD.

Following COBRA, Surviving Spouses and Overage Dependents (as defined above) may elect to purchase Surviving Spouse Continuation of Coverage.

The Surviving Spouse and Overage Dependents (as defined above) may continue to purchase Plan coverage after the 36 months of COBRA Continuation of Coverage until the Spouse remarries. However, if your Spouse remarries within 18 months of your retirement, your Spouse will be offered COBRA Continuation of Coverage for the remainder of the 18 months. The Trustees will determine the rate for Surviving Spouse Continuation of Coverage annually.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Surviving Spouse / Overage Dependent - Not Medicare eligible	$59 per month	$158 per month
Surviving Spouse / Overage Dependent - Medicare eligible	$50 per month	$135 per month

Medicare Wrap Around Continuation of Coverage for Retirees/Dependents

If you retired between ages 60 and 64 or at age 55 or older with Social Security Disability, and you are currently Medicare-eligible, benefits may continue for you, your spouse and your eligible dependents. This continuation allows you to retire and continue medical coverage.

Benefits will be provided under the Medicare Wrap Around for you, your Medicare-eligible Dependents or Spouse. For non-Medicare eligible Dependents or Spouse, benefits will be the same as Active Coverage, except that there is no Disability Continuation of Coverage, Unemployment Continuation of Coverage, Weekly Disability Benefit, Weekly Unemployment Benefit, or Accidental Death and Accidental Dismemberment Benefit, and the Life insurance Benefit for an Eligible Retired Employee is $10,000. Medicare will be their primary coverage and the Fund will be secondary to Medicare. See "Effect of Becoming Eligible for Medicare" below.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Medicare Wrap Around Continuation of Coverage	$50 per month	$135 per month

Dependent Eligibility Following Death of Medicare Wrap Around Continuation of Coverage Retiree - Dependents who are eligible for benefits at the time of the death of the Eligible Retiree will continue to be covered by the Plan at no cost for three (3) months following the date of death of the Employee. Thereafter, Dependent(s) may elect to purchase COBRA, as described on page 19 of this SPD.

Following COBRA, your Surviving Spouse and Overage Dependent (as defined above) may elect to purchase Surviving Spouse Continuation of Coverage. Such coverage is available until the Spouse remarries. However, if your Spouse remarries within 18 months of your retirement, your Spouse will be offered COBRA Continuation of Coverage for the remainder of the 18 months. The Trustees will determine the rate for Surviving Spouse Continuation of Coverage annually.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Surviving Spouse / Overage Dependent - Not Medicare eligible	$59 per month	$158 per month
Surviving Spouse / Overage Dependent - Medicare eligible	$50 per month	$135 per month

Early Continuation of Coverage under Age 55 for Retirees and Dependents

If you retired with Social Security Disability, did not meet the service requirements or you retired under age 55, benefits may continue for you, your spouse and your eligible dependents by electing to purchase COBRA as described on page 19 of this SPD.

MONTHLY PREMIUMS – Effective January 1, 2020

Coverage Type	Individual	Family
Non-Medicare Continuation of Coverage	$839 per month	$2,254 per month

COBRA CONTINUATION OF 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 of Coverage and is available to both Employees and Dependents 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, the Accidental Death and Accidental Dismemberment Benefit, weekly disability benefits, and weekly unemployment benefits.

COBRA Rules for Employees

You may choose COBRA Continuation of Coverage for yourself, your Spouse and 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 of Coverage and must last at least until the end of the 18-month period of coverage for this extension to apply. You must submit the determination from the Social Security Administration to 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 of 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 of Coverage" on page 20.

If COBRA Continuation of 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 of 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 of Coverage.

COBRA Rules for Dependents

If you do not purchase COBRA Continuation of Coverage, your Spouse and Dependent child(ren) can separately purchase COBRA Continuation of Coverage for themselves by making the election and paying the required monthly premium payments. The COBRA Continuation of Coverage for Dependents can be continued for up to 18 months (29 months if there is a disabled person electing 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;
- a child's loss of status as a Dependent under the Plan (See page 11); or
- you become entitled to Medicare after the date of the qualifying event.

If your family experiences another Qualifying Event while receiving COBRA Continuation of Coverage, your Spouse and Dependent Child(ren) may receive additional months of COBRA Continuation of 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 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 of Coverage and Medicare

If you are age 65 or over **OR** are disabled and covered by Medicare before you elect COBRA Continuation of Coverage, and subsequently elect COBRA Continuation of Coverage from this Plan, Medicare will pay first and your COBRA Continuation of 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 of 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 of Coverage, Medicare pays first and your COBRA Continuation of Coverage under this Plan pays second. Note that this provision does not extend the maximum periods of COBRA Continuation of 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 of Coverage

An Employee, Retiree, Spouse or Dependent Child must notify the Plan in writing within 60 days of a divorce, or a child's loss of Dependent status under the Plan. Your Dependents should also notify the Plan in writing within 60 days of your 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 of Coverage" on page 20.

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 Dependents of your rights to purchase COBRA Continuation of Coverage and the cost of the coverage.

Election of COBRA Continuation of Coverage

You and each of your Dependents have an independent right to elect COBRA Continuation of Coverage. To elect COBRA Continuation of 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 of Coverage. See "Where to Send Notices and Information in Connection with COBRA Continuation of Coverage" on page 20.

Termination of COBRA Continuation of Coverage

COBRA Continuation of 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 of 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 of Coverage

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

Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street, 2nd Floor
Long Island, NY 11101
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.

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 you a preferred or negotiated rate. PPO agreements help control medical costs.

PPO networks provide choices regarding where to seek medical care. 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 may 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 by 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 are paid in full when the services are provided in a participating hospital.

If you obtain these services from a non-participating provider, the non-participating provider may bill you separately if the charges exceed what the Welfare Fund allows (e.g., they may balance bill you), so this may result in higher out-of-pocket costs to you.

Enrolling in Your Network

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

All Employees 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, the Plan may suspend payments on behalf of you and/or your Dependents 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 automatically without charge as a separate document. Please contact the Fund Office for information about the various networks.

Hospital and Physician Network

Empire Blue Cross/Blue Shield

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

Mental Health and Substance Use Disorder Network

Optum

The network includes behavioral health, mental health and substance use disorder practitioners, hospitals and other facilities that provide mental health and substance use disorder services. There is no ID Card. The Contact Number for Optum is located on the back of the Empire Blue Cross Blue Shield Identification Card. Present the back of the Empire Blue Cross Blue Shield ID Card whenever you receive Mental Health and Substance Use Disorder services.

Other Preferred Provider Networks

CVS/Caremark	Prescription Benefits
SilverScript	Medicare Prescription Drug Plan
Optum	Employee Assistance Program (EAP)
Cigna Dental Services (Cigna Advantage)	Dental Benefits
CignaPlus	Dental Discount Program for Medicare-Eligible Participants
Vision Screening, Inc.	Vision Benefits
CPS Optical	Vision Benefits
CPS Hearing	Hearing Benefits
Vascular Diagnostic Assoc., P.C.	Cardio Vascular Screening Benefits

The names, addresses and phone numbers of the Preferred Provider Networks with which the Plan has arrangements are listed on pages 125-126.

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. You can view and print up-to-date information about your Medical Benefits and Hospital Benefits by visiting www.empireblue.com or requesting that information be mailed to you. You can view and print up-to-date information about your Mental Health and Substance Use Disorder Benefits by visiting www.liveandworkwell.com or by calling 1-844-884-1852.

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 PPO to provide care to you. In-Network care provides the following advantages:

- You can choose any participating provider from Empire's PPO in New York State or the national network of your PPO. You can also choose any participating provider from Optum's national network of providers for Mental Health and Substance Use Disorder providers.
- You do not need a referral to see a specialist, so you direct your care.
- Benefits are paid at 100% 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 the PPO network. For most covered services, you can choose an In-Network or Out-of-Network provider. 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 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 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 80% the Allowed Amount for of the first $10,000 of eligible expenses (or $2,000 in out-of-pocket expenses) per covered individual or 80% of the Allowed Amount for the first $20,000 (or $5,000 in out-of-pocket expenses) 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. The Allowed Amount is based on 250% of the Medicare allowance.

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

BlueCard PPO Program - Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers throughout the United States. 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 (844) 243-5566 or visit www.empireblue.com to locate participating providers in or outside of Empire's operating area.

Empire offers Medical Benefits and hospital networks on a national level.

Optum also offers Mental Health and Substance Use Disorder providers on a national level. You can call Optum or visit its website for more information or to locate a participating provider.

Here's an example of how costs compare for In-Network and Out-of-Network care.

	IN-NETWORK	OUT-OF-NETWORK
Provider's Charge	$4,500	$4,500
Allowed Amount	$4,000	$4,000
Plan Pays Provider	$3,975	$1,600 ($2,000 x 80% = $1,600)
You Pay Provider	$25 co-payment	$2,900 ($2,000 Deductible plus $400 Coinsurance (2,000 x 20% = $400) plus $500 amount above Plan's Allowed Amount= $2,900)

The following chart shows you specific plan information.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$0	Individual $2,000 / Family $5,000
Co-payment (For office visits and certain covered services)	Primary Care Physician: $25 copay per visit Specialist: $35 copay per visit	Deductible and Coinsurance
Co-payment (For hospital inpatient admissions)	$0	Deductible and Coinsurance
Co-payment (For emergency room)	$150 per visit; waived if admitted to hospital within 24 hours	$150 per visit; waived if admitted to hospital within 24 hours
Coinsurance	$0	You pay 20% of Allowed Amount. Plan pays 80% of Allowed Amount.
Annual Out-of-Pocket maximum	See below	N/A
Annual out-of-pocket Coinsurance	N/A	Individual $2,000* / Family $5,000*
Lifetime Maximum	Unlimited	Unlimited

*Employee is responsible for 20% of the Allowed Amount for the first $10,000 of eligible expenses per Employee or dependent (20% of $10,000 = $2,000)

** Employee is responsible for 20% of the Allowed Amount for the first $25,000 of eligible expenses per family per calendar year (20% of $25,000 = $5,000)

Out-of-Pocket Maximum

The Welfare Fund has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing for covered essential benefits received from In-Network providers related to Hospital, Medical, and Prescription Drug copayments, deductibles, and coinsurance. The Out-of-Pocket Limit is the most you pay from January 1 through December 31 of each year before the Welfare Fund starts to pay 100% for covered essential health benefits received from In-Network providers. There is no Out-of-Pocket Limit applicable to Out-of-Network providers, except that covered emergency services performed in an Out-of-Network Emergency Room will apply to meet the In-Network Out-of-Pocket Limit.

Expenses for In-Network mental health and substance use disorder benefits count toward the In-Network Out-of-Pocket Limit (and Out-of-Network mental health and substance use disorder expenses count toward the out-of-network coinsurance limit) in the same manner as those for In-Network (or Out-of-Network) medical expenses.

The Welfare Fund's **In-Network** Out-of-Pocket Limits for 2020 (January 1, 2020 through December 31, 2020) are as follows:

Benefit Type	Individual	Family
Hospital/Medical and Mental Health/Substance Use Disorder	$5,100	$10,200
Prescription Drug	$1,500	$3,000

If you have Family Coverage under the Welfare Fund, once any covered member of your family meets the Individual Out-of-Pocket Limit, the Welfare Fund will pay 100% of covered essential health benefits received

from In-Network providers **for that covered family member**. All out-of-pocket costs for that covered family member will also apply towards the Family Out-of-Pocket Limit.

The Out-of-Pocket Limit may be adjusted annually, in accordance with limits set by the Department of Health and Human Services.

SUMMARY OF BENEFITS

The following table summarizes your benefits and shows differences between In-Network and Out-of-Network benefits. 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 SPD as well as the Exclusions and Limitations on pages 108-112. The Plan covers benefits that are Medically Necessary. (See Definition on pages 113-118; see pages 35-50 for a more detailed description of Medical Benefits.)

MEDICAL BENEFITS (Physician Services)		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Physician Visits (Home/Office) Primary Care Physician (PCP) Specialist	$25 Co-payment $35 Co-payment	Deductible and Coinsurance
Chiropractic Care	$35 Co-payment	Not Covered
Acupuncture Up to 15 treatments per calendar year [7]	$35 Co-payment	Not Covered
Allergy Testing	$35 Co-payment	Deductible and Coinsurance
Allergy Treatment	$0	Deductible and Coinsurance
Diagnostic Procedures X-Ray and All lab tests	$0	Deductible and Coinsurance
Diagnostic Procedures[4] MRIs/MRAs and other imaging	$0 See Description for Pre-certification Requirements	Deductible and Coinsurance See Description for Pre-certification Requirements
Second Surgical Opinion[6]	$35 Co-payment	Deductible and Coinsurance
Pre-Surgical Testing	$0	Deductible and Coinsurance
Surgery (Inpatient and Outpatient)[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Surgical Assistant	$0	Deductible and Coinsurance
Chemotherapy	$0	Deductible and Coinsurance

MEDICAL BENEFITS (Preventive Care)		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Preventive Care for Adults Annual Physical Exam Diagnostic Screening Tests as required under Preventive Benefits including: ▯ Cholesterol, Diabetes, Colorectal cancer ▯ Fecal occult blood test, Sigmoidoscopy ▯ Routine Prostate Specific Antigen (PSA) in asymptomatic males ▯ Diagnostic PSA See the Preventive Care section beginning on page 26 for a description of all benefits provided under this provision.	$0	Deductible and Coinsurance
Well Woman Care as required under Preventive Benefits including: ▯ Office visits, Pap smears ▯ Bone Density testing and treatment ▯ Mammogram, Ages 35-39 – 1 baseline Ages 40+ - 1 per year See the Preventive Care section beginning on page xx for a description of all benefits provided under this provision.	$0	Deductible and Coinsurance
Well Child Care Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." See the Preventive Care section beginning on page 26 for a description of age-appropriate visits, screenings and assessments. Immunizations (office visits are not required). See the Preventive Services section for a listing of covered immunizations.	$0	Deductible and Coinsurance
Adult Immunizations	$0	Deductible and Coinsurance

MEDICAL BENEFITS (Emergency Care)		
BENEFIT	EMPIRE BC/BS[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Emergency Room Facility Initial visit for Emergency Care	$150 Co-payment Waived if admitted within 24 Hours	$150 Co-payment Waived if admitted within 24 hours
Emergency Room Physician Visit	$0	The Plan will cover services received from a non-participating provider as if the services were performed by a participating provider If you obtain these services from a non-participating provider, the non-participating provider may bill you separately if the charges exceed what the Welfare Fund allows (e.g., they may balance bill you), so this may result in higher out-of-pocket costs.
Ambulance Local professional ground transportation to the nearest hospital	$0 Ground Transportation only	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	$150 Co-payment Waived if admitted within 24 Hours	$150 Co-payment Waived if admitted within 24 hours

MEDICAL BENEFITS (Maternity Care)		
BENEFIT	EMPIRE BC/BS[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Maternity - Physician Charges	$25 Co-payment First visit only	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)	$0	Deductible and Coinsurance
Lab Tests, Sonograms and Other Medically Necessary Diagnostic Procedures	$0	Deductible and Coinsurance
Routine Newborn Nursery Care (In hospital)	$0	Deductible and Coinsurance
Obstetrical Care[4] (In hospital)	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Obstetrical Care[4] (In birthing center)	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required

HOSPITAL BENEFITS		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Inpatient Medical Surgical[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Unlimited semi-private room & board[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Anesthesia	$0	Deductible and Coinsurance
Cardiac Rehabilitation	$25 Co-payment	Deductible and Coinsurance
Outpatient Surgery, Chemotherapy, Radiation Therapy, Mammography & Cervical Cancer Screening (In Hospital)	$0	Deductible and Coinsurance
Outpatient Kidney Dialysis	$0	Deductible and Coinsurance
Organ Transplant Benefits[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required

DURABLE MEDICAL EQUIPMENT AND SUPPLIES		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Durable Medical Equipment[4]	$0 Network Supplier Must Pre-certify	Deductible and Coinsurance Pre-certification Required
Medical Supplies	$0	Deductible and Coinsurance
Orthotics	$0 Network Supplier Must Pre-certify	Deductible and Coinsurance Pre-certification Required
Prosthetic Appliances[4]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Mastectomy Wear	$0	Deductible and Coinsurance
Hearing Aid Up to $500 maximum (once every 36 months)	Not Covered	See Pg. 49 for covered services

SKILLED NURSING AND HOSPICE CARE		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Skilled Nursing Facility[4] Up to 60 days/calendar year in lieu of hospitalization	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Hospice	$0 Limited to 210 days	Deductible and Coinsurance Limited to 210 days

HOME HEALTH CARE		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Home Health Care 200 Visits (Note these limits do not apply if provided for Mental Health and Substance Use Disorder treatment)	$0	Coinsurance
Home Infusion Therapy	$0 Network Supplier	Not Covered Out-of-Network

PHYSICAL AND OTHER THERAPIES		
BENEFIT	EMPIRE BC/BS[1]	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Inpatient Hospital Physical Therapy/Medicine or Rehab[4] Up to 30 days per calendar year	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Outpatient Physical Therapy[4] Up to 30 visits per calendar year	$35 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	$35 Co-payment Pre-certification Required	Deductible and Coinsurance Pre-certification Required

Mental Health Care and Substance Use Disorder		
BENEFIT	**Optum**	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Inpatient Mental Health, Hospital, Rehabilitation and Residential[5]	$0 Pre-certification Required	Deductible and Coinsurance Pre-Certification Required
Outpatient Mental Health Office Visits	$25 Co-payment	Deductible and Coinsurance
Other Outpatient (e.g., Intensive Outpatient Program (IPO) and Partial Hospitalization Program (PHP))[5]	$0 Pre-certification Required	Deductible and Coinsurance Pre-Certification Required

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Substance-Related and Addictive Disorder		
BENEFIT	**Optum**	OUT-OF-NETWORK[2,3]
	YOU PAY	YOU PAY
Inpatient Substance Use Treatment – Hospital[5]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Inpatient Detoxification, Rehabilitation and Residential[5]	$0 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Outpatient Substance Abuse Treatment Office Visits	$25 Co-payment	Deductible and Coinsurance
Other outpatient Substance Use Treatment (e.g., Intensive Outpatient Program (IPO) and Partial Hospitalization Program (PHP))[5]	$0 Pre-certification Required	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 PPO's network. (This does not apply to emergency benefits.) See (5) for Mental Health Care and Substance Use Disorder 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. The visit limits do not apply if provided for Mental Health and Substance Use Disorder treatment. In addition, a $25 copayment will apply for outpatient physical therapy and Other Short-Term Outpatient Rehabilitative Therapies.
(5) In-Network Providers and Facilities are responsible for obtaining pre-certification on your behalf. The In-Network Provider or Facility, and not you, will be responsible for any surcharge for failure to pre-certify. Remember that it is your responsibility to obtain pre-certification for Out-of-Network Providers or Facilities. Precertification for Out-of-Network services by Optum Medical Management Program is required for the following services: Partial Hospitalization (PHP), Intensive Outpatient Program (IOP), Outpatient ECT, Psychological Testing, Medication Assisted Treatment Programs for Substance Use Disorders, Transcranial Magnetic Stimulation, and Applied Behavior Analysis.
(6) Co-payment waived for Second Surgical Opinion, if arranged through Medical Management Program.
(7) These visit limits do not apply if services are provided for Mental Health and Substance Use Disorder treatment and a $25 copayment will apply.

ADDITIONAL MEDICAL BENEFITS	
BENEFIT	DESCRIPTION
Prescription Drug Benefit Retail: Up to 30-day supply through CVS/Caremark network pharmacies	$10 co-pay for generic $50 co-pay for preferred brand $60 co-pay for non-preferred brand
Prescription Drug Benefit Maintenance: Filled at Retail CVS/Caremark network pharmacies	See page 58
Prescription Drug Benefit Maintenance: Filled at Other network pharmacies	See page 59
Prescription Drug Benefit Specialty Medication	See page 59-60

ADDITIONAL MEDICAL BENEFITS	
BENEFIT	DESCRIPTION
Dental Benefits (Offered through DPPO: Cigna Advantage)	In-Network: Paid in full up to $3,000/year Out-of-Network: Paid in accordance with the Plan schedule limited to $3,000/year *Note 1:* There is a $3,000 lifetime orthodontic maximum in or Out-of-Network
Vision Care Benefits (Offered through PPO: Vision Screening & CPS Optical)	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 Assoc. PC.)	Up to 1 screening per year.
Employee Assistance Program (EAP) (Offered through Optum)	Employee Assistance Program (EAP) is designed to provide confidential support for those everyday challenges or more serious problems, and it's available around the clock — anytime you need it.
Hearing Benefits (Offered through CPS Hearing)	CPS Audiologists (in-network hearing care providers) will offer eligible participants a 20% discount off the retail cost of a Hearing Aid as well as unlimited servicing during the first year. You will be responsible for the discounted amount minus the amount covered under the Plan of up to a maximum of $500, payable once in a 36-month period.
Life Insurance	$50,000 - Active Eligible Employee $10,000 - Retired Employee $ 3,000 - Local 1 Represented Employee
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.
Weekly Disability Benefits	$300/week based on State Disability Payments. Maximum 26 weeks.
Weekly Unemployment Benefits	Up to $300/week based on State Unemployment Payments. Maximum 26 weeks.

YOUR MEDICAL BENEFITS

Your medical coverage includes Medical and Hospital Benefits, Mental Health and Substance Use Disorders, and Other Benefits. 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.

When you need to visit your Physician or a Specialist In-Network, you are responsible only for a co-payment. 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 only a co-payment. In-Network visits for ongoing treatment are covered in full.

When you visit an Out-of-Network Physician or other healthcare Provider 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 PPO's 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 cancer diagnosis. Second opinions for surgery are paid in full when arranged by your PPO's 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 $2,000 per person but not more than $5,000 per family.

However, for In-Network benefits, if an eligible person receives services from a participating provider, the annual deductible does not apply and the eligible person pays only a co-payment. There is no deductible for In-Network benefits.

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 provider services including surgeons, 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 as well as inpatient and outpatient facility charges.

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

Empire BC/BS Call 1 (844) 243-5566 or visit www.empireblue.com

See the section entitled "Mental Health and Substance Use Disorder Benefits" for details on these benefits.

Vision Care Benefits, Dental Benefits, Cardiovascular Screening Benefits, Prescription Drug Benefits, Employee Assistance Program, Life Insurance Weekly Unemployment Benefits and Weekly Disability Benefits are not subject to the annual Deductible.

Pre-certification Requirements

Pre-certification is required for hospital and rehabilitation admissions and for certain tests, procedures and for certain Mental Health and Substance Use Disorder treatment. 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 in the following instances:

MEDICAL AND HOSPITAL BENEFITS		
CALL EMPIRE MEDICAL MANAGEMENT TO PRE-CERTIFY:	HOW COVERED	WHO CALLS TO PRE-CERTIFY
ALL HOSPITAL ADMISSIONS (other than Mental Health and Substance Use Disorder) • 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 • As soon as reasonably possible and within the first three months of pregnancy when possible (but not required) • Within 48 hours after the actual delivery date if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: 48 hours for a vaginal birth; or 96 hours for cesarean birth.	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 (inpatient and outpatient care)	In-Network and Out-of-Network	YOU
BEFORE YOU • Rent, purchase or replace prosthetics, orthotics or durable medical equipment	In-Network Only	NETWORK SUPPLIER/YOU

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
CALL OPTUM MEDICAL MANAGEMENT TO PRE-CERTIFY MENTAL HEALTH AND SUBSTANCE USE DISORDER	HOW COVERED	WHO CALLS TO PRE-CERTIFY
ALL HOSPITAL ADMISSIONS FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER ▯ At least two (2) weeks prior to any planned hospital admission ▯ Within 48 hours of an emergency hospital admission or as soon as reasonably possible	In-Network	In-Network Provider or Facility
	Out-of-Network	YOU
BEFORE YOU RECEIVE ▯ Inpatient Detoxification, Rehabilitation or Residential Treatment ▯ Intensive Outpatient Program (IOP) ▯ Partial Hospitalization Program (PHP) ▯ Outpatient Electro-Convulsive Treatment ▯ Psychological Testing ▯ Medication Assisted Treatment Programs for Substance Use Disorders ▯ Transcranial Magnetic Stimulation ▯ Applied Behavior Analysis	In-Network	In-Network Provider or Facility
	Out-of-Network	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 upon retrospective review, no benefits will be paid. To get the most out of your coverage, call the following Medical Management Program:

EMPIRE BC/BS Call 1 (844) 243-5566

Optum* (for Mental Health and Substance Use Disorder) Call 1 (844) 884-1852

*Please note that In-Network Providers and Facilities are responsible for obtaining pre-certification on your behalf. The In-Network Provider or Facility, and not you, will be responsible for any surcharge for failure to pre-certify. It is your responsibility to obtain pre-certification for Out-of-Network Providers or Facilities.

DESCRIPTION OF BENEFITS

Medical Benefits (Physician Services)

Physician Visits

You are eligible for the following services provided by a Physician or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of their license and/or scope of practice:

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

Telemedicine Program –www.livehealthonline.com

In addition to providing Covered Services via telehealth, LiveHealth Online covers online internet consultations between you and Providers who participate in this telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in this telemedicine program. You can check the LiveHealth Online provider directory or contact LiveHealth Online for a listing of the Providers that participate in this telemedicine program. There is a $5.00 copayment for a LiveHealth Online service visit.

Online visits. Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Member Access. To begin the online visit, log on to **www.livehealthonline.com** and establish an online account by providing basic information about you and your coverage. Before you connect to a Doctor, you will be asked to identify: the kind of condition you want to discuss with the Doctor, your local pharmacy, credit card information for billing your cost share for the visit. You will also be asked to agree to the terms of use, and select an available Physician.

The visit with the Physician will not start until you provide the above information and click “connect.” The visit will be documented in an electronic health record.

Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor;
- To request Preauthorization for a benefit under your Plan; or
- To ask the Physician to consult with another Physician.

LiveHealth Online does not include online visits for Mental Health and Substance Use Disorder. See the Mental Health and Substance Use Disorder section for details on online/virtual visits that are available for mental health and substance use disorder.

Chiropractic Care

In-network Chiropractic Care is paid in full subject to a $35 co-payment. 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 $35 co-payment. Out-of-Network services are not covered under the Plan. Please note that the visits limit does not apply for treatment for mental health or substance use disorder and a $25 copayment would apply In-Network.

Allergy Testing and Treatment

For In-Network allergy testing, there is only a $35 co-payment. In-Network visits for ongoing allergy treatment are covered in full. 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.

Using an In-Network Physician does not guarantee 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 $35 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

Except as noted below under Preventive Benefits for Women and Preventive Benefits for Children (relating to children through age 21 and well woman visits), the Plan will cover the expense related to an annual physical exam by an In-Network physician in full with no 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.

Designation of a Primary Care Physician

The Plan does not require but it does allow you to designate a primary care provider. You have the right to designate any primary care provider who participates in the Empire network and who is available to accept you or your family members. You may designate a pediatrician as the primary care provider for your child. You do not need prior authorization from the Welfare Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from an In-Network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office or Empire Blue Cross at 1 (844) 243-5566.

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:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce symmetrical appearance, and
- Prostheses and
- Treatment of 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 plan maximums.

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.

Preventive Services

The Welfare Fund providers coverage for certain preventive services as required by the Patient Protection and Affordable Care Act (ACA) with no cost sharing when those services are provided by an In-Network provider for the following services:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved. (For a complete list of "A" and "B" Recommendations of the Task Force, visit: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
- Routine Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. 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.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA) and include outpatient newborn and well child visits and routine childhood immunizations that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for children in the US, such as DPT, Polio, MMR, HIB, hepatitis, chickenpox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc.
- With respect to women, certain additional preventive care for all covered females for evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force) (For a list of covered services, visit: https://www.healthcare.gov/preventive-care-women/ or http://www.hrsa.gov/womensguidelines.) These benefits include but are not limited to well woman office visits, screening for gestational diabetes, genetic counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, rental of breastfeeding equipment and necessary supplies needed to operate equipment after delivery, lactation support following delivery.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (in other words, you will not have to pay a copayment for these services). You may, however, be required to pay a copayment if the primary purpose of an office visit to a provider is not to receive the preventive service, or for a visit that is billed separately from the preventive service. You will be required to pay the applicable Out-of-Network cost-sharing (deductible and coinsurance) and amounts over the Allowed Amount for any preventive services which are covered by the Plan and provided by an Out-of-Network provider.

To find out if a particular preventive service will be paid at 100% when provided by an In-Network provider, contact the Fund Office or Empire Blue Cross at 1 (844) 243-5566. You should note that the list of preventive services required to be covered without cost sharing will change periodically as the standards change. To the extent required by law, any additional recommendations provided in the future will be covered as of the first plan year beginning on or after the first anniversary of when the recommendations are updated.

If an ACA preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If a frequency for which the preventive service should be performed is not specified, such as is the case for a preventive office visit or cholesterol screening, the Plan will pay for the preventive service when performed no more frequently than once each 12 months. Note that for females, in accordance with the ACA, the Plan will pay both a preventive office visit and a well woman office visit in a calendar year. Where the information in this document conflicts with newly released ACA regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.

Preventive Care for Adults

- Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
- Unhealthy alcohol use/ Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce unhealthy alcohol use, alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings.
- Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with Plan rules.
- Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- Cholesterol screening (Lipid Disorders Screening) for men ages 35 and older and women ages 45 and older; men ages 20 to 35 if they are at increased risk for coronary heart disease; and women ages 20 to 45 if they are at increased risk for coronary heart disease.
- Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: bowel preparation medications, anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
- Depression screening for adults.
- Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Tobacco Use screening for all adults and cessation interventions for tobacco users.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
- Screening for hepatitis B virus infection in adults at high risk for infection.
- Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.
- Screening for latent tuberculosis infection in populations at increased risk.

Preventive Care for Women

For In-Network providers, well woman office visits are covered at 100% for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services as listed below. For Out-of-Network providers, annual gynecological examinations are covered once per calendar year subject to the annual Out-of-Network deductible and coinsurance, plus any amount above the Plan's Allowed Amount. Coverage for Out-of-Network providers 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.

Services for pregnant women or women who may become pregnant

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with Plan rules.
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women age 40 and older.
- Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan Administrator.
- Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.
- Human papillomavirus testing for women age 30 and older with normal Pap smear results, once every three years as part of a well woman visit.
- Chlamydia Infection screening for all sexually active non-pregnant young women age 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women age 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
- Folic Acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.

- Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
- Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women age 65 and older will be eligible for routine screening for osteoporosis. Postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool, will be eligible for screening. The Plan will pay for the most cost-effective test methodology only.
- Rh Incompatibility screening for all pregnant women during their first visit for pregnancy-related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for gestational diabetes in asymptomatic pregnant women between 24- and 28-weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
- Depression screening for pregnant and postpartum women.
- Counseling interventions for pregnant and postpartum women at increased risk of perinatal depression.

Preventive Care for Children

Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:

- Developmental screening for children under age 3, and surveillance throughout childhood
- Behavioral assessments for children of all ages
- Medical history
- Blood pressure screening
- Depression screening for adolescents ages 11 and older
- Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors
- Hearing screening
- Height, Weight and Body Mass Index measurements for children
- Autism screening for children at 18 and 24 months
- Alcohol and Drug Use assessments for adolescents
- Critical congenital heart defect screening in newborns
- Hematocrit or Hemoglobin screening for children
- Lead screening for children at risk of exposure
- Tuberculin testing for children at higher risk of tuberculosis
- Dyslipidemia screening for children at higher risk of lipid disorders
- Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents
- Cervical Dysplasia screening at age 21
- Oral Health risk assessment
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
- Obesity screening for children age 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.

- HIV screening for adolescents age 15 and older and for younger adolescents at increased risk of infection.
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- Screening for hepatitis B virus infection in adolescents at high risk for infection.
- Application of fluoride varnish to the primary teeth of all infants and children to age 5 starting at the age of primary tooth eruption, in primary care practices.
- Syphilis screening for adolescents who are at increased risk for infection.
- For adolescents, screening and counseling for interpersonal and domestic violence.

Well Child Care

Eligible newborn Dependents are entitled to benefits for well-baby care until the Eligible Dependent reaches two (2) years of age (See table on page 26). After age 2, see Annual Physical section. 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.

Routine Immunizations

Routine adult immunizations are covered if you meet the age and gender requirements as well as the following CDC medical criteria for recommendation:

- Immunization vaccines for adults — doses, recommended ages, and recommended populations must be satisfied:

Diphtheria/Pertussis/ Tetanus	Hepatitis A	Hepatitis B	Herpes Zoster
Human Papillomavirus (HPV)	Influenza (flu shot)	Measles/Mumps/Rubella	Meningococcal
Pneumococcal	Varicella (Chickenpox)		

- Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:

Diphtheria/Tetanus/ Pertussis (Whooping Cough)	Rotavirus	Varicella (Chickenpox)
Hemophilus Influenza type B	Hepatitis A	Hepatitis B
Human Papillomavirus (HPV)	Inactivated Poliovirus	Influenza (flu shot)
Measles/Mumps/rubella (MMR)	Meningococcal	Pneumococcal

Medical Benefits (Emergency Care)

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

The Plan will cover certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition (see below for definition) after a $150 copayment.

You do not have to obtain prior authorization before seeking emergency services in a hospital emergency room. The $150 copayment applies whether you obtain those services In-Network or Out-of-Network. However, if you obtain those services from an Out-of-Network hospital, the Out-of-Network hospital may bill you separately if the charges exceed what the Plan allows (e.g., they may balance bill you), so this may result in higher out-of-pocket cost to you. The amount the Plan allows and will pay for Out-of-Network emergency services is equal to the greatest of (1) the amount negotiated with In-Network providers; (2) the amount using the same method the Plan uses to pay for other Out-of-Network services; or (3) the amount paid under Medicare. Out-of-Network emergency services are also subject to the Welfare Fund's general deductible for Out-of-Network care and count towards the Welfare Fund's out-of-pocket maximum for Out-of-Network care.

For the purposes of the above rule, the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The term "emergency services" means a medical screening examination and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility).

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 plan to travel abroad, consider obtaining additional insurance.

Medical Benefits (MaternityCare)

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.

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

Whether services are provided In-Network or Out-of-Network, call your PPO's Medical Management Program within the first three (3) months of a pregnancy to 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 ensure 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 PPO's 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 PPO's Medical Management Program. When using a supplier outside your PPO's operating area, you are responsible for pre-certifying services. A PPO's network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact your PPO's 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 PPO's 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

Comprehensive Professional Systems, Inc. ("CPS") provides In-Network hearing benefits, including services and supplies. CPS Audiologists (in-network hearing care providers) offers eligible participants a 20% discount off the retail cost of a Hearing Aid as well as unlimited servicing during the first year. You will be responsible for the discounted amount minus the amount covered under the Plan, up to a maximum of $500, payable once in a 36-month period. Out-of-Network claims will be processed by CPS. There will be no discounts for Out-of-Network hearing care providers. A list of In-Network providers can be obtained by calling (212) 675-5745 or by visiting www.cpshearing.com.

Skilled Nursing and Hospice Care

In order to receive maximum benefits, please call to pre-certify skilled nursing with your PPO's 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.

Please note that the visit limit does not apply for treatment for mental health or substance use.

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 twelve (12) 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.

Please note that the visit limit does not apply for treatment for mental health or substance use.

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.

Please note that the visits limit does not apply for treatment for mental health or substance use disorder.

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:

Aerosolized Pentamidine	Hydration Therapy
Antibiotic Therapy	Pain Management
Chemotherapy	Total Parental Nutrition (TPN)

Physical and Other Therapies

The Plan provides benefits for physical, occupational, speech and vision therapy. In-Network outpatient physical, occupational, speech and vision therapy services charges are paid in full after a $35 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. Please note that the day limit does not apply for treatment for mental health or substance use disorder.

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 $35 co-payment. In the case of Out-of-Network charges, you are responsible for the annual deductible and coinsurance, plus any amount above the Out-of-Network Plan's Allowed Amount. Please note that the visit limit does not apply for treatment for mental health or substance use disorder and a $25 co-payment applies In-Network.

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 $35 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. Please note that the visit limit does not apply for treatment for mental health or substance use disorder and a $25 co-payment applies In-Network.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a Physician, licensed mental health and/or substance use disorder provider or certified Hospital or Alternate Facility. Precertification is required for Out-of-Network services for: All Inpatient Admissions/Stays including Inpatient Detoxification, Rehabilitation or Residential Treatment, Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP), Outpatient ECT, Outpatient Psychological Testing,

Medication Assisted Treatment Programs for Substance Use Disorders, Outpatient Transcranial Magnetic Stimulation and Outpatient Applied Behavior Analysis. In-Network Providers and Facilities are responsible for obtaining pre-certification for the above-mentioned services on your behalf. The In-Network Provider or Facility, and not you, will be responsible for any surcharge for failure to pre-certify but remember that it is your responsibility to obtain pre-certification for Out-of-Network Providers, Hospitals and Alternative Facilities. See the section entitled "Pre-Certification Requirements" for details on how to obtain pre-certification and any applicable surcharge for failure to obtain pre-certification.

Benefits include the following levels of care:

- Inpatient treatment: Includes room and board in a Semi-private Room (a room with two or more beds)
- Residential Treatment: Includes room and board in a Semi-private Room (a room with two or more beds)
- Partial Hospitalization/Day Treatment: A structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.
- Intensive Outpatient Treatment: A structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- Outpatient treatment: Includes Office Visits and other provider services.
- Telemental Health – Virtual Visits (Liveandworkwell.com): Talk to a licensed therapist or psychiatrist via confidential online video appointments. Clinicians can treat common conditions such as depression and anxiety; psychiatrists can write prescriptions when necessary. Find virtual visits providers in your state using the provider search tool under "Find a Resource" on liveandworkwell.com or you can call 1-844-884-1852.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Urine drug testing services for patients in an active substance use disorder (SUD) treatment program are considered part of the treatment program to support diagnosis and to periodically assess adherence with the recovery plan. All treatment services are covered within the per diem rate paid to the program.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board-Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
    - Assessment and diagnosis completed by a medical physician, psychiatrist or someone with an MD licensure or other licensed provider acting within the scope of his or her license to provide covered services.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this SPD.

Optum provides administrative services for all levels of care. The Optum website, Liveandworkwell.com, is your mental health and substance use disorder benefits hub. Explore informative articles and videos on a wide range of mental health and substance use topics, along with assessment tools and self-help programs, available 24/7. You will also find an easy-to-use claims center, information about your coverage, and a provider search tool that helps you find In-Network care to meet your needs and preferences—by location, specialty, gender and more. Use access code plumbers to enter the site.

You and your family can go online any time to:

- Check benefit information
- Submit online service requests
- Search the online clinician directory
- Use our virtual help centers to find information and resources for hundreds of everyday work and life issues
- Participate in interactive, customizable self-improvement programs

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP can help when you need assistance with a personal or work-related problem. In most cases, issues can be resolved effectively within the EAP. Some people will require more specialized or longer-term treatment. In these situations, the EAP clinician will assist you in connecting with an appropriate mental health and substance use disorder provider. EAP clinicians are independently licensed mental health/substance use-disorder treatment professionals who are contracted with Optum. The services of the EAP include up to three face-to-face or virtual visits counseling sessions per issue with an EAP clinician. A comprehensive evaluation and treatment plan are provided at no cost to you or your eligible family members. The EAP is not intended for long-term treatment of an ongoing problem. Any sessions beyond the three EAP sessions will not be covered under the EAP benefit. However, if ongoing care is needed beyond the three (3) EAP visits, Optum will work with you to transition into benefits provided under the Mental Health and Substance Use Disorder portion of the Plan.

EAP services are entirely voluntary; you do not have to contact the EAP to access Mental Health or Substance Abuse Disorder benefits. EAP clinicians are not employees or contractors of the Fund. No one will be told of your participation in the EAP without your permission, except as required by law in a situation deemed potentially life threatening by a clinician, or to review an appeal initiated by you. If you have completed EAP sessions for one specific issue, you may use the EAP again for the same issue after a minimum wait of 90 days, regardless of the Plan Year as long as you have not been receiving ongoing treatment for this issue through the mental health portion of your benefit.

The EAP can help you with a variety of issues including:

- Parenting concerns
- Marriage and family issues
- Alcohol and drug problems
- Stress related to financial and legal situations
- Emotional stress
- Improving communication at work or home
- Life crises
- Other personal issues

If you require further assistance beyond the EAP assessment, you may continue with your current EAP provider or you may be referred to a provider in the Optum provider network (you may also choose an Out-of-Network provider). The EAP clinician is allowed to provide treatment under the Optum program, but it is your responsibility to obtain precertification for any services that require precertification if the issue would involve support beyond the EAP assessment. It is your decision whether to use a provider referred to you through the EAP.

VISION CARE BENEFITS

The Plan pays up to $100 for an eye examination and/or prescription eyeglass for each Eligible Participant, Spouse and Eligible Dependent Children (age 18 through the end of the month in which the Child turns age 26), once every 24 months. In-Network benefits are available through Vision Screening Inc. or Comprehensive Professional Systems, Inc. In-Network Vision Care Providers can be found as follows:

- **Vision Screening Inc.** - By calling (800) 652-0063 or by visiting www.VScreening.com.
- **Comprehensive Professional Systems, Inc.** - By calling (212) 675-5745 or by visiting www.cpsoptical.com.

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 from an Out-of-Network provider, you must purchase your frames and lenses or contacts within 90 days of the exam in order 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 18 months from the latest date of service. Vision Screening Inc. will process Out-of-Network claims for vision benefits.

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, 2019, you will have to wait until January 15, 2021 before the Plan will pay for 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, 2020, you will have to wait until January 15, 2021 before the Plan will pay 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 $100.

DENTAL BENEFITS

The Plan has an arrangement with Cigna Dental Services (Cigna), which provides a panel of dentists in the Cigna DPPO Advantage Network, a dental PPO plan. When you choose a network dentist, your coverage includes a wide range of eligible services. The Plan covers preventive dental care services, including cleanings, X-rays and more, at no additional cost to you up to the limits of the Plan. Cigna DPPO Advantage Network dentists have agreed to offer services at lower negotiated rates, so you and the Fund will save money when you use an In-Network dentist.

You don't need an ID card, a primary care dentist or a referral to receive care from a specialist.

If you use an Out-of-Network provider, dental charges will be the difference between the Billed Charges and the Plan's reimbursement. Cigna sets the reimbursement rate at the maximum allowable charge by looking at costs for similar services in your geographic area. The Out-of-Network provider may not accept Cigna's maximum allowable charge reimbursement as payment in full. If this happens, you will have to pay any amount above the maximum allowable charge. Pretreatment Review is available on a voluntary basis when work in excess of $200 is proposed.

Benefits are limited to $3,000 per calendar year for each Eligible Employee, Spouse and Adult Child age 19 or older through the end of the month in which the Child turns age 26. These annual benefit amounts are subject to the Plan's limitations and exclusions. For expenses over $200, Pretreatment Review is recommended. Contact Cigna at (800) 244-6224 or go to www.mycigna.com for more information about Pretreatment Reviews.

For Children under age 19, the lifetime orthodontic maximum does not apply. A lump-sum payment of up to the $3,000 orthodontic benefit may be paid by the Plan upon receipt of a paid bill for covered orthodontic services from an Out-of-Network provider of an amount equal to or greater than this limit.

Dental benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Dental claims are administered by Cigna under a separate contract from claims administration for any other benefits under the plan.

DENTAL BENEFITS SUMMARY

Covered Service	Network Provider	Out-of-Network Provider
Calendar Year Maximum $3,000 (Class I, II, III, IX Expenses)	(Class I Applies)	(Class I Applies)
Calendar Year Deductible Per Individual	$0	$0
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on maximum allowable charge (for location of service rendered)
Additional Member Responsibility	None	Yes, the difference between Billed Charges and the Plan reimbursement
Dependent Age	26/26	
Class I Expenses - Preventive & Diagnostic Care Oral Exams Cleanings Routine X-Rays Fluoride Application (Up to age 19 only) Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-Rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class II Expenses - Basic Restorative Care Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal Therapy / Endodontics Relines, Rebases and Adjustments Repairs - Bridges, Crowns and Inlays Repairs - Dentures Brush Biopsy	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class III Expenses - Major Restorative Care Crowns / Inlays / Onlays Dentures Bridges Stainless Steel / Resin Crowns	100%, No Deductible	100%, No Deductible (up to maximum allowable charge) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement

Covered Service	Network Provider	Out-of-Network Provider
Class IV Expenses - Orthodontia Coverage for Eligible Children up to age 19 Only Lifetime Maximum $3,000*	100%, No Orthodontia Deductible (*No maximum for dependent Children under age 19. Dependent Children age 19 – 26 not eligible)	100%, No Orthodontia Deductible (up to maximum allowable charge) (*No maximum for dependent Children under age 19. Dependent Children age 19 – 26 not eligible) Additional member responsibility for the difference between Billed Charges and the Plan reimbursement
Class IX Expenses - Implants Applies Toward Plan Calendar Year Max	100% 1 per Calendar Year	100% 1 per Calendar Year Additional member responsibility for the difference between Billed Charges and the Plan reimbursement.
Pretreatment Review	Available on a voluntary basis when work in excess of $200 is proposed	

IMPORTANT CLAIMS REMINDER:

- Claims should be submitted to Cigna Dental Services. Claims must be submitted within 18 months of the beginning service date.

Dental Limitations

The following dental limitations apply whether services are received from an In-Network or Out-of-Network provider:

Procedure	Exclusions & Limitations
Exams	2 per calendar year
Prophylaxis (cleanings)	2 per calendar year
X-Rays (routine)	Bitewings – 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years
Minor Perio (non-surgical)	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis Over Implants	1 per calendar year if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than six months after installation
Adjustments	Covered if more than six months after installation
Sealants	Limited to posterior tooth up to age 14 and 1 per 3 years

Exclusions: In addition to the general exclusions, limitations and restrictions contained on pages 122-125, the following dental exclusions apply whether services are received from an In-Network or Out-of-Network provider:

- Services performed primarily for cosmetic reasons
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services should be submitted to the Medical Plan
- Services and supplies received from a hospital should be submitted to the Medical Plan
- Charges which the person is not legally required to pay
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatment
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents)
- Charges which would not have been made if the person had no insurance
- Charges for unnecessary care, treatment or surgery
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- Illnesses or injuries due to war or any act of war, declared or undeclared, (includingresistance to armed insurrection)
- Treatment of the teeth or gums, except for the repair of non-occupational injuries to natural teeth, or specifically provided dental benefits
- Medication, services or supplies not prescribed by a Physician or Dentist
- Charges in excess of the Plan's limitations
- 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 Plan)
- 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 person became eligible for coverage
- Services or supplies provided after the eligibility of the person ends
- Any claims submitted more than 18-months after the date of treatment or service, except as otherwise approved by the Plan
- Charges for broken or missed appointments
- Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition
- Copayments of any kind
- Treatment for temporomandibular joint ("TMJ"), including all related expenses; Treatment for TMJ shall be covered only as a dental expense.

Dental Discount Program for Medicare-Eligible Retired Participants

Medicare-eligible retired participants will have access to the CignaPlus Savings dental discount program. The CignaPlus Savings program is offered by Cigna Health and Life Insurance Company with network management and administrative services provided by Cigna Dental Health, Inc. The program provides discounts at certain dentists for dental care when your CignaPlus ID card is presented at the time of service.

CignaPlus membership also gives you access to Cigna Healthy Rewards, a program offering discounts on services, including vision, chiropractic, weight management and smoking cessation programs. With your CignaPlus membership you will have access to Cigna's Identity Theft Program and Cigna's Will Preparation Services.

You can enroll for the program using the promotional code "PlumbersL1" at www.CignaPlusSavings.com, by calling 877-521-0244 or by mailing a completed enrollment form to Cigna Dental, 250 South Northwest Highway, Suite 340, Park Ridge, IL 60068-4244.

Members will be individually billed membership fees for the CignaPlus Savings program. Membership fees are valid for a 12-month period from the effective date of enrollment, unless Cigna Dental's liability related to offering the program is altered by a state or federal law or regulation. Membership will automatically renew at the then current membership fee unless you provide written notice or you call the telephone number on the ID card to cancel your membership.

The CignaPlus Savings program is not available in Alaska, Montana, North Dakota, South Dakota, Hawaii, Rhode Island, California, Wyoming, Idaho or Iowa. For more information on the available dental network and In-Network dentists, visit www.CignaPlusSavings.com.

CignaPlus is not dental insurance and there is no claims process. You are obligated to pay for all dental care services, at the time of service, but will receive a discount for eligible services received from participating dentists. The amount of discount will vary among participating providers and those procedures not included on the negotiated fee schedule may not be discounted. The discounts available under the CignaPlus Savings program may not be used in conjunction with any other discount dental program or insurance program.

CARDIO VASCULAR SCREENING BENEFITS

There are a number of "early warning signs" that can indicate your 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 its 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) and (6) Body Weight Composition with recommendations and Exercise Program.

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	$10.00 co-pay for generic $35.00 co-pay for preferred brand $60.00 co-pay for non-preferred brand

Maintenance Medication Co-pays

You and your eligible Dependents 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.

You may fill prescriptions for 30-day supplies of your 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.

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	$10	$25 ($10 co-pay + $15 surcharge)	$25
Preferred Brand	$35	$55 ($35 co-pay + $20 surcharge)	$80
Non-Preferred Brand	$60	$80 ($60 co-pay + $20 surcharge)	$135

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	$10	$25 ($10 co-pay + $15 surcharge)	Not Covered
Preferred Brand	$35	$55 ($35 co-pay + $20 surcharge)	Not Covered
Non-Preferred Brand	$60	$80 ($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 800-824-6349.

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 3 prescription fills at retail.

Using the CVS/Caremark Mail Service

You will need to complete a mail order form for each individual utilizing the Caremark mail program. This will set up each person's profile in the mail order system. Then 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.

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

Up to 30-day supply through CVS/Caremark mail order	$ 10.00 co-pay for up to 30-day generic $ 35.00 co-pay for up to 30-day preferred brand $60.00 co-pay for up to 30-day non-preferred brand
Up to 60-day supply through CVS/Caremark mail order	$ 17.00 co-pay for up to 60-day generic $ 75.00 co-pay for up to 60-day preferred brand $ 120.00 co-pay for up to 60-day non-preferred brand
Up to 90-day supply through CVS/Caremark mail order	$ 25.00 co-pay for up to 90-day generic $ 80.00 co-pay for up to 90-day preferred brand $135.00 co-pay for up to 90-day non-preferred brand

DISPENSE AS WRITTEN ONE (DAW-1)
In New York State, pharmacists are allowed, by law, to substitute the generic version of a drug when the prescription is written for the brand – EXCEPT when a prescription is written with the Dispense as Written (DAW)-1 requirement by your physician. If you choose to not purchase the generic prescription drug, and would rather purchase the Preferred Brand or Non -Preferred Brand prescription drug, you will be responsible to pay the $35.00 or $60.00 copayment plus the difference in the cost between the Preferred Brand or Non-Preferred Brand prescription drug and the cost of the available generic version of that drug.

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

The mail order pharmacy program is designed to provide you convenience and cost savings. You can fill a 90-day prescription and have the prescription mailed to your home for less than the cost of filling three 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 l 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

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, and decides which medications are on the formulary at all. Each year, CVS/Caremark will review the list and decide which medications to exclude from coverage. For a current list of covered medications, please contact CVS/Caremark at 800-824-6349 or www.caremark.com.

Prior Authorization - If your 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, you and your doctor can have certain prescription medications which are not covered by the Fund approved by CVS/Caremark under certain clinical protocols. If 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	Preferred Brand Drugs
Tier 3	Non-Preferred Brand Drugs

Step Therapy Program

Step Therapy programs require that you try generic or preferred brand medications before receiving 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)	Urinary Antispasmodics
Nasal Steroid	

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 800-824-6349

Prior Authorization for Oral Fentanyl Agents

If your doctor prescribes an Oral Fentanyl agent such as ACTi™, 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 109-111, 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 the mail order program. After 3 refills through a retail pharmacy, maintenance prescriptions that are not mail-ordered will be charged a $15 surcharge on generics and a $20 surcharge 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 attempt to fill a prescription 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 may ask your doctor or pharmacist to request a replacement prescription for any medication you are taking only one time every 365 days up to a maximum cost of $500. 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 to request approval that a thirty-day supply of the prescription drug 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 that is new to the market and that may have limited or exclusive distribution, he/she should call CVS/Caremark to request a coverage determination and an administrative override based on the professional judgment of a CVS/Caremark pharmacist.
- If your doctor prescribes a drug at a dose that is either higher or lower than the one you currently are taking, he/she should call CVS/Caremark to request a coverage determination and an administrative override based on the professional judgment of a CVS/Caremark pharmacist.
- If your doctor prescribes a drug 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 to request a coverage determination and a an administrative override based on the professional judgment of a CVS/Caremark pharmacist.
- If the retail pharmacy where you 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, the pharmacist should call CVS/Caremark to request a coverage determination and an administrative override based on the professional judgment of a CVS/Caremark pharmacist.
- If 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 request a determination regarding whether an administrative override can be granted based on the professional judgment of a CVS/Caremark pharmacist. You 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 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, 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 request an administrative override based on the professional judgment of a CVS/Caremark pharmacist. Please note you 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 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 request an administrative override based on the professional judgment of a CVS/Caremark pharmacist. If your doctor has prescribed a new medication 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 to request a coverage determination and an administrative override based on the professional judgment of a CVS/Caremark pharmacist.
- If you are 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 to request a coverage determination and an administrative override 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 request an administrative override 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, who are not currently eligible as an Active Eligible Employee or a Retired Employee but who previously participated in the Plan).

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, the Beneficiaries 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. Forms for the 401(k) Savings Plan, the PPNPF and 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 Active Eligible Employees only under the Plan:

Accidental Death	An amount equal to the Life Insurance payable. This amount is in 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, the Beneficiaries 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:

    a) your surviving spouse (or the surviving spouse of your Beneficiary if your Beneficiary is receiving benefits);
    b) your children (or the children of your Beneficiary if your Beneficiary is receiving benefits);
    c) your parents (or the parents of your Beneficiary if your Beneficiary is receiving benefits);
    d) your siblings (or the siblings of your Beneficiary if your Beneficiary is receiving benefits); or
    e) 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") regulationsgoverning payment of death benefit 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 threat.
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.

WEEKLY DISABILITY BENEFITS

If an Active Eligible Employee is receiving State Disability Benefits, the Employee will receive up to $300 for each week he or she receives State Disability Benefits, to a maximum of 26 weeks. The Employee must submit proof of receipt of State Disability Benefits.

WEEKLY UNEMPLOYMENT BENEFITS

If an Active Eligible Employee is receiving State Unemployment Benefits, the Employee will receive up to $300 for each week he or she receives State Unemployment Benefits, to a maximum of 26 weeks during a twelve month period. The Employee must submit proof of receipt of State Unemployment Benefits.

Classification	Weekly Benefit
BT Journeyman	$300
BT Apprentice	$150
MES Journeyman & Serviceman	$200
MES Helper	$100
Oil Trades Journeyman & Jr. Journeyman	$250
Oil Trades Helper	$125

Weekly Unemployment 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 (ii) submit additional evidence of your unemployed status, such your tax returns, and your efforts to find work. The Trustees may terminate your Weekly Unemployment Benefits if (i) you fail to submit proof of collecting State Unemployment Benefits, (ii) you fail to appear before the Trustees when requested, (iii) 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) 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.

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 with the following exceptions:

1. No Weekly Disability Benefits, Weekly Unemployment Benefits; or Accidental Death and Accidental Dismemberment Benefits, and
2. Life Insurance Benefits are $10,000.

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 13–18 of this SPD apply. If your Spouse is also Medicare-eligible, then the following benefits apply to both you and your Spouse. If your Spouse is not Medicare-eligible, then your Spouse will be covered by the benefits applicable to Retired Employees who are not Medicare-eligible. Your Eligible Dependent Children will be covered by the Plan benefits applicable to Dependents.

- **Medicare Wrap Around (Medical Hospital)** – See pages 67-68
- **Prescription Drug Benefits** – See pages 69-71
- **Employee Assistance Program** (EAP) - See page 51
- **Hearing Aids Benefit** – See page 47
- **Vision Care Benefit** – See page 52
- **Dental Discount Program** – See page 57
- **Life Insurance** – See pages 63

Medicare Wrap-Around Plan Schedule

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 Medicare PART B $198.00 Annual deductible where applicable. (Note: Medicare Coverage below is based on the Medicare Premium and Deductibles for 2020 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 $1,408 Day 61-90: all but $352/day Day 91-150: all but $704/day 150-day limit Surgical: 80% of approved amount	Hospital Day 1-60: $1,408 Day 61-90: $352/day Day 91-150: $704/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

`	Medicare Coverage	Plan Pays	Retiree Pays
Outpatient Surgery, Therapy (in-hospital)	80% of approved amount	20% of approved amount	$0 (1) * (2) ** See notes 1 & 2 below
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 $176/day 100-day limit/benefit period	Day 1-20: $0 (Medicare) Day 21-100: $176 /day Over 100 days: $0	Day 1-20: $0 Day 21-100: $0 Over 100 days: You pay 100% See note 2 below
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 $1,408 Day 61-90: all but $352/day Day 91-150: all but $704/day 190-day lifetime limit	Hospital Day 1-60: $1,408 Day 61-90: $352/day Day 91-150: $704/day 190-day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100% See note 2 below
Outpatient Mental Health	80% of approved amount	20% of approved amount (limit of 40 visits per year)	0% of approved amount

Service or Supply	Medicare Coverage	Plan Pays	Retiree Pays
Inpatient Substance Use	Hospital Day 1-60: all but $1,408 Day 61-90: all but $352/day Day 91-150: all but $704/day 190-day lifetime limit	Hospital Day 1-60: $1,408 Day 61-90: $352/day Day 91-150: $704/day 190-day lifetime limit	Hospital Day 1-60: $0 Day 61-90: $0 Day 91-190: $0 Over 190 days: You pay 100% See note 2 below
Outpatient Substance Use (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	None	N/A

*(1) Each year the Medicare premiums, deductibles, and copayment rates are adjusted according to the Social Security Act. For 2020, the standard monthly premium for Medicare Part B enrollees will be $144.60. In 2020, you must pay an annual deductible of $198 for Part B services and supplies before Medicare begins to pay its share. This deductible is not paid by the Plan and is subject to change annually based on Medicare regulations.

**(2) Actual amounts you must pay may be higher if Physicians, health care providers or suppliers do not accept assignment. These deductibles and/or coinsurances are subject to change annually based on Medicare regulations.

***(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 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. If 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.

Prescription Drug Benefit for Medicare-Eligible Retired Participants

Medicare Part D Prescription Drug Coverage

Everyone with Medicare is eligible for prescription drug coverage with Medicare Part D Plans and Medicare Advantage Plans (private insurance companies). There are certain times when it's possible to enroll in a Medicare Advantage Plan. For example, you can sign up during the initial enrollment period (that is, when you first become eligible for the Medicare program or when you turn 65 years old). The enrollment period for Part D Plans will begin on October 15th and end on December 7th of each year. In addition, there is a special disenrollment period during which you can drop a Medicare Advantage Plan if you don't want to be a part of the plan any longer. This special disenrollment period lasts from January 1st until February 14th each year. Those who decide to drop a Medicare Advantage Plan during the special disenrollment period must switch to Original Medicare (Medicare Part A and Part B). You may not choose a new Medicare Advantage Plan at this time. If you switch to Original Medicare during this period, you'll have until February 14 to join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form. 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 this Plan will continue to be eligible for benefits notwithstanding his/her eligibility for Medicare Part D. However, if you decide not to enroll in the SilverScript Prescription Drug Plan, and instead enroll

in a different Medicare prescription drug plan, you and your Spouse and Dependents will lose your Welfare Fund coverage (Medicare Wrap-Around Plan or Empire BCBS for Medical and Hospital coverage, SilverScript or CVS Caremark Prescription Drug Plan, Vision and Life Insurance Benefits).

For Prescriptions Filled at a Participating Pharmacy in the SilverScript National Retail Network			
	30-Day Supply (First Fill and After)	60-Day Supply (First Fill and After)	84-90-Day Supply (First Fill and After)
Generic Medication	$10	$20	$30
Preferred Brand	$35	$70	$105
Non-Preferred Brand	$60	$120	$180

Using the CVS/Caremark Mail Service Pharmacy for Maintenance Medications

You will need to complete a mail order form for anyone who will be utilizing the mail program. This will set up each member's profile in the mail order system. 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 prescription has been filled the first time and you have available refills, you can re-order your mail prescription online at www.caremark.com, by calling SilverScript Customer Care or by mailing in your re-order form that you received with your prescription.

You are encouraged to use either CVS/Caremark Mail Service Pharmacy or a local CVS Retail pharmacy in order to obtain maintenance drugs at mail order co-pays.

For the CVS/Caremark Mail Service Pharmacy, your prescriber can submit your original prescription electronically or you can submit it by mail or online at www.caremark.com and your medications will be sent directly to your home or a location of your choice.

Up to 30-day supply through CVS/Caremark Mail Order Pharmacy	$10 co-pay for up to 30-day generic $35 co-pay for up to 30-day preferred brand $60 co-pay for up to 30-day non-preferred brand
Up to 60-day supply through CVS/Caremark Mail Order Pharmacy	$17 co-pay for up to 60-day generic $70 co-pay for up to 60-day preferred brand $120 co-pay for up to 60-day non-preferred brand
Up to 90-day supply through CVS/Caremark Mail Order Pharmacy	$ 25 co-pay for up to 90-day generic $ 80 co-pay for up to 90-day preferred brand $135 co-pay for up to 90-day non-preferred brand

Mail Order Co-pays for Maintenance Medications at CVS Retail

You can fill select maintenance medications for up to a 90-day supply at a CVS Retail Pharmacy and pay the applicable mail order co-pay, which saves you money.

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

	For Maintenance Medication Prescriptions Filled at a CVS Retail Pharmacy		
	30-Day Supply (First Fill and After)	60-Day Supply (First Fill and After)	90-Day Supply (First Fill and After)
Generic Medication	$10	$20	$25
Preferred Brand	$35	$70	$80
Non-Preferred Brand	$60	$120	$135

For a list of covered maintenance medications or for more information, call SilverScript Customer Care at 1-855-282-9586, available 24 hours a day, 7 days a week. TTY users should call 711.

Dental Discount Program for Medicare-Eligible Retired Participants

See page 57 above.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

A Health Reimbursement Arrangement ("HRA") is an individual account under the Plan that uses pre-tax 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. An HRA allows you to 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 contributed to your HRA account from the amount you can deduct on your federal tax return.

Eligibility

The eligibility requirements for participation in the HRA are the same as the requirements for participation in the Plan as previously described (see pages 3-4). An Active Eligible Employee will be eligible on the first day of the calendar month after he/she has been credited with at least 290 hours in Covered Employment within a period of three consecutive months, provided the Plan actually receives the contributions for those hours.

Once an Active Eligible Employee meets the general eligibility requirements, the Active Eligible Employee and his/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 ceased Covered Employment and no longer meets the continuing eligibility requirements for other benefits. A special provision where there is a COBRA Qualifying Event under the Plan is discussed below.

If you lose eligibility for benefits from the HRA because your HRA account has been completely distributed after you ceased Covered Employment, you may re-establish eligibility by satisfying the initial eligibility requirements unless you opt out of the HRA as explained below.

In you die before your HRA has been completely distributed, your Qualified Relatives will be eligible to continued reimbursement from the HRA as long as the account balance is sufficient to cover their claims.

Account balances of $5.00 or less that are inactive (No Contributions) for one year or more are charged an administrative fee of $5.00.

You may opt out of and waive future reimbursements from the HRA annually and upon termination of employment. If you opt out, the remaining amounts in your HRA are suspended and may not be used until you re-establish eligibility in the Welfare Fund.

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

HRA accounts are funded by employer contributions required under the applicable Collective Bargaining Agreement. The amount that you can accumulate in your HRA account is not subject to any maximums, and you may carry over your entire account balance from Plan Year to Plan Year.

Enrollment

Enrollment information must be provided for you and your Qualified Relatives. If you do not notify the Fund Office of a Qualified Relative, the individual cannot be enrolled. Dependents enrolled for purposes of other benefits provided by this Plan are also enrolled in the HRA. Some individuals who may be enrolled as Qualified Relatives in the HRA may not be Dependents for purposes of other benefits provided by this Plan. See page 10 for the definitions of Dependents for purposes of other benefits provided by this Plan.

"Qualified Relatives" may be enrolled as Dependents in 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, sibling, , step-sibling, 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 you and is a member of your household or, in the case of a child, the child lives with his/her other parent. Qualified Relatives must meet all the requirements of 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) 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 2020, limits specified under Section 213(d) and 7702B(b) of the Internal Revenue Code are shown below. These are subject to change each year.);

Age 40 or younger	$ 430 per taxable yr.
Older than 40, younger than 50	$ 810 per taxable yr.
Older than 50, younger than 60	$1,630 per taxable yr.
Older than 60, younger than 70	$4,350 per taxable yr.
Older than 70	$5,430 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 (OTC). These OTC 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. Note that prior to January 1, 2020, your Physician must have prescribed your OTC drug (even though a prescription was not required to make such purchase) in order to be eligible for reimbursement from your HRA and your request for reimbursement must be submitted by a prescription. Prescriptions for OTC drugs purchased on or after January 1, 2020 do not require a prescription.

Following are some examples of OTC 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	Menstrual care products (purchased on or after January 1, 2020)	Ovulation Kits	Pregnancy test kits	Reading glasses
Thermometers				

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

OTC 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 OTC products, you must provide a computerized receipt 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 OTC medicines or drugs may also be reimbursed. These OTC 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. Note that prior to January 1, 2020, your Physician must have prescribed your OTC drug (even though a prescription was not required) in order to be eligible for reimbursement from your HRA and your request for reimbursement must be submitted by a prescription. Prescriptions for OTC drugs purchased on or after January 1, 2020 do not require a prescription. Following are some examples of OTC 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.

EXAMPLE: You take OTC Claritin (Allergy Medicine) to treat your allergies. You may submit your claim for reimbursement up to 36 months from the date of this purchase. Your claim must be accompanied with the receipt. If you purchased the OTC drug before January 1, 2020, your claim must also be accompanied by a prescription.

Over-the-counter supplies and devices are 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; or
- Any item that does not constitute "medical care" as defined under Section 213 of the Internal Revenue Code.

Therefore, 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 36 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. You will receive an Explanation of Benefits for each claim. Account balance statements will be mailed to you at the end of each Plan Year.

COBRA Continuation of Coverage - HRA

Qualified Beneficiaries have the opportunity 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

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 Dependents will be offered the opportunity to extend eligibility by electing and paying for COBRA Continuation of Coverage.

You are NOT required to elect and pay for COBRA Continuation of Coverage to receive reimbursement 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 reimbursement 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 the 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 and paying for COBRA Continuation of Coverage.

You are NOT required to elect and pay for COBRA Continuation of Coverage to receive reimbursement 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 reimbursement 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 and paying for COBRA Continuation of Coverage.

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

Forfeiting Unused Contributions

Upon your death, your eligible Dependents will continue to have access to the HRA and receive reimbursement from the HRA so long as the account balance is sufficient to cover their claims. However, under IRS requirements, if you have no eligible Dependents or if your eligible Dependents 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 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 Disability Continuation of Coverage, Unemployment Continuation of Coverage, Weekly Disability Benefit, Weekly Unemployment Benefit, 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 to which a person belongs 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 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 (ESRD)

If you are an Active Employee and are entitled to Medicare because of 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 you receive 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 of Coverage from this Plan, Medicare will pay first and your COBRA Continuation of 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 of 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 of Coverage, Medicare pays first and your COBRA Continuation of Coverage under this Plan pays second. Note that this provision does not extend the maximum periods of COBRA Continuation of 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 must 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 covers Physician services, outpatient Hospital services and other medical supplies and is optional. 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 Dependents will lose active eligibility for benefits upon your 65th birthday or earlier if you are disabled. The Plan's Active Eligibility Rule – i.e., the Plan provision pursuant to which an Active Eligible Employee and his or her Eligible Dependents lose eligibility for benefits on the last day of the fourth month following the most recent period of three consecutive months in which the Employee worked at least 290 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.

INTERNAL CLAIMS AND APPEALS

This section describes the Plan's procedures for making internal claim decisions and reviewing appeals of denied claims. These procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. With respect to health benefit claims, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the Claims Administrator denies your initial claim for benefits (i.e., if it issues an "adverse benefit determination"), you have the right to appeal the denied claim.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

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. Claims are processed for the Plan by applicable Claims Administrators.

A claim is considered filed as soon as a written claim form is received by the applicable Claims Administrator listed on pages 80-86 by mail, personal delivery, fax or e-mail. Telephone calls (except in the case of Pre-service claims) and e-mails are not acceptable. Filing an incomplete claim or filing a claim with the wrong Claims Administrator 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, a request is not a claim if it is not made in accordance with the Plan's benefit claims filing procedures described in this section, made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative or made anonymously. A request for a determination as to whether you are eligible for benefits that does not request benefits or a question regarding 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 pages 33–47). 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 maximum of $2,500. To maximize your coverage, call:

Empire BC/BS Medical and Hospital Benefits	1-844-243-5566
Optum Mental Health and Substance Use Disorder Benefits	1-844-884-1852

Claims must be filed as soon as reasonably possible after the expense is incurred. We recommend that you send a claim for benefits to the applicable Claims Administrator within 90 days from the date of service. Any claims submitted after 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

Claims Administrator within 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 Dependents must be eligible for benefits and be enrolled in the Plan (e.g., have a completed enrollment form on file at the Fund Office) at the time the claim is incurred.

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.).

You may designate a representative to act on your behalf in filing a claim or an appeal of a denial of a claim. If the Fund Office or Claims Administrator is uncertain whether you have designated a representative, you may be required to put such designation in writing; otherwise the Fund Office or Claims Administrator may decline to communicate with a third party claiming to be a representative until such written designation is received.

There are time limits applicable to 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 is a healthcare claim and involves "urgent care," is a "pre-service claim", "concurrent claim" or is a "post-service claim" or is a disability or life/AD&D 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 terms of the Plan condition receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care. See pages 33-47 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.

"Life Insurance/AD&D Claims" and ***"Disability Claims,"*** which include Weekly Disability and Accidental Dismemberment Claims, will generally be handled as Post-Service Medical Claims. However, there are 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 Administered by 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 pages 125-126.

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 Dependents receive 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 the PPO In-Network allowance as full payment, less any applicable co-payment. Some services require pre-certification. Refer to the chart on pages 33-47.

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 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 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 claims administered by 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. See section entitled "Notice of Initial Benefit Determination" and "Notice of Denied claim" on pages 88-91 for details on contents of notification and timing.

If you have any questions about your claim, you may contact Empire Member Services at 1-844-243-5566, 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 check the status of your claim, view and print EOBs, correct certain claim information and more at any time of day or night by visiting www.empireblue.com.

Assignment – You authorize Empire to make payments directly to participating In-Network providers for covered services. Empire 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 the 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 12.

Coverage and benefits under the Plan are not assignable by any individual 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.

Filing Claims for Mental Health and Substance Use Disorder Benefits

When you receive care from providers or facilities in the Optum network, you generally do not have to file a claim. You will have to file a claim for reimbursement for Out-of-Network covered services from non-participating providers. To obtain a claim form, call Optum's customer service number or you can go online to www.liveandworkwell.com and download a claim form.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse Disorder	Provider files claim directly with Optum	You (the claimant) must file claim with Optum

In-Network Mental Health and Substance Use Disorder

If you receive inpatient or outpatient treatment for Mental Health or Substance Use Disorders, make sure that the provider or facility contacts Optum in order to file claims and check eligibility. The participating provider or facility will accept Optum's In-Network allowance as full payment, less any applicable co-payment. Some services require pre-certification. Refer to the chart on page 49 for a list of services which require pre-certification.

Out-of-Network Mental Health and Substance Use Disorder Claims

You should send any Out-of-Network claims for Mental Health or Substance Use Disorder to Optum within 90 days of the date of service, if possible. Any claims submitted more than 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 Optum within 18 months from the date of service. The 18-month claims limitation does not apply when eligibility is established retroactively due to the payment of delinquent contributions.

Out-of-Network claims may be completed on line by visiting www.liveandworkwell.com. You will need the following information: provider information, visit and service details including diagnosis and CPT code. Log into www.liveandworkwell.com and follow the on line instructions. Out-of-Network claims may also be filed by mailing claims to:

Optum
PO Box 30757
Salt Lake City, UT 84130-0757

The following are tips on completing your claim form which should help expedite the processing and payment of your claim.

- Fill in all the Requested Information: Any bill/ claim submitted requires your full name, address, ID number (usually your SSN), your Plan's name and full address, the patient's full name, full address, DOB, Gender, and relationship to the participant.
- Use the 1500 Claim Form: Optum prefers all claims to be submitted on the 1500 Claim form. For detailed information on this form, visit http://www.nucc.org.
- Provide Additional Insurance Information: If patient has medical coverage through any other insurance plan, submit the name and full address of the insurance company, along with the phone number, group number, etc.
- Verify Patient Name and Covered Individual Have the Same Last Name: If patient has a different last name and/ or is over 19 years of age, Optum will request additional information in order to complete the processing of your claim.
- Copy the completed claim form for your records. If you have any questions, contact Optum's Member Services at the number listed on the back of your Empire BCBS ID card.

The following Provider billing information must be completed (or your claim may be rejected or delayed) and can be obtained from your provider or the facility where you received treatment:

1. Diagnosis – Use the appropriate ICD 10 code "0" and DSM 5 diagnosis code
2. Date(s) of service (break-down of charges per day for facility-based treatment)
3. Place of Service (office or facility)
4. CPT code (description of services rendered by the Provider—procedure code that you can get from your provider)
5. Amount Charged (breakdown of charges per day for facilities; or cost of each visit for providers)
6. Provider Name & Address (actual provider who rendered the service and address of where the service was rendered)
7. Provider Tax ID or Social Security number, and Provider's license level (MFCC, PHD, MD, etc.)
8. Provider's NPI number

Assignment of Benefits - If signed, you authorize Optum to pay benefits directly to the provider. If you do not wish payment to go directly to the provider, leave this line blank. If left blank, payment will automatically be paid to you. If Optum denies your initial claim payment, you will receive a written notification or EOB citing the reasons for the denial. See section entitled "Notice of Initial Benefit Determination" and "Notice of Denied claim" on pages xx-xx for details on contents and timing of the notification.

Out-of-Network Secondary Claims/Coordination of Benefits

Your Spouse may have 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 77. 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, EOB from the primary plan and an Itemized Bill from the provider to the applicable Claims Administrator at the address stated in this section; then
5. The applicable Claims Administrator 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 Participants, the Plan is secondary provided the Participant 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, EOB from Medicare and an Itemized Bill from the provider to the Plan's third-party claims processor "Administrative Services Only, Inc." ("ASO"), within 18 months from the date of service, 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: (877) 782-6659

5. The Plan will process the secondary claim for payment to you or to the provider, if you request an assignment of benefits.

*If a provider submits the claim directly to ASO without a claim form, it is necessary that an EOB from the primary plan is 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 ASO.

Although claims may be filed electronically, you are strongly encouraged 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 by visiting 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 58-61 for co-payment information

If you fill your prescription at an Out-of-Network pharmacy, you must 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 utilizes 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. You may also contact CVS/Caremark directly if you have questions or want to check to see if a certain drug requires pre-approval or is considered a single source or multi-source drug.

If CVS/Caremark does not approve a request for pre-approval/authorization or a request for a drug or benefit based on the terms of the Plan, including the Plan's preferred/non-preferred drugs, the determination will constitute a 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 Caremark denies any claim for prescription drugs, 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".

Dental Benefit Claims

Dental claims must be submitted to Cigna Dental Services (Cigna) in the manner listed below within 18 months of the beginning service date.

Cigna Dental Claims

In-Network claims. There's no paperwork for In-Network care unless you exceed the annual limit. In that case, you will need to pay any amounts over the annual limit; your provider will submit a claim to Cigna for reimbursement of claims up to the annual limit.

Out-of-Network claims can be submitted by the provider if the provider is willing to file on your behalf. Otherwise, you must send your completed claim form and itemized bills to the claims address listed on the claim form.
You may get claim forms by visiting www.Cigna.com or by calling Member Services using the toll-free number 1-800-244-6224.

Cigna will consider claims for coverage when a claim is submitted within 18 months. If services are rendered on consecutive days, the limit will be counted from the last date of service. If claims are not submitted within 18 months, the claim will be denied.

If Cigna denies any claim for dental services, you have the right to seek a review by Cigna in accordance with the procedures described in the next section entitled, "Right to Review Denied Claims/Appeals Procedure".

Vision Benefit Claims

If you use Vision Screening, Inc., or Comprehensive Professional Systems, Inc., there is no claim form to submit. If you receive benefits from 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 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, 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.

Hearing Benefit Claims

If you use CPS Audiologists, there is no claim form to submit. If you receive benefits from an Out-of-Network provider, all expenses associated with the exam and hearing aid must be submitted on the same claim form no later than 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).

Comprehensive Professional Systems, Inc./CPS Hearing
11 Hanover Square, 8th Floor
New York, NY 10005
Phone: (212) 675-5745

If CPS denies any claim, 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."

Life Insurance and Accidental Death & Accidental Dismemberment Claims

A Life Insurance Claim is any claim made by your beneficiary due to 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
50-02 Fifth Street, 2nd Floor
Long Island City, NY 11101
(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 or Retired Employee's death will not be considered.

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.

If your claim for life or AD&D benefits is denied, 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."

Weekly Disability and Unemployment Insurance Claims

You must submit a claim to the Fund Office at the following address:

Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street, 2nd Floor
Long Island City, NY 11101
(718) 835-2700 (phone)

You may obtain the applications by visiting the Fund's website at https://www.ualocal1funds.org or you can call the Fund Office to request an application.

Benefits will be paid by the Fund on a monthly basis, application for Benefit Forms are due in the Fund Office no later than the Second Tuesday of each calendar month for weekly disability benefits, your completed application must be accompanied with proof of each week that you have collected state disability benefits. You may wish to submit a completed Form W-4 for tax withholding; submission of Form W-4 is optional.

For weekly unemployment benefits, your completed application must be accompanied with proof of each week that you have collected state unemployment benefits; You may wish to submit a completed Form W-4 for tax withholding; submission of Form W-4 is optional.

If the Fund Office denies any claim for weekly disability or unemployment benefits, 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."

Notice of Initial Benefit Determination

Health Care Claims - The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an appeal denial based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of an appeal denial is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Urgent Care Claims - The applicable Claims Administrator 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 applicable Claims Administrator 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/Reviews for Hospital and Medical Claims Administered by Empire - With respect to urgent Pre-certification requests, if Empire has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 72 hours of receipt of the request. If Empire needs additional information, it will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Empire will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 48 hours of the earlier of receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

Pre-service Claims - The applicable Claims Administrator 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 applicable Claims Administrator 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 Reviews (Non-Urgent Pre-certification Reviews) for Hospital and Medical Claims Administered by Empire - If Empire has all the information necessary to make a determination regarding a Pre-certification review, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of the request. If Empire needs additional information, it will request it within 15 calendar days. You or your Provider will then have 45 calendar days to submit the information. If Empire receives the requested information within 45 days, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of the additional information. If all necessary information is not received within 45 days, Empire will make a determination within 15 calendar days of the end of the 45-day period allowed to submit the additional information.

Post-service Claims - The applicable Claims Administrator 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 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 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 applicable Claims Administrator needs an extension because you have not submitted information necessary to decide the claim, the notice will 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. All retrospective reviews of services already provided will be completed within 30 calendar days of 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 needed and you and your provider will have 45 calendar days to respond. Empire will make a decision within 15 calendar days of 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 applicable Claims Administrator 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.

Non-Urgent Concurrent Requests/Reviews for Hospital and Medical Claims Administered by Empire - Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of all necessary information. If Empire needs additional information, it will request it within 15 calendar days of the receipt of the request. You or your Provider will then have 45 calendar days to submit the additional information. Empire will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of the additional information or, if Empire does not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

Urgent Concurrent Requests/Reviews for Hospital and Medical Claims Administered by Empire - For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, Empire will make a determination and provide notice to you (or your designee) and your Provider within 24 hours of receipt of the request. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, Empire will make a determination and provide written notice to you (or your designee) and your Provider within 72 hours of receipt of the request. If Empire needs additional information, Empire will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Empire will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of one (1) business day or 48 hours of receipt of the information or, if Empire does not receive the information, within 48 hours of the end of the 48-hour period.

Retrospective Reviews for Hospital and Medical Claims Administered by Empire - If Empire has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your Provider within 30 calendar days of the receipt of the request. If Empire needs additional information, it will request it within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. Empire will make a determination and provide notice to you and your Provider in writing within 15 calendar days of the earlier of receipt of all or part of the requested information or the end of the 45-day period. Once Empire has all the information to make a decision, failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed a denial subject to an internal Appeal.

Retrospective Review of Preauthorized Services for Hospital and Medical Claims Administered by Empire - Empire may only reverse a preauthorized treatment, service or procedure on retrospective review when: (i) the relevant medical information presented upon retrospective review is materially different from the information presented during the Preauthorization review; (ii) the relevant medical information presented upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Empire; (iii) Empire was not aware of the existence of such information at the time of the Preauthorization review; and (iv) had Empire been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Reconsideration for Hospital and Medical Claims Administered by Empire - If Empire does not attempt to consult with your Provider who recommended the Covered Service before making an adverse determination, the Provider

may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider and in writing.

Notice of Denial of Claim

If a claim for Hospital, Medical, Mental Health and Substance Use Disorder, Prescription Drug, dental, vision, cardiovascular, life, AD&D, Weekly Disability or Weekly Unemployment benefits is denied, the Plan or the applicable Claims Administrator will provide you with a written notice that provides:

- Identification of the claim involved (and for health benefit claims, include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- the specific reasons for the denial, (and for health benefit claims, include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- references to the specific Plan provisions on which the denial is based, a description of any additional material or information that might help 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 the Employee Retirement Income Security Act of 1974 (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.

Appeals Procedure

If a claim for benefits is denied, 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 appealing a denial, you may submit written comments, documents, records and other information relating to the claim. 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. Personal appearances on appeals are not permitted. With respect to health benefit appeals, the applicable Claims Administrator will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of denial of an appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of a denial of an appeal is required

to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of an appeal denial will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

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.

All notices sent to claimants relating to internal claims and appeal review for health benefits will contain a notice about the availability of Spanish, Chinese, Tagalog, and Navajo language services. Assistance with filing a claim for internal review in Spanish, Chinese, Tagalog, and Navajo is available by calling the applicable Claims Administrator. Notices relating to internal and external review will be provided in Spanish, Chinese, Tagalog, and Navajo upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al Empire: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 835-2700.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Empire: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 835-2700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 Empire: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 835-2700。
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Empire: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 835-2700.

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. In the case of each reviewer, the decision 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.

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. You are not required to cite all of the Plan provisions that apply or to make “legal” arguments in your appeal; 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.

HOW TO REQUEST A REVIEW OF A DENIED CLAIM

Requests for review of denied Hospital and Medical benefit claims should be made to Empire Blue Cross/Blue Shield.	Send to the following address: 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 (844) 243-5566. In the case of an Urgent Care Claim, you may request review verbally or in writing, and communications between you and Empire the reviewer may be made by telephone, facsimile or other similar means.
Requests for review of denied Mental Health or Substance Use Disorder benefit claims should be made to Optum.	Send to the following address: Optum Appeals and Grievances P.O. Box 30512 Salt Lake City, UT 84130-0512 Fax: 1-855-312-1470 Phone: 1-866-556-8166	Urgent care claims can be submitted by calling Optum at the phone number shown in this chart. In the case of an Urgent Care Claim, you may request review verbally or in writing, and communications between you and Optum may be made by telephone, facsimile or other similar means.
Requests for review of denied Prescription Drug Claims for Actives and Pre-Medicare Retirees should be made to CVS/Caremark.	Send 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 (855) 344- 0930. In the case of an Urgent Care Claim, you may request review verbally or in writing, and communications between you and CVS/Caremark may be made by telephone, facsimile or other similar means.
Requests for review of denied Medicare Retirees Prescription Drug Claims should be made to SilverScript.	Send to the following address: SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department P.O. Box 52000, MC 109 Phoenix, AZ 85072-2000 Fax Number: 1-855-633-7673	Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (855) 344- 0930. In the case of an Urgent Care Claim, you may request review verbally or in writing, and communications between you and SilverScript may be made by telephone, facsimile or other similar means.
Requests for review of denied Dental Claims should be made to Cigna. .	Send to the following address: Cigna Dental Services Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax Number: 1-866-689-3092	Providers may submit urgent appeal requests on behalf of a participant by calling the provider only toll-free number at (866) 443-1183.

Requests for review of denied Medicare Wrap-Around Claims, Vision Claims, Cardiovascular Claims, and HRA Claims for Represented Employees should be sent to the Fund Office (Appeals Committee).	Send to the following address: Plumbers Local Union No. 1 Welfare Fund 50-02 Fifth Street Long Island City, NY 11101 Phone Number (718) 835-2700	The decision on appeal will be made by the Board of Trustees or the Appeals Committee of the Board of Trustees of the Plan.
Requests for review of denied Life Insurance and AD&D Claims for Represented Employees should be sent to Amalgamated.	Send to the following address: Amalgamated Life Insurance Company Life Claims Department 1st Floor 333 Westchester Avenue White Plains, NY 10604 Phone Number (914) 367-5984 Fax Number (914) 367-4115	The decision on appeal will be made by Amalgamated Life Insurance.
Requests for review of denied weekly disability and weekly unemployment insurance claims should be sent to the Fund Office (Appeals Committee).	Send to the following address: Plumbers Local Union No. 1 Welfare Fund 50-02 Fifth Street Long Island City, NY 11101 Phone Number (718) 835-2700	The decision on appeal will be made by the Board of Trustees or the Appeals Committee of the Board of Trustees of the Plan.

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 as described in this section.

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 its 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 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.

Internal Appeals. You, your designee, and, in retrospective review cases, your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. Empire will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your Appeal and, if necessary, inform you of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

Standard Appeal. First Level Appeal. Empire maintains a two-level appeal for appeals as described below.

- **Preauthorization Appeal.** If your Appeal relates to a Preauthorization request, Empire will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

- **Retrospective Appeal.** If your Appeal relates to a retrospective claim, Empire will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

- **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

Empire's failure to render a determination of your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Second Level Appeal. If you disagree with the first level Appeal determination, you or your designee can file a second level Appeal. You or your designee can also file an external review. The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for you to file for external review.

A second level Appeal must be filed within 60 days of receipt of the final adverse determination on the first level Appeal. Empire will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your Appeal and inform you, if necessary, of any additional information needed before a decision can be made.

- **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, Empire will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

- **Retrospective Appeal.** If your Appeal relates to a retrospective claim, Empire will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

- **Expedited Appeal.** If your Appeal relates to an urgent matter, Empire will decide the Appeal and provide written notice of the determination to you (or your designee), and where appropriate, your Provider, within 72 hours of receipt of the Appeal request.

External Review of Certain Types of Claims

If your mandatory first level appeal is denied, you may be eligible for an independent External Review.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care (as defined in this section), you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process.

You or your authorized representative may request it orally or in writing. All necessary information, including Empire's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem BlueCross BlueShield
Attn: Grievances and Appeals
PO Box 1407
Church Street Station
NY, NY 10008-1407

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate an independent External Review.

The External Review decision is final and binding on all parties except for any relief available pursuant to ERISA.

Authority as Claims Fiduciary: Empire BCBS shall serve as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of medical and hospital benefits. Empire BCBS shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties, subject to available judicial review.

Optum Mental Health and Substance Use Disorder Appeal Process

You should contact Optum if you need help understanding any denial of benefits. For claims or denials that involve a clinical review or determination, your provider can contact the Optum reviewer who made the initial determination to discuss the basis for the decision. If you disagree with Optum's decision on your claim, you have the right to appeal. You or your authorized representative may request the review. Contact Optum if you would like to name an authorized representative to appeal on your behalf. A provider may request a review for an Urgent care claim appeal. All appeal requests must be submitted in writing. However, appeals for Urgent Care claims (as defined earlier in this section) may be submitted orally. If you submit an appeal, it will be conducted by someone who was not involved in making the initial non-coverage determination and who is not a subordinate to the reviewer who made the decisions.

Your appeal should include the following information:

- Your name and identification number
- The date of services that were denied
- Any information you would like to have considered, such as treatment records, co-existing condition or other relevant information.

Level 1 Appeal – A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180-calendar days of receipt of the notification (e.g., the date you receive the EOB or initial claim denial) to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review. Optum will make a decision within the following timeframes for 1st Level Appeals:

- *Urgent Care (Expedited):* This is an expedited internal appeals process. If your situation meets the definition of Urgent, Optum will conduct an urgent review. An urgent situation is one in which your health may be in serious jeopardy or, if in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision. Optum will make a determination and notify you (or your provider) verbally and in writing within 72 hours of receipt of your request.

  If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both). Only one level of appeal is available for Urgent Care appeals.

  - *Concurrent Claims.* A determination will be made by Optum on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

  - *Pre-Service (Pre-certification or for services that have not yet been provided)* – Optum will make a determination and you (or your provider) will be notified in writing within 15 days of receipt of your appeal.

  - *Post Service (Services that have already been provided)* – Optum will make a determination and you (or your provider) will be notified in writing within 30 days of receipt of your appeal.

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.

Optum will make a decision within the following timeframes for 1st Level Appeals;

- *Concurrent Claims.* You will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- *Pre-Service (Pre-certification or for services that have not yet been provided)* – You (or your provider) will be notified in writing within 15 days of receipt of your appeal.

- *Post Service (Services that have already been provided)* – You (or your provider) will be notified in writing within 30 days of receipt of your appeal.

External Review of Certain Types of Claims

If the outcome of the Internal Appeal is adverse to you, you may be eligible for an independent External Review.

If Optum continues to deny payment, coverage or services (after you exhaust the internal appeals procedures described above), you may be able to request an external review of your claim by an independent third party, who will review the non-coverage determination and issue a final decision. You may request, free of charge, a paper copy of any relevant documents, records, clinical criteria, benefits provisions, or other information Optum used to make its decision. Some information requires written consent to be released. Clinical Criteria is available on Opium's website at www.providerexpress.com.

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of final denial for an internal appeal. An expedited external review may be available to you if the medical condition (1) is such that the time needed to conduct an expedited internal appeal or standard external review could seriously jeopardize your life, health or ability to regain maximum function; or (2) concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from the facility. If it is confirmed that an expedited review is needed, you will receive a decision within 72 hours of making the request and providing necessary information.

Your request for an external review of a Standard (not Urgent or Concurrent Care) claim must be made in writing. Urgent/Expedited requests may be made orally or via fax. To request an External appeal, you should contact Optum at:

Optum
Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470
Phone: 1-866-556-8166

Authority as Claims Fiduciary: Optum shall serve as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of mental health and behavioral health benefits. Optum shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties, subject to available judicial review.

CVS/Caremark Appeal 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 IRO.

For purposes of Prescription Drug Claims and Appeals, 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 the medication, service or product is not solely for the convenience of the member, member'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 the Plan's single source and/or multi-source drugs, 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.

Timing of Review:

Pre-Authorization Review – CVS/Caremark will make a decision on the denial of a Pre-Authorization request for a Plan benefit within 15 days after it receives the appeal. If the appeal 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 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 will be made not more than 72 hours after the appeal 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 a denial of 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 on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination: Following the review of your 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(s) for the denial;
- Reference to 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 solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. CVS/Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these claims conclusively for all parties, subject to available judicial review.

SilverScript Appeal Process

A coverage decision is a decision SilverScript makes about your benefits and coverage or about the amount SilverScript will pay for your prescription drugs. SilverScript may decide a prescription drug is not covered. If you disagree with this coverage decision, you can file an appeal.

Filing an appeal - If SilverScript makes a coverage decision and you are not satisfied with this decision, you can appeal the decision.

LEVEL 1 APPEALS: When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, SilverScript will review the coverage decision.

To start your Level 1 Appeal, you and/or your attending physician may submit an appeal to SilverScript Insurance Company.

The appeal should include the following information:

- Name of the person the appeal is being filed for;
- SilverScript 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:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department P.O. Box 52000,
MC 109
Phoenix, AZ 85075-2000
Fax Number: 1-855-633-7673

You must submit your Level 1 appeal within 60 calendar days from the date stated on SilverScript's written notice to you of its coverage decision.

LEVEL 1 "FAST APPEAL": If you wish to appeal SilverScript's denial of a drug you have not yet received, you and your physician/prescriber can request a "Fast Appeal". SilverScript will give you an answer within 72 hours

after receipt of the Level 1 "Fast Appeal".

To request a Level 1 "Fast Appeal", you may make it in writing and mail or fax it to SilverScript:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85075-2000
Fax Number: 1-855-633-7673

LEVEL 1 "STANDARD APPEAL": If you wish to appeal SilverScript's denial of a drug you have not yet received; you and your physician or other prescriber can request a "Standard Appeal". SilverScript will give you an answer within 7 calendar days after receipt of the Level 1 "Standard Appeal".

To request a Level 1 "Standard Appeal", you may make it in writing and mail or fax it to SilverScript:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85075-2000
Fax Number: 1-855-633-7673

LEVEL 2 APPEALS: If SilverScript denies your Level 1 "Fast" or "Standard" Appeal, you may file a Level 2 Appeal. A Level 2 Appeal is reviewed by an IRO, which is an independent organization retained by Medicare and which is neither affiliated in any way with SilverScript nor an agency of the government.

To file a Level 2 Appeal, you or your representative, or physician/prescriber must contact the IRO asking for a review of your case. You will receive instructions, including the applicable deadlines and contact information for the IRO.

If you make an appeal to the IRO, SilverScript will send the information regarding your appeal to the IRO. This information is called your "case file".

LEVEL 2 "FAST APPEAL" & "STANDARD APPEAL": When filing a Level 2 Appeal with the IRO, you may request a "Fast Appeal" or a "Standard Appeal".

Level 2 Fast Appeal - If the IRO approves a "Fast Appeal", it must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal. If the IRO approves part or all of what you appealed, SilverScript will provide the drug coverage that was approved by the IRO within 24 hours after receipt of the decision.

Level 2 Standard Appeal - If the IRO approves a "Standard Appeal", it must give you an answer within 7 calendar days after it receives your appeal. If the IRO approves all or part of what you appealed, SilverScript will provide the drug coverage that was approved by the IRO within 72 hours after receipt of the decision.

If you have already purchased the drug that was initially denied and the IRO approves a refund request, SilverScript will send payment to you within 30 calendar days after receipt of the decision.

LEVEL 3 APPEALS: If the IRO denies your Level 2 Appeal, you may have the right to a Level 3 Appeal.

A Level 3 Appeal can only be made if the dollar value of the prescription drug coverage you are requesting meets a minimum amount. If the dollar value of the prescription drug coverage you are requesting is too low, there is no Level 3 Appeal, and the Level 2 Appeal decision **is final.**

Making a Level 3 Appeal - If the dollar value of the prescription drug coverage meets the requirement for a Level 3 Appeal, you will receive instructions on how to file a Level 3 Appeal when you receive a determination

of your Level 2 Appeal from the IRO.

A Level 3 Appeal is reviewed by an Administrative Law Judge who is an employee of the Federal Government.

If the Administrative Law Judge approves your Level 3 Appeal, SilverScript must authorize or provide the drug coverage that was approved within 72 hours or make payment no later than 30 days after the receipt of the decision.

LEVEL 4 APPEALS: If your Level 3 Appeal is denied, you will receive instructions on how to file a Level 4 Appeal when you receive a determination of your Level 3 Appeal from the Administrative Law Judge.

A Level 4 Appeal is reviewed by an Appeals Council which is an entity used by the Federal Government for such appeals.

If the Appeals Council approves your Level 4 Appeal, SilverScript must authorize or provide the drug coverage that was approved within 72 hours or make payment no later than 30 days after the receipt of the decision.

LEVEL 5 APPEALS: If your Level 4 Appeal is denied, you will receive instructions on how to file a Level 5 Appeal when you receive a determination of you Level 4 Appeal from the Appeals Council.

A Level 5 Appeal is reviewed by a Federal District Court.

Authority as Claims Fiduciary: SilverScript shall serve as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of Medicare Part D prescription drug benefits. SilverScript shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties, subject to available judicial review.

Cigna Dental Services AppealProcess

When You Have a Complaint or an Appeal, Start with Cigna Customer Services

If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your, explanation of benefits (EOB), or claim form and explain your concern to one of Cigna's Customer Service representatives. You may also express that concern in writing. If more time is needed to review or investigate your concern, Cigna will get back to you as soon as possible, but in any case, within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure: To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write at the toll-free number on your EOB, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Cigna will respond in writing with a decision within 30 calendar days after an appeal is received for a post-service coverage determination. If more time or information is needed to make the determination, you will be notified in writing of the request for an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

External Review Procedure: If you are not satisfied with the decision of Cigna's internal appeal review regarding Medical Necessity or clinical appropriateness, you may request that your appeal be referred to an IRO. Each IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to

request an external review will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate this external review. Cigna will abide by the decision of the IRO. In order to request a referral to an IRO, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for external review.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, the review shall be completed within 3 days.

Notice of Benefit Determination on Appeal: Every notice of a determination on appeal will be provided in writing or electronically and, if a denial, will include: the specific reason(s) for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and a statements of your right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review.

Relevant Information: Relevant information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action: In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

Authority as Claims Fiduciary: Cigna shall serve as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of dental benefits. Cigna shall have, on behalf of the Plan, sole and complete discretionary authority to determine these claims conclusively for all parties, subject to available judicial review.

Appeal Process Post-Service Claims for Medicare Wrap-Around, Cardiovascular, Vision, Hearing Aid, Health Reimbursement Arrangement (HRA), Weekly Disability and Weekly Unemployment Benefits

If a claim for Medicare Wrap-Around, Cardiovascular, Vision, Hearing Aid, HRAs, Weekly Disability or Weekly Unemployment Benefits is denied and you disagree with the decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of the denial to submit a written request for an internal appeal. Appeals must be submitted in writing within 180-days of the claims denial to the:

Appeals Committee/Board of Trustees
Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street
Long Island City, NY 11101
1-718-835-2700

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments. As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- With respect to health and disability/weekly benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence;
- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- With respect to health and weekly disability benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by appropriate fiduciaries of the Plan who are neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinates of such individual; and
- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciaries will:
  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

- Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeals Decision Timeframes

Medicare Wrap-Around, Cardiovascular, Vision, Hearing Aid, HRAs, Weekly Disability, and Weekly Unemployment Benefits

The Plan will make an appeal determination on all the above claims no later than the date of the Appeals Committee's meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Appeals Committee will notify you in writing of the benefit determination no later than five (5) calendar days after the benefit determination is made.

Appeal Process for Life and AD&D Benefits

Amalgamated Life Insurance Company will make the decision within 90-days of its receipt of your appeal. 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, 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;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

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.

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.

Time Limit to Bringing a Lawsuit

Any action by a Participant or Beneficiary for benefits following the denial of an appeal (other than for dental benefits) must be filed within 365 days after the date of the notice of the denial of the final appeal. Thus, for example, if a particular claim requires two levels of administrative appeal to Empire Blue Cross/Blue Shield (" Empire") and the date of Empire's denial of the second level administrative appeal is January 1, 2020, you have until January 1, 2021 to file a lawsuit for benefits. If the claim at issue only requires one level of appeal to the Welfare Fund, you would determine the period within which to file suit based on the date of the Welfare Fund's denial of the appeal. Remember that you cannot file a lawsuit until you have complied with the Welfare Fund's administrative appeal procedures. However, for dental claims, you have 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services to file a lawsuit.

Venue Requirement for Lawsuits

Any lawsuit related to any claims that a Participant, Spouse or Beneficiary may have against the Fund, the Board of Trustees, or any employee, fiduciary or representative of the Fund may only be brought in the United States District Court for the Eastern District of New York in Brooklyn, New York.

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 or Meridian Resource Company, LLC (Meridian) will require the injured party to sign a Reimbursement/Subrogation acknowledgement form before any benefits are paid. If you, your dependent, 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 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. The Plan's right to subrogation/reimbursement is established by the Plan and not by the acknowledgement form. If 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. The Plan has contracted with Meridian for subrogation/reimbursement services and you are required to cooperate with Meridian in its efforts to obtain monies on behalf of the Plan.

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 and/or Meridian 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 and/or Meridian 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 and/or Meridian.

If an injured party accepts benefits from the Plan and amounts are recovered from claims arising from the injury, 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.

If 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 and/or Meridian 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 and/or Meridian 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 and/or Meridian 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. If 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. 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.

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. 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 Dependents until the Plan is reimbursed for the benefits improperly paid. The Trustees may suspend coverage for you and your dependents until full reimbursement of any claims paid in error has been made to the Fund. In addition, the Plan may take legal action to recover the amounts paid in error.

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 and/or Dependent for repayment. If repayment is not promptly made, the amounts due the Plan may be deducted from any benefits due to the Eligible Employee and his or her Dependents until the Plan is reimbursed for the benefits improperly paid. In addition, the Plan may take legal action to recover the amounts paid in error.

You must reimburse the Plan for any claim paid in error by the Fund Office due to your failure to update your enrollment status. Important events that must be reported include your divorce, 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 Dependents until the Plan is reimbursed for the benefits improperly paid. In addition, the Plan may take legal action to recover the amounts paid in error.

Payment to Third Parties

Generally, benefits payable under the Plan (including any appeal rights concerning those benefits) cannot be alienated, transferred, assigned, or otherwise promised to a person or party other than you. 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.

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 Dependents until the amount you owe the Plan is paid in full. The Plan may also file suit against you or your former Eligible Dependents, 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:

1	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 106
2	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.
3	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.
4	Illnesses or injuries due to war or any act of war, declared or undeclared (including resistance to armed insurrection).
5	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.
6	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).
7	Treatment of the teeth or gums, except: 1. For the repair of non-occupational injuries to natural teeth, or 2. Specifically provided under the Cigna dental benefit
8	Medication, services or supplies not prescribed by a Physician or Dentist.
9	Services for which no charge is made or for which no charge would be made if no coverage existed.
10	Charges that neither the Eligible Employee nor the Eligible Dependent is personally liable to pay.
11	Amounts in excess of actual charges, except when required by contract.
12	Charges in excess of the Plan's limitations.
13	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.
14	Benefits, services, equipment and supplies that are required as a condition of employment.
15	Benefits, services, equipment and supplies promised by an Employer as a result of an agreement (other than an agreement to contribute to the Plan).

16	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.
17	Hospitalization primarily for diagnostic studies and evaluations, x-ray examinations, laboratory examinations or electrocardiograms except where appropriate by virtue of medical necessity.
18	Services or supplies provided before the Employee or Dependent became eligible for coverage, or after eligibility 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.
19	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, or Transitional Living services for individuals needing mental health, substance use and/or physical support.
20	Any claim submitted more than 18 months after the date of treatment or service, except as otherwise indicated or approved by the Plan.
21	Charges for or related to in-vitro fertilization or artificial insemination. However, prescription drugs in connection with such treatment are covered.
22	Charges for broken or missed appointments.
23	Treatment that is experimental, investigational or part of a research program. Experimental or investigational treatment includes: o any treatment not proven in an objective manner to have benefits for the patient; o any treatment that is restricted to use at a medical facility engaged primarily in carrying out scientific studies; o any treatment, drug or supply which is not recognized as acceptable medical practice in the United States; o any items requiring governmental approval which was not granted at the time the services were rendered; o 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); o any treatment that involves drugs not approved by the FDA, including dosages, combinations and uses that are not approved; o any new drug or devise for which an investigational application has been filed with the FDA; o 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. Notwithstanding the above, the Plan will cover the routine patient costs for (and not deny, limit or impose additional conditions on) items and services otherwise covered by the Plan that are furnished in connection with participation in an approved clinical trial if you are: (i) eligible to participate an approved clinical trial to treat either cancer or other life-threatening disease or condition; and (ii) referred by an In-Network provider who has concluded that your participation in the approved clinical trial would be appropriate (or provide medical and scientific information establishing that your participation would be medically appropriate). Routine patient costs do not include and the Plan does not cover: the costs of the investigational drugs or devices; the costs of non-health services required for you to receive the treatment; the costs of managing the research; or costs that would not be covered under the Plan for non-investigational treatments provided in the clinical trial.
24	Treatment to reverse voluntary surgically induced infertility.
25	Charges for treatment for which the claimant has failed to comply with the Plan's request to be examined by a practitioner designated and paid for by the Plan. See page 81.
26	Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition. Notwithstanding this exclusion, nothing in this SPD shall be construed to deny Life Insurance Benefits as described on pages 63-64 to the designated beneficiary of a Participant whose death was the result of an intentionally self-inflicted injury.
27	Confinement to an institution that is not a Hospital or other Facility (Skilled Nursing Facility, Inpatient Rehabilitation Facility, Inpatient Residential Facility) as those Facilities are defined in the Definitions section.
28	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.
29	Co-payments of any kind.
30	Charges for Immunization required for travel outside the United States.
31	Charges for Hypnosis.
32	Charges for LASIK Eye Surgery/Radial Keratotomy.
33	Treatment for temporomandibular joint ("TMJ"), including all related expenses. Treatment for TMJ shall be covered only as a dental expense under the CIGNA benefit
34	Charges for Biofeedback.
35	Charges for or related to weight loss treatment except as required by the ACA. (Prescription drugs and medically necessary procedures in connection with weight loss however, are covered.)
36	Charges related to Gene Therapy. The Fund does not cover any charges related to gene therapy, whether those therapies have received approval from the FDA or are considered experimental or investigational. See the Definitions section of the SPD for a definition of Gene Therapy
37	*Services performed in connection with conditions not classified in the current edition of the* International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.
38	Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
39	Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
40	Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
41	Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
42	Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
43	Urine drug testing and other diagnostic testing that is done in conjunction with any Facility-based treatment or in a Facility, that is done by an outside/independent laboratory is not covered except for non-routine testing that cannot be reasonably expected to be performed by the Facility because it is not equipped to perform such testing .
44	The following services related to drug testing and other diagnostic testing are excluded from coverage: 1. Associated specimen collection and handling charges (these are inclusive within the reported testing codes) 2. specimen validity testing 3. experimental, unproven, or investigational procedures that are not supported by evidence-based medicine and established peer reviewed scientific data.
45	Any services or supplies provided solely for the purpose of meeting court-ordered requirements unless the services are both Medically Necessary and a covered benefit of the Plan.
46	Expenses for physical examinations, screenings (including drug screening), testing and immunizations such as required for functional capacity/job analysis examinations and testing required for employment/career, commercial driving, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, required by any third party, education, travel, marriage, adoption, judicial or administrative proceedings/orders, medical research or to obtain or maintain a license of any type.
47	Services performed in connection with Conduct and Impulse Control Disorders; Gambling Disorder; Learning Disorder; Paraphilic Disorder.

Non-Discrimination Notice

The Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Benefits are provided without regard to an individual's sex assigned at birth, gender identity, or gender.

When necessary, the Fund will provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The Fund also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages upon request. If you need these services, contact the Fund Administrator, Walter Saraceni.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Walter Saraceni, Section 1557 Coordinator, Plumbers Local Union No. 1 Welfare Fund, 50-02 Fifth Street, 2nd Floor, Long Island City, NY 11101, (718) 835-2700 (telephone), (718) 641–8155 (fax), info@ualocal1funds.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Walter Saraceni, the Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718–835-2700.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-718–835-2700.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718–835-2700 (ATS : 1-XXX-XXX-XXXX).
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718–835-2700 번으로 전화해 주십시오.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718–835-2700.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718–835-2700.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718–835-2700.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-718–835-2700.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 718–835-2700.(هاتف الصم والبكم
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718–835-2700.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-718–835-2700.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-718–835-2700.
☐ L করনঃ িযদ আিপন বাংলা, কথা বলেত পাের◌ন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা িপেরষবা উপল 1আছ। 1◌ফান করন ১- 718–835-2700.
718–835-2700.
1 רופט. אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל

DEFINITIONS

Some terms have special meanings when used in this SPD. Some of these terms are defined in the text of the SPD, generally in the section in which they are first used. Other terms are defined below. All defined terms apply throughout the SPD 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 an Employer must make contributions. Therefore, Employees who are eligible under the Plan based solely 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 23.

Allowable Expenses are any Medically Necessary charges for Hospital, Medical, Dental and Vision benefits and services covered by this Plan (except Life Insurance and AD&D) and any other plan covering the person making the claim.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

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.

Autism Spectrum Disorder refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as Autistic disorder, Asperger's Syndrome or Pervasive Developmental Disorder.

Behavioral Healthcare

Management Program see page 33

Beneficiary Designation Form see page 63

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

Concurrent Care Claim 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 Benefits. See page 23.

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 will generally be handled as Post-Service Medical Claims.

Eligible Employee is an Employee who has satisfied the requirements for eligibility for benefits from this Plan as described in this SPD 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 fourth month following the most recent period of three (3) consecutive months in which the Employee works at least 290 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 73-74.

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.

Experimental or Investigational Service(s) - Technology, treatments, procedures, drugs, biological products or medical devices that in judgment of the Claims Administrator are experimental or investigative or obsolete or ineffective including any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:

- Not of proven benefit
- Not generally recognized by the medical community (as reflected in published medical literature)

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. The applicable Claims Administrator may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- There is final market approval by the FDA for the patient's particular diagnosis or condition. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer-review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Freestanding Facility is an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not

cover any charges related to gene therapy, regardless of whether those therapies have received approval from the FDA or regardless of whether they are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T), Kymriah and Yescarta, as well and Luxturna and Zolgensma; new applications for gene therapies are submitted every year.

Health Reimbursement Account ("HRA") see page 73

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 p 47

Facility is an outpatient facility that performs services and submits claims as part of a Hospital.

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.).

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long-term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) is outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment is a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

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

Local 1 - 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.

Medically Necessary means services or supplies when prescribed as necessary by a Physician legally licensed to practice medicine while prescribing within the scope of her or 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 17.

Mental Health Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the designated organization or individual that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participating Providers see page 23

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 they practice, who is practicing within the scope of their 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 terms of the Plan condition, receipt of the benefit, on approval of the benefit in advance of obtaining medical care. See pages 33-47 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.

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 Dependents to elect COBRA Continuation of Coverage. See page 19.

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 72.

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 from the PPNPF. See page 13.

Specialty Guideline Management Program see page 59.

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.

Residential Treatment - **Program/Facility** is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be considered payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state). Residential Care is only covered for behavioral health disorders and not for any other diagnosis. A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Substance-Related and Addictive Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Care Service.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it does not offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage the activities of daily living. They may be used as an addition to treatment when it does not offer the intensity and structure needed to help with recovery.

Transitional Living also includes custodial care and/or supported living arrangements for individuals needing physical support.

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 17.

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

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Plan uses a process by which clinical evidence is compiled and reviewed with respect to certain health care services. From time to time, medical and drug policies will be issued by the Fund's designated organization that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.
Please note:

- If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) the Fund's designated organization may, as it determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that sickness or condition. Prior to such a consideration, the Fund's designated organization must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Uniformed Services see page 5.

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 in the opinion of a Physician, with knowledge of your medical condition, would subject you to severe pain if your claim were not dealt 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 HIPAA PRIVACY

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 Rule may be an inconvenience to you. However, we are doing everything possible to minimize the burden onyou.

The Privacy Rule is detailed. The following questions and answers explain the Rule in more detail and give some important information on how the Privacy Rule affects 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 or other person 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 prohibits 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.)

We are permitted to discuss your medical information with you directly, but we are not able to discuss or disclose your information with third parties, such as your spouse or your union officials, unless you specifically authorize the Plan to do so.

How do I authorize someone to assist me in dealing with the Fund Office? If you are not present, an individual, such as 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

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 consultants 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 contracts with them. Other examples of business associates are the Plan's 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: (1) 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 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 Trustees only in accordance with the provisions of the Plan's Privacy Policy and the provisions of the Plan.

The Plan may disclose your PHI, including your qualification for health benefits and specific claim information to the 401(k) Plan in order for the 401(k) plan to determine your eligibility for a Hardship Withdrawal.

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.

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
Administrator for the Trustees
Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street
Long Island City, NY 11101
1-718-835-2700

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-insured (subject to any applicable stop loss insurance) with the exception of Life Insurance and AD&D benefits which are insured.

Type of Plan: Hospitalization, Medical, Disability, Dental, Vision, Cardiovascular, Prescription, Life and Accidental Death & Accidental Dismemberment, Weekly Disability Benefits, and Weekly Unemployment Benefits.

Date of the End of the Plan Year: December 31

Internal Revenue Service Plan Identification Number: 11-1538293

The Plan Number is: 501

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
50-02 Fifth Street, 2Nd Floor
Long Island City, NY 11101
1-718-835-2700

Loss of Grandfathered Health Plan Status: As of January 1, 2015, the Welfare Fund ceased to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

Service of legal process may be made on any Plan Trustee listed on page 1.

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 Dependents, and for expenses incurred with respect to the operation of the Plan. The Trustees periodically 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: 1-866-831-4336 Website: www.caremark.com
Prescription Drug Card CVS/Caremark P.O. Box 853901 Richardson, TX 75085-3901	 Phone: 1-866-831-4336 Website: www.caremark.com
SilverScript Prescription Drug Cards CVS/Caremark P.O. Box 853901 Richardson, TX 75085-3901	 Phone: 1-855-282-9586 Website: www.silverscript.com
Physician & Hospital Network Empire Blue Cross & Blue Shield P.O. Box 1407 New York, NY 10008	 Phone: 1-844-243-5566 Website: www.empireblue.com
Behavioral Health and Mental Health Optum P.O. Box 30757 Salt Lake City, UT 84130-0757	 Phone: 1-844-884-1852 Website: www.liveandworkwell.com
Vision Benefits Vision Screening 1919 Middle Country Road, Suite 304 Centereach, NY 11720	 Phone: 1-800-652-0063 Website: www.vscreening.com
Vision Benefits Comprehensive Professional Systems, Inc. 11 Hanover Square, 8th Floor New York, NY 10005	 Phone: 1-212-675-5745 Website: www.cpsoptical.com
Dental Benefits Cigna Health and Life Insurance Company, Cigna Dental P.O. Box 188037 Chattanooga, TN 37422-8037	 Phone: 1-800-244-6224 Website: myCigna.com Group ID: 3340321
Dental Benefits – Discount Program for Medicare eligible Participants Cigna Health and Life Insurance Company, Cigna Plus Savings Program 250 South Northwest Highway, Suite 340 Park Ridge, IL 60068-4244	 Phone: 1-877-521-0244 Website: www.CignaPlusSavings.com Group ID: PlumbersL1

Medicare Wrap-Around Claims Processor Administrative Services Only, Inc. 303 Merrick Road Lynbrook, NY 11563-9010	 Phone: 1-877-782-6659 Website: www.asonet.com
Cardiovascular Screening Benefits Vascular Diagnostic Associates, PC 41-61 Kissena Blvd. – Suite #4 Flushing, NY 11355	 Phone: 1-718-886-0600 Website: www.vasculardiagnostic.com
Hearing Benefits Comprehensive Professional Systems, Inc. 11 Hanover Square, 8th Floor New York, NY 10005	 Phone: 1-212-675-5745 Website: www.cpshearing.com

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 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 of 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, 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, Dependents, and Retirees, and eligibility requirements for coverage.

ERISA RIGHTS STATEMENT

As a Participant in the 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 participants shall be entitled to:

Receive Information about Your Plan and Benefits: Examine, without charges, at the Plan 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, your Spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD on the rules governing your COBRA Continuation of Coverage rights.

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

Enforce Your Rights: If your claim for a 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.

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