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

2025

Providing Employee Benefits to the Plumbers of New York City Since 1946

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.

The new SPD also contains detailed changes to Welfare Fund provisions for active employees under the No Surprises Act (the "NSA"). Below is a high-level summary of these changes, which are described in more detail in the SPD.

In General. The NSA protects patients from being balanced billed by the provider or facility if they receive emergency services (and some types of non-emergency services) at certain out-of-network facilities or from a non-PPO provider at an in-network facility or if they need an air ambulance.

- Patient's Costs: Patients receiving these services will only be responsible for paying their in-network cost share of an amount that is similar to the rate that an in-network provider would charge.

Surprise Billing. Starting January 1, 2022, when you get emergency care or get treated by an out-of-network provider at an in-network hospital, freestanding emergency department or ambulatory surgical center, you are protected from surprise billing or balance billing in the following situations:

- Emergency Services: If you have an emergency medical condition and get emergency services (including air ambulance services) from an out-of-network provider or facility, the most the provider or facility may bill you is the plan's in-network cost-sharing amount (such as copayments and coinsurance). Put another way, you can't be balance billed for these emergency services.
- Certain Non-Emergency Services: This protection against balance billing under the NSA also applies to services you may get after you have been stabilized until you are able to use non-medical transportation or non-emergency medical transportation unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Additional Protections. In the circumstances described above when balance billing isn't allowed under the NSA, you also have the following protections:

- Your Costs: You are only responsible for paying your share of the cost under the Plan, like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network. The plan will pay out-of-network providers and facilities directly.
- Plan Coverage: The Welfare Fund generally will:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Prior to this change, the provider or facility could balance bill you.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

Information on In-Network Providers. A list of in-network providers will be made available to you without charge. If you obtain and rely upon incorrect information about whether a provider is an in-network provider from the Plan or its administrators, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network.

Continuity of Care. The Welfare Fund will apply special rules if you are a "Continuing Care Patient," which applies if you are:

- Undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care;
- Scheduled to undergo non-elective or postoperative care after a non-elective surgery; pregnant and undergoing a course of treatment for the pregnancy; or
- Are terminally ill and receiving treatment for such illness and your provider or facility leaves the network.

If you are a Continuing Care Patient as described above, the Welfare Fund's third-party administrator will:

- Notify you in a timely manner of the provider or network's change in status and your right to elect continued transitional care from the provider or facility; and
- Continue to cover claims for that complex care at the in-network cost sharing levels for up to 90-days to allow time for you to transition to an in-network provider.

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) 223 – 4313.

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 January 2025) 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 Plumbers Local Union No. 1 Welfare Fund (the "Welfare Fund," the "Fund," or the "Plan") 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 addresses of the current Trustees are as follows

THE BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
Paul O'Connor, Co-Chair Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Marie Cardoza**, Co-Chair Cardoza Plumbing Corp. 514 Grand Blvd. Westbury, NY 11590
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
Richard Garner Plumbers Local Union No. 1 50-02 Fifth Street, 2nd Floor Long Island City, NY 11101	**Vincent Gamba** Olympic Plumbing & Heating Services Inc. 4 Aerial Way Syosset, NY 11791
Richard Gilligan 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
	Barr Rickman Crescent Contracting Corp. 2800 Webster Avenue Bronx, NY 10458

The Board of Trustees is authorized to interpret this Plan Document/Summary Plan Description ("SPD") and the Trust Agreement. The Board has the discretion to decide all questions about the Fund or Trust, including questions about your eligibility for participation, benefits and the definition of 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 benefit claims.

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
1-718-223-4313
info@nypl1f.org
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, including contribution history, eligibility, beneficiary and dependent information, account balances, transaction history, and certain claims status, by logging into the Fund Office's online secure portal at MyBenefits.nypl1f.org . 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 access this SPD and any modifications at UALocal1funds.org.

ELIGIBILITY

Eligibility for benefits from the Fund is based upon hours worked under Collective Bargaining Agreements ("CBAs") 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 the Fund on your behalf. You must satisfy eligibility requirements described further **below** in this booklet.

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

The rules and benefits described in this booklet apply to Journeymen 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 and other related terms are explained below and in the "Definitions" section found on page **111** of this booklet:

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

A "***Collective Bargaining Agreement***" or "***CBA***" is an agreement between an Employer and Local 1 that requires the Employer to contribute to the Fund.

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

"***Covered Employment***" is work under a CBA or Participation Agreement for which contributions must be paid to the Fund.

An "***Active Eligible Employee***" is an Employee whose eligibility for benefits is based on hours worked for which their Employer must make contributions. In addition, Employees who are eligible under Unemployment Continuation of Coverage, Workers' Compensation 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 for coverage 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 the Fund. An Employee becomes a Retired Employee on the effective date of their Pension.

Initial Eligibility for Employees

You will be eligible for benefits as an Active Eligible Employee on the first day of the calendar month following 3 consecutive months of Covered Employment with Contributing Employers in which you are credited with at least 290 hours in Covered Employment. 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.

You may purchase up to 16 hours to apply to a period of three consecutive months in order to retain eligibility. The cost is determined by the Trustees annually. In certain circumstances you may pay COBRA premiums or make a self-payment for continued health coverage. These special circumstances are described in the section entitled "COBRA Continuation of Coverage" on page 18.

Reciprocal Plans – The Fund 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 lower rate than this Plan's contribution rate, your credited hours will be prorated. If the reciprocal Plan contributions are at a higher rate than this Plan's contribution rate, you will be credited with additional prorated hours. Contributions made to this Plan and forwarded to a reciprocal Plan are not 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 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 the prorated hours from a reciprocal Plan are not sufficient to maintain eligibility and you have exhausted the up to 12 months of coverage at no cost from the date your eligibility would otherwise terminate, effective July 1, 2024, you may be eligible for MES Helper Benefits if the prorated hours from a reciprocal Plan are sufficient to maintain eligibility for the MES Helper Benefits. If you have a question regarding reciprocal agreements, 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 may 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.

Be sure to keep track of the hours you work each month. If you are working for a Delinquent Employer (i.e., an employer who has not paid 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 for any hours 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 after July 31st (4 months after March).

If you work fewer 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 per hour is 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 page 7 and page 63.

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 for 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 Fund 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 Fund 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, 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.

Continuing Eligibility During New York State Paid Family Leave

If you are eligible for New York State Paid Family Leave ("NYS PFL"), you are entitled to keep your health coverage on the same terms as if you continued to work. For information on NYS PFL, visit https://paidfamilyleave.ny.gov/. Your Employer is required to continue making contributions to the Fund on your behalf while you are on PFL leave. Please contact the Fund Office if you are planning to take NYS PFL so that the Plan is aware of the Employer's responsibility to report and contribute during the NYS PFL period.

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 18 months from the date eligibility would otherwise terminate. However, your 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 per month for the additional 18-month extension is 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:

- If you were eligible for benefits 10 months prior to becoming disabled and you reject COBRA upon termination of coverage, you will be eligible for a maximum of 5 months of the Disability Continuation of Coverage at no cost plus an additional 18 months of coverage at the Fund's self-pay rate.
- If you were eligible for benefits for 18 months prior to becoming disabled and you reject COBRA upon termination of coverage, you will be eligible for a maximum of 9 months of the Disability Continuation of Coverage at no cost plus an additional 18 months at the Fund's self-pay rate.
- If you were eligible for benefits for 36 months or more prior to becoming disabled and you reject COBRA upon termination of coverage, you will 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 the Fund's self-pay rate.

DISABILITY CONTINUATION OF COVERAGE MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
First 18 months	$0 per month	$0 per month
Additional 18 months	$1,021 per month	$2,728 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 requested information. 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). You must notify your Employer within 30 days of the accident or the onset of the illness and notify the Fund within 2 years from the date of the accident or onset of the illness.

If your eligibility is extended, you must submit a statement to the Fund Office no earlier than the 20th day of each month preceding the month for which the 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 the current paystubs during the timeframes stated above. The statement must affirm that you are disabled and must be accompanied by proof of disability, such as an affidavit documenting the disability. You must notify the Fund Office immediately if you return to Covered Employment and provide proof of Covered Employment.

Your Temporary Disability Extension will be terminated if you fail to submit (i) monthly proof of your continued receipt of State Disability Benefits or Workers' Compensation benefits, (ii) the monthly statement, or (iii) any additional requested information.

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 IME results in determining whether to continue the Temporary Disability Extension, and they may terminate the Temporary Disability Extension if the IME result 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, (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 page **102**.

Effect of Permanent Disability Award or Medicare on Eligibility for Temporary Disability Extension: You are not eligible for the Temporary Disability 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 or becoming Medicare eligible***. If you receive a Social Security Disability Award or Medicare and fail to notify the Fund Office, you are responsible for paying the Fund 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 or Medicare.

For Social Security Permanent Disability Awards granted on or after January 1, 2017, the Plan will not seek reimbursement of the lesser of the amount the Participant would have paid in retroactive COBRA premiums (if COBRA had been elected instead of the Temporary Disability Extension) or actual claims paid during the temporary disability extension.

Effect of Retirement on Eligibility for Temporary Disability Extension: Eligibility for the Temporary Disability Extension will terminate for a Retired Employee on the effective date of your pension.

Effect of 401k Employee Savings Plan Termination of Employment: Eligibility for the Temporary Disability Extension is not permissible if you apply for 401k Termination from Employment benefit.

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 because of unemployment, you may apply for an Unemployment Extension within 1 year from the date your eligibility would otherwise terminate. Generally, under the Unemployment Extension, you may continue coverage for up to 6 months at no cost from the date your eligibility would otherwise terminate, plus an additional 6 months of coverage at the Fund's self-pay monthly rate.

However, the total Unemployment Extension cannot exceed 50% of the length of the period during which you were eligible for benefits, 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 monthly cost for the additional 18-month extension is determined by the Trustees annually. If you elect COBRA Continuation of Coverage, you are not eligible for the Unemployment Extension.

Examples of Eligibility Scenarios:

- If you were 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 will be eligible for a maximum of 5 months of the Unemployment Extension at no cost plus an additional 18 months of coverage at the Fund's monthly self-pay rate.
- If you were 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 will be eligible for a maximum of 9 months of the Unemployment Extension. The first 6 months of the Unemployment Extension is at no cost and the next 3 months is at the Fund's monthly self-pay rate. Following the Unemployment Extension, you are eligible for an additional 18 months at the Fund's self-pay monthly rate.
- If you were 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 will be eligible for a maximum of 12 months of the Unemployment Extension. The first 6 months of the Unemployment Extension is at no cost and the second six (6) months is at the Fund's monthly self-pay rate. Following the Unemployment Extension, you are eligible for an additional 18 months of coverage at the Fund's monthly self-pay rate.

UNEMPLOYMENT CONTINUATION OF COVERAGE MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
First 6 months (Month 1 to Month 6)	$0 per month	$0 per month
Following 3 months (Month 7 to Month 9)	$247 per month	$664 per month
Following 3 months (Month 10 to Month 12)	$495 per month	$1,326 per month
Additional 18 months (Month 13 to Month 30)	$1,021 per month	$2,728 per month

You must submit a written request 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 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. You must submit this statement to the Fund Office in person no earlier than the 20th of each month preceding the month for which the statement is given and no later than the 20th of each month following the month for which the 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 the Unemployment Extension will terminate for a Retired Employee on the effective date of your pension.

Effect of 401k Employee Savings Plan Termination of Employment: Eligibility for the Unemployment Continuation of Coverage Extension is not permissible if you apply for 401k Termination from Employment benefit.

Examples of evidence that you are unemployed:

- If you had been eligible for benefits prior to unemployment, you must 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 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 the 4-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 the Unemployment Extension for August.
- 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 the Unemployment Extension for August, a statement is due no earlier than July 20th and no later than September 20th.

For purposes of continued eligibility during the Unemployment Extension, you will be deemed eligible for benefits on a monthly basis for up to 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 are 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. However, if you are 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 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 will 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.

You may be required 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. Your Unemployment Extension will be terminated if (i) you fail to submit in person the monthly statement, (ii) you fail to appear before the Trustees when requested, (iii) you fail to submit additional requested information, (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

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

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 continues through the end of the fourth month following the most recent period of 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, 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 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, 2025, 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 military service. The Plan coverage will be primary for your Eligible Dependent(s).

Requirements of USERRA: You must meet the following requirements 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 5 years;
- Upon leaving Uniformed Service, you must report 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 periods of time:
    - Uniformed Service of fewer 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 fewer 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

When you become eligible for benefits, certain of your Dependents may also become eligible for benefits. "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 from a plan other than the plan of a parent or stepparent.
- "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 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 their own support or (b) depend on you for more than one-half of their 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 5 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 their 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 submitted to the Fund Office. If you gain a dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll such Dependent. However, you must submit an enrollment form to the Fund Office within 180 days after the marriage, birth, adoption or placement for adoption. Eligibility for enrollment received after this 180-day period may be granted by the Fund. However, eligibility will be effective from the first day of the month in which enrollment was granted by the Fund. Each change in Dependent Enrollment (adding or terminating a Dependent) after the initial enrollment must be submitted with satisfactory evidence or proof of Dependent status.

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 on behalf of a divorced Spouse or stepchild after the date of divorce are the financial responsibility of the Employee and the former spouse.

You and your former spouse will be jointly and severally liable for any amounts paid on behalf of your former Spouse or stepchild following a divorce. In addition to having to pay the Fund the costs of any benefits provided, or premiums paid on behalf of your 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 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).

If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may 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 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 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 their coverage at no cost for 6 months following the date of the Employee's death. Thereafter, Dependents may elect to purchase COBRA Continuation as described on page 18.

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.

Eligibility for the different levels of Surviving Spouse/Dependent Continuation of Coverage is determined by Age and Service. If you qualify for Surviving Spouse/Dependent Continuation of Coverage, your level of benefits and your monthly cost will change when you become Medicare-eligible, your Dependent reaches age 26 or if the Trustees change the eligibility rules.

- **Early Continuation of Coverage for Surviving Spouse/Dependents:**
  If you retired between ages 55 and 59 and met the service requirements.
- **Non-Medicare Continuation of Coverage for Surviving Spouse/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 Advantage Plan for Surviving Spouse/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.

Surviving Spouse and Dependent Eligibility Rules - You may be eligible for Surviving Spouse and Dependent Benefits if you meet the following requirements. You must satisfy both the applicable age and service requirements. In addition, you must elect Surviving Spouse/Dependent coverage during the 6-month period following the death of an Active Eligible Member. Failure to elect Surviving Spouse/Dependent Continuation of Coverage at the required time will result in the permanent forfeiture of all eligibility for Surviving Spouse/Dependent Coverage. Under no circumstances can you elect Surviving Spouse/Dependent Coverage after the expiration of the date upon which to elect such coverage.

- **Age** – The level of Surviving Spouse/Dependent Continuation of Coverage that may be available to you is determined by the Age of the Active Eligible Member at time of death. See above Eligibility Overview for the different age groups.
- **Service** - The level of Surviving Spouse/Dependent Continuation of Coverage that may be available to you is determined based on how long the deceased Active Eligible Member worked in Covered Employment, i.e., the length of service.

  1. The deceased Active Eligible Member must have been eligible for benefits (a) for at least 10 years and (b) for at least 84 out of the last 120 months prior to the date of death. Months during which the Active Eligible Member had COBRA coverage are not counted in determining whether the 84 of 120 eligibility months service test is satisfied.
  2. In addition to satisfying requirement 1 above, a deceased Active Eligible Member must have had at least 500 hours of work reported to the Welfare Fund for the last 3 years prior to the date of death. If disabled, the deceased Active Eligible Member must have had 500 hours reported during the 36-month period prior to the date of death.
  3. In addition to satisfying requirements 1 and 2 above, the deceased Active Eligible Member must have 20 years of Pension Credit with the United Association National Pension Fund ("UANPF"), or one of the prior plans.

Surviving Spouse and Dependent Benefits - You may be eligible for the following Surviving Spouse and Dependent Benefits if you meet the above-listed requirements.

Early Continuation of Coverage for Surviving Spouse/Dependents:
The following coverage types and premium amounts apply if the Active Eligible Employee did not satisfy the above-described service requirements as of the date of death.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
6 MONTHS FOLLOWING DEATH OF ACTIVE MEMBER	$0 per month	$0 per month
36 MONTHS FOLLOWING 6-MONTH PERIOD OR [1] SURVIVING SPOUSE REMARRIES. [2] UNTIL DEPENDENT REACHES AGE 26.	$664 per month	$1,724 per month

Early Continuation of Coverage for Surviving Spouse/Dependents:
The following coverage types and premium amounts apply if the Active Eligible Employee was between ages 50-59 and met the above-described service requirements at the time of death.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
6 MONTHS FOLLOWING DEATH OF ACTIVE MEMBER	$0 per month	$0 per month
36 MONTHS FOLLOWING 6-MONTH PERIOD OR [1] SURVIVING SPOUSE REMARRIES. [2] UNTIL DEPENDENT REACHES AGE 26.	$664 per month	$1,724 per month

Early Continuation of Coverage for Surviving Spouse/Dependents:
The following coverage type and premium amounts apply if the Active Eligible Employee was age 60 or older or had a Social Security Disability Award that was granted at age 55 or older and met the above-described service requirements at the time of death.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
6 MONTHS FOLLOWING DEATH OF ACTIVE MEMBER	$0 per month	$0 per month
UNTIL [1] SURVIVING SPOUSE IS MEDICARE ELIGIBLE OR [2] SURVIVING SPOUSE REMARRIES. [3] UNTIL DEPENDENT REACHES AGE 26	$161 per month	$400 per month
MEDICARE ADVANTAGE PLAN UNTIL SURVIVING SPOUSE REMARRIES	$102 per month	$250 per month

Termination of Dependent Coverage

Coverage 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 stepchildren, the first day of the month following the date the Employee and the stepchildren'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 **81**;
- 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;
- 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 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 the 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 may 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, 2023, in the absence of eligibility for Special Enrollment, you will not be able to reenroll your spouse for coverage until December 1, 2024. In addition, you must request re-enrollment in writing at least 30 days in advance. In this example, you would have to apply in writing to the Fund Office for re-enrollment by no later than November 1, 2024. If you do not reenroll your spouse for coverage beginning December 1, 2024, then you must wait until December 1, 2025 (with 30 days' advance notice required). Such coverage will be prospective only; retroactive coverage will not be provided. Because your Employer is required to make the same hourly contribution to the Fund for your coverage even if your spouse or other dependents opt out of coverage, it does not make financial sense for Active Employees to terminate coverage for dependents. However, the premium for a surviving spouse of a deceased Eligible Employee will be lower if a dependent's coverage is terminated.

Qualified Medical Child Support Orders ("QMCSO")

Qualified Medical Child Support Orders require health plans to recognize State court orders, which the Fund determines to be a QMCSO as defined by federal law. A QMCSO requires the Fund to cover 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.

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 offers 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 the time of your retirement will result in the permanent forfeiture of your opportunity to elect Retiree coverage. Upon becoming eligible for Medicare, you MUST notify the Fund Office immediately. 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 change the Fund's eligibility 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 Advantage Plan 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 their Pension. If you retire and you are receiving a pension from the UANPF, you may be eligible for Retiree Continuation of Coverage 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 the expiration of the date upon which to elect such coverage.

- **Age** – The level of Retiree Continuation of Coverage available to you is determined by Age. See above Eligibility Overview for the different age groups.
- **Service -** The level of Retiree Continuation of Coverage 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 for at least 10 years and for at least 84 out of the last 120 months prior to the start of your retirement. Months during which you had COBRA coverage are not counted in determining whether the 84 of 120 eligibility months service test is satisfied.
  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 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 UANPF, 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 UANPF, or have reached a certain age, or have earned a certain amount of Pension Credit with the UANPF. As explained above, if you leave the industry, you may not meet the service requirement described above, and you will not be eligible for Retiree Continuation of Coverage. In order to become eligible for Retiree Continuation of Coverage, you must return to Covered Employment and remain eligible for benefits long enough to 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 will vary depending on how long you were out of the industry and the service required at the time as illustrated above.

Retirees Who Do Not Meet the Continuation of Coverage Eligibility Rules

Members who retire and do not qualify for retiree medical coverage may qualify for up to 4 months of coverage under active eligibility, based on hours worked leading up to retirement. See active eligibility rules on page 3.

Retiree Continuation of Coverage Cost & Benefits Overview

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

If you retire before age 60 under a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the UANPF, you may 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 page 5 for more information about the Temporary Disability Extension. If you are not eligible for the Temporary Disability Extension, you must elect and pay for COBRA. 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 page 5 of the SPD, regardless of whether you have elected to commence a "Contingent Early Retirement Pension-Awaiting Social Security Award" from the UANPF. If you receive a Social Security Disability Award, you will qualify for Retiree Coverage as outlined above. 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

Once Medicare eligible, you and your Eligible Dependents will have access to retiree Medicare Advantage benefits under the Welfare Fund. See page 64 for a description of this benefit.

When can I enroll in the Welfare Fund Medicare Advantage Plan or join, switch, or drop a plan?

Initial Enrollment Period: When you first become eligible for Medicare, you can enroll in the Welfare Fund Medicare Advantage Plan.

Effect of Enrolling in Another Medicare Advantage Plan: If you decide not to enroll in the Welfare Fund Medicare Advantage Plan, and instead enroll in a different Medicare Advantage plan, you and your Spouse and Dependents will lose Welfare Fund coverage (Aetna Medicare Advantage Plan or Anthem for medical and hospital coverage, Prescription Drug Plan Aetna Medicare Advantage or CVS Caremark, Vision and Life Insurance Benefits).

Re-Enrollment to the Welfare Fund Medicare Advantage Plan: From October 15 – December 7 of each year, you can re-enroll in the Welfare Fund Medicare Advantage Plan. Your coverage will begin on January 1 (as long as the Plan receives your request by December 7) of the following year.

Your Retiree Benefits

See the "Benefits for Retired Employees" section on page 64 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. If your Spouse is not Medicare eligible at the time of your death, your Spouse will be offered COBRA and/or Surviving Spouse Continuation of Coverage.

Termination of Retiree Benefits

Your benefits terminate if you stop paying monthly premiums, enroll in another Medicare Advantage Plan or 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, 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 Advantage Plan 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.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Early Continuation of Coverage	$664 per month	$1,724 per month

DEPENDENT ELIGIBILITY FOLLOWING DEATH OF EARLY CONTINUATION OF COVERAGE RETIREE - Dependents who are eligible for benefits at the time of an Eligible Retiree's death will continue to be covered at no cost for three (3) months following the date of the Retiree's death. Thereafter, Dependents may elect to purchase COBRA, as described on page **18** of this SPD.

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

The Spouse and overage Dependent of a deceased Eligible Retiree may purchase Plan coverage until the last day of the month before the Retiree's 65th birthday or until the Retiree 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 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, 2025

Coverage Type	Individual	Family
Surviving Spouse / Over age Dependent Continuation of Coverage	$664 per month	$1,724 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. Upon becoming Medicare eligible, your coverage may continue under the Medicare Advantage Plan for Retirees/Dependents as described below. See also the section above 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, they will be covered under the Medicare Advantage plan.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Non-Medicare Continuation of Coverage	$161 per month	$400 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 at no cost for three (3) months following the date of the Retiree's death. Thereafter, Dependents may elect to purchase COBRA, as described on page 18 of this SPD.

Surviving Spouses and Overage Dependents may elect to reject COBRA and purchase Surviving Spouse Continuation of Coverage.

The Surviving Spouse and Overage Dependents may continue to purchase Plan 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.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Surviving Spouse/Overage Dependent - Not Medicare eligible	$161 per month	$400 per month
Surviving Spouse/Overage Dependent - Medicare eligible	$102 per month	$250 per month

Medicare Advantage Plan 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, coverage 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 Advantage Plan 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. See "Effect of Becoming Eligible for Medicare" above.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Medicare Advantage Plan	$102 per month	$250 per month

DEPENDENT ELIGIBILITY FOLLOWING DEATH OF MEDICARE ADVANTAGE PLAN RETIREE - Dependents who are eligible for benefits at the time of the death of the Eligible Retiree will continue to be covered at no cost for 3 months following the date of the Retiree's death. Thereafter, Dependent(s) may elect to purchase COBRA, as described on page 18 of this SPD.

Surviving Spouse and Overage Dependent may elect to reject COBRA and 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.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Surviving Spouse/Over age Dependent - Not Medicare eligible	$161 per month	$400 per month
Surviving Spouse/Over age Dependent - Medicare eligible	$102 per month	$250 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 18 of this SPD.

MONTHLY PREMIUMS – Effective January 1, 2025

Coverage Type	Individual	Family
Non-Medicare Continuation of Coverage	$1,021 per month	$2,652 per month

COBRA CONTINUATION OF COVERAGE

In certain circumstances in which coverage 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 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 elect 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 ("SSA"). Your disability must 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 SSA's determination to the Fund Office within the later of 60 days of the date of SSA's 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 **19**.

If COBRA Continuation of Coverage is extended because of a disability and the disability ends, you must notify the Fund Office within 30 days of SSA's final determination 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 monthly premium payments. 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 **12**); 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, Medicare will pay first, and the Plan's COBRA Continuation of Coverage 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, the Fund 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 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 Plan coverage 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 Fund Office 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 Fund Office in writing within 60 days of your death. An Employer must notify the Fund Office within 60 days of an employee's death or eligibility for Social Security benefits. The Fund Office 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 19.

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 Fund Office 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 19.

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 Fund 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 new plan limits coverage due to pre-existing conditions and the pre-existing condition limitation actually applies to the Employee, Spouse or Dependent after the Fund's coverage 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 City, NY 11101
Phone (718) 223-4313

Keep Your Plan Informed of Address Changes

You must inform the Fund Office 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 BENEFIT FOR ACTIVE EMPLOYEES

Provider Networks

Your Direct POS plan consists of in-network and out-of-network coverage offered by Anthem Blue Cross and Blue Shield ("Anthem") (formerly known as Empire BlueCross BlueShield). Under the Direct POS, the network of health care providers is made available to you through Anthem (the "POS Network").

Anthem's "POS Network" consists of health care providers who have agreed to provide services to Anthem's members. Depending on the health care service you need, you have a choice. For most services, including office visits to your doctor and inpatient hospital care, you can choose providers who either participate in the POS Network, or you can choose outside providers at a higher cost to you.

You get the most advantages when you use POS Network Providers because your out-of-pocket costs are lower, and your providers must call medical management for those services requiring precertification. Using the POS Network is a smart way to save money and get the care you need.

Services by Non-Participating Providers

The Fund 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 Into Your Network

Enrollment information must be provided for all Employees and Dependents including Medicare-eligible Employees and Dependents. You must notify the Fund Office in writing if you wish to enroll a Dependent. The Fund Office 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.

You are required to provide any 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 applicable state. 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 Fund Office may suspend payments on behalf of you and/or your Dependents for whom documentation is missing until the required documentation has been provided.

The following are the networks with which the Plan has arranged. 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

ANTHEM BLUE CROSS AND 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 separate ID Card for Optum. The contact information for Optum is located on the back of Anthem's Identification Card. Present the back of Anthem's ID Card whenever you receive Mental Health and Substance Use Disorder services.

Other Preferred Provider Networks

CVS/CAREMARK	Prescription Benefits
AETNA	Medicare Advantage with 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
LIVONGO	Glucose Levels Monitoring and diabetes management
MEMORIAL SLOAN KETTERING CANCER CENTER (MSK) THROUGH MSK DIRECT	Access to expert cancer treatment

The names and contact information for the Plan's Preferred Provider Networks are listed **on page 124**.

SUMMARY OF BENEFITS FOR ACTIVE EMPLOYEES

The key to using your POS 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 and Hospital Benefits by visiting www.anthembluecross.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 POS to provide care to you. In-Network care provides the following advantages:

- You can choose any participating provider from Anthem's POS in New York State or the national network of your POS. 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 POS 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 Fund 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 Fund.
- For physician, hospital or healthcare facility services received from outside providers, the benefits paid are subject to an annual deductible.
- After the deductible, the Fund pays 80% of the Allowed Amount for the first $12,500 of eligible expenses (or up to $2,500 in out-of-pocket expenses) ***per covered individual*** or 80% of the Allowed Amount for the first $25,000 (or up to $5,000 in out-of-pocket expenses) of eligible expenses ***per family*** per calendar year and you are responsible for the balance. Thereafter, the Fund pays 100% of eligible expenses for that calendar year. The Allowed Amount is based on 250% of the Medicare allowance.

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

BlueCard POS Program - Blue Cross and Blue Shield plans have established POS networks of physicians, hospitals and other healthcare providers throughout the United States. By presenting your Anthem I.D. card to a provider participating in the BlueCard POS Program, you receive the same benefits as you would receive from an Anthem POS network provider. Call 1-844-243-5566 or visit www.anthembluecross.com to locate participating providers in or outside of Anthem's operating area.

Anthem 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
FUND PAYS PROVIDER	$3,975	$1,200 ($1,500 x 80% = $1,200)
YOU PAY PROVIDER	$25 co-payment	$3,300 ($2,500 Deductible plus $300 Coinsurance (1,500 x 20% = $300) plus $500 amount above Plan's Allowed Amount= $3,300)

The following chart shows you specific plan information:

	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$0	Individual $2,500 / Family $5,000
CO-PAYMENT *(For office visits and certain covered services)*	Primary Care Physician: $25 copay per visit Specialist: $55 copay per visit	Deductible and Coinsurance
CO-PAYMENT *(For urgent care)*	$50	Deductible and Coinsurance
CO-PAYMENT *(For hospital inpatient admissions)*	$0	Deductible and Coinsurance
CO-PAYMENT *(For emergency room)*	$200 per visit; waived if admitted to hospital within 24 hours	$200 per visit; waived if admitted to hospital within 24 hours
COINSURANCE	$0	You pay 20% of the Allowed Amount. Fund pays 80% of Allowed Amount.
ANNUAL OUT-OF-POCKET MAXIMUM	See below	N/A
ANNUAL OUT-OF-POCKET COINSURANCE	N/A	Individual $2,500* / Family $5,000*
LIFETIME MAXIMUM	Unlimited	Unlimited

*Employee is responsible for 20% of the Allowed Amount for the first $12,500 of eligible expenses per Employee or dependent (20% of $12,500 = $2,500).
** 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 2025 (January 1, 2025 through December 31, 2025) 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, once any covered family member meets the Individual Out-of-Pocket Limit, the 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 listed benefit amounts are all based on the POS discounted allowances. For additional information, review the detailed description later in this SPD as well as the Exclusions and Limitations on page **106**, The Fund covers benefits that are Medically Necessary. (See Definition **111.** See page **31** for a more detailed description of Medical Benefits.)

MEDICAL BENEFITS (PHYSICIAN SERVICES)

BENEFIT	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Physician Visits (Home/Office) Primary Care Physician (PCP)	$25 Co-payment	Deductible and Coinsurance
Specialist	$55 Co-payment	Deductible and Coinsurance
Chiropractic Care	$55 Co-payment	Not Covered
Acupuncture Up to 15 treatments per calendar year [7]	$0	Not Covered
Allergy Testing	$55 Co-payment for Office Visit	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]	$55 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	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] 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 36 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 36 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 36 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	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Urgent Care	$50 Co-payment	Deductible and Coinsurance
Emergency Room Facility Initial visit for Emergency Care	$200 Co-payment Waived if admitted within 24 Hours	$200 Co-payment Waived if admitted within 24 hours
Emergency Room Physician Visit	$0	The Plan will cover Emergency Services received from a non-participating provider as if the services were performed by a participating provider. If you obtain services from a non- participating provider (and if the services are not No Surprises Services), the non-participating provider may bill you separately if the charges exceed the Fund's allowance (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.
Worldwide Travel Emergency room facility	$200 Co-payment Waived if admitted within 24 Hours	$200 Co-payment Waived if admitted within 24 hours

MEDICAL BENEFITS (MATERNITY CARE)

BENEFIT	ANTHEM[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	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] 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	$55 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	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] 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 page 46 for covered services

SKILLED NURSING AND HOSPICE CARE

BENEFIT	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Skilled Nursing Facility[4] Up to 60 days per 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	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Home Health Care 200 Visits (These limits do not apply to 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 (combined hospital and medical) These limits do not apply to Mental Health and Substance Use Disorder treatment	ANTHEM[1] YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Inpatient Hospital Physical Therapy/Medicine or Rehab[4] Up to 30 days per calendar year	$55 Pre-certification Required	Deductible and Coinsurance Pre-certification Required
Outpatient Physical Therapy[4] Up to 30 visits per calendar year	$55 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	$55 Co-payment Pre-certification Required	Deductible and Coinsurance *Pre-certification Required*

MENTAL HEALTH CARE AND SUBSTANCE USE DISORDER

BENEFIT	OPTUM YOU PAY	OUT-OF-NETWORK[2,3] 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

SUBSTANCE-RELATED AND ADDICTIVE DISORDER		
BENEFIT	OPTUM YOU PAY	OUT-OF-NETWORK[2,3] YOU PAY
Inpatient Substance Use Treatment – Hospital[5]	$0 Pre-certification Required	Deductible and Coinsurance *Pre-certification Required*
Inpatient Detoxification, Rehabilitation and Residential5	$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. See the Section of this SPD on emergency care (starting on page **41**) for special rules that apply to Out-of-Network Emergency Services that are subject to the No Surprises Act. In addition, to the extent required by the No Surprises Act, if an In-Network Provider leaves the Network, a Continuing Care Patient who is receiving care with that provider may continue to receive such care at the same In-Network Provider allowance and patient responsibility for up to 90 days after the Provider leaves the Network.

(3) Out-of-Network services are those from a provider who does not participate within your POS/PPO's network. (This does not apply to emergency benefits.) See (5) for Mental Health Care and Substance Use Disorder Services. See the Section of this SPD on emergency care (starting on page **41**) for special rules that apply to Out-of-Network Emergency Services that are subject to the No Surprises Act.

(4) Pre-certification by your POS/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 to Mental Health and Substance Use Disorder treatment. In addition, a $55 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. However, 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 to 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 55
Prescription Drug Benefit Maintenance: Filled at other network pharmacies	See page 55
Prescription Drug Benefit Specialty Medication	See page 59
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 Fund will pay for the cost of an eye examination and/or prescription eyeglasses for each Eligible Dependent Child until the child turns age 18. 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.
Employee Assistance Program (EAP) (Offered through Optum)	The EAP provides confidential support for those everyday challenges or more serious problems, and it is 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 are 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.

ADDITIONAL MEDICAL BENEFITS	
BENEFIT	DESCRIPTION
Weekly Disability Benefits	$300 per week based on State Disability Payments. Maximum 26 weeks.
Weekly Unemployment Benefits	Up to $300 per week based on State Unemployment Payments. Maximum 26 weeks.
Livongo	Smart blood glucose meter and diabetes management, a connected app, access to expert coaches.
Memorial Sloan Kettering Cancer Center (MSK) through MSK Direct	Program that offers guided access to expert cancer treatment at MSK.

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 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 they are 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 POS/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 Fund pays Medical Benefits. The deductible applies to each eligible person in each calendar year. The annual deductible is $2,500 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 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.

Present your medical identification card any time you receive medical care. If you need to replace your identification card, please call

Anthem at 1-844-243-5566 or visit www.anthembluecross.com.

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

Vision Care Benefits, Dental Benefits, Prescription Drug Benefits, Employee Assistance Program, Life Insurance 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 treatments. The pre-certification requirement is intended to prevent 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 ANTHEM 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 3 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 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:

ANTHEM 1-844-243-5566

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

* 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. However, you are responsible for obtaining 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 for non-emergency medical conditions. 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 LiveHealth Online. 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, and credit card information for billing your cost share for the visit. You will also be asked to agree to the terms of use, and to select an available Physician.

The Physician visit 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;
- To request Preauthorization; 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 $55 co-payment. Out-of-Network services are not covered under the Plan.

Acupuncture

The Plan allows for 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 $0 co-payment. Out-of-Network Acupuncture services are not covered under the Plan. However, this 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 $55 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 your responsibility 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 $55 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 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 ("PCP"). You have the right to designate any PCP who participates in the Anthem network and who is available to accept you or your family members. You may designate a pediatrician as the PCP for your child. You do not need prior authorization from the Fund or from any other person (including a PCP) in order to access 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 Anthem 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,
- 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 3 injections to prevent Lyme disease. This vaccine is not part of the annual physical.

Preventive Services

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

- 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 ("CDC") 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 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 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 share (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 Anthem at 1-844-243-5566. 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 Fund 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 Fund will pay for the preventive service when performed no more frequently than once each 12 months. In accordance with the ACA, the Plan will pay for both a preventive office visit and a well woman office visit for women in a calendar year. Where the information in this SPD conflicts with subsequently released ACA regulations applicable to preventive care coverage, the Fund 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/ 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 aged 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 Fund will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Fund 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 (BMI) 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 aged 65 years and older who are at increased risk for falls.
- Vitamin D supplementation to prevent falls in community-dwelling adults aged 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 Plan's x-ray/lab and medical benefits.

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 a 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 aged 40 and older.
- Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians for 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.
- Cervical Cancer screening for women ages 21 to 29 with Pap smear every 3 years; for women ages 30-65, screening with Pap smear alone every 3 years, or screening with Pap smear and HPV testing every 5 years.
- HPV testing for women aged 30 and older with normal Pap smear results, once every 3 years as part of a well woman visit.
- Chlamydia Infection screening for all sexually active non-pregnant young women aged 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 aged 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 who 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 aged 24 and younger and in older women 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 STIs, 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 aged 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 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 BMI 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.
- 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 aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents aged 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 21 years of age (see table on page **25**). After age 21, 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 $200 copayment.

You do not have to obtain prior authorization before seeking emergency services in a hospital emergency room. The $200 copayment applies whether you obtain those services In-Network or Out-of-Network. However, except in cases for emergency services subject to the No Surprises Act (see below), if you obtain 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 costs to you. Where the No Surprises Act does not apply, 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 general deductible for Out-of-Network care and count towards the out-of-pocket maximum for Out-of-Network care. See below for special rules that apply to emergency services and certain other services under the No Surprises Act.

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.

For claims not covered by the No Surprises Act, 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). See the definitions section (page **111**) for the special definition of “Emergency Services” for claims subject to the No Surprises Act.

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, unless otherwise required by the No Surprises Act.

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 POS 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 POS 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. See below for exceptions to these requirements where the claim is governed by the No Surprises Act.

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 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 unless the claim is governed by the No Surprises Act, so you may have out-of-pocket expenses if the No Surprises Act does not apply. The annual deductible is waived if you are admitted within 24 hours.

Worldwide Travel

Blue Cross Blue Shield Global Core® Program. If you plan to travel outside the United States, call Member Services for information about Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. **The Plan only covers Emergency Services, including ambulance and Urgent Care outside of the United States.** Remember to take an up-to-date health ID card with you when you travel.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center 24 hours a day, 7 days a week. The toll-free number is 800-810-2583. Or you can call them at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact Anthem for preauthorization. If you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with Blue Cross Blue Shield Global Core®. In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any applicable Copayment, Coinsurance or Deductible amounts. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms, you can get international claim forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.
- You will find the address for mailing the claim on the form.

No Surprises Act

The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;
- Without regard to whether the provider furnishing the emergency services is an In-Network provider or an In-Network emergency facility, as applicable, with respect to the services.
- Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;
- Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or an In-Network emergency facility;
- By calculating the cost-sharing requirement for Out-of-Network emergency services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Emergency Services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

- The provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation.
- You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and
- You give informed consent to continued treatment by the Out-of-Network provider, acknowledging that you understand that continued treatment by the nonparticipating provider may result in greater cost to you.

Non-Emergency Services

The No Surprises Act requires non-emergency services to be covered as follows if they are considered No Surprises Services (see the Definitions on page 111):

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network provider;
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Recognized Amount for the items and services; and
- By counting your cost-sharing payments for these Out-of-Network services toward your In-Network deductible and In-Network Out-of-Pocket maximum in the same manner as those received from an In-Network Provider.

Notice-and-Consent Exception

Notwithstanding the above, non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on your Out-of-Network coverage if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network provider , the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and
- You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Provider Directory

The provider directory will be updated at least every 90 days. If you are informed or receive inaccurate information from a provider directory that a provider is In-Network, services provided by that Out-of-Network Provider will be covered as if the provider was In-Network.

Special Claims Procedures

Notwithstanding any contrary provision in this SPD, providers of No Surprises Services will receive payment, or a denial, of a post-service claim within 30 days of the Plan's receipt of all information necessary to adjudicate the claim, to the extent required by (and in accordance with the rules under) the No Surprises Act.

Medical Benefits (Maternity Care)

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

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 Anthem'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.

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 $55 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 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 by 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 Anthem's Medical Management Program.

Durable Medical Equipment and Supplies

The 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 Anthem's Medical Management Program. When using a supplier outside Anthem's operating area, you are responsible for pre-certifying services. A network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Anthem'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 the "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 the 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 Anthem'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, such as eating, toileting, bathing, walking, and transferring from bed to chair, 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. For 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 plus an additional $750 per calendar year for additional mastectomy wear (this can be used for bras, camisoles, or additional prosthesis). For information about 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) offer eligible participants a 20% discount off the retail cost of a Hearing Aid as well as unlimited servicing during the first year. You are 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, call your POS's Medical Management Program to pre-certify skilled nursing.

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.

The visit limit does not apply to treatment for mental health or substance use.

Hospice Care Benefits

The 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 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 the "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 an 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 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.

The visit limit does not apply to 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:

- Part-time services by an RN or LPN.
- Part-time home health aide services (skilled nursing care).
- Physical, speech or occupational therapy, if restorative.
- Medications, medical equipment and supplies prescribed by a Physician; and
- Laboratory tests.

The visits limit does not apply to 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 Parenteral 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 $55 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.

Call the Medical Management Program to pre-certify all physical, occupational, speech and vision therapy to ensure that you receive maximum benefits. Ask your therapist 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. The day limit does not apply to 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 $55 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. The visit limit does not apply to 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 $55 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. The visit limit does not apply to 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. However, 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 3 hours per day, 2 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 visit 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/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 Optum’s 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. If you require more specialized or longer-term treatment, 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 6 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 6 EAP sessions will not be covered under the EAP benefit. However, if ongoing care is needed beyond the 6 EAP visits, Optum will work with you to transition into benefits provided under the Fund's Mental Health and Substance Use Benefit.

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 Fund's mental health 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, 2024, you must wait until January 15, 2026 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 your child (under age 18) receives an eye exam on January 15, 2024, they must wait until January 15, 2025 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 contracted with Cigna Dental Services (Cigna), to provide 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 based on 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 aged 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 ACA. 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*

Covered Service	Network Provider	Out-of-Network Provider
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*
Class IV Expenses - Orthodontia Coverage for Eligible Children up to age 19 Only *Lifetime Maximum $3,000 *No maximum for dependent Children under age 19. *Dependent Children ages 19 – 26 not eligible	100%, No Orthodontia Deductible	100%, No Orthodontia Deductible (up to maximum allowable charge) **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 must be submitted within 18 months of the beginning service date to Cigna Dental Services.

Dental Limitations

The following dental limitations apply to services received from both In-Network and Out-of-Network providers:

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 6 months after installation
Adjustments	Covered if more than 6 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 page 106, the following dental exclusions apply to services received both from In-Network and Out-of-Network providers:

- 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 (these should be submitted under the Medical Benefit)
- Services and supplies received from a hospital (these should be submitted under the Medical Benefit)
- 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 (including resistance
- 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 the Fund)
- 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 person's eligibility ends
- Any claims submitted more than 18 months after the date of treatment or service, except as otherwise approved by the Fund
- 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 Retirees

Medicare-eligible Retirees 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. Your CignaPlus membership will also give you access to Cigna's Identity Theft Program and Cigna's Will Preparation Services.

You can enroll in 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.

You 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 cancellation 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 you will receive a discount for eligible services provided by participating dentists. The amount of discount will vary among participating providers. Procedures that are not included in 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.

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 $10 co-pay for generic
Through CVS/Caremark $35 co-pay for preferred brand
Network Pharmacies $60 co-pay for non-preferred brand

Maintenance Medication Co-pays

You 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 3 times at the applicable retail co-pay. Starting with the 4th 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 is how the co-payments for maintenance medications work:

For Prescriptions Filled at Retail CVS Pharmacies			
	30-Day Supply (First 3 fills)	**30-Day Supply** (4th fill and after)	**84-90-Day Supply** (1st 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 3 fills)	**30-Day Supply** (4th fill and after)	**84-90-Day Supply** (1st 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 ($60 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

Maintenance drugs are drugs for which you have a continuing, long-term prescription. You may fill 3 maintenance prescriptions at retail. Although you may continue to fill your maintenance prescriptions at retail (rather than through CVS Pharmacies or the Fund's mail service (described below)), you will pay more to do so. Maintenance prescriptions purchased through network pharmacies instead of CVS Pharmacies or the mail service 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 must complete a mail order form for each individual utilizing the Caremark mail program to 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 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 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	$17 co-pay for up to 60-day generic $75 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	$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

DISPENSE AS WRITTEN ONE (DAW-1)

In New York State, pharmacists are allowed 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 do not purchase the generic prescription drug, and instead purchase the Preferred Brand or Non-Preferred Brand prescription drug, you will be responsible for the $35 or $60 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 provides 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 3 30-day prescriptions at a retail pharmacy.

To use the mail-order program, you need a prescription written for a 90-day supply. When you switch from retail pharmacy to mail order, make sure to get a new prescription from your doctor for a 90- day supply. If you 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 pro-rated copayments work.

The Plan has a 3-Tier Prescription Program which is described below. Mail Order is available if you 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 manages 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 I** 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. See below for information regarding the **PrudentRx Copay Program** for certain specialty medications.

Formulary Program

In order to provide comprehensive prescription drug benefits, while controlling costs, CVS/Caremark frequently reviews the list of covered medications (also known as the formulary) to determine which medications are on the formulary and which tier – i.e., Generic, Preferred or Non-Preferred - that the medications fall under. CVS/Caremark reviews the list annually and decides which medications to exclude from coverage. For a current list of covered medications, contact CVS/Caremark at 800-824-6349 or visit www.caremark.com.

Prior Authorization - If your doctor wants you to take a medication which is not on the CVS/Caremark formulary list, 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.

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 you to try safe, effective, and less expensive generic or preferred brand medications before the Fund covers certain non-preferred brand medications.

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 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 or 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 call CVS/Caremark at 855-240-0536.

Prior Authorization for Compound Core Service

The **Compound Core Service** requires you to obtain a prior authorization for all compound drug claims over $300 (no fill limit). To initiate the Prior Authorization process, you or your doctor should call CVS/Caremark at 855-240-0536

Prescription Drug Benefit Exclusions, Limitations and Restrictions

In addition to the general exclusions, limitations and restrictions contained on page 106, 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. The Plan encourages you to purchase a 90-day supply of maintenance drugs through the mail order program or at a CVS pharmacy. After 3 refills through a retail pharmacy (other than CVS), 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 you have a prescription for them;
    - 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.

PrudentRx Copay Program for Specialty Medications

The PrudentRx Copay Program helps enroll individuals who are prescribed certain specialty programs in manufacturer copay assistance programs (explained below). Medications in the specialty tier will be subject to a **30% co-insurance**. However, enrolled participants who obtain a copay card for their specialty medication (if applicable) will not have any out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications, particularly specialty medications. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs; all data sharing is done in compliance with HIPAA.

If you are prescribed one or more medications on the PrudentRx Program Drug List, you will receive a phone call and welcome letter from PrudentRx. The letter will have specific information about the program as it pertains to your medication. All eligible participants will be automatically enrolled in the PrudentRx program, but you can choose to opt out by calling 1-800-578-4403.

Some manufacturers require you to sign up for their copay assistance program – in that case, you must call PrudentRx at 1-800-578-4403 to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Program.

If you are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can contact PrudentRx or they will contact you so that you can take full advantage of PrudentRx.

The PrudentRx Program Drug List may be updated periodically. Contact PrudentRx for a current list of applicable drugs.

Copayments for these medications, whether made by you, the Fund, or a manufacturer's copay assistance program, do not count toward your deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the ACA, participant cost-share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's Out-of-Pocket Maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for you.

These special rules only apply to a prescription drug if it is on the PrudentRx Program Drug List.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

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, CVS/Caremark may 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 once every 365 days up to a maximum cost of $500. CVS/Caremark will not approve 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 shortage of raw material 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 for a 30-day supply of the prescription drug to be filled at a retail pharmacy. Such a request for an administrative override will be decided 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, they should call CVS/Caremark to request a coverage determination and an administrative override which will be decided based on the professional judgment of a CVS/Caremark pharmacist.
- If your doctor prescribes a drug at a higher or lower dose than your current prescription, they should call CVS/Caremark to request a coverage determination and an administrative override which will be decided 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 2 times per day, they should call CVS/Caremark to request a coverage determination and an administrative override which will be decided based on the professional judgment of a CVS/Caremark pharmacist.
- If the retail pharmacy where you filled a 30-day prescription incorrectly entered the days' supply information for the prescription, for example, the pharmacist incorrectly calculated the number of doses in an asthma inhaler, the pharmacist should call CVS/Caremark to request a coverage determination and an administrative override which will be decided based on the professional judgment of a CVS/Caremark pharmacist.
- If you run out of your current medication 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 your current medication 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 delivery delay is due to your late submission of that prescription, your doctor or pharmacist should call CVS/Caremark to request an administrative override which will be decided 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 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 which will be decided based on the professional judgment of a CVS/Caremark pharmacist. If your doctor has prescribed a new medication for you to start taking on that same day, and 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 which will be decided 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 which will be decided 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, and if you require an immediate prescription, your doctor or pharmacist should call CVS/Caremark to request an administrative override which will be decided based on the professional judgment of a CVS/Caremark pharmacist.

Glucose Levels Monitoring Benefits

Livongo provides a smart blood glucose meter for diabetes management, a connected app that tracks your numbers, and access to expert coaches for advice on diet, lifestyle, and more. The program is offered at no cost to you if you have diabetes.

Text "GO UALOCAL1FUNDS" to 85240 to learn more about Livongo and join. You can also join by visiting join.livongo.com/UALOCAL1FUNDS/register or by calling 1-800-945-4355 and using registration code: ALOCAL1FUNDS.

MEMORIAL SLOAN KETTERING CANCER CENTER (MSK) THROUGH MSK DIRECT BENEFITS

You and your family members can receive guided access to expert cancer care at Memorial Sloan Kettering ("MSK"), with locations in Manhattan, Long Island, New Jersey, and Westchester County.

Call your dedicated MSK Direct number 833-293-3893 or 646-449-2551 if your doctor suspects or has diagnosed you with cancer. The MSK Direct team will:

- schedule an initial appointment at MSK, as quickly as within 2 days;
- gather all necessary medical records;
- meet you at your first appointment to provide support, logistical assistance, and introduce you to your care team; and
- remain a resource throughout your course of care at MSK.

There is no enrollment necessary for MSK Direct — eligibility is automatic. There are no charges to use MSK Direct. MSK is an in-network provider for the Fund. If you have a family member who is not covered under the Fund, call MSK Direct to verify potential access to the program.

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

**The Trustees provide life insurance benefits to Active Eligible Employees on a fully insured basis through an insurance policy. In the event of a conflict between the SPD and the Life and AD&D insurance policy, the insurance policy will govern.*

***Employees represented by Plumbers Local Union No. 1 who are / were employed under the terms of an agreement between Plumbers 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 Fund Office. 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 Plan's receipt 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 form provided by the Plan. No other form of designation may be used. The same form is used for designating your primary and contingent beneficiaries for the Plan's life insurance benefit. There are different forms for the 401(k) Savings Plan, the UANPF and the United Association Burial Expense Benefit.

If you have not provided a designation of beneficiary form to this Plan, you should do so immediately.

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 pre-deceased you, 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 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.

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.

If you die:

1. The Life Insurance Benefit and 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 their 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") regulations governing payment of a 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.

WEEKLY DISABILITY BENEFITS

If an Active Eligible Employee is receiving State Disability Benefits, the Employee will receive up to $300 for each week they receive 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 traditional State Unemployment Benefits, the Employee will receive up to $300 for each week they receive State Unemployment Benefits, to a maximum of 26 weeks during a 12 - month period. The Employee must submit proof of receipt of State Unemployment Benefits. Effective January 1, 2025, weekly unemployment claims must be submitted within 6 months of the week for which you are claiming benefits. In addition, as noted above, the payment of retroactive claims is limited to 5 weeks. In no case will the Fund pay more than 5 weeks of benefits. This means that a delay in filing weekly claims may result in the loss of 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 will 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.

Example of Eligibility Scenarios:

- If you had been eligible for benefits prior to becoming unemployed during a period in which the Union has certified there is unemployment in its jurisdiction, and you are receiving traditional State Unemployment Benefits, you may receive up to $300 for each week you receive traditional State Unemployment Benefits, to a maximum of 26 weeks during an 18-month period.
- If you had been eligible for benefits prior to becoming unemployed during a period in which the Union has certified there is unemployment in its jurisdiction, and you are not receiving traditional State Unemployment Benefits, but rather you are receiving State Extended Benefits Program, or extended benefits from a comparable Federal or State program as determined by the Trustees, you are not eligible to receive any Weekly Unemployment Benefits from the Fund.

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 its jurisdiction.

BENEFITS FOR RETIRED EMPLOYEES

Retired Employee Benefits Up to Age 65 (Non-Medicare Eligible)

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 are payable to Retirees, and
2. Life Insurance Benefits are $10,000.

Retired Age 65 and Over (Medicare-Eligible)

The Plan provides the following benefits to all Medicare-eligible retirees and their Medicare- eligible Spouses under the Medicare Advantage plan. For maximum benefits, you must maintain Medicare Part B coverage by self-paying the Medicare Part B premium. Failure to elect/pay Medicare Part B coverage will result in a loss of benefits. The eligibility rules for Retired Employees stated on page **14** 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 benefits applicable to Dependents.

- **Medicare Advantage Plan** **17 below**.
- **Employee Assistance Program (EAP)** – See page **50**
- **Vision Care Benefit** – See page **51**
- **Hearing Aid Benefit** – $500 once every 36-Months, covered under Medicare Advantage Plan.
- **Dental Discount Program** – See page **55**
- **Prescription Drug Benefit Exclusions, Limitations and Restrictions** – See page **58**
- **Memorial Sloan Kettering Cancer Center (MSK)/MSK Direct** – See page **60**
- **Glucose Levels Monitoring** – See page **60**
- **Life Insurance** – See page **61**
- **Administrative Overrides** – See page **59**

Medicare Advantage Plan

Benefits are provided through the Plan's Medicare Advantage program. The program is administered by Aetna on a fully insured basis.

The Aetna Medicare Advantage PPO plan offers the same coverage as original Medicare Part A (Hospital), Part B (Medical) and Part D (prescription drug) under one ID Card. Additional benefits include Resources For Living®, Healthy Home Visit, telehealth, Teladoc®, MDLIVE® behavioral health program and a 24-hour nurse line. Extra benefits include SilverSneakers, Non-Emergency Transportation and Meal delivery following an inpatient stay. Over 1,000,000 network providers, and more than 4,000 network hospitals accept the Aetna Medicare Advantage PPO plan.

Call Aetna for information about the Aetna Medicare Advantage PPO at 1-800-307-4830 (TTY: 711), Monday–Friday, 8 AM–9 PM ET. You can also visit AetnaRetireePlans.com to learn more.

Effect of Becoming Eligible for Medicare

Upon becoming eligible for Medicare, Medicare is the primary coverage under the Aetna Medicare Advantage arrangement. For maximum benefits, you must maintain Medicare Part B coverage by self-paying the Medicare Part B premium. Failure to elect/pay Medicare Part B coverage will result in a loss of benefits.

When can I enroll in the Welfare Fund Medicare Advantage Plan or join, switch, or drop a plan?

Initial Enrollment Period: When you first become eligible for Medicare, you can enroll in the Welfare Fund Medicare Advantage Plan.

Effect of Enrolling in Another Medicare Advantage Plan: If you do not enroll in the Welfare Fund Medicare Advantage Plan, and instead enroll in a different Medicare Advantage plan, you and your Spouse and Dependents will lose Welfare Fund coverage (Aetna Medicare Advantage Plan or Anthem BCBS for medical and hospital coverage, Prescription Drug Plan Aetna Medicare Advantage or CVS Caremark, Vision and Life Insurance Benefits).

Re-Enrollment to the Welfare Fund Medicare Advantage Plan: From October 15 – December 7 each year, you can re-enroll in the Welfare Fund Medicare Advantage Plan. Your coverage will begin on January 1 (as long as the Plan receives your request by December 7) of the following year.

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

You begin participating in the HRA immediately upon your commencement of "Covered Employment" (defined below). Building Trades Division Probationary Apprentices and Oil Trades Probationary Helpers are excluded from Participation.

"Covered Employment" is work under a CBA or Participation Agreement for which the Participating Employer is required to contribute on your behalf to the Plan and forward HRA Contributions to the Plan. Participating Employers are:

- Employers who have entered into a collective bargaining agreement with Plumbers Local Union No. 1;
- Plumbers Local Union No. 1;
- Plumbers Local Union No. 1 Welfare Fund; and
- Fifth Street Real Estate Company LLC

Once an Active Eligible Employee meets the general eligibility requirements, the Active Eligible Employee and their Qualified Relatives will remain eligible for HRA benefits as long as they maintain an account balance of greater than $0, even if they have ceased Covered Employment and is no longer eligible for other benefits. A special provision where there is a COBRA Qualifying Event under the Plan is discussed below.

If you lose eligibility for HRA benefits 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.

If you have an HRA account balance when you die, your Qualified Relatives will be eligible to submit claims for reimbursement from the HRA as long as your account balance is sufficient to cover their claims.

Account balances of $5 or less that are inactive (No Contributions) for one year or more are charged an administrative fee of $5.

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

Retiree Eligibility

Retirees who have an HRA account balance 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 CBAs. 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 Fund benefits are automatically enrolled in the HRA. Some individuals who may be enrolled as Qualified Relatives in the HRA may not be Dependents for purposes of other Fund benefits. See page 11 for the definitions of Dependents for purposes of other Fund benefits.

A "Qualified Relative" who may be enrolled as a Dependent in the HRA is an individual who qualifies as a dependent under Section 152 of the Internal Revenue Code ("Code") including a 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 Code.

HRA Debit Card Feature

You are able to access your HRA account via an HRA Debit Card from a company called WEX. The WEX card offers

- a customized mobile app to manage your benefits;
- an online portal for managing your HRA claims; and
- continued access to your HRA Employer Contributions on the MyBenefits portal.

These tools make it easy to manage your account; you'll also have convenient ways to pay for your health services and care.

Access Your HRA Account Anytime, Anywhere

The WEX mobile app gives fast 24/7 access to your account information. You are able to:

- quickly check available balances and account details;
- view charts summarizing account information;
- set account alerts and get notifications via text message;
- view claims requiring receipts;
- use your device of choice – including iPhone®, iPad®, iPod touch® and Android™ smartphones and tablet devices; and
- find the Fund's Mobile App in your Google Play or Apple Store. Seach, "Plumbers Local Union No. 1 Welfare Fund HRA Benefits"

Make Debit Card Payments with Ease

All it takes is a swipe of your HRA Debit Card to pay for Rx copays and qualified over-the-counter healthcare expense. Payments are automatically withdrawn from your account, so there are no out-of-pocket costs. Because these purchases are substantiated at the point of purchase at participating merchants, you will need to submit fewer claims manually. You can also have reimbursements direct deposited to the account of your choice, select to pay the provider directly, and schedule recurring payments, such as retiree coverage or COBRA premiums.

Accessing the Wex Portal is easy. Simply visit HRAbenefits.nypl1f.org and click on "Get Started" under the New User section of the website to create your account.

You can also register as a new user via the Mobile App. Simply download the "Plumbers Local Union No. 1 Welfare Fund HRA Benefits" App and select "New User Registration" to create your account. Once your account is created, you can set up biometric access (device permitting) for easier access in the future.

You will use the same username and password for both the WEX Portal and Mobile App.

Will All Pharmacies and Merchants Accept My HRA Debit Card?

Most in person and online pharmacies accept the Debit Card. Please ensure you have enough money in your HRA account for the full transaction amount. If you run your card for any amount over your available balance, the card will decline. Check the Mobile App for your most up to date account balance information.

If your pharmacy does not accept the Debit Card, you can file a claim for reimbursement via the WEX portal, Mobile App or paper claim process. You will need to provide a copy of your receipt or Rx bag tag for manual claims submissions.

Can I Use the HRA Debit Card at a Doctor's Office, Dentist or Vision Center?

The HRA Debit Card can currently be used to pay for Rx copays and qualified over-the-counter healthcare expenses. Use at a Doctors Office, Dentist or Vision Center will be provided as a future improvement.

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. For a list of Health Care Eligible Expenses which may be submitted, visit HRAbenefits.nypl1f.org. 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;
- Disability & Workers Compensation Continuation of Coverage premiums;
- Long-term care insurance premiums (For taxable years beginning in 2025, limits specified under Section 213(d) and 7702B(b) of the Code are shown below. These are subject to change each year.);

Attained Age Before the Close of the Taxable Year	Limitation on Premiums
Age 40 or younger	$ 480 per taxable yr.
Older than 40, younger than 50	$ 990 per taxable yr.
Older than 50, younger than 60	$1,800 per taxable yr.
Older than 60, younger than 70	$4,810 per taxable yr.
Older than 70	$6,020 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.

Over the Counter: You may also request reimbursement for Over the Counter (OTC) medicines and/or drugs and/or products, provided that they otherwise qualify as eligible expenses under the Plan. These OTC drugs must not otherwise be covered by the Plan and must be for the treatment of illness or injury (as defined by the Code), not merely to advance your general good health. OTC supplies and devices are covered without a prescription.

Additionally, menstrual care products qualify as eligible expenses. Examples include tampons, pads, liners, cups, sponges, or similar products.

NOTE: To be reimbursed for eligible OTC and menstrual care products, you must provide a computerized receipt showing the name and cost of the item purchased and satisfy all other applicable plan requirements for reimbursement. For example, in some cases, certain OTC medicines, drugs, or products may only be reimbursable if they are required and recommended by a physician that specializes in the field of your diagnosis (in which case you may need to provide a signed statement from your physician confirming the medical necessity of the item).

Mattress and Recliner Expenses

The Fund will allow reimbursement of a mattress with a letter of medical necessity and reduces the total cost of the mattress by $500 and reimburses for any remaining balance, not inclusive of tax, base, and delivery. The Fund will allow reimbursement of up to 1 recliner with a letter of medical necessity.

Ineligible Expenses

Expenses that do not meet the definition of "medical care" under Code Section 213(d) and certain other expenses 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;
- 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 Code Section 213.

Therefore, you cannot be reimbursed for the following products:

ChapStick/Lip balm	Cosmetics	Deodorant	Denture adhesive products	Face creams
Hand lotion	Moisturizers	Suntan lotion	Toothpaste/Mouthwash	Swimming Pools/Hot Tubs/Spas

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

Remember that your right to HRA reimbursement is expressly conditioned upon having an eligible expense, and that your HRA Account balance is only available to pay eligible expenses that are actually incurred. If you submit any documentation in support of an HRA claim that is determined by the Trustees or Fund Office staff, in their sole discretion, to likely be fraudulent, incorrect, inaccurate or misleading in any way, you will be prohibited from taking an HRA withdrawal for 12-months. If it is determined that you received HRA reimbursement under false pretenses, you will be required to immediately reimburse the Fund the amount of the claim. If you do not submit payment within 10 days of demand, the Fund will issue you a Form 1099 on the amount of the claim and the Fund may commence litigation against you to recover the amount improperly distributed plus interest and collection costs. In addition, the creation of a false business record such as a receipt from a provider or the submission of a receipt for services not actually rendered is a crime which may result in referral to law enforcement.

How to File a Claim for HRA Reimbursement

Prior to January 1, 2025, an HRA claim can be filed up to 36 months from the date the reimbursable expense was incurred. Effective January 1, 2025, an HRA claim must be filed within 12 months from the date the reimbursable expense was incurred.

You will have the option to use the WEX Portal or Mobile App to file a claim and upload your receipts. You can also continue to file paper claims. 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 in the SPD. 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. For claim expenses greater than $500, you can submit a balance forward statement and designate the HRA claim as "pay to Provider." You can submit a claim as often as necessary.

The minimum claim payment is $25 which means that the Fund does not reimburse Eligible Expenses until you have submitted at least $25 in reimbursable expenses and at least $25 is available in your HRA account. Claims submitted or awaiting payment that are less than $25 will be reimbursed quarterly. All reimbursements will be made payable to the Employee. Claims greater than $500.00 can be made payable to Provider upon request by the Member.

HRA claims are processed no later than 30 days from date received by the Fund. You will receive an Explanation of Benefits for each denied claim. HRA statements showing your balance will be mailed to you at the end of each Plan Year.

How Can I Elect Direct Deposit for Reimbursements?

In addition to receiving a check by mail, you can also have reimbursements direct deposited to the account of your choice. For this option you will need to manage your banking information by accessing the new Member Portal. For your protection, a Micro-deposit (trial deposit) or a small amount of money (less than $1.00) will be transferred into and out of your listed bank or money management account to make sure there's an established connection. The transfers are completed via the ACH process within 3 business days from your election. This is a two-step process and once the Micro-deposit is transferred you will need to access the Member's Portal within 10 days and enter the Micro-deposit amount. Once this is done, the Micro-deposit will be transferred out and all your HRA reimbursements will be via direct deposit. Previously elected HRA direct deposit elections will not be transferred to the new Member Portal.

Will I Be Provided with More Than One HRA Debit Card?

One HRA Debit Card will be mailed to you. Additional cards can be requested for your eligible dependents for their use when away from home such as while attending college. A one-time $5.00 per card fee will be charged to your HRA Account for each additional Card.

Remember To Keep Your HRA Debit Card Safe!

Payments with a debit card are taken instantly from your HRA Account and shopping with Debit Cards comes with the added risk that your information may be stolen. Using your HRA debit card opens up the possibility that a fraudster will gain access to the funds in your HRA account.

You must report lost or stollen HRA cards immediately via the WEX portal, Mobile App or by contacting the Fund Office HRA Department at 718-223-4313. When considering if it is safe to use a Debit Card for in-person purchases, follow these rules to protect your transactions.

- Check your Account Statements Often via the WEX portal or Mobile App.
- Protect your PIN number.
- Report problems or suspicious activity to the Fund Office immediately. You must contact the Fund Office no later than one hundred eighty (180) days after the suspected transaction(s) is posted to the Card Account. In case of a discrepancy or questions about HRA Debit Card Account transactions you will need to tell us:
    1. Your name and the 16-digit Card number.
    2. A description of the transaction(s) including the date and dollar amount.
    3. Why you believe there is a discrepancy.

If you provide this information orally, we may require that you send the details listed above in writing within 180 days after we posted the transaction(s) you are questioning.

You must agree to cooperate fully with our investigation and to provide any additional information or documentation we may need for the claim.

Once we have the required details, information, and/or documents, we will determine whether a discrepancy occurred. If we ask you to put details in writing and you do not provide them within 180 days of the date, we posted the transaction(s) you are questioning, we may not be able to resolve the claim in your favor.

We will tell you the results in writing after completing our investigation. If we determine a discrepancy occurred, we will correct the discrepancy promptly and credit the HRA Debit Card Account. If we decide there was no discrepancy, we will send you a written explanation.

COBRA Continuation of Coverage - HRA

Qualified Beneficiaries may 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 Fund's extension 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 Fund Benefits. You 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 use your HRA to pay your COBRA premiums.

However, you may contribute 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 Fund's extension rules, you may 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 Fund Benefits. You 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 use the HRA to pay COBRA premiums.

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 Fund's Definition of "Dependent"

If you lose eligibility because of your divorce from the Employee or because you no longer meet the Fund's definition of "Dependent," you have a Qualifying Event. If eligibility is not extended under one of the Fund's extension rules, you may extend eligibility for benefits by electing and paying for COBRA Continuation of Coverage.

In order 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 can 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.

If HRA reimbursements are due to a minor, the Fund may pay the benefits to the person having custody or care of the minor and with whom the minor resides, provided such person agrees in writing to apply the reimbursements solely for the minor's support and to comply with any other conditions established by the Trustees or required by law. Alternatively, the Trustees may reimburse the minor by depositing the amount in an insured bank account for the minor and giving notice to the minor.

WELFARE FUND ASB ACCOUNT

Benefit Highlights

You begin participating in the Welfare Fund ASB Account immediately upon your commencement of "Covered Employment" (defined below). "Covered Employment" is work under a CBA or Participation Agreement for which the Participating Employer is required to contribute on your behalf to the Plan and forward your Welfare ASB Contributions to the Plan. Participating Employers are:

- Building Trades Division Employers who have entered into a collective bargaining agreement with Plumbers Local Union No. 1.
- Plumbers Local Union No. 1.
- Plumbers Local Union No. 1 Welfare Fund; and
- Fifth Street Real Estate Company LLC

Once an Active Eligible Employee meets the general eligibility requirements, the Active Eligible Employee will remain eligible for Welfare Fund ASB benefits as long as he/she maintains an account balance of greater than $0, even if they have ceased Covered Employment and are no longer eligible for other benefits. If you lose eligibility for Welfare Fund ASB Account benefits because your account has been completely distributed after you ceased Covered Employment, you may re-establish eligibility by satisfying the initial eligibility requirements.

If you are an Eligible Employee as defined above, you will be enrolled in the Fund's ASB Account. You will have a separate account which will hold Employer (Account A), Employee (Account B) and Employee (Account C) contributions received for hours worked. Subject to the Fund's limits and eligibility requirements, you may receive all or some of your Account balance in the form of the various benefits. Benefits cannot exceed your Account balance and are subject to the limitations and eligibility requirements described below.

In addition to contributions,1 the Fund allocates the investment gains and losses and the administration and investment costs directly to Participant accounts. Accounts are valued on a monthly basis based on market value, and the Trustees determine the monthly administrative expenses and investment expenses to be charged to individual accounts.

The Investment Expense will be deducted from the "gross investment return" of the investment and the "net investment return" will be updated to your investment account. For example, for October 2023, the annualized expense ratio is 0.19%. This amount will be adjusted, as necessary.

The Administrative Expense includes all "non-investment related expenses," such as Recordkeeping, Administration, Collection, Accounting, Legal, Consulting and Custody fees. Currently, $180 per year ($15 per month) is deducted from your account to cover Administrative Expenses. This amount will be adjusted, as necessary.

The Fund will compute the value of your account monthly as of the last day of each month. After the end of each quarter, you will receive a Statement of Benefits, showing your Individual Account as of the end of such quarter.

How will My Account be Valued? Your individual account (Account A, Account B and/or Account C) is credited with any contributions made on your behalf, and then adjusted for your share of the Fund's earnings and expenses.

Your account is "valued" each month to reflect your share of any monthly administrative expenses, benefit payments, contributions, earnings or losses, and investment expenses. This "valuation" is a four-step process:

- First, all administrative expenses (except investment expenses) incurred are charged against each account on an equal basis, regardless of your account balance.
- Second, your account is reduced by any benefit payments to you or on your behalf.
- Third, your account is credited with employer contributions received on your behalf for the month.
- Fourth, a proportionate share of investment earnings/losses and investment expenses is allocated to your account (based on the amount of your account balance).

[1] Employer contributions to Accounts A and B have not been required since January 1, 2009. The only contributions that may be added to those Accounts are any past due contributions collected as a result of the Fund's collection program. Account C contributions become effective on January 1, 2021.

Can my Account balances increase and/or decrease due to financial markets? Yes. Your individual Account A, Account B and/or Account C balances may increase or decrease on a monthly basis due to financial market conditions.

BENEFIT	AMOUNT
Supplemental Unemployment Benefit Payable to Employee	Greater of (a) $300 or (b) the amount of the Employee's weekly base pay in accordance with the normal working hours per week under the applicable CBA less the amount of State unemployment benefits.
Supplemental Workers' Compensation Benefit Payable to Employee	Greater of (a) $300 or (b) the amount of the Employee's weekly base pay in accordance with the normal working hours per week under the applicable CBA less the amount of State workers' compensation benefits.
Supplemental Disability Benefit Payable to Employee	Greater of (a) $300 or (b) the amount of the Employee's weekly base pay in accordance with the normal working hours under the applicable CBA less the amount of State disability benefits.
Supplemental Income Maintenance Payable to Employee who is unemployed, underemployed, injured on the job, or disabled and not eligible for Supplemental Unemployment, Supplemental Workers' Compensation or Supplemental Disability	Greater of (a) $300 or (b) the amount of the Employee's base pay per week based on the normal working hours under the applicable CBA up to a maximum of $1,500 per week.
Emergency Benefit for Economic Catastrophe- Disaster, Fire or Flood Payable to Employee	No maximum.
Severance Benefit Payable to Employee	Maximum of 2 times the Employee's annual wages in the year immediately preceding severance of employment in the industry.
Funeral Benefits Payable for the funeral/burial expenses of an Employee or Dependents	No maximum.
Death Benefit Payable upon the death of the Employee. Paid after the funeral benefit to the Beneficiary if different from the person applying for Funeral Benefits.	The Beneficiary may elect to receive the Death Benefits in a single payment or in monthly payments. However, if at time of payment, the account balance is $5,000 or less, death benefits will be paid in a lump-sum payment. The Beneficiary who elects monthly payments will receive the Employee's Account in 84 monthly payments.
Supplemental Vacation Benefit Payable to Employee	Maximum of $50,000 per year. Vacation Benefits not used in a calendar year may be withdrawn in the following calendar year.
Legal Services Benefit Payable to Employee	No maximum.
Education/Training Benefit Payable for education/training of the Employee, spouse or eligible Dependents.	No maximum.

Eligibility for Benefits

Eligibility for benefits is based upon hours worked under the CBA which obligated employers to contribute to the Fund on your behalf, and for which contributions have been received. You may not make individual or self-contributions. **After 2016, no CBA has required employer contributions to Account A and employee contributions to Account B. Unless the Fund recovers past due contributions for Accounts A and/or B, you cannot establish initial eligibility for an Account unless the Fund receives contributions for Account C**.

The determination of your Account balance is based upon contributions actually received by the Fund.

This section of the SPD uses different terms to refer to categories of Employees who are affected by Plan rules. These terms and some other related terms are described below:

- **"Employee"** means an employee of a participating Employer covered by a CBA between that Employer and the Union.
- **"Collective Bargaining Agreement" or "CBA"** means the labor agreement in force and effect between the Union and the Association of Contracting Plumbers of the City of New York, Inc. or another employer, together with any modifications, supplements or amendments that required contributions to this Fund.
- **"Prior Plans"** means the additional security benefit funds and supplementary benefit funds of former Local Unions 1, 2, and 371 which were merged to form this Plan on December 7, 1999 as well as the Plumbers Local Union No. 1 Vacation and Holiday Fund (the "Vacation Fund") which was merged into this Plan on January 1, 2014, as well as the ASB Fund which was merged into this Plan on December 31, 2019.
- **"Covered Employment"** means work under a CBA for which contributions were required to this Fund prior to 2016. For purposes of determining eligibility during the period immediately following the mergers on December 7, 1999, January 1, 2014 and December 31, 2019, eligibility will be determined by applying the Plan rules to hours worked under this Plan and Prior Plans as if they were hours worked under this Plan.
- **"Eligible Employee"** means an employee who has satisfied the requirements for eligibility for benefits from this Fund as described herein and who is currently eligible for benefits.

How an Employee Becomes Eligible for Plan Benefits

Initial Eligibility for Employees Covered by a CBA
Prior to 2016, you became eligible for benefits after you were credited with at least 270 hours in Covered Employment under this Plan or the Prior Plans within a period of 3 consecutive months provided the Plan actually received the contributions for those hours. After 2016, you are entitled to benefits if you had an Account established for you before 2016 or if the Fund recovers contributions for months owed prior to 2016 which would have established your initial eligibility in the Plan under the Plan Rules. On or after January 1, 2021 you become eligible for benefits when you are credited with any Account C Employee contributions for work in Covered Employment.

Continuation of Eligibility
If you become an Eligible Employee, you and your Eligible Dependents will remain eligible for benefits so long as you have an Account balance.

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

- the date the Plan terminates, or
- the date your Account balance has been completely distributed.

Reinstatement of Eligibility
If you have lost your eligibility for benefits under the Plan because your Account has been completely distributed after you have ceased Covered Employment, you may re-establish eligibility when you are credited with any Account C Employee contributions for work in Covered Employment.

Eligibility Following Cessation of Contributions
As previously explained, other than new Account C contributions, or delinquent contribution recoveries, no new contributions are payable to the Fund to Account A and Account B which means that (a) employees who have not established eligibility for benefits cannot establish eligibility and (b) employees who have lost eligibility for benefits cannot re-establish eligibility. Eligibility will terminate if the Plan terminates or when your Account balance has been completely distributed.

Eligibility for Dependents

Your Eligible Dependents include your spouse and any other individual who qualifies as a dependent under Code Section 152. To qualify as a dependent under this provision of the Code, the individual must be a relative (as listed in the law) for whom you provide more than one half of their support in the calendar year. This may include your children, including children placed for adoption and foster children placed with you; grandchildren; stepchildren; siblings and stepsiblings; parents; stepparents; grandparents; nieces and nephews; and in-laws.

Each Eligible Dependent must be listed on an Enrollment Form signed by the Employee and filed with the Fund Office before benefits will be paid for that Dependent. Each change in Dependent Enrollment (adding or terminating a Dependent) must be submitted with evidence or proof of Dependent status satisfactory to the Trustees. If there is a change in your marital status, such as a divorce or legal separation, so that the spouse or former spouse is no longer a Dependent, you are responsible for notifying the Fund Office immediately. You must also notify the Fund Office immediately if a previously enrolled Dependent ceases to qualify for Dependent status under this Plan.

Termination of Dependent Coverage

Benefits for 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 stepchildren, the date the Employee and spouse are divorced.
- The date the Employee ceases to provide a majority of the individual's support.
- Upon the payment of the Death Benefits following the Eligible Employee's death.

You may not remove a Dependent who continues to qualify as a Dependent under the Plan. However, a Dependent may be removed based on a Court Order.

The Fund Office may investigate the status of any Dependent and it may require copies of court orders, property settlement agreements, 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.

Description of Benefits

If you are an Eligible Employee, your Account will be credited with Employer and Employee Contributions for hours worked. As explained previously, new Employer contributions are no longer made under CBAs. However, on or after January 1, 2021, you become eligible when you are credited with any Account C Employee contributions for Covered Employment.

You will be able to receive the amounts in your Account in the form of the various benefits provided by the Plan. Benefits payable to you or your Eligible Dependents cannot exceed your Account balance and are subject to the limitations and eligibility requirements described below. Income is credited to Accounts. The gains, loss, administrative and investment fees applied to each Employee's Account will be determined by the Trustees for each calendar month.

Some benefits are taxable to you based on IRS and/or New York State rules. When legally required, the Fund will withhold taxes from your benefits paid from Account A (Employer Contributions) when they are paid to you. A Form 1099 is issued when amounts are paid to a beneficiary. If the tax rules change, the Fund will comply with all applicable changes.

If benefits paid from Account A are subject to FICA tax, the Fund will deduct the Employee's share of FICA tax from the benefit and pay it to the IRS plus the Employer matching FICA payment which is paid by the Fund. Employers submitted an additional contribution to the Fund, which was not credited to the Employee's individual account, but which was applied to pay the Employer FICA tax.

For the Building Trades Division, MES Division and Oil Trades Division:

Contributions for hours worked through December 31, 2005 were made by your employer on a pre-tax basis. Benefits are taxed to you when they are distributed to you or your beneficiary. The tax rules for this portion of the account, which is referred to as Account A (Employer Contributions), remain the same, and are detailed in a chart on page **79** of this SPD.

Contributions for all hours worked on and after January 1, 2006 are taxed differently. You were taxed on these contributions at the time they were paid to the Fund by your Employer as if they were wages. However, when benefits are distributed to you or your beneficiary, you will not have to pay FICA, Federal, State or City taxes. Instead, you and/or your beneficiary will only have to pay tax annually on any gains that are credited to your account. You will receive an annual statement reflecting investment gains/losses. The portion of your account based on contributions for work on and after January 1, 2006 is referred to as ASB Account B (Employee Contributions) because these amounts were already taxed to you as if they were your wages.

Delinquent contributions for all hours worked prior to 2006 and received by the Fund on or after January 1, 2009, and/or contributions due under the January 1, 2014 merger of the Vacation Fund into the ASB Fund will continue to be made by your employer on a pre-tax basis. However, these contributions will be allocated to individual accounts on a post-tax basis. You will be taxed on these contributions at the time they are allocated as if they were wages, and the Fund will issue an annual Form W-2. However, when benefits are distributed to you or your beneficiary, you will not have to pay FICA, Federal, State or City taxes. The tax rules for this portion of your account, which is referred to as ASB Account B (Employee Contributions), are different.

Effective February 1, 2009, the Building Trades Division CBA ceased requiring contributions for this benefit.

Effective April 1, 2009, the Mechanical Equipment and Service Division & Oil Trades Division CBA ceased requiring contributions for this benefit.

Effective January 1, 2014, the Vacation Fund merged into this Fund. As a result, effective January 1, 2014, the Vacation Fund is no longer receiving contributions. Any pre-tax contributions received after the January 1, 2014 merger for Covered Employment before 2014 will be allocated to the ASB "Account B" post-tax. These amounts will be payable by the ASB Account B under the various Benefit payment options listed herein.

Effective January 1, 2021, contributions to Account C of this Fund commenced under the Building Trades Division CBA. Contributions are based on 5% of Gross Wages deducted from net pay.

For the Civil Service Division and Other Divisions:

Contributions for all days and/or hours worked through December 31, 2008 were made by your employer and allocated to individual accounts on a pre-tax basis. Benefits are taxed to you when they are distributed to you or your beneficiary. The tax rules for this portion of your account, which is referred to as ASB Account A (Employer Contributions), remain the same.

Contributions for all days worked on or after January 1, 2009 and/or delinquent amounts received on or after January 1, 2009 continue to be made by your employer on a pre-tax basis but will be allocated to individual accounts on a post-tax basis. You will be taxed on these contributions at the time they are allocated as if they were wages, and the Fund will issue an annual Form W-2. However, when benefits are distributed to you or your beneficiary, you will not have to pay FICA, Federal, State or City taxes. The tax rules for this portion of your account, which is referred to as ASB Account B (Employee Contributions), are different. Any investment gains or losses to your account will be reported on your annual statement. Consult your tax advisor to see how these gains or losses may affect you. This portion of your account based on contributions to this Fund for work on and after January 1, 2009 is referred to as ASB Account B (Employee Contributions) because these amounts were already taxed to you as if they were your wages.

Effective January 1, 2016, the CBAs applicable to the Civil Service Division and all other Divisions ceased requiring contributions for this benefit.

How Distributions will be Made

- Distributions will be made from Account A (Employer Contributions) unless you designate otherwise. Claims are paid twice per month.
- Amounts available for benefit payments will be the market value of Accounts A, B and C as of the end of the month prior to applying for benefits less an additional estimated amount to cover any market decline between the end of the prior month and the date of distribution plus administrative and investment expenses. The estimated additional amount withheld will vary as the Fund's asset value varies with market conditions. The Trustees will determine this additional estimated amount at the time in which benefit payment amounts are being determined.
- Following receipt of a benefit application, the Fund will pay an initial Benefit payment which will be adjusted for any estimated market change between the last monthly valuation date and the date of payment. Upon completion of the valuation for the month end immediately prior to the benefit payment, and contingent upon the results of the valuation, an additional automatic payment may be made to you in the amount of the difference between the adjusted benefit payment and the actual valuation.

For example: A benefit application received prior to March 26th will be paid the week of April 8th based on the February 28th value with an additional adjustment as necessary to reflect the changes in the value between February 28th and the date of payment in April. When the value as of March 31st is determined, an additional payment will automatically be made ***if*** the adjusted amount paid based on the estimate is lower than the amount determined in the valuation.

Supplemental Unemployment Benefits

- **What are Supplemental Unemployment Benefits?**
  Supplemental Unemployment Benefits provide you with additional unemployment benefits if you become unemployed and/or become eligible for or are receiving State unemployment benefits.
- **How Much Does the Supplemental Unemployment Benefit Pay?**
  You are entitled to the greater of (a) $300 or (b) the amount of your weekly base wage (in accordance with the normal working hours per week under the applicable CBA) less the amount of State unemployment benefits received. Upon filing an Application Form with the Fund Office, Benefits begin when you are eligible for state unemployment benefits and end when state unemployment benefits terminate.
- **Applying for Benefits:**
  You must submit your completed Application Form and proof of your receipt of state unemployment benefits.

Supplemental Workers' Compensation Benefits

- **What are Supplemental Workers' Compensation Benefits?**
  Supplemental Workers' Compensation Benefits provide you with additional workers' compensation benefits if you become injured on the job and are receiving State workers' compensation benefits.
- **How Much Does the Supplemental Workers' Compensation Benefit Pay?**
  You are entitled to the greater of (a) $300 or (b) the amount of your weekly base wage (in accordance with the normal working hours per week under the applicable CBA) less the amount of State workers' compensation when received. Upon filing of an Application Form with the Fund Office, benefits begin when you receive Workers' Compensation Benefits and end when Workers' Compensation Benefits terminate.
- **Applying for Benefits:**
  You must submit your completed Application Form and proof of your receipt of State Workers' Compensation Benefits.

Supplemental Disability Benefits

- **What are Supplemental Disability Benefits?**
  Supplemental Disability Benefits provide you with additional disability benefits if you become disabled and are receiving State disability benefits.
- **How Much Does the Supplemental Disability Benefit Pay?**
  You are entitled to the greater of (a) $300 or (b) the amount of your weekly base wage (in accordance with the normal working hours per week under the applicable CBA) less the amount of State disability benefits. Benefits end when you are no longer receiving State disability benefits.
- **Applying for Benefits:**
  You must submit your completed Application Form and proof of your receipt of State disability Benefits.

Supplemental Income Maintenance

- **What are Supplemental Income Maintenance Benefits?**
  Supplemental Income Maintenance provides you with income maintenance if you become unemployed, underemployed, injured on the job, disabled or if you are participating in union-related matters. When you become eligible for Supplemental Unemployment Benefits, Supplemental Workers' Compensation Benefits, or Supplemental Disability Benefits, the Supplemental Income Maintenance will cease, and the other benefit will be paid instead.
- **How Much Does the Income Maintenance Pay?**
  You are entitled to the greater of (a) $300 or (b) the amount of your weekly base wage (in accordance with the normal working hours per week under the applicable CBA) up to a maximum benefit of $1,500 per week.
- **Applying for Benefits:**
  You must submit an Application Form indicating the amount requested and an affidavit with supporting documentation. You must attest and submit satisfactory documentation that you require these benefits due to unemployment, underemployment, on-the-job injury or disability. If you are unemployed or underemployed, you must submit a quarterly certification that you are ready, willing and able to work the normal working hours per week under the applicable CBA.

Emergency Benefits for Disaster, Fire or Flood

- **What are Emergency Benefits for Disaster, Fire or Flood?**
  Emergency Benefits for economic catastrophes such as Fire or Flood provide you with benefits for expenses due to such events. In order to be eligible for this benefit, the Expenses must be for the repair of your principal residence and if the expenses must qualify as deductible casualty expenses under Section 165 of the Internal Revenue Code and must satisfy any other related requirements. Trustee approval is required for this benefit.
- **How Much Does the Emergency Benefit for Disaster, Fire or Flood Pay?**
  There is no maximum benefit.
- **Applying for Benefits:**
  You must submit an Application Form along with proof of economic catastrophe.

Severance Benefits

- **What are Severance Benefits?**
  Severance Benefits provide you with benefits following your severance of employment in the industry. You are considered to have severed employment in the industry and are first eligible for this benefit after no contributions have been made on your behalf to the Fund, or any related funds, for 6 consecutive months. This is the Severance Date.
- **How Much Does the Severance Benefit Pay?**
  The benefit is the lesser of (i) your Account Maximum or (ii) 2 times your annual wages in the year immediately preceding your severance of employment in the industry. Benefits are payable in a lump sum or in equal quarterly installments and must be paid within 24 months of your Severance Date.

  If you are eligible for a Severance Benefit and do not apply and receive the benefit within the 24-month period following your Severance Date, you will not be eligible for Severance Benefits. In order to be eligible for the Severance Benefit again, you must return to work in the industry for a minimum of 750 hours. Once this requirement is met, you will be eligible for the Severance Benefit on any subsequent Severance Date.
- **Applying for Benefits:**
  You must submit an Application Form.

Funeral Benefits

- **What are Funeral Benefits?**
  Funeral Benefits provide funeral and burial expenses for you or your Dependents.
- **How Much Does the Funeral Benefit Pay?**
  There is no maximum amount.
- **Applying for Benefits:**

  You must submit a completed Application Form and proof of payment of funeral bills. The payment may also be assigned to the Funeral Home.

Death Benefits

- **What are Death Benefits?**
  Death Benefits provide your Beneficiary with benefits after your death. Death Benefits are payable after the above-described Funeral Benefit if your Beneficiary is someone other than the person claiming the Funeral Benefit. Your Beneficiary may elect to receive the Death Benefit in a single sum or in monthly payments.
- **How Much Does the Death Benefit Pay?**
  For amounts in Account A, your Beneficiary may elect to receive Death Benefits as (1) a single sum payment of the Account Balance or (2) Monthly Payments over a period of 7 years (i.e., 84 monthly payments). If your account balance is $5,000 or less at the time of payment, the death benefit will be paid in a lump-sum payment. Amounts in Account B and C will be paid in a lump sum.
- **Can Monthly Death Benefit Payments be changed?**
  For amounts in Account A, your Beneficiary may elect to modify Monthly Payments over a period of 7 years (i.e., 84 monthly payments) one time based on a financial hardship. This modification will allow the Beneficiary to convert the remaining monthly payments to a lump sum payment or increase/reduce the monthly payment amount.

- **Payment of Benefits; Designated Beneficiary:**
  - The Death Benefit is paid based on the last Beneficiary designation received in the Fund Office before your death (or before your Beneficiary's death if your Beneficiary is receiving benefits). If more than one Beneficiary is designated, they will share equally unless you specify otherwise.
  - If you fail to designate a Beneficiary or if all designated Beneficiaries die or are invalidated and you die without having received the distribution of your account balance, the account balance will be distributed in the following order: (1) your surviving spouse (or your Beneficiary's surviving spouse if your Beneficiary is receiving benefits); (2) your children (or your Beneficiary's children if your Beneficiary is receiving benefits); (3) your parents (or your Beneficiary's parents if your Beneficiary is receiving benefits); (4) your siblings (or your Beneficiary's siblings if your Beneficiary is receiving benefits); or (5) the personal representative of your estate or your Beneficiary's estate (if your Beneficiary is receiving benefits).
  - If your Beneficiary dies while receiving benefits and further payments are due for periods after death, such payments shall be made to your Beneficiary(ies)' designated Beneficiary(ies).
  - If Death Benefits are due to a minor, the Fund may pay the benefits to the person having custody or care of the minor and with whom the minor resides, provided such person agrees in writing to apply the payments solely for the minor's support and to comply with any other conditions established by the Trustees or required by law. Alternatively, the Trustees may make payment to a minor by depositing the amount in an insured bank account for the minor and giving notice to the minor.
  - Except as provided above, Benefits will be paid within a reasonable time following notification to the Fund of the death of the Employee.
- **Applying for Benefits:**
  Your Beneficiary must submit a completed Application Form and a certified copy of the Death Certificate. For Death Benefit amounts less than $100, alternative evidence of death will be accepted where a certified death certificate is not available.

Supplemental Vacation Benefits

- **What are Supplemental Vacation Benefits?**
  Supplemental Vacation Benefits provide you with vacation benefits.
- **How Much Does the Supplemental Vacation Benefit Pay?**
  The benefit has a limit of $50,000 per year. Vacation Benefits not used in a calendar year may be withdrawn in the following calendar year.
- **Applying for Benefits:**
  You must submit a completed application form indicating the amount requested for vacation benefits. You may apply for benefits 3 times per year.
- **Tax withholdings for Account A:**
  Under the law, there are different levels of tax withholding depending on a number of factors including the type of payment and the number of payments each year. In the case of Supplemental Vacation Benefits, certain tax withholdings apply to benefits paid in the last week of January each year (fixed payment). Supplemental Vacation Benefits paid at other times are subject to different tax withholdings. See discussion of tax withholding rules on page 79. In order for the tax withholdings for the fixed payment to apply, you must specify on your application that you are applying for this benefit to be paid as required in the last week of January and you must attach a Form W-4. If your application does not indicate that you are applying for the fixed payment or does not include a Form W-4, the tax withholdings that apply to all other Supplemental Vacation Benefits will be used. The Fund Office must receive an application for distribution and a valid Form W-4 by no later than the third Tuesday of January.

Legal Services Benefits

- **What are Legal Services Benefits?**
  Legal Services benefits provide you with reimbursement of amounts paid for legal services for you or your Dependent.
- **How Much Does the Legal Services Benefit Pay?**
  Legal Services benefits provide you with reimbursement of amounts paid for legal services for you or your Dependent.
- **Applying for Benefits:**
  You must submit a completed Application Form with a copy of your legal services paid bill.

Education/Training Benefits

- **What are Education/Training Benefits?**
  Education and/or Training Benefits provide you with expenses for your education or training and for the education or training of your spouse and/or eligible dependents.
- **How Much Does the Education/Training Benefit Pay?**
  There is no maximum amount.
- **Applying for Benefits:**
  You must submit a completed Application Form along with copies of bills for education or training.

TAX RULES

Account A – Employer Contributions

The money in your Individual Account A is not considered taxable income until you actually receive it. When you receive benefits from your Account A balance, the amount must be reported as taxable income. All benefits (except Funeral Benefits and Death Benefits) are subject to withholdings. For more information concerning taxes and withholdings, see the charts and examples listed below.

Account B and C – Employee Contributions

FICA/Medicare, Federal, State or City taxes will not be paid when the benefits are distributed. The only tax that you and/or your beneficiary must pay is on the interest accrued in the account annually.

Tax Withholdings (Account A Only)

As required by law, the Fund deducts FICA/Medicare, Federal, State and City Taxes from all taxable ASB benefit payments. Any taxable benefit payment made to you will be net of the following taxes:

Benefit		FICA/Medicare	Federal	State	City
a.	Supplemental Unemployment	0.00%	22%	11.7%	4.25%
b.	Supplemental Workers' Comp.	7.65%	22%	11.7%	4.25%
c.	Supplemental Disability	7.65%	22%	11.7%	4.25%
d.	Supplemental Income Maintenance	7.65%	22%	11.7%	4.25%
e.	Emergency Benefit for Disaster	7.65%	22%	11.7%	4.25%
f.	Severance Benefit	7.65%	22%	11.7%	4.25%
g.	Funeral Benefit(1)	0.00%	0.00%	0.00%	0.00%
h.	Death Benefit(1)	0.00%	0.00%	0.00%	0.00%
i.	NA	-	-	-	-
j.	Supplemental Vacation (all other)	7.65%	22%	11.7%	4.25%
k.	Supplemental Vacation (fixed payment)(2)	7.65%	Varies	Varies	Varies
l.	Legal Services Benefit	7.65%	22%	11.7%	4.25%
m.	Education/Training Benefit	7.65%	22%	11.7%	4.25%

Note 1: Funeral Benefits and Death Benefits are Taxable to the Beneficiaries.

Note 2: "Annual" tax withholding tables can be used for Supplemental Vacation Benefits (fixed payment) paid during the last week in January only if you provide the Fund with a valid Form W-4. If a valid Form W-4 is not provided, withholdings will be the same as the above-stated withholdings for "all other Supplemental Vacation" (Item j).

Special Rule on Supplemental Vacation Benefit Tax Withholdings (Fixed Payment) - Account A Only

The tax withholdings for Supplemental Vacation Benefits depend on when benefits are paid (see chart above). Vacation Benefits paid in January (fixed payment) of each year and are subject to the special (often lower) income tax withholdings, subject to your submission of a valid Form W-4 with your application.

The following examples summarize the tax withholdings that apply to the Supplemental Vacation Benefit fixed payment when you submit a valid Form W-4. If a valid Form W-4 is not provided, withholdings will be the same as applicable to all other Supplemental Vacation Benefits. These examples, which are based on the 2024 tax rates, illustrate withholdings for an unmarried individual, a married individual, and a married individual with two children who does not itemize deductions and whose only source of income is wages from employment. If you are married and have additional income from a working spouse or from other types of investments, your tax bracket may be higher, and your withholdings may be that much greater. These examples include FICA/Medicare, Federal, State and City income tax rates based on annual tax tables issued by the respective taxing authorities and are merely for illustrative purposes. Check with your tax advisor to see how electing Supplemental Vacation Benefits (fixed payment) can affect you.

Example 1 – Assume you elect a Supplemental Vacation Benefit fixed payment of $18,000 paid in the last week of January and you submit a valid Form W-4 to the Fund.

	FICA/Medicare	Federal	State	City	Payment
Single w/Zero	$1,377.00	$1,310.00	$434.50	$323.75	$14,554.75
Married w/Zero	$1,377.00	$320.00	$409.75	$307.50	$15,585.75
Married w/2	$1,377.00	$0.00	$322.00	$234.00	$16,067.00

Example 2 – Assume you elect a Supplemental Vacation Benefit fixed payment of $12,000 paid in the last week of January and you submit a valid Form W-4 to the Fund.

	FICA/Medicare	Federal	State	City	Payment
Single w/Zero	$918.00	$675.00	$184.00	$143.50	$10,079.50
Married w/Zero	$918.00	$0.00	$162.00	$133.25	$10,786.75
Married w/2	$918.00	$0.00	$82.00	$92.25	$10,907.75

Example 3 – Assume you elect a Supplemental Vacation Benefit fixed payment of $9,000 paid in the last week of January and you submit a valid Form W-4 to the Fund.

	FICA/Medicare	Federal	State	City	Payment
Single w/Zero	$688.50	$375.00	$64.00	$82.00	$7,790.50
Married w/Zero	$688.50	$0.00	$42.00	$71.75	$8,197.75
Married w/2	$688.50	$0.00	$0.00	$30.75	$8,280.75

Special Rule on Benefit Payments - Account C Only

Account C benefits are similar to Accounts A and/or B benefits, except that Account C must maintain a minimum account balance of $7,500 for BT Journeymen and $3,750 for BT Apprentices, with skill level determined at time of benefit payment. This minimum account balance can be used as an "Emergency Relief Fund" for the following benefit payments:

a. Supplemental Unemployment Benefit
b. Supplemental Workers' Compensation
c. Supplemental Disability Benefit
d. Supplemental Income Maintenance
e. Emergency Benefit for Disaster, Fire or Flood
f. Legal Services Benefit
g. Funeral Benefit

Amounts in excess of the minimum balance can be used for the following benefit payments:

h. Supplemental Vacation Benefit
i. Education/Training Benefit

Minimum account balance does not apply for the following benefit payments under the terms of the Plan:

j. Severance Benefit
k. Death Benefit

How to File a Claim for Benefits

Claim forms are available from the Fund Office and on the Fund's website at www.ualocal1funds.org.

Read the claim form carefully, answer all questions and include all required information. Claims must be filed within 36 months of the qualifying event.

The claim and all required attachments should be mailed to:

Plumbers Local Union No. 1 Welfare Fund

50-02 Fifth Street, Second Floor

Long Island City, New York 11101

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 Fund has a Coordination of Benefits ("COB") 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 and Accidental Dismemberment ("AD&D").

"Coordination" means that benefits from this Fund 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 the Fund (except Life Insurance and AD&D) and any other plan covering the claimant. Expenses not covered by any plan under which a person is covered 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

The Fund always pays Allowable Expenses after a plan that does not have a COB 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 custodial parent has not remarried, the plan covering the custodial parent pays benefits first. The plan covering the parent without custody pays benefits second.
  - If the custodial parent has remarried, the plan covering the parent pays first, the plan of the stepparent 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. The Plan's medical benefits will be your primary coverage (and your Spouse's, if they are 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, keep the following points 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 Fund does not require that Active Employees aged 65 or over and Spouses of Active Employees aged 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 the Fund 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 the Fund pays second. This provision does not extend the maximum periods of COBRA Continuation of Coverage; once you exhaust the maximum COBRA period, your Fund coverage will end.

Medicare Coordination for Retirees

If you are a retiree or an inactive disabled Employee and become eligible for Medicare, Medicare will be your primary coverage under the Aetna Medicare Advantage arrangement. 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 aged 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. **Failure to elect Medicare Part B coverage will result in a loss of benefits from the Fund** (Aetna Medicare Advantage Plan or Anthem BCBS for medical and hospital coverage, Prescription Drug Plan Aetna Medicare Advantage or CVS Caremark, Vision and Life Insurance Benefits).

All medical claims after your enrollment in Medicare and in the Aetna Medicare Advantage Plan must be submitted to Aetna.

Enrolling in Medicare

It is important that you or your Eligible Dependent visit an office of the Social Security Administration ("SSA") during the 3-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, contact the Fund Office.

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 their 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. A Medicare recipient's choice of retaining or canceling coverage under this Plan 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 timely claim review and to ensure 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 (i.e., an initial "claim") is payable. If the Claims Administrator denies your initial claim (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, a claim must be filed in accordance with 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. Review the following procedures carefully. Claims are processed by the applicable Claims Administrators.

A claim is considered filed as soon as a written claim form is received by the applicable Claims Administrator listed on page **85** 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 these procedures, 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 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, the following procedures do not apply.

Some but not all benefits require pre-certification or pre-approval (see page **32**). Pre-approval must be obtained when it is required and your failure to do so may result in a reduction of benefits, up to 50% or a maximum of $2,500. To maximize your coverage, call:

Anthem 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 claimant 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 your representative until such written designation is received. You may not, however, transfer, assign, or otherwise promise your appeal rights to any person or party other than you.

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 applicable time period 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," "post-service claim," or a disability or life/AD&D claim. These and other important terms are defined below.

"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 page 32 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 Anthem

The Plan makes healthcare easy by paying providers directly when you stay In-Network. Therefore, when you receive care from in-network providers or facilities, 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 POS's service area. To obtain a claim form, call the POS's customer service number at 1-844-243-5566.

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

*Note: The provider files claim directly with Anthem or the 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 POS In-Network allowance as full payment, less any applicable co-payment. Some services require pre-certification. Refer to the chart on page **32**.

Out-of-Network Hospital and Medical Benefit Claims

You should send any Out-of-Network claim for benefits to the POS 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 POS 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 ANTHEM

Hospital Claims:

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

Medical Claims:

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

Anthem Out-of-Network claims – You should send any Out-of-Network claim for benefits to the POS in which you are enrolled, at the address stated above, within 90 days of the date of service. Anthem 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 or if an adjustment is made to your claim. If Anthem 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 **90** and **92** for details on the contents of the notification and timing.

If you have questions about your claim, you may contact Anthem Member Services at 1-844-243-5566, www.anthembluecross.com or in writing. When you call, be sure to have your Anthem 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.anthembluecross.com.

Assignment – You authorize Anthem to make payments directly to participating In-Network providers for covered services. Anthem reserves the right to make payments directly to you. Except where Anthem 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 issued by Anthem 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 QMCSO. See page **13**.

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, Anthem 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 visit 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 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 charts on page **33** for a list of services which require pre-certification.

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

You should send Out-of-Network claims for Mental Health or Substance Use Disorder to Optum within 90 days of the date of service. 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 submitted online 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 instructions. Out-of-Network claims may also be mailed to:

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

The following tips on completing your claim form should 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), the 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 information on this form, visit http://www.nucc.org.
- Provide Additional Insurance Information: If the 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 that the Patient and Covered Individual Have the Same Last Name: If the patient has a different last name, Optum will request additional information 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 Anthem 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 and 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 in which case payment will be paid to you. If Optum denies your initial claim, 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 page **92** 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 their 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). To determine which plan is primary coverage, refer to page **81**. As a reminder, this Plan uses the "Birthday Rule" in determining which plan is primary for Dependent Children.

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

1. You receive "covered" services from a provider.
2. The claim is submitted to the primary plan.
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; benefits will be reduced so that the total benefits paid by both plans will not be greater than the allowable expenses. The Plan will not pay more than the amount the Plan would normally pay if the Plan were primary.

Medicare Advantage Plan Claims/Coordination of Benefits

1. Medicare-Eligible Participants receive "covered" services from a provider.
2. The claim is submitted to Aetna.
3. You receive an EOB from Aetna, your primary insurance.
4. Aetna will process the claim for payment to you or to the provider if you request an assignment of benefits.

Prescription Drug Benefit Claims/Mail Order Drug Benefit Claims

Special procedures apply to prescription claims. If you fill the prescription at a participating (in-network) pharmacy, you do not have to complete a claim form; you just present the card to the participating pharmacy. See page **55** 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. OTC medications for which a prescription is not legally required are not covered by the Plan although you may be able to obtain HRA reimbursement.

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 and to 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 contact CVS/Caremark directly if you have questions or want to check whether 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 Plan's terms, 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 "Notice of Denied Claims"

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 is 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 they are 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 a claim services, you have the right to seek a review by Cigna in accordance with the procedures described in the next section entitled “Notice of Denied Claims.”

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 “Notice of Denied Claims.”

Livongo Glucose Levels Monitoring Benefit Claims

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

Memorial Sloan Kettering Cancer Center (MSK) through MSK Direct Benefit Claims

There are no claims to submit if 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 “Notice of Denied Claims.”

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) 223-4313 (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 5 years after the death of the Eligible Employee or Retired Employee. Claims submitted after 5 years of the Eligible Employee's 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 by Amalgamated Life Insurance Company for all other Life or AD&D claims, in accordance with the procedures described in the next section entitled "Notice of Denied Claim"

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) 223-4313 (phone)

You may obtain the applications by visiting the Fund's website at www.ualocal1.org or you can call the Fund Office to request an application.

The deadline for filing weekly disability claims is 18 months.

Effective January 1, 2024, weekly unemployment claims must be submitted within 12 months of the week for which you are claiming benefits. Effective January 1, 2025, weekly unemployment claims must be submitted within 6 months of the week for which you are claiming benefits. In addition, as noted above, the payment of retroactive claims is limited to 5 weeks.

Benefits will be paid by the Fund on a monthly basis. Claim forms are due in the Fund Office by no later than the second Tuesday of each calendar month. Claims for weekly disability benefits must include your completed application along 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.

Claims for weekly unemployment benefits must include your completed application along 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 "Notice of Denied Claims"

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 Anthem - If Anthem has all information necessary to make a determination on an urgent Pre-certification request, it 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 Anthem needs additional information, it will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Anthem will make a determination and provide written notice to you (or your designee) and your Provider 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 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 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 Anthem - If Anthem has all the information necessary to make a determination regarding a Pre-certification review, it will make a determination and provide written notice to you (or your designee) and your Provider within 15 calendar days of receipt of the request. If Anthem 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 Anthem receives the requested information within 45 days, it will make a determination and provide written notice to you (or your designee) and your Provider within 15 calendar days of receipt of the additional information. If all necessary information is not received within 45 days, Anthem 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 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 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 Anthem - 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 Anthem 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. Anthem 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 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 Anthem - Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and written notice provided to you (or your designee) and your Provider within 15 calendar days of receipt of all necessary information. If Anthem 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. Anthem will make a determination and provide written notice to you (or your designee) and your Provider within 15 calendar days of receipt of the additional information or, if Anthem 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 Anthem - 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, Anthem 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, Anthem 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 Anthem needs additional information, Anthem will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Anthem will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of 1 business day or 48 hours of receipt of the information or, if Anthem 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 Anthem - If Anthem 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 Anthem 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. Anthem will make a determination and provide written notice to you and your Provider 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 Anthem has all the information to make a decision, failure to make a 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 Anthem - Anthem 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 Anthem; (iii) Anthem was not aware of the existence of such information at the time of the Preauthorization review; and (iv) had Anthem 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 Anthem - If Anthem 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 written notice of adverse determination will be given to you and your Provider.

Notice of Denial of Claim

If a claim for Hospital, Medical, Mental Health and Substance Use Disorder, Prescription Drug, dental, vision, life, AD&D, Weekly Disability, Weekly Unemployment, Supplemental Unemployment, Supplemental Workers' Compensation, Supplemental Disability, Supplemental Income Maintenance, Emergency Benefit for Disaster, Fire or Flood, Funeral Benefit, Severance Benefit, Death Benefit, Supplemental Vacation Benefit, Legal Services or Education/Training 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, 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, a statement that you have the right to request the applicable diagnosis and treatment code and their corresponding meanings.
- 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 with an explanation of the scientific or clinical judgment for the determination applying the Plan's terms 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. 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 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 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 Anthem: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 223-4313.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Anthem: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 223-4313.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 Anthem: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 223-4313.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Anthem: (844) 243-5566; Optum: 1-866-556-8166; CVS/Caremark: 1-866-689-3092; Fund Office: (718) 223-4313.

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 or who 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 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 applicable Plan provisions 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 Anthem.	Send to the following address: **Anthem Blue Cross and 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 Anthem 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 Dental Claims should be made to Cigna.	Send to the following address: **Cigna Dental Services Appeals Department** P.O Box 188044 Chattanooga TN 37422 Fax: 859-550-2680	Providers may submit urgent appeal requests on behalf of a participant by calling the provider only toll-free number at 866-370-8573.
Requests for review of denied Vision Claims and HRA 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: (718) 223-4313	The decision on appeal will be made by the Board of Trustees or the Appeals Committee of the Board of Trustees.

Anthem Blue Cross and 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, Anthem'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 Anthem'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 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 Anthem'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.

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. Anthem 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. Anthem maintains a two-level appeal for appeals as described below.

Preauthorization Appeal. If your Appeal relates to a Preauthorization request, Anthem 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, to your Provider within 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, Anthem 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 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 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 2 business days of receipt of the information necessary to conduct the Appeal.

Anthem'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 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 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. Anthem 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, Anthem 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 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, Anthem 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 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, Anthem 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, and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review.

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

An External Review request 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 External Review orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem 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 an expedited basis.

All other requests for External Review should be submitted in writing unless Anthem 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 and 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.

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure, excluding any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. You have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Authority as Claims Fiduciary: Anthem serves as the claims fiduciary solely for the purpose of adjudicating appeals relating to the coverage of medical and hospital benefits. Anthem 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

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 appeals must be submitted in writing. However, appeals of 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 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. 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 Claims (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 Claims (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 Optum's website at www.providerexpress.com.

Your request for external review of a standard (not Urgent Care) claim must be made in writing within 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, 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

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure, excluding any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. You have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Authority as Claims Fiduciary: Optum serves 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 claimant, the claimant'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 based on 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 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 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 also be communicated by telephone or fax.) This notice will include:

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

Authority as Claims Fiduciary: CVS/Caremark serves 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.

Cigna Dental Services Appeal Process

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, call the toll-free number on your EOB or claim form and explain your concern to Cigna's Customer Service representative. 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 written appeal 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 the toll-free number on your EOB or claim form.

Your appeal will be reviewed, and the decision will be 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 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 Plan benefits. 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, (a) reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (b) a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your appeal, and (c) 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 statement 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 may be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within 3 years after proof of claim is required under the Plan for Out-of-Network services.

Authority as Claims Fiduciary: Cigna is 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 for Post-Service Claims

For Vision, Hearing Aid, Health Reimbursement Arrangement (HRA), Weekly Disability, Weekly Unemployment, Supplemental Unemployment, Supplemental Workers' Compensation, Supplemental Disability, Supplemental Income Maintenance, Emergency Benefit for Disaster, Fire or Flood, Funeral, Severance, Death, Supplemental Vacation, Legal Services or Education/Training Benefits

If a claim for Vision, Hearing Aid, HRA reimbursement, Weekly Disability, Weekly Unemployment, Supplemental Unemployment, Supplemental Workers' Compensation, Supplemental Disability, Supplemental Income Maintenance, Emergency Benefit for Disaster, Fire or Flood, Funeral, Severance, Death, Supplemental Vacation Benefit, Legal Services, or Education/Training 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 appeal. Appeals must be submitted in writing within 180 days of the claim denial to the:

Appeals Committee/Board of Trustees Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street
Long Island City, NY 11101
1-718-223-4313

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

- The opportunity, upon request and without charge, to have reasonable access to and copies of all documents, records and other information relevant to your claim.
- The opportunity to submit written comments, documents, records and other information relating to your claim.
- With respect to health and weekly disability benefit claims 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
  - 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

Vision, Hearing Aid, HRAs, Weekly Disability, Weekly Unemployment, Supplemental Unemployment, Supplemental Workers' Compensation, Supplemental Disability, Supplemental Income Maintenance, Emergency Benefit for Disaster, Fire or Flood, Funeral, Severance, Death, Supplemental Vacation, Legal Services, Education/Training Benefits, or Eligibility.

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 appeal, unless the appeal 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 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 appeal. 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 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 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; and
- 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 Anthem and the date of Anthem's denial of the second-level administrative appeal is January 1, 2024, you have until December 31, 2024 to file a lawsuit for benefits. If the claim only requires one level of appeal, you 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 3 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, your attorney or the legal guardian of a minor or incapacitated individual 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 its Agents 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.

Subrogation and Reimbursement

The Plan's Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained, and you have a right to a Recovery or have received a Recovery from any source.

The Plan has contracted with Carelon Insights ("Carelon") (formerly known as Meridian Resource Company, LLC and Healthcare Recovery Solutions, LLC ("HRS") (collectively, the "Agents") for subrogation/reimbursement services and you are required to cooperate with the Plan's Agents in their efforts to obtain monies on behalf of the Plan.

Definitions: As used in these Subrogation and Reimbursement provisions, "you" or "your" includes anyone on whose behalf the Plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former participants and beneficiaries as well as to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's rights under these provisions shall also apply to the personal representative or administrator of your estate, your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements allocate or characterize the money you receive as a Recovery; it shall be subject to these provisions.

Subrogation: Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on your behalf from any party or insurer responsible for compensating you for your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement: If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage: The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment: In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have regardless of whether you choose to pursue the claim.

Applicability to All Settlements and Judgments: Notwithstanding any allocation or designation of your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery you make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement judgment, or verdict pertaining to your Recovery identify the benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust: By accepting benefits from the Plan, you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. You and your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights: The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from your Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim: By accepting benefits from the Plan, you acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before you receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make you whole or to compensate you in part or in whole for the losses, injuries, or illnesses you sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation: You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Agents, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

If you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

You acknowledge that the Plan has the right to investigate the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, Carelon, HRS, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion: The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in their entirety and reserves the right to make changes as it deems necessary.

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 workers' 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 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 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 Plan's terms irrespective of whether you have signed the acknowledgment form. Therefore, the Plan has the rights described in this section even if you have not notified the Plan or signed the form.

If monies are recovered and the Plan is not reimbursed the amount 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 their 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 Participant and/or Dependents for repayment. If repayment is not promptly made, the amounts due to the Plan may be deducted from any benefits due to the Participant and their 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 to the Fund Office include your divorce, loss of custody, and the marriage or gainful employment of a child. If reimbursement is not promptly made, the amounts due to the Plan may be deducted from any benefits due to you and your 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 chooses to do so. If there has been a benefit overpayment, or you otherwise owe money to the Plan, the Plan may 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

Covered services and supplies 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 reimburse the Plan for benefits 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 and/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 documents 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 workers' 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.
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: • For the repair of non-occupational injuries to natural teeth, or • 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 Participant 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 patient became eligible for coverage, or after eligibility has terminated. To be covered, all treatments must be completed while the patient 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 (including recovery residences).
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: • any treatment not proven in an objective manner to have benefits for the patient. • any treatment that is restricted to use at a medical facility engaged primarily in carrying out scientific studies. • any treatment, drug or supply which is not recognized as acceptable medical practice in the United States. • any items requiring governmental approval which was not granted at the time the services were rendered. • any service or supply that is available only on approval of an Institutional Review Board (as required by Federal statute), including ones that require completion of an informed consent for experimentation on human subjects (as required by Federal regulations). • any treatment that involves drugs not approved by the FDA, including dosages, combinations and uses that are not approved. • any new drug or devise for which an investigational application has been filed with the FDA. • any treatment that is available only through participation in FDA Phase I or Phase II clinical trials or Phase III experimental or research clinical trials sponsored by the National Cancer Institute; and/or any services or supplies that have protocols or consent documents describing them as an alternative to more conventional therapies. 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 **83**.
26	Treatment for intentionally self-inflicted injuries, unless the injury is the result of a medical condition, mental health condition or domestic violence. Notwithstanding this exclusion, nothing in this SPD shall be construed to deny Life Insurance Benefits as described on page **61** 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 unless the injury is the result of a medical condition, mental health condition or domestic violence.
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: associated specimen collection and handling charges (these are inclusive within the reported testing codes) specimen validity testing 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.
48	Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the Individual with Disabilities Education Act.
49	Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials"

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, Wendy Salvatierra.

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: Wendy Salvatierra, Section 1557 Coordinator, Plumbers Local Union No. 1 Welfare Fund, 50-02 Fifth Street, 2nd Floor, Long Island City, NY 11101, (718) 223-4313 (telephone), (718) 641–8155 (fax), info@nypl1f.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Wendy Salvatierra, 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 1-718–223-4313.

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 1-718–223-4313.

ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-718–223-4313 (ATS : 1-718-223-4313).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-718–223-4313

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718–223-4313.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718–223-4313.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718–223-4313.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-718–223-4313.

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 1-718–223-4313.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-718–223-4313.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-718– 223-4313.

□ L করনঃ িযদ আিপন বাংলা, কথা বেলত পাে◌◌রন, তাে◌হল ি◌◌নঃখরচায় ভাষা সহায়তা িেপরষবা উপল 1আছ। 1◌ফান করন ১- 718–223-4313.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1 718–223-4313

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 Fund will pay for covered services. See page 31.

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 is 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.

Ancillary Services mean the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

Apprentice is a job classification of Employee of an Employer under the Local 1 CBA for a participant in the apprenticeship program of the Plumbers Local Union 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 48.

Beneficiary Designation Form see page 61.

Collective Bargaining Agreement ("CBA") 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.

Continuing Care Patient means an individual who is (any of the following):

- Receiving a course of treatment for a "serious and complex condition;"
- Scheduled to undergo non-elective surgery (including any post-operative care);
- Pregnant and undergoing a course of treatment for the pregnancy;
- Determined to be terminally ill and receiving treatment for the illness; or
- Is undergoing a course of institutional or inpatient care from the provider or facility.

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 CBA or Participation Agreement for which contributions must be paid to this Plan.

Deductible is the amount a Participant or Eligible Dependent pays before the Plan pays Benefits. See page 22.

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 10.

Disabled Dependent Child see page 10.

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 4th month following the most recent period of 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 67.

Emergency Condition or Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (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.

See page 40.

Emergency Room Care means Emergency Services you get in an emergency room or any facility that is geographically separate and distinct from a hospital and is licensed under state law to provide Emergency Services.

Emergency Services mean with respect to an Emergency Condition, (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Condition, (2) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished), (3) Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility regardless of the department of the hospital in which such items or services are furnished (also includes post stabilization services, which are services after the patient is stabilized, and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Condition), until:

- The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and
- You are supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed; and
- You give informed consent to continued treatment by the nonparticipating provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

Employee is an individual who is covered by a CBA or a Participation Agreement that requires their Employer to contribute to this Plan on their 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 contribute to the Plan.

Experimental or Investigational Service(s) - Technology, treatments, procedures, drugs, biological products or medical devices that in the 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. or
- 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.

Gender Dysphoria Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician. For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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, Luxturna and Zolgensma; new applications for gene therapies are submitted every year.

Health Reimbursement Account ("HRA") see page 65.

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

Hospital means a legally constituted general acute care non-governmental institution duly accredited by the Joint Commission on Accreditation of Hospitals or any similar Hospital in a foreign country and operated for the treatment of acute illness or injured person with facilities for surgery and having 24-hour nursing and full medical services. An institution for the aged, chronically ill, a convalescent, rest or nursing home is not a Hospital. No benefits are payable to an institution that is not a Hospital unless otherwise stated in the Plan. In addition, with respect to pregnancy, the word "Hospital" includes alternate birthing facilities under the supervision of a Physician or a licensed nurse-midwife. See page 40.

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 3 hours per day, 2 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 CBA 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 their 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 their family;
4. The treatment is not primarily custodial; and
5. The treatment is the most appropriate level of the service or supply.

Medicare Advantage Plan see page 64.

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.

No Surprises Services mean the following, to the extent covered under the Plan:

- Out-of-Network Emergency Services,
- Out-of-Network air ambulance services;
- Non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network provider at an In-Network facility; and
- Other Out-of-Network non-emergency services performed at an In-Network facility with respect to which the provider does not comply with federal notice and consent requirements.

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 20.

Participation Agreement is an agreement between the Plan and an Employer which obligates the employer to contribute 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 page 32 for information concerning which benefits require pre-approval.

Preferred Provider Organization (PPO/POS) 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 20.

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:

- It is a legend drug for which Federal Law requires a prescription;
- It is a prescription requiring compounding; or
- 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 18.

Qualifying Payment Amount ("QPA") means generally the median contracted rates of the plan or issuer for the item or service in the geographic region, as defined in the No Surprises Act.

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, stepsibling, 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 their other parent. Qualified Relatives must meet all the requirements as stated under Section 152(b) and (d) of the Internal Revenue Code. See page 61.

Recognized Amount means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the QPA.
- For air ambulance services furnished by non-POS providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

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 their Pension from the UANPF. See page 3.

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 who 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.

Serious and Complex Condition means one of the following:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent injury; or
- In the case of a chronic illness or condition, a condition that is the following:
- Life-threatening, degenerative, potentially disabling, or congenital; and
- Requires specialized medical care over a prolonged period of time.

Specialty Guideline Management Program see page 64.

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.

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, including those defined in the American Society of Addiction Medicine (ASAM) Criteria, 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 doesn't 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 activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery. Please note these living arrangements are also known as supportive housing (including recovery residences).

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 5.

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 1 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 9.

Urgent Care Claim is a pre-service claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health or ability to regain maximum function; or, 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. 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 POS/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 on you.

The Privacy Rule is detailed. The following questions and answers explain the Rule in more detail and give 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 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 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) 223-4313 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, 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, POS/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 to law enforcement officials your PHI 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 their 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 Plan provisions.

The Plan may disclose your PHI, including your qualification for health benefits and specific claim information to the Plumbers Local Union No. 1 401(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 6 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:

Wendy Salvatierra
Administrator for the Trustees
Plumbers Local Union No. 1 Welfare Fund
50-02 Fifth Street
Long Island City, NY 11101
1-718-223-4313

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 Medicare Advantage, Life Insurance and AD&D benefits which are insured.

Type of Plan: Hospitalization, Medical, Disability, Dental, Vision, Prescription, Life and Accidental Death & Accidental Dismemberment, Weekly Disability, Weekly Unemployment, Supplemental Unemployment, Supplemental Workers' Compensation, Supplemental Disability, Supplemental Income Maintenance, Emergency Benefit for Disaster, Fire or Flood, Funeral, Severance , Death, Supplemental Vacation , Legal Benefit or Education/Training Benefits.

Date of the End of the Plan Year: December 31

Internal Revenue Service Plan Identification Number: 11-1538293

Plan Number: 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 Fund
50-02 Fifth Street, 2Nd Floor
Long Island City, NY 11101
1-718-223-4313

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

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.

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 CBAs between Plumbers Local Union No. 1 and Employers or Participation Agreements, by individuals through self-payments, and from any income earned from investments of contributions. All monies are used exclusively for providing benefits to Participants 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, with information as to whether an Employer is contributing to this Plan on behalf of Employees working under a CBA.

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
Physician & Hospital Network Anthem Blue Cross and Blue Shield P.O. Box 1407 New York, NY 10008	Phone: 1-844-243-5566 Website: www.anthembluecross.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 Advantage Plan Aetna Medicare PO Box 981106 EL Paso, TX 79998-1106	Phone: 888-267-2637 (TTY 711), Website: www.AetnaRetireePlans.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
Livongo 2 Manhattanville Rd Purchase, NY 10577	Phone: (800) 945-4355 Website: join.livongo.com/UALOCAL1FUNDS
Memorial Sloan Kettering Cancer Center (MSK) through MSK Direct 1275 York Avenue New York, NY 10065	Phone: 833-293-3893 Website: www.mskcc.org/nypl1f

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 or for any other reason. 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 CBAs 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 charge, 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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