SUMMARY PLAN DESCRIPTION & PLAN RULES AND REGULATIONS OF THE HEATING, PIPING AND REFRIGERATION MEDICAL PLAN

(Revised as of May 1, 2024)

For Information about Eligibility Call or Write:

PHONE: (800) 618-2879 FAX: (240) 303-2484

Mailing Address
Heating, Piping and Refrigeration Medical Fund
PO Box 21427, Eagan, MN 55121

For Information about Claims Call or Write:

PHONE: (800) 618-2879 FAX: (206) 441-9110

Mailing Address
Heating, Piping and Refrigeration Medical Fund
PO Box 34567, Seattle, WA 98124

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INTRODUCTION

This booklet sets forth the Plan of Benefits provided to eligible Employees and their Dependents by the Heating, Piping and Refrigeration Medical Fund. This booklet also serves as your Summary Plan Description. It replaces prior booklets, and it applies to all claims for services incurred on or after May 1, 2024.

We urge you to read this booklet carefully so that you will be familiar with the Plan's benefits, its eligibility requirements, and procedures for filing claims. We hope that you will share the Trustees' pride in your Medical Plan and the measure of security it provides to those who work at the trade in our industry.

The Plan is maintained exclusively for your benefit and for the benefit of your dependents, and it is intended to continue for an indefinite period. However, this does not prevent the Trustees from amending or terminating the Plan of Benefits if conditions make such action necessary or appropriate.

Only the Board of Trustees is authorized to interpret this Plan. The Board has the discretion to decide all questions about the Plan, including questions about your eligibility for benefits, the amounts and benefits payable to you, and the application of any terms or provisions of the Plan. The Board also has discretion to make any factual determinations about any claim.

Your Employer or Union representative does not have the authority to interpret and apply the Plan on behalf of the Board or to act as an agent of the Board. Please contact the Fund office if you have any questions about the Plan and what it provides, or questions about how the Plan applies to you.

We are in a time of rapid change in our healthcare system, so constant assessment of the Plan to maintain the Fund's financial stability is essential. The Trustees are working closely with their advisers to keep up with and respond to these developments.

IMPORTANT

IF YOU HAVE ANY QUESTIONS ABOUT YOUR ELIGIBILITY OR BENEFITS, OR IF YOU HAVE ANY QUESTIONS ABOUT SPECIFIC SERVICES OR PROCEDURES, PLEASE CONTACT THE FUND OFFICE.

IF YOU HAVE A CHANGE IN FAMILY STATUS, SUCH AS MARRIAGE, DIVORCE, THE ADDITION OF A NEW DEPENDENT, OR A CHANGE IN ADDRESS, YOU MUST INFORM THE FUND OFFICE OF SUCH CHANGE WITHIN 30 DAYS OF THE EVENT.

LANGUAGE ASSISTANCE SERVICES, FREE OF CHARGE, MAY BE AVAILABLE FOR ANYONE COVERED OR ELIGIBLE TO BE COVERED BY THIS PLAN.

YOU CAN CALL OR WRITE THE FUND OFFICE AT:

Heating, Piping and Refrigeration Medical Fund
WPAS, Inc.
8700 Ashwood Drive, Suite 150
Capitol Heights, Maryland 20743

Mailing Address:
PO Box 21427
Eagan, MN 55121

Phone: (800) 618-2879
Fax: (240) 303-2484

Nondiscrimination Requirements under the ACA

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

When necessary, the Heating, Piping and Refrigeration Medical 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 Heating, Piping and Refrigeration Medical 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 Office.

If you believe that the Heating, Piping and Refrigeration Medical 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 the Fund Office: Heating, Piping and Refrigeration Medical Fund, c/o WPAS, Inc., PO Box 21427 Eagan, MN 55121. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please contact the Fund Office at 800-618-2879.

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)
OCRComplaint@hhs.gov
Complaint forms are available at https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

IMPORTANT CONTACT INFORMATION

You can always call the Benefits Office at (800) 618-2879 if you have a question about your Medical Plan. Here are some phone numbers and websites to help you get answers to your questions quickly. Please have your Member Identification Number available when you make a call.

Information	Contact	Phone/Website
Medical Claims	Fund Office	(800) 618-2879 HPRBenefitFunds.com
Prescription Claims	CVS Health – Non Medicare SilverScript - Medicare	(800) 594-3083 (888) 624-1141 caremark.com
Medical Center	Marathon Health	(301) 363-2302 My.marathon-health.com
Vision	NVA	(800) 672-7723 e-nva.com
Dental Care	Delta Dental	(800) 932-0783 deltadentalins.com
Telemedicine	Teladoc	(800) 362-2667 MyDrConsult.com
Employee Assistance Program	SupportLinc	(888) 881-5462 Support-linc.com

BENEFITS AT A GLANCE

Do not rely on the information in this section alone; it merely summarizes important plan features and the benefits payable. **It is important that you read this entire booklet to find what benefits are payable for each specific kind of expense and what expenses are not covered. All benefits are subject to the definitions, limitations, and exclusions set forth in this booklet. Medical Benefits provided under this Plan are afforded without regard to an individual's sex assigned at birth, gender identity, or gender.**

Eligibility Rules for Covered Employees

- *Initial Eligibility*. You will be initially eligible for benefits under the Plan on the first day of the second month after working 120 hours in Covered Employment.

- *Continuing Eligibility*. After you establish eligibility, you must work in Covered Employment at least 300 hours in each Work Quarter to be eligible for benefits under the Plan in the corresponding Eligibility Quarter. Under certain circumstances, you can extend coverage through a Reserve Account, Unemployment Set Aside Account, or by self-paying.

More specific information about the Plan's eligibility requirements for Covered Employees, as well as Special Eligibility Rules for Owner Employees and Salaried Employees, for are provided in the Eligibility Section of this book. Please contact the Benefits Office if you have questions about your Eligibility.

Important Coverage Information

For Covered Employees, Covered Retirees, Dependents

- *In-Network v. Out-of-Network*. The Fund has contracted with a Preferred Provider Network (PPO) to make available the PPO's network of doctors at discounted prices. If you use a PPO provider, that means you are accessing care In-Network. If you do not use a PPO provider, that means you are accessing care Out-of-Network. You and the Fund will pay less money if you stay In-Network.

- *Deductible*. A Deductible is the amount of Covered Expenses that must be paid each calendar year before the Fund pays benefits. After you become eligible for benefits, you must meet the applicable annual Deductible before the Fund will pay your health claims. The annual individual Deductible for In-Network claims is $400, and the annual family Deductible is $800. Once two individuals meet the individual deductible level, the family deductible is considered met for all other family members.

  Medicare-Eligible Covered Retirees, Medicare-Eligible Dependents, and Medicare-Eligible Totally Disabled Ex-Employees are not subject to a deductible. Dependents not eligible for Medicare are subject to the individual deductible.

  Medical services and prescription drugs provided at the Steamfitters Local 602 Family Medical Center are not be subject to a deductible.

- *Coinsurance – What the Plan Pays & What You Pay.* For Major Medical Benefits, once you satisfy the applicable Deductible, the Plan will cover 80% of covered medical expenses and you must pay the remaining 20%. For Diagnostic Imaging services only, however, the Plan pays 90% of Allowable Charges for In-Network and 70% of Allowable Charges for Out-of-Network claims once the calendar year deductible has been met. **Note:** Federal law protects you against balance billing in certain instances. More information about the restrictions on balance billing is provided throughout the Plan.

- *Out-of-Pocket Maximum.* The Plan limits your responsibility to pay for covered medical expenses to an annual Out-of-Pocket Maximum of $5,000 per individual and $10,000 per family. After you meet this threshold, the Plan will cover 100% of all applicable claims paid under Major Medical, the Outpatient Physician/Office Visit Benefit, Mental or Nervous Disorder and Substance Abuse Treatment Benefits, the Dental Benefit, or the Vision Benefit for Dependents under age 19 who incur spending above the Vision Benefit Annual Maximum. See the section of the Schedule of Benefits describing prescription drug benefits for information about the prescription out of pocket maximum benefit.

- *Steamfitters Local 602 Family Medical Center*. Medical services and prescription drugs provided at the Steamfitters Local 602 Family Medical Center will be covered with **no charge** to Covered Employees, Covered Retirees, or Dependents and will not be subject to annual copayments,

coinsurance, deductible, maximums or limitations that may apply to other medical benefits provided under the Plan.

- *Maximum Annual Benefit.* There is no Maximum Annual Benefit limit for Essential Health Benefits under the Plan. Non-Essential Health Benefits and Non-Health Benefits may have annual or lifetime limits as listed. Benefits may also have usage limits other than a dollar limit, such as a maximum number of visits per year.

- *Schedule of Benefits.* The Plan covers the follows benefits under Major Medical after the applicable Deductible is paid:

  Surgical Benefit: Allowable charges paid at 80% of Usual, Customary and Reasonable (UCR) rate per surgical episode. Cosmetic surgery excluded unless within two years of an Injury.

  Outpatient Surgical Facility: Allowable charges per surgical episode.

  Hospital Inpatient Physician Visit: One visit per day for up to 3 Physicians.

  Hospital Inpatient Room & Board, Misc. Services: Paid under Major Medical

  Outpatient Physician/Office Visit/Specialist. Patient co-payment…$20*
  After initial co-payment, 100% of allowable charges.

  *The $20 Co-Payment does not apply to Medicare-Eligible Retirees.

  Physical therapy, chiropractic care, acupuncture, occupational therapy, and speech therapy. Patient co-payment… $20, subject to the limitations set forth in the Medical Benefits "Other Coverage" section of this booklet.

  Organ Transplants. Allowable charges for pre-authorized, prescreened, non-experimental and non-investigational organ transplants paid under Major Medical at 80% of UCR; Donor services may also be covered for a person donating an organ to a Participant. Donor services include donor evaluation, work-up for mobilization and collection of stem cells up, to a maximum of $30,000.00, subject to the conditions set forth in greater detail below. Initial co-payment may not apply to office visit that is primarily for preventive services (see Preventive Care Benefit section for details).

Mental or Nervous Disorder and Substance Abuse Benefits: Paid on same basis as coverage for other medical care; for example, a Mental Outpatient Office Visit is paid the same as Outpatient Physician Visit/Office Visit Benefit above.

Hospice Care Benefit (prior authorization required). Paid under Major Medical

Home Health Care Benefit: (prior authorization required)Paid under Major Medical, not to exceed 30 days per year, unless authorized for one additional 30-day period upon prior submission and approval of treatment plan indicating necessity of additional days. Additional days in excess of the additional 30-day period may also be authorized when approved by the Plan's case management services provider.

Preventive Care Benefit/Preventative Services. All preventive services (Including well childcare) 100% of PPO contract rate. Out of network care paid at UCR with out of network deductibles and copayments.

Rehabilitation Service Benefit: (prior authorization required) - Paid under Major Medical but only up to 6 weeks.

Skilled Nursing Facility Benefit: (prior authorization required) Inpatient treatment as alternative to hospitalization paid under Major Medical, but with 100 day lifetime maximum.

Private Duty Nursing: (prior authorization required) Private Duty Nursing Services are paid under Major Medical when approved by the Plan's secondary utilization reviewer, subject to applicable medical guidelines adopted by the Plan's secondary utilization reviewer, as alternative to hospitalization paid under Major Medical, and subject to periodic review.

Temporomandibular Joint Dysfunction (TMJ)Benefit. The Plan covers TMJ-related procedures covered under Major Medical up to $1,500 for your lifetime.

The Plan covers the following benefits under the Prescription Drug Benefit:

After co-payment, 100% of actual charge through participating retail or mail order pharmacy through the CVS Health network (which includes retail pharmacies other than CVS), otherwise, up to average wholesale price and dispensing fee.

Prescription drugs provided through the Steamfitters Local 602 Family Medical Center are not subject to the annual copayments, maximums, or limitations that apply to the Prescription Drug Benefit

Prescription Out of Pocket Maximum Benefit
Subject to all other limitations, there are no additional co-payments for prescription drugs during any calendar year for any individual who has incurred annual co-payments of $1,600 for an individual or $3,200 for a family for prescription drugs.

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Type of Drug	**Cost if You Use In-Network Retail Pharmacy for up to 30-Day Supply**	**Cost if You Use the Mail Order Service for up to 90-Day Supply**
Generic	$5 Copayment	$10 Copayment
Preferred Brand Name	$10 Copayment	$20 Copayment
Non-preferred Brand Name	$25 Copayment	$50 Copayment
Specialty drugs	Generic: $5 Copayment Preferred brand: $10 Copayment Non-preferred brand: $25 Copayment	

Accident & Sickness, Death, AD&D, Dental, Vision, and Hearing Benefits

- *Weekly Supplemental Occupational Accident Benefit – Covered Employees Only.* If you experience an Injury or Illness caused by Covered Employment in Maryland or Virginia, you may receive supplemental benefits for time lost from work, up to the maximum amount payable under the D.C. Workers' Compensation law. You may receive up to $150 per week for up to 52 weeks. Individuals who own 5% of more of the company do not qualify for this benefit.

- *Weekly Disability Benefit – Covered Employees Only.* If you experience an Injury or Illness, not caused by Covered Employment, you may receive supplemental benefits for time lost from work, up to thirty-three (33) weeks:

Skill Level	Weekly Benefit
1st Year Apprentices through 4th Year Apprentices, and Helpers	$500
5th Year Apprentices and Journeypersons	$750

  5% and greater owners do not qualify for this benefit

- *Death Benefits.* Upon your death, your beneficiary is entitled to receive a Death Benefit from the Fund. If you are a Covered Employee or Covered Retiree at the time of your death, the benefit amount is $1,000.

- *Dental Benefits.* The Plan covers comprehensive dental services, including Orthodontia and Dental Implants, up to $4,500 per calendar year at 100% when an In-Network provider is used, and 80% when an Out-Of-Network provider is used. All expenses in excess of $200 are subject to prior authorization. The annual maximum includes services for Orthodontics and Dental Implants Separately, there is a lifetime maximum of $4,500.00 on Orthodontia..

  The annual and lifetime maximum limit generally do not apply to Dental Benefits provided to Participants or Dependents who are under age 19.

The annual maximum on Orthodontics and Dental Implants applies to Participants or Dependents who are under age 19.

- *Vision Benefit*. The Plan covers one (1) eye examination by a licensed optometrist or ophthalmologist at 100%, and one (1) set of lenses and frames, or contact lenses, up to $275 per calendar year. If your vision expenses exceed $275, they will be eligible for payment under your medical benefit and subject to the same deductibles and copays as other medical expenses. For Participants and Dependents under age 19, the annual dollar limit only applies to frames.

- *Hearing Aids.* The Plan covers hearing aids, once every three (3) years, when ordered by a Physician or licensed audiologist for hearing loss, up to $3,000. You may use any remaining benefit towards repair and maintenance.

Self-Pay Rates at a Glance

The Plan allows you to make self-payments in order to maintain you and your family's health coverage during periods of unemployment or Disability. Disabled Employees, Totally Disabled Employees and surviving spouses of deceased Employees or Retirees, and certain other Retirees may also make monthly payments to continue their coverage.

The following is a schedule of monthly Self-Payment rates as of May 1, 2024. The Self-Payment rates may change from time-to-time as determined by the Trustees in their sole discretion.

Employees

Full benefits..... *

Retirees

Non-Medicare Eligible

Age 55-60..... $469

Age 60-62 with a retirement date on or before 1/1/2014……$141

Age 60-62 with a retirement date after 1/1/2014……$238
Age 62 until eligible for Medicare with a retirement date on or before 1/1/2014…… $93
Age 62 until eligible for Medicare with a retirement date after 1/1/2014…… $238

Medicare-Eligible
with a retirement date before 6/1/94 ..... $11
with a retirement date 6/1/94–5/31/04 ..... $21
with a retirement date on or after 6/1/04 ..... $47

*Totally Disabled Ex-Employees****
Retired prior to 06/01/1990
Family coverage $11
Retired on or after 06/01/1990
Individual coverage $47
Family coverage $53

Surviving Spouse of Employee or Retiree
Not Medicare Eligible
Individual coverage..... $115
Family coverage..... $238
Medicare Eligible
Individual coverage..... $47
Family coverage..... $115

COBRA Premiums. Subject to revision at 12-month intervals, 102% of the cost of providing such coverage, 150% for any extension of coverage due to disability

* Self-Pay Employees Desiring Full Benefits and all Non-Bargaining Unit Covered Employees, pay an amount each month based on 40 hours per week times the hourly rate in effect under the current Collective Bargaining Agreement.

*** Totally Disabled Ex-Employees eligible for Medicare pay the same applicable rate as Retirees eligible for Medicare.

Covered Retirees, Dependents Over the Age 65, Totally Disabled Ex-Employees and Dependents Eligible for Medicare

Subject to payment of all applicable self-payment requirements, all medical benefits, as shown above, are coordinated with Medicare, unless limited by law.

Prescription Drug Benefit, Dental Benefit, and Vision Care Benefit are all the same as above.

PREFERRED PROVIDER ORGANIZATIONS

For members in Maryland, Washington, DC and Northern VA, the CareFirst BlueCross BlueShield Preferred Provider Organization (PPO) network is available to everyone covered by the Heating, Piping and Refrigeration Medical Plan. For members in Virginia, the Virginia Health Network PPO is available. The Fund may also participate in additional provider or benefit networks from time to time for specific cases, specialized treatments, or other reasons. These PPO networks contract with Physicians, specialists, Hospitals, and other treatment facilities that have agreed to provide services at a discount.

The PPO provides members with access to health care through a select group of providers (In-Network providers). Providers outside of the PPO network are referred to as Out-of-Network Providers. Covered Services may be provided by either an In-Network or Out-of-Network provider; **however, you and the Fund will pay more if you receive care from an Out-of-Network provider.** Since you usually pay a percentage of the charges billed by providers, these PPO discounts will result in your paying a percentage of a smaller amount. This means that you will pay a lower out of pocket amount for services rendered by these providers and facilities. This also means that the Plan will pay a smaller amount for these services. However, the use of providers in the PPO networks is not mandatory. It is your choice.

The PPO directories of CareFirst BlueCross BlueShield and the Virginia Health Network include information on Physicians, Hospitals, and other treatment facilities that are available. You may contact the Fund office for this

information or check whether a provider is part of CareFirst by going to www.carefirst.com or www.vhn.com, respectively.

Please present your identification card to all service providers so that those who are in the PPO network can identify your status with the PPO. The provider will submit your claim directly to the PPO who will discount it and forward it to the claims administrator for payment. Lists of providers in the PPO networks are available to you free of charge.

Balance Billing

An Out-of-Network provider may charge the Participant for the remainder (or "balance") of the provider's bill after applying payment from the Fund—this practice is often referred to as *balance billing*. Certain states prohibit balance billing, in which case you should not be responsible for amounts balance billed. In addition, when you receive Emergency Services for an Emergency Medical Condition, you are protected from balance billing by a federal law known as the No Surprises Act. Protection for Emergency Services for an Emergency Medical Condition may extend to services you receive after you're in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

You are also protected from balance billing by the No Surprises Act if you are treated by an Out-of-Network provider at an In-Network facility, unless you give written consent and give up your protection from being balance billed for such treatment. However, in certain cases, such a provider cannot balance bill you under any circumstances. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist services, and other items or services rendered by an Out-of-Network provider if there was no In-Network provider at the facility who could provide the item or service.

Finally, you are also protected from balance billing if you receive air ambulance services and while you are considered a Continuing Care Patient.

Out-of-Network Services Treated as In-Network

In certain cases, services provided by an Out-of-Network provider will be

subject to the In-Network coinsurance levels. The following care will qualify for such special treatment:

- *Services Covered by the No Surprises Act*. Out-of-Network services covered by the No Surprises Act will be treated as if rendered In-Network. These services include **Emergency Services** for an **Emergency Medical Condition**, services rendered by an Out-of-Network provider at an In-Network facility, such as a lab, anesthesiologist or radiologist at a PPO Hospital (unless, if permitted, you waive your protection from being balance billed), and air ambulance services.

  In general, the term "Emergency Medical Condition" means an illness, injury, symptom, or condition severe enough that you reasonably believe it will risk serious danger to your health if you don't get medical attention right away. Officially, the term "**Emergency Medical Condition**" means a medical condition, including a 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 one of the following conditions: 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.

  In general, the term "Emergency Services" means services received in an emergency room or appropriately licensed urgent care facility to check for an Emergency Medical Condition and treat you to keep such a condition from getting worse. Officially, the term "**Emergency Services**" means, with respect to an Emergency Medical Condition: an appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department appropriately licensed under state law

(including ancillary services routinely available to the emergency department or independent freestanding emergency department) to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the emergency department or independent freestanding emergency department, as are required under the Social Security Act (or would be required if the Social Security Act applied to the freestanding emergency department) to stabilize the patient. Emergency Services also include services you may receive after you're in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

- *Continuity of Care.* Services rendered by a provider who leaves the PPO network during a continuous course of treatment if, as the result of the provider leaving the network, the Participant would be required to change Physicians during the course of treatment. For these purposes, a continuous course of treatment means a limited and specific plan or program of treatment to address a specific Sickness or condition such as a pregnancy or a course of chemotherapy.

- *Provider Directory Issues.* The Fund maintains a provider directory and other protocols for verifying a provider's In-Network or Out-of-Network status. If the directory or other protocol incorrectly advises you that a provider is In-Network, the services you receive from that provider will be treated as if rendered In-Network. (Incorrect advice furnished by the provider directory or other protocol must be verified through supporting documentation for this provision to apply.)

- *Chiropractic Treatment.* Chiropractic treatment will be treated as if rendered In-Network if chiropractors are not included in the PPO network.

- *Psychologists, etc.* Care provided by a psychologist or psychiatric social worker will be treated as rendered In-Network if these providers are not included in the PPO network.

- *Out-of-Area Provider.* Your benefits will be paid at the In-Network level if you live in an area covered by a PPO but there is not an appropriate PPO provider within 30 miles of where you live.

If a provider is treated as In-Network because of one of the above exceptions, an ongoing continuous course of treatment by that provider will also be considered In-Network.

CASE MANAGEMENT

Case management is a collaborative process that facilitates and coordinates treatment to assure that it is appropriate, efficient, and in the most effective setting. It may be helpful for the Fund to use case management with individuals whose treatment needs are covered by the Fund but may be difficult to manage appropriately because they are complex, costly, extensive, rehabilitative, or repetitive.

Case management may take many forms, but typically, a case management professional works closely with the patient, family, and health care providers to assist in determining appropriate treatment options to best meet the patient's needs, while also keeping costs manageable to protect the Fund's ability to provide benefits to all.

The Fund may request or require Participants and Beneficiaries to use case management services. This is most likely to arise in cases where involving claims in excess of $100,000, but the Trustees reserve the right to require the use of case management services for all conditions or cases, including but not limited, to the management of chronic or other appropriate conditions.

DEFINITIONS

The following terms have special meaning when used in this SPD, and are capitalized throughout this booklet. If you encounter a capitalized term that you do not know the meaning of while you are reading this booklet, you should refer to the definitions listed in this section. If you still do not understand the meaning or usage of the term, please contact the Fund Office.

Allowable Expenses – Any Usual, Customary and Reasonable charges for benefits and services covered in full or in part under one or more plans that cover the covered person.

Birthing Center – A licensed facility set-up, equipped, and operated under the direction of a Physician solely as a setting for prenatal care, delivery, and immediate postpartum care.

Collective Bargaining Agreement – The contract(s) or labor agreement(s), as amended, between Steamfitters Local Union No. 602 of the United Association of Journeymen and Apprentices of the United States and Canada AFL-CIO and any Employer or between Local 602 and the Mechanical Contractors Association of Metropolitan Washington.

Confinement – An admission (or a series of admissions) to a Hospital for any one Illness or Injury.

Covered Employment – Work in a position covered by this Plan for which an Employer is required to make contributions to the Medical Fund.

Covered Expenses – Any charge that is allowable under the Plan for a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation, or cure of an Illness or Injury to a structure or function of the mind or body.

Coinsurance – The percentage amount any individual covered by this plan must pay towards Covered Expenses after the Deductible has been met, subject to the out-of-pocket maximum set forth above.

Co-payment – The flat dollar amount any individual covered by this plan must pay towards Covered Expenses, subject to the out-of-pocket maximum set forth above.

Deductible – Out-of-pocket expenses that you must pay before a benefit is payable.

Dependent – Your Dependent spouse and children that meet the requirements for being considered "Dependents" under the Plan explained in the "Eligibility" section below.

Dentist – A person who is duly licensed and acting within the scope of his license to practice dentistry, or a Physician furnishing dental care which he is licensed to provide.

Disability (and Disabled) – Your inability to perform substantially all of the duties of your occupation in Covered Employment because of a physical or mental Illness or Injury. See also, "Total Disability."

Durable Medical Equipment ("DME") – Equipment that 1) can withstand repeated use with an expected life of at least 3 years; 2) is primarily and customarily used to serve a medical purpose; 3) is generally not useful to an individual in the absence of an illness or injury; and 4) is appropriate for use in the home.

Eligibility Quarter – A period of three consecutive calendar months beginning on the first day of any May, August, November, or February.

Employee – A person who works for an Employer in a covered position and on whose behalf the Employer makes the required contributions to the Heating, Piping & Refrigeration Medical Fund. An unincorporated sole proprietor or partner in a partnership cannot be treated as an Employee under this Plan and **cannot** be covered by this Plan.

Employer – Any Employer obligated under a Collective Bargaining Agreement or a signed stipulation to make contributions to the Fund on behalf of its Employees. The Union and the Training Fund are also considered Employers for the purpose of covering their Employees.

Essential Health Benefits – These benefit categories generally include most major medical, hospitalization, and prescription drug benefits. The scope and definition of the items and services encompassed by this term shall be determined in accordance with the Patient Protection and Affordable Care Act

Extended Care Services – Services provided in a Skilled Nursing Facility for a limited time following a Hospital stay and for the treatment of the same condition for which the patient was hospitalized.

Hospital – Hospital means an institution accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the primary purpose of which is to provide inpatient services, both diagnostic and therapeutic, surgical and non-surgical, for a variety of medical conditions.

Illness – A disease or disorder resulting in an unsound condition of the mind or body.

Injury – A wound or damage to the body sustained accidentally and through external force.

Medical Fund or Plan – The Heating, Piping and Refrigeration Medical Fund or Plan, as set forth in this booklet and as amended from time to time.

Medically Necessary – services or supplies furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected Illness or Injury, the furnishing of which is consistent with the diagnosis and treatment of the patient's condition; in accordance with the standards of good medical practice; required for reasons other than the convenience of the patient, Physician, or other licensed provider; and the most appropriate level or service that can safely be provided for the patient. When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

Medicare – The health insurance benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Nurse-Midwife – A member of the American College of Nurse-Midwifery who is duly certified to practice midwifery.

Other Health Plans – Individual or group plans (insured or self-insured) such as benefits available from your spouse's Employer, Medicare, and no-fault automobile insurance.

Physician – A medical doctor, doctor of osteopathy, or other medical care provider who is licensed by his or her jurisdiction and acting within the scope of his or her license to practice medicine, perform surgery, or provide other benefits covered by the Plan. In determining what services are covered by this Plan, a doctor or Physician includes any licensed provider acting within

the scope of his or her license as required by Section 2706 of the Patient Protection and Affordable Care Act (PPACA).

Preventive Services – Means 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 with respect to the individual involved; immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and with respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, when services are obtained through a preferred provider (or pharmacy benefit manager, as appropriate). Any change to a recommendation or guideline that occurs after September 23, 2009 will be covered as a preventive service as of the first day of the first plan year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Rehabilitation Hospital – The rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of acute medical issues. The industry is largely made up by independent hospitals that operate these facilities within acute care hospitals. There are also inpatient rehabilitation hospitals that offer this service in a hospital-like setting, but separate from acute care facilities. Most inpatient rehabilitation facilities are located within hospitals.

Retiree – A person who has separated from service with any and all employers, and from any and all self-employment, in the plumbing and pipefitting industry, and who has retired from and is receiving a pension from the Heating, Piping, and Refrigeration Pension Fund. Such a person will also be considered a Retiree if he or she is not vested in the Heating, Piping, Refrigeration Pension Fund when he retires, but he is covered by this Plan at that time as an active bargaining unit employee under a Local 602 collective bargaining agreement with an Employer that does not participate in the Heating, Piping and Refrigeration Pension Fund. The rules for the coverage of Retirees are set forth elsewhere in this booklet.

Skilled Nursing Facility – A Medicare-certified institution that primarily provides skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, Disabled or sick persons; and is properly licensed and regularly provides 24 hour skilled nursing care by and under the direction of licensed registered nurses (R.N.s), and which also provides therapeutic services by licensed, qualified therapists, acting within the scope of their licenses.

Spouse – The person to whom a Participant is Married. Effective June 26, 2013, "Married" refers to the legal relationship between two individuals, whether of the same or opposite sex, who are lawfully married.

Steamfitters Local 602 Family Medical Center – The medical facility located at 8700 Ashwood Drive, Capitol Heights, MD 20743 that provides medical services and prescription drug benefits to Covered Employees, Covered Retirees, and Dependents.

Surgical Procedure – Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

Terminally Ill – A Covered Person is considered Terminally Ill if his or her Attending Physician certifies that the patient's medical condition is such that he or she is not expected to live for more than six months.

Therapeutic Abortion – An abortion that is necessary because the life of the mother would be endangered if the fetus were carried to full term.

Total Disability (and Totally Disabled) – Your complete inability to engage in substantial, gainful activity because of a physical or mental Injury or Illness that is expected to last permanently and indefinitely.

Union – Steamfitters Local Union No. 602 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

Usual, Customary and Reasonable (UCR) – A level of charges that does not exceed the prevailing level generally charged by providers in the "locality" for like or comparable service or supplies. The term "locality" means a geographic area that includes a cross-section of persons or entities regularly furnishing the type of treatment, services, or supplies for which the charge is

made. In determining whether charges are Usual, Customary, and Reasonable, due consideration shall be given to the condition being treated as any medical complications or unusual circumstances that may require additional time, skill, or experience. In no event shall the Covered Expenses under this Plan exceed the actual amount charged for a service or supply, up to the Usual, Customary and Reasonable level. With respect to a PPO Preferred Provider, the Usual, Customary and Reasonable charges shall also not exceed the charges allowed in the agreement between the PPO Preferred Provider and PPO.

Work Quarter – A period of three consecutive calendar months beginning on the first day of December, March, June, or September during which an Employee must accrue the required number of hours of Covered Employment to remain a Covered Employee under the Plan during the following Eligibility Quarter.

EMPLOYEE COVERAGE

To participate as an employee under this Plan, you must either: (1) work in a covered position under a Collective Bargaining Agreement between your Employer and the Union; (2) be a full-time officer or Employee of the Union; (3) be a full time Employee of the Heating, Piping & Refrigeration Training Fund; or (4) otherwise satisfy the requirements established by the Trustees. This is referred to as "Covered Employment." No medical examination is required in order for you to participate in this Plan. However, your Employer must be required to and must make contributions to the Medical Fund in order for you to be covered by this Plan.

Initial Eligibility. You are initially eligible for benefits under the Plan on the first day of the second month after you have worked 120 hours in Covered Employment. These hours must be worked within no more than a nine-consecutive month period. You are then eligible for at least three months of coverage before you must satisfy the additional requirements for continued coverage described below.

Continuing Coverage. After you become eligible for benefits under the Plan, your continued coverage depends on whether you work for a minimum num-

ber of hours in each calendar quarter. You must work in Covered Employment at least 300 hours in each of the Work Quarters listed below to be eligible for benefits in the corresponding Eligibility Quarter.

Work Quarter	**Eligibility Quarter**
If you worked at least 300 Hours During the months of:	*You are Eligible for benefits during the months of:*
December, January, February	May, June, July
March, April, May	August, September, October
June, July, August	November, December, January
September, October, November	February, March, April

In order to ensure that there is sufficient time for employment reports to be received and processed by the Fund Office; "lag months" are used in determining your quarterly eligibility. The lag months are the months between the end of a Work Quarter and the beginning of the next Eligibility Quarter.

Special Eligibility Rules for Owner Employees and Salaried Employees

Any persons who are owner Employees or salaried Employees of a contributing Employer who are no longer in the bargaining unit may participate in this Plan provided*:*

- They are compensated Employees of that Employer; *and*
- Their duties as an Employee include supervising the work of the trade, or they are otherwise working in the management of that Employer; and
- They were a member of the bargaining unit represented by Steamfitters Local Union 602 in the past, and during some period in the past, they were covered by the Medical Fund for any employer as a member of the bargaining unit;
- The Employer is signed to the Collective Bargaining Agreement requiring employer contributions to the Medical Fund on behalf of its bargaining unit Employees;
- Timely *c*ontributions are being made on their behalf under the terms of a Participation Agreement on behalf of non-bargaining unit employees to which the Employer is bound; and

- They are not a sole proprietor or a partner if the Employer's business is unincorporated.

The Employer must contribute each month on behalf of covered owner Employees and salaried Employees at the journeyman contribution rate in the Collective Bargaining Agreement times 40 hours for each week with the Employer. Employees of an Employer who are not in the bargaining unit may not be covered unless they were previously covered by this Plan while in the bargaining agreement.

For initial eligibility, covered owner Employees and covered salaried Employees must meet the same requirements as all other covered Employees as set forth above (120 hours in nine months; no hours accumulated in Reserve Account until 1,000 hours worked). However, covered bargaining unit Employees may move into non-bargaining unit positions without a loss of coverage if they are eligible as a bargaining unit employees when they move, and the Employer commences contributions under the Participation Agreement immediately.

Covered owner Employees and covered salaried Employees will be eligible under this Plan on a month-by-month basis, but that eligibility will only continue as long as monthly contributions are properly and timely made by the Employer. If the contributions are not made timely for any month, the coverage of the owner Employees will end as of the last day of the second month following the date for which the contributions were due. For example, if an owner works in January and makes the contributions timely (January work is due on February 15), this would provide Medical Fund coverage for April. If the owner did not pay January contributions timely, his coverage would terminate on March 31. Owners are required to pay a minimum of 40 hours per week for all weeks; there are no exclusions for vacations and holiday time for owners.

Covered owner employees are not entitled to coverage and may not obtain or retain eligibility under any other section of this Plan, unless specifically provided for under such section. For example, Covered owner employees are not entitled to a Reserve Account, an Unemployment Set Aside Account, or Extended Coverage during Disability under the Self-payment options set forth in the Plan, or Reinstatement of Coverage After Loss of Coverage. Covered

owner employees are entitled to COBRA Continuation Coverage and Retiree Coverage if they satisfy the requirements set forth in this Plan.

When the eligibility of covered owner Employees under the Plan terminates, they must re-establish eligibility under the Plan by working 300 hours in Covered Employment within a six-consecutive month period. However, any Covered owner employee whose coverage under the Plan terminates, and who subsequently obtains a bargaining unit employee position with a Contributing Employer, may elect to apply retroactively hours worked as a Covered owner employee towards the 300 hour eligibility requirement provided the Employer made timely contributions for those hours. For example, if a Covered owner employee's coverage terminates on March 31, and they obtain a bargaining unit employee position with a Contributing Employer effective April 1, for the purpose of establishing eligibility for coverage as a Covered Employee they may apply any contributory hours reported as worked on their behalf to the Benefit Funds over the previous nine-month period ending March 31.

Coverage under a Reserve Account

After you establish initial eligibility, and work at least 1,000 hours in Covered Employment, if you work more than 300 hours in Covered Employment during a Work Quarter after you have attained initial eligibility, all of your hours over 300 are credited to a "Reserve Account" established in your name up to a maximum of 300 hours. Reserve Account hours are used during periods of unemployment or low employment in determining your eligibility under the Plan.

If you have hours in your Reserve Account and you become Disabled, your Reserve Account hours are "frozen" while you remain Disabled and are credited to you after your extended no cost eligibility ends.

Covered Retirees do not retain eligibility through a Reserve Account, which reverts to zero upon retirement. Covered Retirees who return to Covered Employment may not accumulate a new Reserve Account.

Covered Employees in the helper classification are not entitled to a Reserve Account.

Covered Owner and Salaried Employees are not entitled to a Reserve Account.

Unemployment Set Aside Account

If you lose your coverage because you were laid off due to a lack of work and were unable to work the required 300 hours, and you have already used all of the hours in your Reserve Account, you may continue your coverage until the end of the next Eligibility Quarter by taking hours from the Unemployment Set Aside Account. You may also use this Account if you are fired without just cause, if you did not work because of a directive from the Union, or if you are injured on the job and receiving Workers' Compensation benefits.

If you use this Account because you are injured on the job and receiving Workers' Compensation benefits, you may continue your coverage by taking hours from the Unemployment Set Aside Account for a period of two successive Eligibility Quarters after you have already used all of the hours in your Reserve Account.

The Account may not be used if you are not available for work in Covered Employment, on a daily basis, if you refuse any jobs in Covered Employment, if you are not in the geographic area covered by the Union, or if you leave the unionized pipefitting industry.

The Unemployment Set Aside Account is funded by an allocation of six cents per hour from current Employer contributions to the Fund, plus interest on the unused monies that are set aside. At their discretion, the Trustees may limit the number of hours covered to the number of hours that can be paid from the money allocated for the Unemployment Set Aside Account. As there may be a limited number of hours available for all Employees under this Account, the coverage is made available on a first-come, first served basis until the Trustees determine that there are not sufficient funds to continue the coverage.

In order to receive hours from this Account, you must file an application with the Fund office. Except in the case of individuals injured on the job and receiving Workers' Compensation Benefits, you may only use the Unemployment Set Aside Account for the first two Work Quarters following your loss of work, in which you have less than 300 hours and have insufficient hours in your Reserve Account to maintain coverage. A separate application must be submitted for each Work Quarter for which assistance is sought. Once you have received a benefit from the Account, you may not use it again until after you have reestablished your eligibility by working 300 hours in Covered Employment in a Work Quarter.

Coverage while Traveling to Other Jurisdictions

The Medical Fund participates in the United Association national reciprocity program. This includes a national "money follows the man" reciprocal agreement that may apply when you travel to a job under a collective bargaining agreement in the jurisdiction of another local union. If the away-from-home health and welfare fund is signed to the national reciprocity agreement, the away-from-home fund will forward contributions made for your hours as a traveler.

Once those away-from-home contributions are received by the Heating, Piping and Refrigeration Medical Fund, the hours worked in the reciprocating jurisdiction will count for eligibility under this Plan based on the ratio that the received reciprocal contribution rate bears to the then current contribution rate for the Heating, Piping and Refrigeration Medical Fund. If the away-from-home fund's rate is higher, you will receive proportionately more hours under the Heating, Piping and Refrigeration Medical Plan. If the away-from-home fund's rate is lower, you will receive proportionately fewer hours under the Heating, Piping and Refrigeration Medical Plan.

Extended Coverage during Disability

If at any time before you retire, you become temporarily Disabled while eligible as an Employee under the Plan, you and your Dependents will continue to be covered by the Plan for up to six months after your coverage would normally end. You will not be required to pay for this additional six months of coverage. However, if you want to continue your coverage after end of the six months and your Reserve Account is depleted, you must make any applicable monthly self-payments. You may be required to furnish proof of your Disability to the Fund office.

Coverage During Military Service

If you are on active duty in the U.S. Armed Services or the National Guard for 30 days or less, you will continue to receive health care coverage under the Plan for up to 30 days, in accordance with the Uniformed Service Employment and Reemployment Rights Act (USERRA).

If your active duty is longer than 30 days, you can continue coverage under the Plan for yourself and your Dependents at your own expense for up to 24 months. This continuation right operates the same way as COBRA Continu-

ation Coverage by paying the COBRA premiums as explained below. In addition, your Dependents may be eligible for health care coverage under TRICARE. This Plan will coordinate benefits with TRICARE.

Coverage will not be offered for any Illness or Injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veteran's Affairs will provide care for service-connected disabilities.

When you are honorably discharged from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to work within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 181 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are Hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years.

If you immediately return to Covered Employment after your discharge from military service, coverage for you and your Dependents begins on the date you return to work. Any hours that you received credit for before you enter military service are credited to you when you return to work.

Coverage under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12 month period due to:

- the birth, adoption, or placement of a child with you for adoption;
- to provide care for a spouse, child, or parent who is seriously ill; or
- your own serious Illness.

In addition, the Family and Medical Leave Act contains special provisions for military service members and their families. You may take up to 12 workweeks of unpaid leave for any qualifying exigency arising from the foreign employment of your spouse, dependent, or parent with the Armed Forces. You may also take up to 26 workweeks of unpaid leave during a single 12 month period to care for certain service members with a serious injury or illness that is your spouse, dependent, parent, or next of kin.

During your leave, you can continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for leave under the FMLA if you:

- have worked for the same Contributing Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- have worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

You remain eligible for coverage until the end of the leave, provided your Contributing Employer properly grants the leave under the FMLA and the Contributing Employer makes the required notification and payments to the Fund.

WHEN COVERAGE ENDS

If you do not work at least 300 hours in Covered Employment during a Work Quarter, and have used the accumulated hours in your Reserve Account, coverage for you and your Dependents automatically terminates at the end of the current Eligibility Quarter. (See the chart in the "Employee Coverage" section of this booklet for an explanation of how Work Quarters relate to Eligibility Quarters.) However, if you are working in Covered Employment and your coverage ends because you work less than 300 hours during a Work Quarter, you may continue coverage for yourself and your eligible Dependents by making monthly self-payments to the Fund Office. The requirements for making these self-payments are described in the "Self-payments" section of this booklet.

If you are covered under this Plan but are not working in a job covered under a Collective Bargaining Agreement, your coverage will terminate if your Employer does not make payments to the Fund on your behalf. Termination for you and your Dependents will be effective as of the beginning of the month for which payment is due. In these circumstances, you cannot use your Reserve Account.

If you leave Covered Employment in the unionized pipefitting industry, you cannot use your Reserve Account, and coverage for you and your Dependents under this Plan terminates at the end of the month during which you leave. However, you and your Dependents will automatically lose eligibility for the following benefits on the day that you leave Covered Employment.

- Prescription Drugs Expenses
- Dental Expenses
- Vision Care Expenses
- Weekly Accident and Sickness Benefits
- Benefits for non-emergency (elective) surgery
- Access to the Steamfitters Local 602 Family Medical Center

If you lose coverage for any of these reasons, you may extend your coverage by electing COBRA Continuation Coverage and making the applicable self-payments.

You may also lose coverage under the plan if the Plan itself is terminated or if you do not submit any information requested by the Fund Office. If you lose coverage for either of these reasons you will not be entitled to elect COBRA Continuation Coverage.

If you stop working for an Employer who participates in this Plan, but you are still working in the unionized pipefitting industry within the jurisdiction of a Union that does not have a reciprocal agreement with this plan, you will not receive credit under this Plan for the hours you work. Once your coverage is terminated, you must re-qualify for benefits under this Plan by meeting the initial eligibility requirements explained above.

Reinstatement of Coverage After Loss of Coverage

If you lose coverage under the Plan for any reason, you may regain eligibility for coverage if you work at least 300 hours in Covered Employment over six consecutive months. If you satisfy the 300 hours requirement, your coverage under the Plan will be reinstated effective the first day of the second month

after you worked 300 hours, regardless of the reason for that coverage was lost in the first instance.

DEPENDENT COVERAGE

As soon as you are eligible for coverage, so are your eligible Dependents. Your eligible Dependents under the Plan are:

- your spouse;
- your child who has not yet attained age 26. A child can include your natural child, legally adopted child or child legally placed for adoption, stepchild, or legal foster child. Child coverage ends on the last day of the month in which your child turns age 26.
- your unmarried natural or legally adopted child, or stepchild, over age 26, as long as the child lives with you, receives most of his or her financial support from you and is unable to work because of mental retardation or disability that began before age 26 while the child was covered under this Plan. The child will be considered Disabled if he or she is unable to engage in substantial gainful activity because of a mental Injury or Illness that is expected to last indefinitely. Proof of a child's disability or mental retardation must be provided to the Fund office within 31 days after the child's coverage would otherwise end.
- your grandchild, for whom you have been granted sole legal and physical custody by a court order, provided the child receives over one-half of his or her financial support from you. Coverage of grandchildren ends when the grandchild turns age 26.

If your Dependent is found to be Disabled, the Trustees may require that you periodically provide proof that the Disability is continuing and may, at the Plan's expense, require your Dependents to undergo a medical examination to verify the continued Disability. If you do not provide the proof requested, or do not agree to have your Dependents undergo a medical examination, the coverage for your Dependents may be refused or terminated.

You must complete an enrollment form to add your dependents to your Plan. The form can be obtained by contacting the Fund Office or visiting the Participant Portal website, HPRBenefitFunds.com and registering as a Participant.

In order to determine if your Dependents meet the Plan's definition of "Dependents" the Trustees may require you to provide any of the following documentation:

- proof of marriage;
- Child's birth certificate; or
- a court order, where applicable.

There is no coverage for spouses who marry a Retiree after the effective date of his or her pension from the Heating, Piping and Refrigeration Pension Fund or after Retiree coverage is otherwise effective.

When Dependent Coverage Ends

Coverage for your Dependents automatically ends on the date your coverage, coverage for all Dependents, or the entire Plan terminates, or when any required self-payment is not made. Coverage for your Dependents also ends when they fail to meet the requirements for being considered a "Dependent" under the Plan as explained above or when they become covered under the Plan as Employees. As long as your Dependents meet the coverage requirements set forth above, your consent to their coverage is not required.

No payments are made under this Plan for expenses incurred by you or your Dependents after their coverage ends, even if the expenses are in connection with a medical condition that started before the coverage ended.

Qualified Medical Child Support Orders

The Plan will honor medical child support orders that it finds to be Qualified Medical Child Support Orders (QMSCO's) under ERISA. QMSCO's are defined by federal law and include judgments, decrees, or orders issued by courts of competent jurisdiction or by state administrative bodies that have the force of court judgments, decrees, or orders. To be a QMSCO, a judgment, decree, or order must require a child to be enrolled in the Plan under state domestic relations law or enforce a state law relating to medical child support, and must meet a series of federal legal requirements. Most of these orders come from state child support agencies, which use standardized orders

called National Medical Support Notices. You may obtain a copy of the Plan's procedures governing QMSCO's without charge from the Fund Office.

RETIREES, SURVIVORS OF DECEASED EMPLOYEES & RETIREES, & TOTALLY DISABLED EX-EMPLOYEES

Retirees

If you are a Retiree and if you meet the following additional requirements, you will be able to continue your coverage under this Plan upon your retirement by making all required monthly self-payments to the Fund from when you first retire.

If you retire before you reach age 55, you and your Dependents are not eligible for Retiree coverage from this Plan, unless you qualify for coverage under the provisions for Totally Disabled Ex-Employees.

If you retire after you reach age 55 while covered under this Plan, and you were covered under this Plan excluding periods of COBRA continuation coverage, for the 10 years immediately preceding your retirement date, or for 10 of the 12 years immediately preceding your retirement date, you and your Dependents may continue your coverage by making self-payments to the Fund.

The amount of the monthly self-payment charge is shown in the above Self-Pay Schedule. These self-payment amounts are subject to change by the Trustees at any time. If the Retiree stops making the monthly self-payments and loses his coverage, he or she will never again be eligible for Retiree coverage from this Plan.

If a Covered Retiree returns to work in Covered Employment, the applicable monthly self-payments must still be paid for every month in Covered Employment even though the Employer is also making contributions, except as follows: If the Covered Retiree is on a monthly pension from the Heating, Piping and Refrigeration Pension Fund, and if his pension is suspended under

that Pension Plan, he will not be required to make the applicable self-payments to maintain medical coverage for each month his pension benefit remains suspended after he works sufficient hours to attain initial eligibility as an active employee, provided he would have had coverage for that month as an active employee based on his hours in Covered Employment.

If a working Covered Retiree or a working Suspended Retiree loses his coverage under this Fund because of any failure to make his or her required monthly self-payments to the Fund, he or she will not be permitted to reinstate Retiree Coverage at a later date. A working Retiree is not entitled to a Reserve Account and is also not entitled to the Weekly Accident and Sickness Benefit. If a covered Retiree works in the plumbing and pipefitting industry for an Employer that is not signatory to an agreement with the Union, his or her Retiree coverage will immediately terminate and he will never again be eligible for Retiree coverage from this Plan.

Once you are eligible for Retiree coverage under this Plan, your coverage will continue until you no longer qualify as a "retiree" under the Plan or you fail to make a timely self-payment. Your coverage may also terminate if you do not provide any information requested by the Fund office. Of course, your coverage will also terminate if the Plan itself, or the portion of the Plan that provides Retiree coverage, is terminated. Once your Retiree coverage terminates for any reason, you may not reinstate the coverage at a later date.

Eligible Dependents of Deceased Employees and Retirees

If you die while you are covered as an Employee under this Plan, the coverage for your surviving Dependent spouse and your surviving Dependent children will continue for up to one year free of charge, unless your spouse remarries within that one-year period. If you were vested under the Heating, Piping and Refrigeration Pension Fund at the time of your death, your surviving Dependent spouse and your surviving Dependent children may continue to receive benefits after the one-year period by making monthly self-payments to the Fund office. Coverage for your surviving Dependent spouse and surviving Dependent children automatically ends on the date your spouse remarries.

If you die while covered as a Retiree under this Plan, the coverage for your surviving Dependent spouse and surviving Dependent children may continue for up to one year without charge or, if earlier, until the date your spouse remarries. After this one-year period, your surviving Dependent spouse can

continue coverage for him or herself and your surviving Dependent children by making monthly self-payments to the Fund office. Coverage is not available to the surviving Dependent spouse and surviving Dependent children of a Retiree unless the Retiree and the surviving Dependent spouse were married on the effective date of the Retiree's pension from the Heating, Piping and Refrigeration Medical Fund and remained married until the date of the Retiree's death.

Coverage for your surviving Dependent spouse and surviving Dependent children automatically ends on the date your surviving Dependent spouse remarries, the date your surviving Dependent spouse or surviving Dependent children fail to provide any information requested by the Fund office, or the last day of the month for which a timely self- payment is made. The applicable self-payment rates are set forth in the Self-Pay Schedule. These amounts may change from time to time as the Trustees deem necessary. The coverage for your surviving Dependent spouse and surviving Dependent children may end earlier if the Plan itself terminated or if the part relating to this coverage is eliminated. Once the coverage for your surviving Dependent spouse and surviving Dependent children terminates for any reason, the coverage may not be reinstated at a later date.

Any benefits that are payable to your surviving Dependent spouse and surviving Dependent children under this Plan are reduced by any amounts they obtain or are eligible to obtain under Medicare.

If you were receiving COBRA continuation coverage at the time of your death, your surviving Dependent spouse and surviving Dependent children are not eligible for the coverage described in this section. However, they may be eligible for an extension of their COBRA continuation coverage. See the "COBRA Continuation Coverage" section of this booklet for more information about your COBRA continuation coverage rights.

Totally Disabled Ex-Employees

If you become Totally Disabled while covered under this Plan as an Employee and have exhausted your extended coverage, you may continue coverage for yourself and your Dependents for up to 24 months by making monthly self-payments.

You may continue making self-payments for this 24-month period as long as: (1) you are unable to work in your job in Covered Employment; and (2) you have applied for or are appealing your denial of Social Security or Workers'

Compensation benefits. The self-payment amount is shown in the Schedule of Benefits.

If you become Totally Disabled while you are covered under this Plan as an Employee, and if you are awarded Social Security Disability benefits, and if on the date you become Totally Disabled, you were eligible to receive benefits under this Plan, excluding periods of COBRA Continuation Coverage, for the ten years, or for ten out of the twelve years, immediately preceding such date of Disability, you may continue coverage for you and your Dependents by making monthly self-payments as set forth in the Self-Pay Schedule provided you are receiving a disability pension from the Heating, Piping and Refrigeration Pension Fund. The applicable self-payment amounts may change from time to time as the Trustees deem necessary. Your Effective Date of Total Disability for Retiree Medical Fund Coverage is the Disability Effective Date established by Social Security.

Your coverage automatically ends on the date you cease to be eligible for Social Security Disability benefits, or the date you otherwise stop being Totally Disabled, or the date you fail to provide any information request by the Fund office, or the last day of the month for which you made a timely self-payment. In addition, your coverage can end earlier if the Plan itself is terminated, or if the part relating to this coverage is eliminated. If your coverage is eliminated in any of these ways, you may not later reinstate it unless you recover and attain initial eligibility by a return to work in Covered Employment

VERIFICATION OF ELIGIBILITY

You or a doctor or Hospital may call the Fund Office (800) 618-2879) to verify your eligibility or the eligibility of a Dependent. A verification of eligibility means only that you or your Dependents are covered by the Plan and may receive benefits in accordance with the Plan's terms. Verification of eligibility **does not** mean that you or your Dependents are covered for the treatment provided if the terms of the Plan are not met. You or your Dependents are subject to the limitations and exclusions contained in the Plan. You should become familiar with the provisions of the Plan, as they are explained in this booklet, so that you can determine whether services provided to you and your Dependents will be covered.

SELF-PAYMENTS

There are some ways you may be able to extend your coverage under this Plan by making monthly self-payments to the Fund office. The Plan allows you to make self-payments in order to maintain your family's coverage during periods of unemployment or Disability. Disabled Employees, Totally Disabled Employees and surviving spouses of deceased Employees or Retirees, and certain other Retirees may also make monthly payments to continue their coverage. The amount of your self-payment will depend on whether you are an Employee, and Ex-Employee, or a Retiree and the reason that coverage was lost. The Trustees reserve the right to change the monthly self-payment rates at any time.

If you leave the geographic area covered by the Local 602 Agreement or the unionized pipefitting industry, you are not permitted to make self-payments except under any applicable COBRA provisions of the Plan explained in the "COBRA Continuation Coverage" section of this booklet. You should note that the Fund's COBRA self-payment rates are often higher than those charged under the Fund's self-payment provisions. If any self-payment rate is higher than then current COBRA self-payment rate, you may elect COBRA Continuation Coverage in lieu of the self-payment.

Employees Working in Covered Employment

If you are working in Covered Employment and coverage for you and your Dependents ends because you work less than 300 hours in a Work Quarter, you may extend eligibility for yourself and your Dependents by making monthly self-payments to the Fund office. For each Work Quarter, the monthly payment is based on the current hourly contribution rate charged to your Employer, multiplied by the difference between 300 hours and the number of hours that you worked. For example, if the contribution rate charged to your Employer is $4.00 per hour, and you worked 200 hours in Covered Employment during the Work Quarter, you will be required to pay $400.00 ($4.00 (x) 100 hours) to continue eligibility in the corresponding Eligibility Quarter.

Your monthly contribution must be received by the 7th day of the first month in your Eligibility Quarter. If you contribution is not received by the Fund office by that date, you must meet the eligibility requirements described earlier in this booklet in order to reestablish your coverage.

You may not make self-payments under this section if you did not work in Covered Employment during the Work Quarter. However, even if you did not work in Covered Employment during the Work Quarter, you may be able to extend your eligibility by making self-payments under one of the self-payment provisions described below.

Employees Not Working in Covered Employment

If you are not working in Covered Employment and your coverage is terminating, and if you do not meet any of the other provisions for continuing coverage, and if you did not work in Covered Employment in the previous Work Quarter, you may continue your coverage for up to 24-months by making monthly self-payments to the Fund office. The amount of the monthly payments is based on the current hourly contribution rate charged to the Employers times 160 hours per month. However, this amount is reduced to the level for Totally Disabled Ex-Employees if you are receiving weekly Workers' Compensation benefits and if you provide proof of receipt of those benefits to the Fund office. If you are receiving workers compensation and are marking disability self-payments to maintain coverage, once you return to covered employment, you may continue making monthly disability self-payments for a maximum period of three months. If, after three months, you have not satisfied the eligibility requirements, you will be required to make full COBRA payments provided you have not exhausted your COBRA coverage period of 18 months since the initial loss of coverage due to disability.

Your monthly contribution must be received by the 7th day of each month. If your contribution is not received by the Fund office on or before the 7th day, your coverage is considered to have ended on the last day of the preceding month, and you must meet the initial eligibility requirements described earlier in this booklet in order to reestablish your coverage.

Totally Disabled Ex-Employees

If you are Totally Disabled and are not eligible for benefits under any other provisions in this Plan relating to coverage during periods of Disability, you may continue coverage for yourself and your Dependents for a period of up to 24 months by making monthly self-payments to the Fund office, as long as: (1) you are unable to work at your job in Covered Employment; and (2) you have applied for or are appealing your denial of Social Security Disability or Workers' Compensation benefits.

You cannot make self-payments under this provision if you are able to resume your job in Covered Employment or if there is a final determination denying

your Social Security Disability or Workers' Compensation appeal. The amount of your monthly payments while you are awaiting a decision on Social Security Disability or Workers' Compensation benefit is based on the current hourly contribution rate charged to Employers times 160 hours per month.

You must notify the Fund office within 10 days after you receive your first Social Security Disability or Workers' Compensation benefit payment. The Trustees may require you to furnish any information necessary to determine whether or not these benefits are actually being paid. If you fail to provide this notice or information, your coverage may be terminated.

Your monthly contribution must be received by the 7th day of each month. If your contribution is not received by the Fund office on or before the 7th day, your coverage is considered to have ended on the last day of the preceding month, and you must meet the initial eligibility requirements described earlier in this booklet to reestablish your coverage.

Dependents

If coverage for your Dependents ends because your coverage terminated, your Dependents may be able to continue under the COBRA Continuation Coverage benefits described later in this booklet. However, the maximum period for which COBRA benefits are payable to your Dependents is reduced by any periods of time that you have made self-payments on their behalf.

Retirees

If you retire before reaching age 55, you may not make self-payments to continue your coverage under this Plan, other than under the COBRA continuation coverage provisions explained below.

If you retire after you reach age 55 and meet the eligibility requirements described earlier in this booklet, you may continue your coverage by making the applicable monthly self-payments to the Fund office. Your monthly contribution must be received by the 7th day of each month. If your contribution is not received by the Fund office on or before the 7th day, your coverage is considered to have ended on the last day of the preceding month.

Alternatively, a retiree may elect COBRA Continuation Coverage in lieu of Retiree Coverage as set forth below.

Surviving Spouses and Dependents of Deceased Employees or Retirees

Your surviving Dependent spouse and surviving Dependent children may be able to retain coverage after your death if they meet the eligibility requirements described earlier in this booklet are met and if the applicable self-payments are made.

Monthly payments for surviving Dependent spouses and surviving Dependent children of deceased Employees and Retirees must be received by the 7th day of each month. If the contribution is not received by the Fund office on or before the 7th day, coverage is considered to have ended on the last day of the preceding month.

COBRA CONTINUATION COVERAGE

The federal COBRA law requires that group health plans offer Employees and Dependents the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") in circumstances (called "qualifying events") when their coverage under the Plan would otherwise end. To receive this continuation coverage, the employee, spouse, and/or dependent must make timely monthly payments directly to the Fund. An Employee or Dependent who becomes eligible for COBRA coverage is called a qualified beneficiary.

You may have other options available to you if you lose coverage under this Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace at https://www.HealthCare.gov or by calling 1-800-318-2596. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Coverage purchased through the Marketplace becomes effective on the first day of the next month if purchased on or before the 15th of the month, and becomes effective on the first day of the second month if purchased on the 16th through the end of the month. For more information about health insurance options available through the Marketplace, visit https://www.HealthCare.gov.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

You may also be entitled to make payments under a self-payment provision of the Plan.

COBRA Rules for Employees

Employees have the right to choose COBRA continuation coverage for themselves, their spouses, and their dependent children for up to a maximum of 18 months if their loss of coverage is due to the following qualifying events:

- A reduction of hours of in Covered Employment; or
- The voluntary or involuntary termination of employment for any reason other than gross misconduct.

If you are entitled to make payments under any other self-payment provision of this Plan at the time you lose coverage due to one of these qualifying events – including Retiree Medical Coverage – you may elect COBRA coverage in lieu of the other self-payment. The maximum 18 month period of COBRA continuation coverage is offset by any period of self-payments made under the Plan's self-payment provisions.

COBRA Rules for Dependents

If the Employee chooses not to purchase COBRA continuation coverage, the Dependent Spouse and/or Dependent children may separately purchase COBRA continuation coverage for themselves by making the election and the required monthly payments. COBRA continuation coverage for Dependents can be continued for up to 18 months if coverage would otherwise end because of the termination of employment for reasons other than the Employee's gross misconduct or a reduction in the Employee's hours. However, coverage can be continued for up to 36 months for the Employee's Dependent spouse and Dependent children if their coverage would otherwise end because of the following qualifying events:

- The death of the Employee;
- The divorce or legal separation of the Employee and Spouse; or
- A child's loss of status as a Dependent under this Plan.

If the Dependent spouse or Dependent child is entitled to make payments under any other self-payment provision of this Plan at the time of a qualifying event, she may elect COBRA coverage in lieu of the other self-payment. The maximum 36 month period of COBRA coverage is offset for any period of self-payments made by the Dependent spouse or Dependent child under the Plan's self-payment provisions.

In addition, if the Employee becomes eligible for Medicare (either Part A or Part B or both) before experiencing a qualifying event that is a reduction in hours or termination of employment, the period of coverage for the Employee's Dependent Spouse and Dependent Children ends with the later of the 36 month period that begins on the date the Employee became entitled to Medicare, or the 18 month period (or 29 month period if any of the members of the family is disabled as described below) that begins on the date of the Employee's termination of employment or reduction in hours. For example, if the Employee becomes eligible for Medicare coverage six months prior to terminating employment in October of 2007, his Dependent Spouse and Dependent children will be entitled to 30 months of COBRA coverage beginning in October of 2007.

Disability Extension

The 18 month maximum COBRA continuation period for an Employee and his Dependents may be extended up to an extra 11 months (for a total of up to 29 months from the qualifying event) if the Employee has a Social Security Disability award. If the determination of disability was issued by the Social Security Administration prior to the commencement of COBRA coverage, written notice must be provided to the Fund office within 60 days of the commencement of COBRA coverage. If the determination of disability is issued by the Social Security Administration after the start of COBRA coverage, written notice must be provided to the Fund office within 60 days of the disability determination and prior to the expiration of the initial 18 month COBRA coverage period. This disability extension period will end if the disabled Employee recovers before the end of the disability extension period. The disabled Employee must notify the Plan within 30 days of a final determination by the Social Security Administration that the person is no longer disabled, or, if later, within 30 days of the date the individual is informed of this notice requirement and procedure.

Multiple Qualifying Events while Covered by COBRA

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. *You must notify the Fund Office within 60 days after a second qualifying event occurs.*

During an 18-month period of COBRA continuation coverage resulting from loss of coverage due to a termination of employment or reduction in hours, the Employee dies, becomes divorced or legally separated, or if a Dependent child ceases to be a Dependent under the Plan, the maximum COBRA continuation period for the affected Dependent spouse and/or Dependent child is extended to 36 months from the date of the termination of employment or reduction in hours. This extended period of COBRA continuation coverage is not available to anyone who becomes the Employee's spouse after the termination of employment or reduction in hours. However, this extended period of COBRA continuation coverage is available to any child(ren) born to, adopted by, or placed for adoption with the Employee during the 18-month period of COBRA continuation coverage.

In no event is the Employee entitled to COBRA continuation coverage for more than a total of 18 months if employment is terminated or there is a reduction in hours (unless the Employee is entitled to an additional COBRA coverage period on account of disability). As a result, if the Employee experiences a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second qualifying event, and COBRA may not be extended beyond 18 months from the initial qualifying event.

Notification Requirements

The Fund office (in cooperation with the employers) will track Employee terminations and reductions in hours. If one of these qualifying events occurs, the Fund office will notify the Employee of his or her rights to purchase COBRA continuation coverage and the cost of such coverage.

The Employee or his or her Dependents must first notify the Fund office in writing within 60 days of a divorce or of a child's loss of Dependent status under the Plan. The Employee's Dependents must first notify the Fund office in writing within 60 days of an Employee's death. Following receipt of any such notices, the Fund office will notify the Dependents of their rights to purchase COBRA continuation coverage and the cost of such coverage.

Notifications should be sent to the Fund Office:

Heating, Piping and Refrigeration Medical Fund
PO Box 21427
Eagan, MN. 55121

Election of COBRA Continuation Coverage

When information is received by the Fund office that a qualifying event has occurred, the Employee or Dependent will be sent an individual COBRA notice explaining the right to COBRA continuation coverage. The individual COBRA notice will provide information on the cost and include a COBRA election form. To elect COBRA continuation coverage, the qualified beneficiary must complete the election form and submit it to the Fund office within 60 days after the later of the date coverage would otherwise end or the date the beneficiary receives the notice of the right to elect COBRA continuation coverage.

Each qualified beneficiary will have the right to elect COBRA continuation coverage. This means that the Employee, the Dependent Spouse, and each Dependent child have a separate right to elect COBRA coverage on behalf of him or herself. In addition, Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

COBRA Rules for Retirees

If you are eligible for Retiree Coverage at the time you Retire, you must choose between COBRA Continuation Coverage or Retiree Coverage described above. If you choose Retiree coverage, you will not qualify for COBRA Continuation Coverage even if your Retiree Coverage later terminates.

If your Dependent Spouse and/or Dependent children experience another Qualifying Event during the first 18 months of receiving Retire Coverage, the Spouse and dependent children in your family can get up to 36 of COBRA Continuation Coverage from the effective date of your retirement. This extension is available to your Dependents if you die, become entitled to Medicare (Part A, Part B, or both), you and your Spouse get divorced, or if your

Dependent child stops being eligible under the Plan as a dependent child. You, your Dependent Spouse, or Dependent child must notify the Fund Office within 60 days after a second qualifying event occurs.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

The COBRA premium is determined according to the cost of providing coverage plus an additional 2% for the cost of administration. This amount differs from the other self-payment rates which are subsidized by the Medical Fund. If COBRA coverage is extended beyond the initial 18 month period because of disability, the premium is determined based on the cost of providing coverage plus an additional surcharge. You are responsible for paying the entire cost of COBRA continuation coverage. The Fund office will notify you of the amount of the charge when you become entitled to elect COBRA continuation coverage.

If you elect COBRA continuation coverage, your first premium payment will be due to the Fund office no more than 45 days after you make this election. Thereafter, the COBRA premium is due by the 7th day of each month. If your contribution is not received by the Plan Administrator on or before the 7th day, your coverage is considered to have ended on the last day of the preceding month.

When Will COBRA Coverage End?

Although COBRA Continuation Coverage may continue in effect for up to the maximum period described above, it will terminate earlier if:

- The health coverage offered by the Plan to all active Employees and their Dependents terminates;
- Any required premium is not paid on time;
- The qualified beneficiary becomes covered under another plan;
- The qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing Continuation Coverage; or

- The Social Security Administration makes a determination that the qualified beneficiary is no longer disabled.

If the Employer stops participating in this Plan, the Plan will continue to carry the COBRA obligations for the Employees and Dependents of that Employer only if that Employer does not substitute another plan. If the Employer establishes one or more group health plans or starts contributing to another multiemployer group health plan, the plan established by the Employer or the other multiemployer plan must make COBRA continuation coverage available to the Employee and Dependents who were receiving coverage under the Plan and whose qualifying event occurred in connection with, an Employee whose last employment before the qualifying event was with the Employer.

What Benefits are Included in COBRA Continuation Coverage?

COBRA continuation coverage includes the same medical, dental, and vision benefits that are offered to Covered Employees under the Plan, including access to the Steamfitters Local 602 Family Medical Center. Non-Medical benefits such as the Weekly Supplemental Occupational Accident Benefit, the Weekly Accident and Sickness Benefit, and Death Benefits are not included as part of COBRA continuation coverage.

COBRA and Other Extensions of Coverage

Any extensions of coverage that are provided under this Plan at no cost to the Employee or Dependent will be made available to you first, followed by COBRA Continuation Coverage or other self-pay coverage.

What if I want to enroll in Marketplace coverage instead of COBRA?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.
To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." However, if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of

time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration website at http://www.dol.gov/ebsa or call their toll-free number at 1-866-444-3273. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

MEDICAL BENEFITS

Medical Benefits provided under this Plan are afforded without regard to an individual's sex assigned at birth, gender identity, or gender.

Major Medical Benefits

Certain medical expenses are paid under this Plan for you and your Dependents under the Major Medical Benefit as a result of an Illness or Injury. A Major Medical Benefit is payable for Inpatient Hospital Care, Outpatient care, Physician Visits, Preventive Care, Mental or Nervous and Substance Abuse treatment, Diagnostic Laboratory and X-ray expenses, as well as covered services under the provisions set forth below. No benefits are payable for amounts which exceed the Plan's maximum Allowable Charge; or Usual, Customary and Reasonable charges for a given service.

For all benefits covered under this section except Diagnostic Imaging expenses, the Plan pays 80% of certain Allowable Charges after the annual Deductible is met. You are responsible for paying the remaining 20%.

For Diagnostic Imaging expenses only, the Medical Fund will pay 90% of Allowable Charges for in-network and 70% of Allowable Charges for out-of-network claims once the calendar year deductible has been met. If you are a retiree covered by Medicare as your primary coverage, claims for Diagnostic Imaging services will be considered in network.

The individual Deductible is currently $400 and applies to each person in your family who is covered under this Plan. However, the maximum Deductible amount that can be applied to your entire family in a calendar year is $800.

Covered Major Medical Care includes the Usual, Customary and Reasonable charges for the following necessary medical services, supplies and treatments.

Medical expenses will not be paid for inpatient or outpatient non-hospital stays or services that are furnished by a provider at a facility that is located one-hundred and fifty-one (151) or more miles from the participant's residence, except upon ten days prior authorization and a determination that the services are medically necessary.

a. Covered Hospital Care

Covered Hospital Care includes the following services or supplies furnished in a Hospital or Birthing Center:

- Room and board for each Hospital or Birthing Center Confinement for semi-private room and board charges. Newborn Dependent children are covered from birth. If private accommodations are used, amounts that exceed the daily rate for a semi-private room are disregarded unless the room is ordered by your Physician for valid medical reasons;
- Physician visits;
- Operating room fees;
- Diagnostic services (such as laboratory and X-Ray examinations)
- Kidney dialysis;
- Radiotherapy including use of X-ray and other high-energy Modalities, radon, radium, cobalt, and other radioactive substances,

including radioactive isotope therapy and chemotherapy, when ordered by a Physician;

- Bandages, surgical dressings, casts, splints, trusses, crutches, and braces, excluding replacement, adjustment or repair of braces unless replacement is necessary due to the growth of a child;
- Prescription drugs taken or administered during Hospitalization;
- Anesthesia, Oxygen, and other gases and their administration;
- Whole blood (if not replaced), blood plasma, plasma extenders, and blood transfusions;
- Services of a licensed physiotherapist;
- Services of a Dentist for treatment of fractures or dislocations of the jaw including oral surgery and replacement of permanent teeth within 12 months of the Injury that led directly to such condition;
- Services of a Nurse-Midwife;
- Ambulance service for emergency transportation of the patient to or from the nearest Hospital or Birthing Center equipped to provide the required Medical care. Service is available up to three times annually.

Benefits are also paid in connection with the pregnancy, childbirth, miscarriage or therapeutic abortion of you or your spouse in a Hospital or Birthing Center. Precertification is required for inpatient delivery and pregnancy service benefits. Any Hospital expense that is covered as a benefit under another provision of the Plan will be paid in accordance with that provision.

b. Hospital Inpatient Physician Visits

The Plan pays for up to one visit per day per Hospital but no more than three Physicians.

c. Outpatient Physician/Office Visit Benefits under Major Medical

The Plan covers the charges for Inpatient and Outpatient Physician visits that are in excess of the amounts provided under the Inpatient and Outpatient Physician Benefit (subject to all other limitations of those benefits). More information about Outpatient Physician/Office Visit Benefits are provided below under the Section OUTPATIENT PHYSICIAN/OFFICE VISIT BENEFITS.

d. Services of a Nurse-Midwife

The Plan also pays for charges of a Nurse-Midwife (a Nurse-Midwife is a member of the American College of Nurse-Midwifery who is duly certified to practice mid-wifery) or other provider licensed to provide mid-wifery, to the extent they do not exceed charges of a Physician performing the services, up to the maximum listed in the Schedule of Benefits, provided such services are performed under the supervision of a Physician. No benefit is payable for charges by a Physician in conjunction with the services rendered by a Nurse-Midwife unless the Physician's services are rendered as a result of a complication of pregnancy. A complication of pregnancy is any of the following: (1) surgical operations for extrauterine pregnancy; (2) intraabdominal surgery after termination of pregnancy; (3) Confinement in a Hospital for pernicious vomiting of pregnancy; (4) Confinement in a Hospital for toxemia; (5) delivery by caesarean section; (6) threatened miscarriage; and (7) severe postpartum hemorrhage. When a complication of pregnancy occurs, the benefit is payable to the provider that submits a bill first.

e. Medical Emergency Conditions

The Plan pays for charges for outpatient care in an emergency room at a Hospital that is provided for the treatment of an accidental Injury or a sudden or serious Illness that requires immediate treatment. A serious Illness is one that places the health of the individual in serious jeopardy, and that could result in serious impairment of bodily functions or serious impairment of a bodily organ or part. The Fund will provide in and out-of-network benefits on the same basis for Emergency Services for Emergency Medical Conditions, as those terms are defined herein.

Coverage for outpatient care under this benefit includes:

- Physician's services
- Emergency room charges
- X-ray and laboratory services
- Miscellaneous charges

If you or your Dependents go to an emergency room for a condition that is not an Emergency Medical Condition the Plan will only pay charges that would be incurred under a non-emergency condition such as the services of a Physician. Any other additional emergency-room-specific charges, such as facility charges, will not be paid.

f. Miscellaneous Hospital Charges

The Plan pays for other Hospital charges incurred while you are confined in the Hospital if they are Allowable Expenses. Coverage includes charges by a Hospital for services and supplies such as the use of an operating room, X-rays, laboratory tests, drugs and medicine, and charges for the administration of anesthesia.

g. Surgical Benefits

You and your Dependents are reimbursed by the Plan for charges by a surgeon in connection with a Surgical Procedure that is performed in a Hospital, a Physician's office or some other outpatient facility in connection with an Illness or Injury. Benefits are also payable for Surgical Procedures performed in connection with your or your spouse's pregnancy. For covered outpatient surgeries, facility fees are also reimbursed.

Surgical Services consist of all surgeries performed in or out of a Hospital as well as endoscopic procedures (inserting a tube to examine internal organs) including cystoscopy, proctoscopy and sigmoidoscopy. The Plan also provides medical and surgical benefits for mastectomies and for certain reconstructive surgery. This covers reconstructive surgery of the breast on which the mastectomy was performed, surgery on the other breast to improve appearance, and prostheses and treatment for physical complications of all stages of mastectomy, including lymphedemas. Surgical claims will be paid to the Usual, Customary and Reasonable level as set forth in the Schedule of Benefits. Surgeon charges in excess of the Allowable Expense are not covered.

h. Single Surgeries

Any one Surgical Procedure is covered up to the Usual, Customary and Reasonable amount or Allowable Expense. Successive operations are considered a single surgery unless:

- you are completely recovered from the first surgery;
- the surgeries are separated by at least two months;
- the causes of each surgery are completely unrelated; and
- each surgery is performed on a different part of your body through different incisions.

i. Second Surgical Opinions

In order to encourage you and your Dependents to seek second surgical opinions before undergoing elective, non-emergency surgery, the Plan will

pay the fee charged by a second examining Physician. Charges incurred for a third surgical opinion will also be paid if the second surgical opinion does not confirm the need for the proposed surgery.

No Second Surgical Opinion Benefit shall be payable for the following:

- consultation with a Physician who is not certified as a specialist in the medical field of the proposed surgery;
- more than two consultations (second and third opinions) in connection with the proposed surgery;
- a consultation with a Physician or associate of the Physician who performs the surgery or has a financial interest in the outcome of the recommendation;
- a consultation in connection with proposed surgery for which a Surgical Benefit would not be payable under the Plan;
- a consultation where the patient is not examined in person by the Physician rendering the opinion; or
- a consultation obtained after surgery is performed.

j. Gastric Bypass Surgery

Gastric Bypass surgery is covered under the surgical benefit, if the procedure is first approved by the Fund office before the surgery is performed. Your request for approval of Gastric Bypass surgery will be reviewed by a utilization review firm in order to assist in the determination of whether the planned surgery is medically necessary. In addition, for the planned surgery to be covered, all of the following criteria must be met:

- You must be at least 18 year of age and have reached full expected skeletal growth;
- You must have a Body Mass Index of 40 or greater for at least 24 months, or a Body Mass Index of 35 or 39.9 for at least 24 months and at least one significant co-morbidity (e.g., cardiovascular disease, diabetes, hypertension, coronary artery disease, etc.);
- You must present acceptable medical documentation of a physician supervised weight loss program for a minimum of six months in the past 24 months; and
- Within the past 12 months, you must have undergone an evaluation by a qualified bariatric surgeon recommending surgical treatment, a separate medical evaluation recommending bariatric surgery, and

a mental health provider must have cleared you for the surgery (psychological screening).

k. Oral Surgery

The Plan pays the Usual, Customary and Reasonable charges for the surgical services of a Dentist or oral surgeon when treatment is required as a result of an accidental bodily Injury.

In addition, the Plan pays for oral and maxillofacial surgery, but only when it does not include a tooth structure, alveolar process, periodontal disease or disease of gingival tissue.

Surgical Benefits are also provided for the following oral surgery procedures:

- The excision of partially or completely unerupted impacted teeth;
- The excision of a tooth root without the extraction of the entire tooth; or
- Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

Surgical Benefits are not payable for any other expenses for dental services or oral surgery. However, additional benefits are available for the dental services and procedures described later in this booklet.

l. Organ Transplants

The Plan pays the Usual, Customary and Reasonable charges for organ transplants when the services are pre-authorized, pre-screened, non-experimental and non-investigational.

In addition, the Plan pays up to a maximum of $30,000.00 for certain covered expenses related to donors of organ transplants, but only after it is sufficiently demonstrated that: 1) the donor's medical plan does not provide coverage related to the expenses; and 2) the provider and the donor have exhausted all avenues to obtain funding to cover the expenses from any available source, including, but not limited to, private or public grants.

Covered expenses related to donors of organ transplants include:

- Donor match evaluation for immediate family members;
- Donor acquisition and transportation expenses;
- Transplant evaluation tests;

- Transplant surgical fees and related facility fees; and
- Reimbursement for reasonable travel and lodging expenses, not to exceed $100 per day.

m. Cosmetic Surgery

Generally, cosmetic surgery (any operation performed to improve appearance rather than for therapeutic reasons) is not covered by the Plan unless such surgery is for the repair of an accidental bodily Injury and is performed within two years of the accident.

n. Diagnostic Laboratory and Pathology Test and X-Ray Examination Benefits

The Plan pays a benefit for expenses in connection with laboratory or X-ray services that are performed for diagnostic purposes.

Diagnostic Laboratory and Pathology Test and X-ray Examination Benefits are not payable for:

- Dental X-rays, except in the case of an accidental bodily Injury to natural teeth;
- Examinations or tests that are not recommended or approved by a legally qualified Physician or surgeon; or
- Eye examinations.

For Diagnostic Imaging services only, the Plan pays 90% of Allowable Charges for In-Network and 70% of Allowable Charges for Out-of-Network claims once the calendar year deductible has been met.

o. Mental or Nervous Disorder and Substance Abuse Treatment Benefits

A mental or nervous disorder is a neurosis, psychoneurosis, psychopathy, or mental or emotional disease or disorder that is not chemically induced. Charges made in connection with mental and nervous disorders for you or your Dependent and for alcohol or substance abuse are covered in the same way as medical care as a Major Medical Benefit. The following expenses are also allowable charges, subject to Major Medical limitations, your applicable deductibles and out-of-pocket maximums: group therapy; collateral visits with members of the patient's immediate family; services of a licensed clinical social worker, a licensed clinical psychologist, licensed clinical counselors, and a psychiatric registered nurse (R.N.).

Outpatient office visits for mental health or substance abuse treatments are provided on the same basis as medical office visits and subject to the same copayment.

Precertifcation is required for inpatient Mental or Nervous Disorder and Substance Abuse Treatment benefits. Inpatient stays in excess of fifteen days in a calendar month require concurrent review and approval.

No mental health or substance abuse benefits shall be payable for: 1) services furnished by someone other than a provider satisfying the highest licensure standards required to provide substance abuse or mental health treatment within the state that such services are provided; 2) services provided in a facility that is not accredited by the Joint Commission on Accreditation of Health Care Organizations; and 3) services for which preauthorization has not been obtained from the Plan.

p. Hospice Benefits

Hospice benefits are provided to eligible Participants who have been diagnosed as reaching the end stages (last six months) of a terminal Illness, as a more humane alternative to traditional treatment approaches. Hospice benefits are covered if a Physician certifies that you or your Dependent has 6 months or less to live and if benefits are provided pursuant to a written treatment program established by a certified, licensed hospice care agency and approved in advance by the Board of Trustees. The Hospice Benefit Period begins on the date a Covered Person is certified as being a Terminally Ill patient and ends on the earlier of six months after it began or on the date of the Terminally Ill patient's death. The six-month period may be extended subject to medical review.

The Hospice benefits provided by the Plan include home health aides, physical and respiratory therapy, nutrition counseling, up to six visits by a licensed social worker, and the services of a registered nurse. Once a hospice plan is adopted, only services provided pursuant to that plan shall be considered for payment by the Plan.

No Hospice Benefits are payable for care that you or your Dependents receive from a volunteer or from a member of your household. Inpatient care is subject to the same provisions and limitations as other inpatient care under this Plan.

q. Home Health Care Benefit

The Plan pays a Home Health Care Benefit for skilled medical services; physical, respiratory, speech (subject to the limitations set forth below) or inhalation therapy; prescription drugs; medical supplies and other allowable charges that would have been paid if you or your Dependents were Hospitalized for up to a maximum of 30 days per year, unless authorized for one additional 30-day period. Additional days in excess of the additional 30-day period may also be authorized when approved by the Plan's case management services provider. Nursing care services and therapy are only covered if they are provided by licensed registered nurses or licensed therapists.

In order to receive this benefit, your Physician must certify that you or your Dependent is under his continued care and, without the non-institutional care, you must be Hospitalized. The agency that you receive the services from must submit a detailed written plan of treatment indicating the need for such services.

Home Health Care Benefits are not payable unless the services are precertified, and the care begins within the 30 days after authorization is received. The 30 day calendar maximum period may be extended up to one additional 30 calendar day period if an updated, detailed, written plan of treatment indicating the necessity of continuation of such services is submitted by the Covered Person's Physician and approved prior to such services being rendered. Additional days in excess of the additional 30-day period may also be authorized when approved by the Plan's case management services provider upon reviewing an updated, detailed, written plan of treatment indicating the necessity of continuation of such services is submitted by the Covered Person's Physician and approved prior to such services being rendered.

Further, the services must be performed in your home, must be provided by someone who is not related to you and who does not normally reside in your home, and must be provided according to a written plan submitted by an agency that is certified by Medicare as a home health agency. In addition, benefits are not payable for: nursing services or services of a home health aide provided in shifts of eight hours or more; speech therapy; treatment of mental Illness; routine maternity care; housekeeping services; visits by your Physician; custodial care; or routine monitoring of a medical condition or medical evaluations.

r. Rehabilitation Service Benefit

Covered Persons are entitled to a Rehabilitation Service Benefit for Covered Expenses incurred for a Covered Rehabilitation Service up to the Usual, Customary and Reasonable Amount or the actual charges for the Covered Expenses, whichever is less. A Covered Rehabilitation Service is pre-authorized, short-term, intensive physical therapy provided as an alternative to confinement in a Hospital or acute care facility and as a continuation of the care or treatment of the Illness, Injury, or condition which required the prior Hospital stay. Short-term is defined as a period not to exceed six (6) weeks per Illness, Injury or condition.

No Rehabilitation Services Benefit shall be payable for: services provided by someone other than a provider licensed to provide physical therapy or rehabilitations services; services provided in a facility other than a Skilled Nursing Facility or rehabilitation facility; services for which pre-authorization has not been obtained from the Plan; or services after maximum restorative functioning has been obtained.

Precertification is required for the Rehabilitation Services Benefit.

s. Skilled Nursing Facility Benefit

The Plan pays a Skilled Nursing Facility benefit for Covered Expenses incurred for pre-authorization Extended Care Services in a Skilled Nursing Facility for a lifetime of up to 100 days of post-Hospital care. No Skilled Nursing Facility Benefit shall be payable unless care is provided after maximum restorative potential has been achieved as an alternative to Hospitalization in an acute care facility or as continuation of care requiring a prior Hospital stay for the treatment of the same Illness or Injury which resulted in the need. Such care must be pre-authorized, and is limited to a maximum of 100 days.

t. Temporomandibular Joint Dysfunction Benefit

Temporomandibular Joint Dysfunction (TMJ) Benefits are payable for you or your Dependents, up to a lifetime maximum of $1,500. Expenses in excess of this maximum amount are not payable.

u. Private Duty Nursing

The Plan pays a Private Duty Nursing benefit for Covered Expenses incurred for pre-authorized Private Duty Nursing Services when approved by the Plan's secondary utilization reviewer, subject to applicable medical

guidelines adopted by the Plan's secondary utilization reviewer. The Plan's secondary utilization reviewer shall rely on the applicable medical guidelines to determine the participant's appropriate level of care. No Private Duty Nursing benefit shall be payable unless care is provided after maximum restorative potential has been achieved as an alternative to Hospitalization in an acute care facility or as continuation of care requiring a prior Hospital stay for the treatment of the same Illness or Injury which resulted in the need. Such care must be pre-authorized, and is subject to periodic review as necessary.

v. Other Coverage

Medical benefit expenses are paid under this Plan for the following services:

- Routine Nursery Care of a newborn Dependent child of an Employee, Retiree, or Spouse;
- Rental (or purchase, if purchase is less expensive than rental) of a wheelchair, motorized wheelchair, Hospital bed or other durable medical equipment. The cost for purchase of a motorized wheelchair will be reimbursed at 50% of the Usual, Reasonable and Customary charges once every five years from the date of the original purchase after August 1, 2014. All other durable medical equipment is covered at 80% of the Usual, Reasonable and Customary charges. For all durable medical equipment, the Fund pays only the value of the least expensive alternative and requires a pre-certification of medical necessity;
- Up to 52 sessions of physical therapy, in a calendar year, if authorized by a Physician and performed by a licensed, qualified physical therapist (not a chiropractor). The Plan will also pay 50% of the covered medical expenses of an additional 52 sessions of physical therapy in a calendar year, when authorized by a Physician, performed by a licensed, qualified physical therapist (not a chiropractor), and determined to be medically necessary;
- 52 sessions of speech therapy, and 52 sessions of Occupational Therapy, in a calendar year, if authorized by a Physician and performed by a licensed, qualified therapist. The Plan will also pay 50% of the covered medical expenses of an additional 52 sessions of speech therapy, and an additional 52 sessions of Occupational

Therapy, in a calendar year, when authorized by a Physician, performed by a licensed, qualified therapist, and determined to be medically necessary;

- Up to 26 sessions of sessions of acupuncture, when authorized by a Physician and performed by a licensed, qualified provider operating within the scope of their license.
- Artificial limbs, eyes and larynx, but not eye examinations, eye glasses, contact lenses (unless medically required as a result of accidental Injury, or post cataract multifocal lenses);

- Up to 52 visits per calendar year with a licensed chiropractor. The Plan will cover the first 12 visits in a calendar year with a licensed chiropractic, and may cover 40 additional visits in the calendar year, if authorized by a Physician and performed by a licensed chiropractor;
- Pulmonary therapy and rehabilitation services if such services are performed in preparation for surgery requiring general anesthesia;

- Services of a registered nurse (R.N.) or provider licensed to provide nursing services, except as otherwise provided elsewhere in this booklet.

- Educational services associated with treatment of Diabetes. The educational services must be ordered by a Physician through a written referral made in advance, naming the specific education program that will be providing the services.

w. Excluded Coverage under Major Medical Benefit

Benefits are **not** payable under the Major Medical Benefit for any of the following:

- Services of a Dentist for adults age 19 and older;
- Dental appliances and fittings (unless required because of an Injury to the natural teeth) for adults age 19 and over;
- Prescription drugs covered by the Prescription Drug Benefit;
- Eye examinations;
- Nursing services outside of a Hospital;

- Inpatient care outside of a Hospital except as provided under the Skilled Nursing Facility Benefit and the Rehabilitation Service Benefit;
- Rehabilitative services except as provided under the Rehabilitation Service Benefit;
- Hearing aids;
- Vision care including visual eye training or other visual therapy, and eyeglasses or contact lenses (unless required as a result of Injury, or post cataract multifocal lenses) for adults age 19 and over;
- Death Benefits;
- Weekly Disability Benefits; or
- Weekly Supplemental Occupational Accident Benefits.

However, some of these benefits are payable under other provisions of this Plan.

MEDICAL OUT OF POCKET MAXIMUM BENEFIT

Subject to the annual maximums and the other limitations of the Plan, there are no additional co-payments or coinsurance during any calendar year for any individual Employee, Retiree, or Dependent, who has incurred annual co-payments, coinsurance and Deductibles totaling $5,000, (or $10,000 for a family) or more for all benefits that are paid under Major Medical Benefits, the Outpatient Physician/Office Visit Benefit, the Dental Benefit, or the Vision Benefit for Dependents under age 19 who incur spending above the Vision Benefit Annual Maximum.

STEAMFITTERS LOCAL 602 FAMILY MEDICAL CENTER BENEFITS

The Plan Pays 100%

Of medical and prescription drug expenses incurred for care from the Steamfitters Local 602 Family Medical Center.

The Family Medical Center provides primary care, preventive care, chronic condition management, and limited prescription drug benefits with no charge to Covered Employees, Covered Retirees, or Dependents.

All Employees become eligible to access the Steamfitters Local 602 Family Medical Center the first of the month following the month in which they become a Covered Employee under the Plan. When a Covered Employee becomes eligible to use the Steamfitters Local 602 Family Medical Center, his or her Covered Dependents also become eligible. Access to the Steamfitters Local 602 Family Medical Center ceases when an individual ceases to be eligible for coverage under the Plan.

Medical services and prescription drugs provided at the Steamfitters Local 602 Family Medical Center will be covered with no charge to Covered Employees, Covered Retirees, or Dependents and will not be subject to annual copayments, coinsurance, deductible, maximums or limitations that may apply to other medical benefits provided under the Plan.

PERIODS OF CONFINEMENT

If you or your Dependents are confined to a Hospital more than once, each Confinement is considered separate only if it is due to an entirely different, unrelated cause; if it is separated from the last Confinement by at least 30 days; or if you completely recover from the Injury or Illness that resulted in the earlier Confinement.

OUTPATIENT PHYSICIAN/OFFICE VISIT BENEFITS

The Plan covers the charges made by your Physician for visits to your home or the doctor's office as a result of an Injury or Illness. You must pay an initial copayment for a visit as shown in the Schedule of Benefits. After your initial copayment, the Plan will pay 100% of the allowable charges for the visit.

No benefits are payable under this provision for dental services or treatment, eye examinations, eyeglass fittings, diagnostic X-rays, or visits by a surgeon on or after the date of surgery.

PREVENTIVE CARE BENEFITS

As required by federal law, Preventive Services are covered by this Plan In-Network at 100% coverage, and no Deductible applies. This level of coverage is available only to services provided by or obtained In-Network. Services provided by an Out-of-Network provider are subject to the Out-of-Network deductible and co-insurance without regard to whether the service would otherwise be considered a Preventive Service.

Preventive Service Billing Practices

The following rules apply to office visits associated with Preventive Services:

- if a Preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then this Plan will impose cost-sharing requirements with respect to the office visit;
- if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive item or service, then this plan will not impose cost-sharing requirements with respect to the office visit and;
- if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive item or service, then this plan will impose cost-sharing requirements with respect to the office visit.

Example: An individual covered by this Plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the Plan for an office visit.

Conclusion. In this example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items

or services described in the third bullet point paragraph above. Therefore, the Plan will impose a cost-sharing requirement for the office visit charge.

The following services are considered Preventive Services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("Advisory Committee") with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").
- With respect to women, evidence informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), which will be commonly known as HRSA's Women's Preventive Services: Required Health Care Plan Coverage Guidelines.

A comprehensive list of available preventive services may be found at the following website:

www.healthcare.gov/preventive-care-benefits/

The types of preventive services required by law may be updated from time to time and will be deemed to have been incorporated in the Plan by reference. A service is covered as a Preventive Service by the Plan as of the plan year that begins on a date that is after the one year anniversary of the adoption of any recommendation from one of the sources listed above. For example, additions or modifications to the list that occurred during 2024 will take effect on January 1, 2026.

Certain Services Treated as Preventive Services

One routine physical examination per eligible person per calendar year for male and female adults will be treated as a Preventive Service regardless of whether such examination otherwise qualifies as a Preventive Service.

Medically Necessary colonoscopies will be treated as a Preventive Service regardless of whether such examination otherwise qualifies as a Preventive Service.

Coronavirus Preventive Services

Preventive services identified as qualifying coronavirus preventive services under applicable federal law are not subject to the Plan's Deductibles and are paid in full by the Fund when rendered In-Network.

The types of qualifying coronavirus preventive services the Plan will cover are items, services, or immunizations that are intended to prevent or mitigate COVID-19 and that are either:

- an evidence-based item or service with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) or
- an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

The Plan will cover qualifying coronavirus preventive services within 15 days of the Task Force's or CDC's recommendation. However, effective for claims incurred after May 11, 2023, the Plan will cover COVID-19 vaccines, but will not cover over-the-counter tests. These rules are consistent with the Plan's coverage parameters for all preventive services under the Affordable Care Act.

Preventive Services List

The list below shows the Preventive Services subject to this no Deductible/100% In-Network coverage as of July 1, 2014. In the event there is a discrepancy between this list and the actual recommendations in place from the government groups listed above, the recommendations will control.

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Obesity screening and counseling for all adults
- 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 higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Well-woman visits to obtain recommended preventive services

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Depression screening for adolescents
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus

    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

HEARING BENEFIT

The Plan pays for Hearing Aids ordered by a Physician or licensed audiologist for hearing loss. The maximum benefit is $3,000.00 toward the purchase of a Hearing Aid once every three years and the repair and maintenance of the hearing aid. The $3,000.00 limit applies even if more than one Hearing Aid is prescribed. For purposes of the Plan, a Hearing Aid is an electronic apparatus that amplifies sound and is worn to compensate for poor hearing.

PRESCRIPTION DRUG BENEFITS

The Plan pays for certain drugs that are prescribed by your Physician as set forth in the Schedule of Benefits. A Co-payment must be paid for each prescription or refill that you receive. The Plan will withhold the payment of all Prescription Drug Benefits if there is evidence of misuse.

If you or your Dependent gets a prescription filled by a pharmacy covered by the Plan's agreement with CVS Health, the Plan pays for the total cost of the prescription or refill other than the co-payment which you must pay.

If you or your Dependent gets a prescription filled or refilled at a pharmacy other than a participating pharmacy with CVS Health, you must pay the entire cost of the prescription or refill. The Plan will reimburse you, but only up to the average wholesale cost and dispensing fee minus the Co-payment, if you submit a form to CVS Health requesting the reimbursement.

Important

Prescription drugs provided through the Steamfitters Local 602 Family Medical Center are covered with **no charge** to Covered Employees, Covered Retirees, or Dependents, and the annual copayments, coinsurance, deductible, maximums or limitations do not apply.

CVS Health Maintenance Program

Certain prescription drugs may be obtained at a discounted price as part of the CVS Health Maintenance Program. This program permits you to obtain a 90-day supply of maintenance medication at either a CVS mail order facility or a CVS retail pharmacy.

If you wish to obtain your supply by mail order, you must submit a request to CVS Health on a mail order form that it provides. The procedure for obtaining Covered Prescription Drugs may be changed by the Trustees from time to time.

You must use the mail order service for maintenance medication, unless you obtain 90-day supplies at a local retail CVS pharmacy. If you do not use a CVS retail pharmacy, you must use mail order after two 30-day maintenance fills at a local pharmacy.

For information about obtaining maintenance medication through the Health Maintenance Choice Program, call CVS Health at 800-594-3083.

Prescription drugs that are considered to be preventive services will be provided without cost to Participants and Dependents. See the description of Preventive Services.

CVS Health Specialty Pharmacy

Certain Specialty Medications must be obtained through the CVS Health Specialty Pharmacy. Step Therapy is a program that manages excess drug costs by ensuring you get front line drugs (usually generics) first before trying higher cost back-up drugs (name brand drugs).

Prior Authorization may be required for some higher cost medications. Prior authorization affects relatively few members and has the potential for significant savings by preventing inappropriate prescribing.

Prescription Drug Benefit Exclusions

Prescription Drug Benefits are **not** paid for:

- Medications lawfully obtainable over-the-counter, medications not requiring a prescription order from a Physician, and any medication that is equivalent to an over-the-counter medication. However, insulin and pre-natal vitamins are covered.
- Therapeutic devices or appliances, including but not limited to, hypodermic needles, syringes, support garments, and other non- medical substances. However, the purchase of diabetic supplies are covered but includes only the following: insulin needles, insulin syringes, blood testing strips, ketone testing strips, ketone tablets, lancets, lancet devises and urine testing strips.
- Immunization agents, biological serum, blood or blood products.
- Experimental drugs, drugs limited by federal law to investigational use, and medications with no approved FDA indications.
- A medication that is consumed or administered at the place it is dispensed;
- A medication that is to be taken or administered, in whole or in part, while the Covered Person is in a Hospital, rest home, sanatorium, extended care facility, convalescent or nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any refill dispensed after twelve months from the date of the order of the Physician, a refill that exceeds the number of refills specified by the Physician subject further to a maximum of five refills in any six-month period;
- Over-the-counter forms of birth control;
- Medications used to treat infertility except clomiphene citrate (clomid);

- Prescription medications which may be properly received without charge under local, state, or federal programs, including Workers' Compensation;
- Allergy serum;
- Over-the-counter smoking cessation products (prescribed smoking cessation products will be covered for a maximum of 180 days per lifetime);
- A prescription in excess of a 31-day supply when purchased from a retail pharmacy (mail order and Maintenance Choice prescriptions are not subject to this limit);
- Medications used to enhance athletic performance;
- Appetite suppressants;
- Vitamins (including B-12), but excluding pre-natal vitamins, fluoride, and dietary supplements (except calcium acetate to control hyperhosphatemia in connection with end stage renal failure); however coverage is provided for Rocaltrol; coverage is also provided under Major Medical for prescribed medical food in connection with propionic academia or a similar inherited metabolic disease;
- Drugs not dispensed from a licensed pharmacy or dispensed from an outpatient Hospital or Physician's office;
- Compound medications unless one ingredient is a legend drug;
- More than the maximum permitted doses of oral erectile disfunction medication in a calendar month;
- Replacement prescription medications resulting from loss, theft, or breakage.

Medicare Part D

The Medicare, Prescription Drug Improvement and Modernization Act of 2003 ("MMA") added a new prescription benefit for Medicare eligible individuals called Medicare Part D. The Trustees have determined, with the assistance of an actuary, that the Plan's prescription drug coverage for covered persons who are eligible for Medicare is "actuarially equivalent" to Medicare Part D. This means, on average, the Plan's benefits are equal to or better than the standard Medicare Part D drug plan.

As required by MMA, each covered person who is Medicare eligible will periodically receive a notice, called a Notice of Creditable Coverage, advising

whether the Plan's prescription drug benefit continues to be actuarially equivalent to Medicare Part D. Such covered persons are also entitled to receive such notices upon request to the Fund Office.

Covered persons who are Medicare eligible are required to and will be automatically enrolled in the Medicare Part D Prescription Drug Plan available through the Medical Plan. Medicare eligible covered persons who do not enroll in the Medicare Part D Prescription Drug Plan will be expelled from the Plan. However, this paragraph will not apply to covered dependents who receive employer-sponsored retiree prescription drug coverage that is coordinated with the Medical Plan's coverage under the Medical Plan's Coordination of Benefits provisions, where the employer-sponsored retiree prescription drug coverage acts as secondary coverage to Medicare and the Medical Plan offers tertiary coverage to Medicare and the employer-sponsored retiree prescription drug coverage.

The Medicare Part D Prescription Drug Plan will provide coverage for the cost of your prescription benefits. The Medical Plan also uses a supplemental "wrap product" to ensure that your co-payment for prescription drugs are consistent with other participants in the Plan.

Through the Medicare Part D Prescription Drug Plan, covered persons may go to any pharmacy and receive a 90 day prescription drug supply for the cost of three copayments. However, if you go to a pharmacy in the CVS Health network, you may receive a 90 day prescription drug supply for the cost of two copayments. For more information, please contact SilverScript customer service at 888-624-1141.

Prescription Out of Pocket Maximum Benefit

Subject to all other limitations, there are no additional co-payments for prescription drugs during any calendar year for any individual who has incurred annual co-payments of $1,600 for an individual or $3,200 for a family for prescription drugs.

Dental Benefits

The Fund has contracted with a Dental Service Preferred Provider Organization – **Delta Dental** – to make available an expansive group of dental care providers to participants. You may find a provider that participates with Delta Dental by visiting deltadentalil.com. You may also call Delta Dental customer service toll-free at (800) 932-0783 or contact the Fund Office.

The Plan pays for certain dental services, supplies and treatments for you and your Dependents, up to the maximum amounts shown in the Schedule of Benefits under the primary dental benefit maximum. These services are considered primary dental benefits. Expenses for preventive care, the treatment of dental abnormalities, Illness or Injuries, and the restoration and replacement of missing teeth are covered under the primary dental benefit. The Plan also pays for Dental Implants and Orthodontia up to the maximum amounts shown in the Schedule of Benefits.

If you or your Dependents receive treatment or supplies from an In-Network Delta Dental Dentist, the Plan pays your expenses up to $4,500 per year under the primary dental benefit maximum.

If you or your Dependents receive treatment or supplies from an Out-of-Network Dentist for primary dental benefit services, the Plan pays 80% of the charges, up to the yearly maximum of $4,500.00. Any expenses in excess of these maximum amounts must be paid by you or your Dependents.

Generally, for Participants and Dependents under age 19, the $4,500.00 annual dollar limit on primary dental benefits does not apply. However, the annual maximum for Dental Implants and Orthodontia apply to Participants or Dependents who are under the age of 19. Dental spending over the $4,500.00 limit on primary dental benefits is paid under Major Medical and subject to the same deductibles and copays.

There is a separate Employee Benefit Booklet for Dental Benefits that sets forth the Deductibles, Maximums, Contract Benefit Levels, Services, Limitations, and Exclusions provided under the Plan for primary dental benefits and dental implant benefits. The Employee Benefit Booklet will be provided to you. If you need an additional copy of the Employee Benefit

Booklet, please contact the Fund Office. The Employee Benefit Booklet for Dental Benefits is incorporated reference as if set forth in this Plan.

Vision Benefits

The Fund has contracted with a Vision Service Preferred Provider Organization – **National Vision Administrators (NVA)** – to make available vision examinations and high-quality lenses and frames to eligible individuals. You may find a provider that participates in the NVA network by visiting the NVA website at www.e-nva.com or calling NVA at (800) 672-7723. If you go to an out-of-network provider, you will have to submit a claim form to NVA and your provider may require you to pay the cost of the visit before you receive any reimbursement from NVA.

The Plan pays for one eye examination by a licensed optometrist or ophthalmologist for each Covered Person, once every 12 months, and one set of lenses and frames (or contact lenses) for each individual, up to a maximum of $275.

For Participants and Dependents under age 19, the $275 annual limit only applies to the cost of eyeglass frames. Spending above the $275 annual limit is covered under Major Medical and subject to the same deductibles and copays.

Vision Benefits are not payable for lost, broken or scratched lenses or frames, lenses or frames that are not prescribed, treatment or surgery for eye disease, or prescriptions that are filled more than 90 days after the examination date. Vision benefits are payable for post cataract multifocal lenses.

Death Benefits

If you die while you are covered under this Plan in a job class other than a helper – whether on the job or off – the amount shown in the Schedule of Benefits is payable to your Beneficiary. Individuals working in a helper classification are not covered by the Death Benefit.

To obtain the Death Benefit, your Beneficiary must make- a written request for the Death Benefit to the Fund Office within one year of your death and submit- a copy of your Death Certificate. If the Death Benefit is payable to a minor, payment will be made to the minor's legally appointed guardian, or the adult assuming physical custody and principal support of the child.

Beneficiary Designation

You may name anyone as your Beneficiary and you may change your Beneficiary at any time by filling out the proper form and filing it to the Fund Office. Upon receipt by the Fund Office, your Designated Beneficiary Form shall be effective as of the date that it was signed. However, the Plan will not be responsible for any payments that were made or any action taken prior to receipt of a properly executed and filed Designation of Beneficiary Form.

No Designated Beneficiary

If you do not name a Beneficiary, or if the person named does not survive you, your Beneficiary will be the surviving person or persons in the first of the following classes: (1) your spouse; (2) your children, including legally adopted children; (3) parents; (4) brothers and sisters; or (5) the executor or administrator of your estate. If two or more persons are entitled to benefits, they will be paid equal shares unless you specify otherwise. Your Beneficiary Designation does not automatically change because of your divorce, marriage, legal separation or the birth of your child; it can only be changed if your Beneficiary dies before you or if you file a new Beneficiary Designation Form with the Fund Office. It is your responsibility to review your current Beneficiary Designation Form and make sure that it accurately reflects your wishes.

Weekly Disability and Weekly Accident and Sick Benefits

The Plan pays you a weekly benefit as shown on the Schedule of Benefits for up to 33 weeks while you are unable to work on account of a non-occupational accident, Illness, or Injury, or pregnancy or pregnancy-related condition. A non-occupational Illness or Injury is one that does not arise out of or in the course of employment and is not compensable under a Workers' Compensation or similar law.

The weekly benefit begins on the first day of Disability, if the Disability requires you to be confined in a Hospital. If you do not need to be confined in a Hospital, and the Disability lasts more than seven days, the weekly benefits begin on the first day that you miss work because of the Disability. However, no Disability will be considered to have begun more than one day prior to the first visit to a Physician.

Successive periods of Disability are considered one continuous period of Disability, unless they are due to different and unrelated causes or unless you return to full-time work in Covered Employment for at least one Work Quarter.

It is not necessary for you to be confined to your home to collect benefits, but you must be under the care of a legally qualified Physician and medical evidence of your Injury must be provided to the Fund office. A benefit is not payable if you die before you receive your weekly payment. Also, benefits are not payable for a Disability that results from alcohol or substance abuse.

Effective January 1, 2015, you must be working in Covered Employment when your Disability begins to be eligible for the weekly benefit. If you are not working in Covered Employment when your Disability begins or if you are required to make self-payments to continue your coverage as described elsewhere in this booklet you are not eligible to receive Weekly Accident and Sickness Benefits. No Weekly Disability Benefits shall be paid while you are receiving Workers' Compensation Benefits. If you are receiving coverage under the Unemployment Set Aside Account when your Disability begins, you are not eligible to receive this weekly benefit.

In general, as described above, you must be actively at work in Covered Employment when your Disability begins in order to receive the Weekly Disability Benefit. However, if at the time your Disability begins, you are eligible under the Medical Fund as a result of having applied for and been granted the Penny Fund (the Unemployment Set Aside Account described elsewhere in this booklet), you will be eligible to receive the Weekly Disability Benefits if you meet all of the requirements for those benefits. Please note the Weekly Disability Benefit is still not payable if you become disabled while making self-payments or COBRA payments to the Medical Fund to continue your coverage.

Weekly Accident and Sickness Benefits are payable only during your period of Disability. Once you recover from a Disability, you must notify the Fund office of your recovery. If you receive disability payments after your recovery, those payments must be returned to the Fund. If an overpayment is made for a period when you are not Disabled, and you do not return the payments to the Fund, the amount of the overpayment plus any interest charge that the Fund may impose will be deducted from your next claim for benefits.

Weekly Supplemental Occupational Accident Benefits

If you are Disabled because of a work-related Injury, and you are receiving Workers' Compensation benefits in connection with that Injury, you may also be eligible to receive weekly benefits from the Plan depending on the jurisdiction that is providing Workers' Compensation benefits. Benefit levels are generally lower under the Maryland or Virginia Workers' Compensation laws, as compared to the District of Columbia benefit levels. The Plan provides a supplementary benefit, as shown in the Schedule of Benefits, designed to bolster benefit levels if your benefits are payable from Virginia or Maryland, so that your benefits will be approximately equal to the benefits which would have been payable from the District of Columbia.

In order to be eligible for these weekly benefits, you must become Disabled while you are working in Covered Employment within the geographic jurisdiction of Steamfitters Local Union No. 602, and you must be working under a Collective Bargaining Agreement between Steamfitters Local Union No. 602 and your Employer that requires the payment of a supplemental contribution designed to cover the cost of such coverage. Please note, Helpers are not eligible for this benefit. In addition, your Disability must begin within 90 days after your Injury and must prevent you from performing all of the duties of your regular occupation in order to be eligible for these benefits. Your benefits begin on the fourth day of your Disability or, if later, the date you become eligible for Workers' Compensation benefits as a result of your Injury. Once you stop receiving Workers' Compensation benefits, your weekly benefits under this section will automatically end.

The Weekly Supplemental Occupational Accident Benefit does not cover losses that result from commuting to and from work; intentionally self-inflicted injuries or suicide, committed while sane or insane; war or act of war; Illness, disease, pregnancy, childbirth, miscarriage or bacterial infection (except when resulting from accidental cut or wound); or injuries that you do not file a claim for within one year.

If there is a question about where you should be receiving Workers' Compensation benefits (Maryland, Virginia, or the District of Columbia) that will make a difference in the amount you receive, the Plan will pay the

Supplemental Occupational Accident Benefit after you sign a written statement agreeing to repay any benefits that are more than the amount you are entitled to once the Workers' Compensation award is finally determined

In determining whether you are Disabled or if a Disability is continuing, the Fund reserves the right to request that you submit to a periodic physical examination at the Fund's expense by a Physician selected by the Fund. Your benefits may be terminated if you refuse to undergo a physical examination requested by the Fund.

GENERAL EXCLUSIONS

The following are not Covered Expenses and cannot be considered for any purpose under this Plan:

1. Expenses incurred while you or your Dependents are not covered by this Plan;
2. An Injury or Illness for which benefits are covered under a Workers' Compensation or similar law except to the extent that benefits may be payable under the Plan's Weekly Supplemental Occupational Accident Benefit;
3. An Injury or Illness that arises out of or in the course of any occupation or employment for wage or profit;
4. Cosmetic surgery, except for the repair of Injuries sustained in an accident and reconstructive mastectomy surgery, which includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment for physical complications of all stages of the mastectomy, including lymphedemas;
5. Expenses incurred because of an intentionally self-inflicted act except when the self-inflicted act results from a medical condition (including both physical and mental health conditions);
6. Charges that would not have been made if no coverage existed, or charges that neither you nor your Dependent is required to pay;

7. Charges for services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government, except as otherwise required by law;

8. Charges for services or supplies that are furnished, paid for, or otherwise provided for by any local, state, or federal government agency, program, or institution except community general Hospitals;

9. Charges for services and supplies that are not necessary for treatment of an Injury or Illness, except routine physical examinations;

10. Charges for services or supplies that are not Medically Necessary;

11. Charges for services and supplies not recommended and approved by the attending Physician or charges to the extent that they are unreasonable or unnecessary;

12. Charges for skilled, intermediate or custodial care by nursing homes, rest homes, places for the aged, convalescent homes, or similar facilities (however, preauthorized extended care serviced in a skilled nursing facility are covered as set forth In the Skilled Nursing Facility Benefit);

13. Charges for custodial care, rest cures, and medical services or supplies for which a charge is made by a nursing home, rest home, convalescent home, home for the needy, home for nursing or domiciliary care, infirmary or orphanage, sanatorium, maternity home for pre-natal or post-natal care, or similar establishment, and custodial or domiciliary care provided on a non-institutional basis;

14. Personal comfort services, such as telephones, radio and television, air conditioners, humidifiers, beauty and barber services, cosmetics, wigs, club fees, exercise equipment, whirlpools, tanning beds, water beds, telephones, admission kits, heating pads, or other items not essential for treatment of an Illness or Injury;

15. Orthotics (except when approved by the Trustees as an alternative to surgery); orthopedic shoes (except when joined to braces); supportive devices for the feet; elastic stockings; treatment for chronic foot conditions; callus or corn paring; toenail trimming or removal (except for diabetic patients);

16. Travel and lodging, even when prescribed by a Physician;

17. Intermediate, custodial, or domiciliary nursing care, except as otherwise authorized by the Plan;

18. Injuries or Illnesses that result from or during participation in the commission of a crime, or in a riot or public disturbance;

19. Organ transplants, unless the transplant is non-experimental or non-investigational, the treatment is pre-authorized, and patient screening is done to verify the need for the transplant;

20. In vitro fertilization or any other treatment to correct infertility or reverse voluntary, surgically-induced infertility;

21. Educational or experimental services or supplies (with the exception of Diabetic Education);

22. Treatment of learning disabilities, mental retardation, special education, behavioral problems, developmental delay;

23. Replacement or repair of prosthetic devices within a five-year period, except when needed because of the growth of a child;

24. Myofunctional therapy; pulmonary therapy (except in preparation for surgery requiring general anesthesia);

25. Hypnotism, biofeedback, stress management, or goal-oriented behavior modification, electroconvulsive, electroshock therapies;

26. Radial Keratotomy;

27. Transportation of family members, medical personnel, supplies or equipment, and organs for transplant;

28. Treatment related to sexual dysfunction (unless caused by a physical Illness or Injury; however, up to the maximum permitted number of doses of oral erectile disfunction medication or similar drugs per month may be obtained under the Prescription Drug Benefit);

29. Chiropractic services except as provided under the Major Medical Benefit;

30. Elective abortions (except therapeutic abortions);

31. Failure to appear for a scheduled appointment or to provide claim forms or documents; charges for the completion of forms of for supplying medical records;

32. Nonprescription drugs, vitamins, dietary foods or supplements, except as otherwise provided elsewhere in this booklet;

33. Therapeutic devices or appliances such as hypodermic needles, syringes (other than insulin supplies), support garments, and non-medical substances, regardless of their intended use;

34. Private duty nursing care by a member of the patient's household or family;

35. Stand-by charges for anesthesia, Hospital benefits, or Physician's services provided as part of a surgical or maternity procedure for which no services are actually provided to the patient;

36. Medicare Part B premiums;

37. Non-institutional or home health care except as provided under the Hospice Benefit or the Home Health Care Benefit;

38. Charges relating to any Injury or Illness sustained while operating or riding in or on an aircraft or falling or descending from the aircraft while it is in flight or motion, except when a fare-paying passenger on a commercial airline flying on a regularly scheduled route between definitely established airports;

39. Services or care by or in, a nursing home, or any other facility that is not a Hospital except as provided herein;

40. Non-emergency care when traveling outside the United States;

41. Weight loss programs except as provided under the Major Medical Benefit;

42. Any services or supplies not shown as covered; any benefits not otherwise provided for herein;

43. Charges that exceed the Usual, Customary, and Reasonable for the services provided; and

44. Any claims for which a third party may be liable as described under the "Third Party Liability Claims" section of this booklet on pages __.

45. Any claims for care or treatment for an Injury or Illness that is the result of engaging in a Dangerous and Hazardous hobby or activity. For the purposes of this exclusion, only the following activities are considered Dangerous and Hazardous:

    - Skydiving
    - Auto or motorcycle racing
    - Hang gliding
    - Bungee jumping
    - Parasailing

COORDINATION OF BENEFITS

The benefits provided under this Plan are "coordinated" with any benefits payable to you or your Dependents for the same expenses from other group health plans, insurance plans, and Medicare. Coordination means that benefits from this Plan and from other benefit plans, insurance plans, and Medicare cannot exceed 100% of the Allowable Expenses for each covered person in each calendar year. Coordination is intended to permit up to full payment of actual Allowable Expenses without duplication of benefits.

When a covered person is entitled to benefits under more than one plan, the rules outlined below show an order of benefit determination to decide which plan is the primary plan. If this Plan is the primary plan, then its benefits will be determined without taking into account the benefits of the other plan. If this Plan is the secondary plan, then its benefits will be applied to the balance remaining after the primary plan's benefit in accordance with the Plan's terms, including any Deductible or coinsurance amounts due.

Of course, if you or your Dependents are covered under more than one health plan, including this Plan, and your expenses are not covered under any of the plans, these coordination rules do not apply. You alone will be responsible for the payment of the expenses.

Also, if you or your Dependents are covered under more than one health plan, including this Plan, and one of the other plans does not have a coordination

of benefits provision, that plan will be considered the "primary plan" and benefits under that plan will be payable before benefits under this Plan. In such cases, this Plan will be the "secondary plan."

Coordination with Other Health Plans

Benefits are coordinated in the following order:

- A plan covering someone not as a dependent pays benefits before a plan covering that person as a dependent.
- A plan covering someone as a current employee will always be considered the primary plan for that individual.
- The plan of a parent whose birthday (month and day only) falls earlier in the calendar year covers Dependent children first. This is known as coordinating payments under the "birthday rule," and is applied only when the other plan also recognizes this order of payment.
- If a priority cannot be established under these rules, the plan that has covered the individual for the longest period of time will be the Primary Plan.
- This Plan always pays after a plan that does not have a coordination of benefits provision.
- A plan covering a person as a laid-off or retired Employee, or a Dependent of such person, pays benefits after any other plan covering the person as an Employee.
- Benefits are paid under a secondary plan only to the extent that they are not payable under any other plan.
- The maximum amount payable under this Plan is the amount that would have been payable if this Plan was the primary plan.
- When two individuals in the same family are covered by this Plan as Employees or when someone is a Dependent of two persons who are Covered Employees, this Plan is treated as two separate plans for coordination of benefits. However, the Plan's maximum limitations do not increase.
- When this Plan is a Secondary Plan, the Plan will provide benefits for covered expenses, but only to the extent that such payments are not payable under the primary Plan.
- If this Plan and another plan are both secondary, these rules are repeated until each plan's responsibility is determined.

- In no event will the benefits provided under this Plan exceed the benefits that would have been provided if this Plan were the primary plan.
- There are special rules for coordination of benefits for Dependents when there is a legal separation or divorce (or if the parents have never married). If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses for a child, benefits are determined in accordance with the court decree. Otherwise:
  - If the parent with custody has not remarried, the benefit plan covering the parent with custody shall have primary responsibility for the child's benefit, and the plan covering the parent without custody shall have secondary responsibility;
  - If the parent with custody has remarried, the plan covering the parent with custody is primary, the stepparent's plan is secondary, and the plan of the parent without custody is third.
  - If two plans are both secondary, the rules shown above are repeated until one plan is primary.

  For example, consider an individual who is a Participant in Plan A and covered as a Dependent in this Plan. Plan A is therefore the primary plan. The individual incurs a $1,000 Hospital charge. Plan A covers hospital expenses at 50%, so it pays $500 of the Hospital charge, leaving a $500 balance. This Plan pays Hospital charges as a Major Medical Benefit, meaning that it pays 80% of Allowable Charges after the annual Deductible is met. This individual has $200 remaining on her annual Deductible. Therefore, from the $500 balance, the individual must pay the $200 to cover the remaining Deductible, and the Plan will then pay 80% of the remaining $300, or $240. After coordinating benefits on the $1,000 Hospital charge, the individual owes $260 ($200 deductible plus $60).

Coordination with Medicare

When you or your Dependents become eligible for Medicare benefits, coverage under this Plan is coordinated with Medicare coverage, whether or not you or your Dependents are enrolled under Medicare. This means that any payments for benefits that you receive under this Plan will be reduced by any amounts you would have received from Medicare had you enrolled. In addition, if you visit a health care provider that does not accept Medicare, benefits will be coordinated under this Plan as if the health care provider had accepted

Medicare, and you will be responsible for paying the amount that would have been paid by Medicare.

When you or your spouse reaches age 65, or you or one of your Dependents becomes Totally Disabled, you or your Dependents may be eligible for Medicare. In addition, if you or your spouse become eligible for Social Security at age 65 while you are still working, coverage by Medicare is possible even if you don't retire. Medicare includes Hospital insurance benefits (called "Part A") as well as supplementary medical insurance benefits (called "Part B"). You must pay a monthly premium to receive Part B.

The Fund strongly encourages you to enroll in Medicare (both Parts A and B) as soon as you are eligible, because the benefits of Medicare Parts A and B will be taken into account, and coordinated with this Plan whether or not you enroll in Medicare. Since this Plan will usually be secondary, you failure to enroll in Medicare could result in no benefits from Medicare and substantially reduced benefits from this Plan.

If you are a Covered Retiree, including Disabled Retirees, benefits will be payable under Medicare before they are payable under this Plan. If you are a Disabled Ex-Employee and you are covered under this Plan, benefits will be payable from Medicare before they are payable under this Plan. If you are a Covered Dependents and you qualify for Medicare, benefits will be payable under this Plan before benefits are payable under Medicare.

When you or your spouse reach age 65 while you are still working, benefits will be coordinated with Medicare, but this Plan will be primary. However, if you are not still working when you or your spouse reaches age 65, but your spouse is still working, her plan will be primary, Medicare will be secondary, and this Plan will be third.

After you or your Dependents enroll in Medicare, you should submit all of your Medical claims to Medicare first. This Plan considers a Claim for any remaining expenses and pays any balances unpaid by Medicare for covered Plan expenses that are considered Usual, Customary and Reasonable.

It is important that you or your Dependents visit an office of the Social Security Administration during the first three-month period before your 65th birthday to learn all about Medicare. If you have any questions about the coverage provided by this Plan, or need help in comparing the benefits offered by this Plan and Medicare, please contact the Fund office.

PROCEDURES FOR MAKING A CLAIM

Generally

With the exception of Dental Benefit and Vision Benefit Claims, all claims for benefits must be made in writing on forms acceptable to the Fund Office. Dental Benefit Claims must be made directly to Delta Dental consistent with the Claims process described in the Employee Benefit Book for Dental benefits, which is incorporated by reference into this booklet. Similarly, vision claims must be made directly to National Vision Administrators consistent with the Claims process adopted by National Vision Administrators written documents, which are incorporated by reference into this booklet.

For all other claims for benefits which are made to the Fund Office, a claim must be accompanied by billings from the provider, and you must submit any other proof that is required by the Trustees. Claims may be made by the Employee or Retiree, by a spouse or Dependent, or through a provider subject to the Plan's limitations on assignments of benefits. Claims may also be made by your authorized representative if you notified the Fund Office in writing of the name, address, and phone number of the authorized representative. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims for benefits. Requests for determinations of whether someone has attained eligibility are also not considered claims for benefits.

The time periods and procedures for initial claim determinations and appeals of adverse claim determinations are discussed in detail below.

The provisions of this Section do not apply to disputes initiated by providers regarding claims subject to the No Surprises Act. Such disputes shall be resolved in accordance with the open negotiation and dispute resolution provision of that Act, its underlying regulations, and other applicable governmental guidance.

Claims – Time Limits, Where to File, Forms

You should file any claim for benefits as soon as reasonably possible after the expense is incurred. A claim for benefits will be considered filed only when a written claim form is received by the Fund Office. **No benefit will be paid on claims filed more than one year after the expense is incurred.**

All claims for medical and vision benefits are processed on behalf of the Fund under a contract with a third party administrator, except for benefits paid through your prescription drug card. Please contact the Fund Office to request claim forms for these benefits, or for questions relating to any specific claims.

Some benefits have special claims forms, so specify the type of benefit when requesting forms. Please follow the instructions on the forms. If you have any questions about how to complete a form or whether an alternative form is acceptable, please contact the Fund office. Claim forms may also be picked up at the local union office.

There are different time frames for deciding claims and some special procedures, depending on the type of claim. For all claims, and if applicable, the Fund Office will timely provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. In addition, and if applicable, the Fund will also provide you with new or additional rationale on which the Fund intends to make an adverse benefit determination, prior to the Fund's decision and sufficiently in advance of the date of any decision to allow you a reasonable opportunity to respond to the new or additional evidence or rationale.

Post-Service Claims: These claims involve the payment or reimbursement of costs of health care that has already been provided. Most claims filed with the Fund Office are Post-Service Claims. The Fund Office will notify you in writing of the decision on a Post-Service Claim within a reasonable time, but not later than 30 days after it receives your claim for benefits. However, if special circumstances require an extension of time to process the claim, the Fund office may continue its review of your claim for an additional 15-day period, as long as the Fund office notifies you of the extension and special circumstances before the initial 30-day period expires. If applicable, the Fund Office will timely provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. If applicable, the Fund will also provide you with new or additional rationale on which the adverse benefit determination was based.

Claims For Prescription Drug Benefits: These claims are handled by the prescription benefits manager retained by the Trustees. Periodically, you will be sent a plastic prescription drug identification card. When you need to have a prescription filled, you should consider using a pharmacy that honors your prescription drug card. Most drug chains, as well as many independent pharmacies will honor the card. If you have a prescription filled at a participating

pharmacy, you only have to present your prescription drug benefit card instead of completing a written claim form. However, if the pharmacy is not a participating pharmacy, you must first pay the pharmacist and then seek reimbursement by filing a written claim form, along with your receipt, with the prescription benefits manager. If the prescription benefits manager denies any claim for prescription drugs in whole or in part, you may seek a review by the Trustees in accordance with the appeals procedures explained in the following section.

Pre-Service Claims: "Pre-Service Claims" are claims for medical or dental benefits that the Plan conditions the receipt of, in whole or in part, on the approval of the benefit in advance of receiving medical care. Examples of pre-service claims are benefits under the Plan for which pre-authorization is required, such as Substance Abuse Treatment Benefits, Hospice Benefits, and Home Health Care Benefits for services in excess of $200.

The Fund Office will notify you in writing of the decision on a Pre-Service Claim within a reasonable time, but not later than 15 days after it receives the claim. However, if special circumstances require an extension of time to process the claim, the Fund office may continue its review of your claim for an additional 15-day period, as long as the Fund office notifies you of the extension and special circumstances before the initial 15-day period expires. If you have not provided enough information for the Fund office to decide your Pre-Service Claim, the Fund office may seek an extension. The Fund's notification of the extension will describe the information that it needs to decide your claim, and state that you have at least 45 days from receiving the notice to provide this information.

Claims for Dental Benefits: Before you see the Dentist, you should first obtain a Dental Statement of Claim form from the Fund office. This special dental claim form is a dual purpose form which may be used by the Dentist for a pre-treatment estimate and for actual billing of dental services upon completion of treatment.

If, after examination, it is found that dental treatment is required, the Dentist should be consulted regarding the recommended treatment plan and the total amount of his fee, since charges of $200 or more require pre-authorization by the Fund office. If the Dentist's fee for services and/or supplies will not amount to $200 or more, the dental claim form may be completed by the Dentist and submitted to the Fund office upon completion of the work. If the

Dentist's fee for services will amount to $200 or more, the Dentist must complete a pre-treatment estimate of services and charges on the dental claim form and submit it to the Fund office for pre-authorization before the treatment is started. The treatment plan and charges will be reviewed by the Fund office and the attending Dentist will be advised of eligibility and the amount to be paid by the Plan. After services are completed, the Dentist should resubmit the dental claim form for billing.

Claims for Dental Benefits: Dental Benefit Claims must be made directly to Delta Dental consistent with the Claims process described in the Employee Benefit Book for Dental benefits. The procedures for making claims for dental benefits are also set forth in the Employee Benefit Book for Dental benefits.

Urgent Care Claim: "Urgent Care Claims" are Pre-Service claims for which the Fund office or a Physician with knowledge of your condition determines that applying the time frames for Pre-Service Claims for medical care or treatment would endanger your life or health. Urgent Claims also include Pre-Service Claims for which a Physician with knowledge of your medical condition thinks that a failure to apply the Urgent Claim time frames would subject you to severe pain. The Fund office will notify you in writing of the decision on an Urgent Claim as soon as possible but no longer than 72 hours after it receives your claim. If you have not provided enough information for the Fund office to decide your Urgent Claim, the Fund office will notify you, within 24 hours of receiving your claim, of the information it needs to decide your claim. You will then have at least 48 hours to provide the information. The Fund office will notify you of its determination within 24 hours after receiving the additional information.

Concurrent Care Decisions: "Concurrent Care Decisions" are decisions to terminate or reduce certain benefits the Fund has previously granted to you. If the Fund office has approved an ongoing course of treatment to be provided over a period of time or a number of treatments it will notify you in advance of any reduction in or termination in benefits for this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund will notify you in writing of its determination within 24 hours after receiving your claim, provided you claim is received 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.

Claims for Weekly Disability Benefits or for Supplemental Occupational Benefits: You must complete and file special claim forms for these benefits. The Fund office will notify you in writing of the decision on these claims within a reasonable time, but not more than 45 days after the Fund office receives your claim for benefits. However, if special circumstances require an extension of time to process your claim, the Fund office may continue its review of your claim for an additional 30-day period, as long as the Fund office notifies you of the special circumstances in writing before the initial 45-day period expires. This notification will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed by the Fund office to resolve these issues. The Fund office may continue its processing of your claim for a second 30-day period if the Fund office sends you a similar written notice of the special circumstances, before the previous 30-day period expires.

Claims for Death Benefits: Special claims forms must be filed for this benefit along with a sealed copy of the death certificate. The Fund office will notify you in writing of the decision on a claim for death benefits within a reasonable period of time, but no later than 90-days after the Fund office receives your claim. However, if special circumstances require an extension of time to process your claim, the Fund office may continue its review of your claim for an additional 90-day period, as long as the Fund office notifies you of the special circumstances in writing, before the initial 90-day period expires.

Claims – Content of Denial Notice

If any claim for benefits described above is denied, in whole or in part, the Fund office (or an individual acting on its behalf) will provide you with a written or electronic notice that: provides sufficient information to identify the claim, including where applicable the date of service of the denied claim, the name of the health care Provider, the amount of the claim, and a notice of your right to receive the diagnosis code and treatment code as well as an explanation of their meaning upon request; states the reasons for the denial, including any applicable denial code and its meaning, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including your right to an external appeal and the right to bring a civil action under

Section 502(a) of ERISA following an adverse determination on appeal. If required, the notice will also include a statement that it is available in a language other than English if the Plan serves a county with more than 10% non-English speakers.

In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, you will be provided with either the specific internal rule, guideline, protocol or similar criterion that was relied upon, or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

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 orally, within the time frames described above. You will be provided with written notification within 3 days of oral notification.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

If you disagree, in whole or in part, with the Fund Office's determination on any claim, you may request a review by the Board of Trustees.

Time Period to Appeal, Where to File, Content of Appeal

All appeals must be in writing and must be received by the Fund office within 180 days of your receipt the written notice of the denial of your claim. The

failure to file an appeal within the 180 day period will constitute a waiver of your right to appeal.

Appeals of Dental Benefit Claim determinations must be made directly to Delta Dental consistent with the Appeals process described in the Employee Benefit Book for Dental benefits. The procedures for appealing adverse benefit determinations for dental benefits are also set forth in the Employee Benefit Book for Dental benefits.

You will have the opportunity to submit written comments, documents, records, and other information relating to the appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may appoint an authorized representative to act on your behalf for purposes of filing your claim or your appeal, by notifying the Fund office in writing of the name, address, and phone number of the authorized representative. Neither you nor your representatives will have the right to make personal appearances before the Trustees.

Your appeal should be filed at the following address:

Board of Trustees
Heating, Piping and Refrigeration Medical Fund
c/o WPAS, Inc., Fund Administrator
PO Box 21427
Eagan, MN. 55121

Your written appeal should state the reason why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits you are claiming. The Trustees can best consider you position if they clearly understand your claims, reasons, or objections.

Your appeal will be reviewed by the Board of Trustees. Their review shall take 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 benefit determination. The Trustees will also not afford deference to the initial determination by the Fund office.

In deciding an appeal of a Fund Office 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 Trustees will consult with a health professional who has appropriate training and expertise in the particular field of medicine. Such health care professional will not be the same individual who was consulted by the Fund office for its determination, nor a subordinate of that individual. You will also be provided with the identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process with regard to whether that advice was relied on. If applicable, the Fund office will timely provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your appeal. If applicable, the Fund will also provide you with new or additional rationale on which it intends to make an adverse benefit determination, prior to the Fund's decision and sufficiently in advance of the date of any decision to allow you a reasonable opportunity to respond to the new or additional evidence or rationale.

Time Frames for Notification of Decisions on Appeal: The time frames for making decisions on appeals differ according to the type of claim.

Urgent Care Claims: The Trustees will notify you of their decision of an Urgent Care Claim appeal as soon as possible, but not later than 72 hours after receiving your request for review.

Pre-Service Claims: The Trustees will notify you of their decision on any pre-service claim appeal within a reasonable period of time, but not later than 30 days after receiving your request for review.

Post-Service Claims: If you appeal an adverse determination on a post-service claim, the Trustees will review your appeal at their bi-monthly meeting immediately following receipt of your appeal. However, if your appeal is not received in the Fund office more than 30 days prior to the meeting, the Trustees may not be able to review your appeal until the second bi-monthly meeting following receipt of the appeal. You can contact the Fund office to find out the dates of the next scheduled Trustees meetings. If special circumstances require a further extension of time so that the Trustees may complete their review of your appeal, a decision will be rendered not later that the third Trustees meeting following receipt of your appeal. You will

be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written notice of the decision of the Trustees within 5 days of their decision.

If your appeal is denied, in whole or in part, the written notification will include the specific reason or reasons for the denial, and references to the specific Plan provisions on which the denial is based. In addition, statements of any internal rules, guidelines, procedures, protocols or similar criterion that were relied upon in making the adverse determination will be included in the written notice. You will also be able to request copies of any internal rules, guidelines, procedures, protocols or similar criterion that were relied upon in declining your appeal free of charge from the Fund office. If the adverse determination was based on a medical necessity determination or experimental treatment or similar exclusions or limitations, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the your medical circumstances or a statement that such explanation will be provided free of charge upon request will be included in the notification.

External Review

If you receive an adverse benefit determination on appeal concerning your health care claim or a recission of your coverage, you (or your authorized representative) have the right to request external review. The external review process is limited to adverse benefit determinations that involve medical judgement, whether the Fund is complying with applicable surprise billing and associated cost-sharing protections under federal law, and recissions of coverage.

A determination involves medical judgment if, for example, it is based on the Plan's requirements for medical necessity, appropriate health care setting, level of care, or a determination that a treatment is experimental. Other examples of determinations that involve medical judgement include: (1) whether a treatment is for Emergency Services; (2) whether a claim for items or services provided by an Out-of-Network provider at an In-Network facility are subject to the protections under the No Surprises Act; (3) whether you were in a condition to receive a notice about the availability of the protections against balance billing and gave informed consent to waive those protections; (4) whether a claim for items and services was coded correctly, consistent

with the treatment you received, thus entitling you to the protections against balance billing; and (5) whether cost-sharing was correctly calculated for ancillary services provided by an Out-of-Network provider at an In-Network facility.

The request should be sent to the address identified in this Chapter for submitting an appeal to the Board of Trustees. Your request for an external review must be made no later than four months from the date you receive adverse decision on your appeal. If there is no corresponding date four months after the date of receipt of such notice, the request must be filed by the first day of the fifth month following the receipt of the notice.

The Fund has contracted with various independent review organizations ("IROs") to perform the External Reviews. At no cost to you, these IROs will conduct an independent review of the adverse benefit determination. At the end of their review, the IRO may decide to uphold or reverse the Fund's determination. You will be allowed to submit additional information in support of your claim to the IRO. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision: (1) your medical records; (2) the attending health care professional's recommendation; (3) reports from appropriate health care professionals and other documents submitted by you, your treating provider, or the Fund; (4) the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law; (5) appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations; (6) any applicable clinical review criteria developed and used by the Fund, unless the criteria are inconsistent with the Plan's terms or with applicable law; and (7) the opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

The IRO will complete its review within 45 days of receiving the request for external review, unless it is an urgent care claim or otherwise eligible for expedited review, in which case the IRO will reach a decision as quickly as possible but no more than 72 hours after receiving the review. The written decision of the IRO will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence based standards considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under the state or federal law to either the group health plan or to you;

(6) A statement that judicial review may be available to you; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Fund, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Fund from making payment on

the claim or otherwise providing benefits at any time. The Fund must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Fund, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Claims for Weekly Disability Benefits or for Supplemental Occupational Benefits: Appeals for denials of claims for the Weekly Disability Benefit or Supplemental Occupational Benefits will be determined under the time frames for Post-Service Claims explained above.

Claims for Death Benefit: Appeals for denials of claims for the Plan's Death Benefit will be determined under the time frames for Post Service Claims explained above.

Other Appeals: If you receive any correspondence from the Fund Office that does not involve a claim for benefits, but could be interpreted as adversely affecting your interests under the Plan, you may appeal to the Trustees for a review of that correspondence. Such a request for review must be made in writing and must be made within 180 days of receipt of the correspondence from the Fund office. The Trustees will review the matter, and they will provide you with written notice of their determination.

Judicial Review: If, after exhausting the internal or external review process, you are still unsatisfied with the outcome, you may seek judicial review. The Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

SUBROGATION & REIMBURSEMENT CLAIMS

In General

This Plan does not cover any Illness, Injury, disease or other condition (collectively referred to as "Injury" or "Injuries") for which another party may be

directly or indirectly liable. Benefits are not paid for such Injuries under this Plan regardless of whether the expenses are caused by a third parties' negligence, intentional act, or a breach of any legal obligation that the third party may have. Before the Plan pays any benefits to you or to your Dependents for any loss or expense for which there might be a claim against another party, you must take the following steps:

- You must sign a written agreement stating that the Plan will be reimbursed for any amounts that it pays in connection with the Injury if you later receive payment from another party for that Injury.
- You and your attorney must provide proof, satisfactory to the Trustees, that no right, claim, interest or cause of action against another party has been, or will be, discharged or released without the written consent of the Board of Trustees. In addition, any claims that you make against a third party must first be approved by the Trustees.
- You must agree to help the Fund in pursuing your claims against the third party, or to allow the Fund to pursue the claims on your behalf. This is sometimes called "subrogation." The Fund can seek recovery of any amounts you receive from another party even if you fail to inform the Fund of your claim, of if you fail to sign an agreement with the Fund, and even if you are not otherwise made whole.

If the person who was injured is a minor, the parent or legal guardian must fulfill the above requirements on the child's behalf.

If you or your Dependent, or your attorney refuse to sign the written agreement referenced above, the Plan may withhold payment of any benefits as a result of such Injury and may recoup by offset or lawsuit any amount already paid. The Plan's reimbursement/subrogation interest is governed by the terms of the Plan whether or not the injured person has signed the agreement. The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence, or by the common fund doctrine.

The Trustees have absolute discretion to settle subrogation and reimbursement claims on any basis they deem warranted and appropriate under the circumstances.

Reimbursement

The Plan has the right to recover any benefits that are paid to you or your family, or to any representative of you or your family, for any Injury for which

you receive payment from another source. By accepting benefits from the Plan, you agree that any amounts recovered by you from any source, by judgment, settlement or compromise are assets of the Plan to the extent of claims paid by the Plan and will be applied first to reimburse the Plan, in full and without reduction for attorneys' or any other fees or costs, even if you do not recover all of your losses and are not made whole – and regardless of the manner in which the proceeds are paid or characterized. By accepting benefits from the Plan, the injured person further agrees that the Plan shall have an equitable lien in any amounts that you recover, or will recover, for the entire amount paid by the Fund for the claim, and the injured person agrees to fully cooperate with the Plan in connection with any claim brought by the Plan to recover its reimbursement interest.

No benefits are payable in excess of $50,000 for any Injury arising out of a single occurrence for which another party is or may be liable if a claim is pending against that party. This limit will not apply if a claim of liability against another party is resolved in favor of the party, if no claim is pursued against the party, or if no payment on the claim is otherwise received.

The Plan's subrogation and reimbursement rights are established by the Plan and not by any agreement you may sign. The Plan has a right to first reimbursement out of any recovery you or your Dependents receive from another party, whether or not you are made whole. This includes any amounts that you may receive from a personal homeowner's insurance policy, an automobile insurance policy or a group insurance arrangement of any kind. If the Plan pays benefits to you or your Dependents and you do not reimburse it after you recover from another party, the Plan can withhold and offset any other benefits that may be payable to you or your Dependents, or may take legal action against you, in order the recover the amount paid, plus interest.

If it becomes necessary for the Fund to institute legal action against you for failure to reimburse it, in full, or to honor the equitable interest in the amount recovered by you from another party, you will be liable for all costs of collection, including attorneys' fees. The Fund's right to reimbursement also includes the right to reimbursement from any payment made to you from any source to which you assign any claim against, or otherwise agree to reimburse any recovery from, the person who caused your Injury.

Subrogation

This Plan shall be fully subrogated to any and all rights of recovery and causes of action which the injured person may have against any liable third party.

The Plan is not required to participate in an injured person's claims to demand reimbursement or to invoke its subrogation rights. The Plan may request that the injured person assign or subrogate his or her claim or any other right of recovery to the Plan so that the Plan can enforce its right to recovery. The injured person must cooperate fully with the Plan in connection with any claim brought by the Plan to recover its assigned or subrogated interest. By accepting benefits from the Plan, the injured person authorizes the Plan to elect to pursue any claims arising from the Injury in the name of the injured person and/or the Plan's name and to sue, compromise or settle such claims without the approval of the injured person to the extent of benefits paid and/or to be paid.

If the injured person does not cooperate or if the injured person or anyone acting in his or her interest takes any action which harms the Plan's subrogated interest, the Plan is entitled to cease payment of any benefits connected to the third-party caused Injury and recover from the injured person the amount of Plan benefits paid. The Plan may bring a lawsuit against the injured person to collect payments already made or may collect these amounts by offset against any future benefit payments otherwise due to the injured person and their immediate family. If legal proceedings were instituted, the Plan may recover the costs and attorney's fees incurred.

MISCELLANEOUS

Action of Trustees

The Trustees have full discretion and authority over the standard and amount of proof required in any case to resolve disputed facts and over the application and interpretation of this Plan. No legal proceeding shall be filed in any Court of before any administrative agency against the Plan or the Trustees, unless all review procedures with the Trustees have been exhausted.

Exclusive Rights

No individual shall have any right to any benefits provided under this Plan except as specified in this Booklet. The Plan will not be bound by any oral representations that are inconsistent with the contents of this Booklet, and you should not rely on any oral representations that are inconsistent with the terms of this Plan. None of the benefits provided under this Plan are vested.

No Assignment of Benefits

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or providers of medical care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider can be considered to be a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so. All benefits under the Plan shall be exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal process or proceedings.

Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. However, if an error is discovered and it is determined that the Fund has paid you any benefits to which you are not entitled, the Trustees have the right to seek repayment from you. This includes the right to reduce future benefit payments by the amount of the erroneous payment.

Misrepresentation or Fraud

If you receive benefits as a result of fraud or intentional misrepresentation of material fact, such as false information or misleading or fraudulent misrepresentations, you will be required to repay all amounts and you will be liable for all costs of collection including attorney's fees. The Trustees reserve the right to deduct the amounts owed from any future benefits due to you, or your respective dependents until the Plan is fully reimbursed. Your benefits may also be rescinded (retroactively terminated) after you have been given 30 day notice of the rescission.

No Fund Liability

The use of the services of any Hospital, Physician, or other provider of health care, whether designated by the Fund or otherwise, is your voluntary act. Even if some benefits may be obtained only from providers designated by the Fund, this is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors. They are not employees of the Plan. The Trustees make no representations regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of

any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

The Heating, Piping and Refrigeration Medical Fund, the Board of Trustees, or any of their designees are not engaged in the practice of medicine; nor do they have any control over any diagnosis, treatment, care or lack thereof, or over any health care services provided or delivered to anyone by any health care provider.

Right to Amend or Reduce Benefits

The Board of Trustees in accordance with this document and the Trust Agreement, has the right to amend the Plan at any time. This includes, but is not limited to, eliminating the existence of, or change in the duration of coverage; changing eligibility and requirements for coverage; changing the availability, nature and extent of benefits, and the conditions for and methods of payment of benefits for any person covered by the Plan. The Trustees have the right, at any time, to reduce or terminate benefits. All benefits under the Plan, including Retiree Benefits, are not guaranteed and are provided only from assets of the Fund collected and available for such purposes.

No Liability for Practice of Medicine

Neither the Plan, nor the Board of Trustees, nor any of their designees are engaged in the practice of medicine. Nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care serviced provided or delivered to the Covered Person by any health care provider. Neither the Plan, nor the Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or Injury caused to the Covered Person by any health care provider by reason of negligence, by failure to provide care or treatment or otherwise.

Workers' Compensation

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by a Workers' Compensation law or similar legislation.

Disclaimer

None of the benefits provided under this Plan are guaranteed by the Board of Trustees, any Employer, Union or other individual or entity or are insured by a contract of insurance. Benefits may be provided only from the assets of the Fund collected and available for such purpose.

Right to Information

The Board of Trustees has the right to release to, or to obtain from, any insurance company, organization, or person any information necessary for purposes of applying the coordination of benefits rules to the extent permitted by law. In addition, you must furnish, upon request by the Fund office, any information that is required to determine how benefits should be paid under these rules.

Right to Correct Erroneous Payments

If these rules aren't applied correctly and a payment is made under Medicare or by another Health Plan that should have been made under this Plan, the Board of Trustees will have the right to repay the organization that made the payment. The Trustees will repay only such amount as they determine to be required under the rules explained in this section. Once such payment is made, the Plan shall be fully discharged from any liability with respect to the payment.

Right to Recover Payments

The Board of Trustees has the right to recover any payments that are made in error or in excess of the amounts required to be paid under these provisions. The Trustees have this right regardless of to whom the payment is made. Thus, the Trustees may recover the erroneous or excess payment, from any one or more of the following: a person to or for with respect to whom the payments were made, an insurance company, or any other organization.

No Pre-existing Condition Limitation

The Plan does not have any limitations for pre-existing conditions.

No Rescission of Coverage

Except in the case of Fraud or intentional misrepresentations of material fact, no individual's coverage will be retroactively rescinded. If your coverage is to be terminated under the Plan's rules, you will be provided up to 30 days advance notice unless it is due to the absence of contributions.

Choice of Physicians and No Referral Requirement

The PPACA requires that participants know of their rights to (1) choose a primary care provider or a pediatrician when a plan requires designation of a

primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

Choice of Primary Care Physician

The Fund currently does not require participants to designate a primary care physician. However, participants are allowed to make such a designation if they wish to have a primary care physician to coordinate their medical treatment. Selection of a primary care physician is completely voluntary and not a requirement for coverage. Should you choose to make such a selection, you have the right to designate any primary care physician who participates in CareFirst Blue Cross/Blue Shield's preferred provider network and who is available to accept you or your family members, and you may change this provider selection at any time. For children you may designate a pediatrician as the primary care physician.

No Referral Required for Obstetrics or Gynecology

The Plan does not require participants to obtain prior authorization from the Fund Office, from CareFirst Blue Cross/Blue Shield or from any other person (including a primary care provider) in order to obtain access to treatment from any health care professional, either in-network or out-of-network, including those who specialize in obstetrics or gynecology. CareFirst Blue Cross/Blue Shield's network providers, however, may be required to comply with certain network contractual procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or specified procedures for making referrals.

Provider Nondiscrimination

In accordance with Section 2706 of the Public Health Service Act as amended by the Affordable Care Act, the Plan will pay benefits covered under its terms to any provider who bills for Covered Expenses within the scope of that provider's license or certification under applicable State law.

Routine Patient Costs in Clinical Trials

Notwithstanding any exclusion listed in the Plan for experimental services, supplies, or treatments, in accordance with Section 2709 of the Public Health Service Act as amended by the Affordable Care Act, the Plan will pay routine patient costs for items or services that are furnished in connection with participation in a clinical trial if those same costs would otherwise be Covered

Expenses under the Plan. The term "routine patient costs" has the same meaning as that term is defined in Public Health Services Act Section 2709 and includes items or services that are otherwise covered under the Plan and are used for the direct clinical management of the patient, but does not include items or services used solely to satisfy the data collection and analysis needs of the clinical trial.

GENERAL INFORMATION

Plan Administration

The following information is provided as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Official Name of Plan: Heating, Piping and Refrigeration Medical Fund.

Type of Administration: The Plan is administered and maintained by a joint Board of Trustees, consisting of three Union representatives and three Employer representatives. The Trustees contract with a third party administrator for administration and claims payment services.

Type of Plan: Wholly self-funded hospitalization, medical, disability, dental, vision, and prescription drugs.

Agreement and Declaration of Trust: The Plan is subject to and controlled by the provisions of the Restated Agreement and Declaration of Trust. In the event of a conflict between the provisions of the Plan and the provisions of the Restated Agreement and Declaration of Trust, the provisions of the Restated Agreement and Declaration of Trust will prevail.

Plan Sponsor and Administrator: The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Board of Trustees consists of Employer and Union representatives selected in accordance with the Restated Agreement and Declaration of Trust. The Board of Trustees has been designated as Agent for Service of Legal Process. The names, titles, and addresses of the Trustees are:

Employer Trustees	Union Trustees
Carey Dove M&M Welding and Fabricators, Inc. 2701 Back Acre Circle Mt. Airy, MD 21771	Christopher Madello Steamfitters Local No. 602 8700 Ashwood Drive 2nd Floor Capitol Heights, MD 20743
Matt Corrigan M&M Welding and Fabricators, Inc. 2701 Back Acre Circle Mt. Airy, MD 21771	Sidney Bonilla Steamfitters Local No. 602 8700 Ashwood Drive 2nd Floor Capital Heights, MD 20743
Tom Bello MCAMW 9200 Corporate Blvd., Ste. 240 Rockville, MD 20850	Otis Biggs Steamfitters Local No. 602 8700 Ashwood Drive 2nd Floor Capital Heights, MD 20743

Professional Advisors:

Legal Counsel: O'Donoghue & O'Donoghue, LLP
4748 Wisconsin Ave., N.W.
Washington, DC 20016

Auditor: Sarfino & Rhodes
11921 Rockville Pike, Suite 501
North Bethesda, MD 20852-2794

Consultant: Segal Consulting
1800 M Street, N.W.
Suite 900 S
Washington, DC 20036

Third Party Administrator: The day-to-day administration of the Plan is handled by a third party administrator. Inquiries about eligibility, claims, and the Plan in general should be directed to the third party administrator:

WPAS, Inc.
PO Box 21427, Eagan, MN 55121
(800) 618-2879
http://HPRBenefitFunds.com

Preferred Providers: The Board of Trustees may from time to time, in its sole discretion, enter into written agreements with Preferred Provider Organizations. The use of such Preferred Providers is wholly at your option. The existence of any Preferred Provider Agreement shall not in any manner imply an endorsement of any specific provider, nor shall it constitute any guarantee of the services rendered.
The Board of Trustees has contracted with the CareFirst Blue Cross Blue Shield and Virginia Health Network to provide access by Plan Participants to each company's respective Preferred Provider Organization (PPO).

CareFirst BlueCross BlueShield's website is www.CareFirst.com. Its coverage includes Maryland, Washington DC and Northern, VA. Virginia Health Network's website is www.vhn.com and is concentrated only in Virginia.

Prescription Drug Benefit Administration: The Board of Trustees has contracted with CVS Health for the Prescription Drug Benefit. CVS Health is located at the following address:

One CVS Drive
Woonsocket, RI 02859
Key Phone Numbers at CVS Health:

- Customer Service – Non- Medicare 800-594-3083
- Customer Service – Medicare (Silverscript) 888-624-1141
- Pharmacy Help Desk (800) 364-6331

Governing Law: All questions pertaining to the validity and construction of the Plan shall be determined in accordance with ERISA and other federal law.

Limitation of Action: No action shall be filed in a court or before an agency for the payment of benefits under the Plan unless all review procedures with the Trustees are exhausted.

Gender: Whenever a masculine pronoun is used in this Plan, it includes the feminine unless the context clearly indicates otherwise, and vice versa.

Words used in the singular form also include the plural form in all situations where they would also apply, and vice versa.

Source of Financing of the Plan and Identity of Entity Through Which Benefits are Provided: The benefits under the Plan are wholly self-funded and provided by the Heating, Piping and Refrigeration Medical Fund. Payments are made to the Fund by individual Employers under the provisions of the Collective Bargaining Agreement, by some Employees through self-payments, and from any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible Employees and their Dependents, and for paying expenses incurred with respect to the operation of the Plan. The assets of the Fund are held in trust in accordance with an Agreement and Declaration of Trust. If you make a written request, the Fund office will tell you whether an Employer is contributing to this Fund on behalf of Employees working under a Collective Bargaining Agreement.

No payments provided for in this Plan are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment above and beyond the amount collected and available for such purpose. The Trustees have the right to terminate, suspend, withdraw, amend or modify the Plan, in whole or in part, at any time, including changes to all eligibility rules.

The Employer contributions to this Plan are non-elective by the Employee. Employer contributions are made on a per hour basis pursuant to the terms of the Collective Bargaining Agreement and in accordance with the Agreement and Declaration of Trust. Contributions for any Employee not in the collective bargaining unit must be made by the Employer on the basis of 40 hours per week times the current rate in effect under the Collective Bargaining Agreement.

Collective Bargaining Agreement: Contributions to this Plan are made in accordance with the Collective Bargaining Agreements and other participating agreements between Employers and Steamfitters Local Union No. 602 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO.

Plan Year: This is a calendar year plan. The Plan Year starts on January 1 and ends on December 31.

Tax Identification Number of the Plan: 53-0207840

Plan Number: 501

Plan Termination: The Trustees intend to continue the Plan as it is set forth in this booklet indefinitely. Nevertheless, they reserve the right to terminate or amend the Trust and Plan. In addition, the Trust and Plan may be terminated by the Trustees if there is no longer an agreement in effect between the Employers and the Union requiring contributions to this Medical Fund, there are no individuals living who can qualify for benefits, or if the Trust Fund is, in the opinion of the Trustees, inadequate to meet the payments due or to become due or is inadequate to carry out the Fund's intent and purpose.

Should the Plan terminate, the Trustees will: (1) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (2) arrange for a final audit of the Fund; (3) give any notice or prepare and file any reports which may be required by law; and (4) apply the assets of the Fund in accordance with the Plan, including amendments adopted as part of the termination, until the assets of the Fund are distributed.

The Trustees reserve the right to amend the eligibility rules at the time of termination. Retiree Benefits are funded from current contributions and are not guaranteed. In any case, the Trustees will use any remaining assets of the Fund to provide benefits and pay administration expenses or otherwise to carry out the purpose of the Plan in an equitable manner until the remainder of the Fund has been distributed. Under no circumstances will any portion of the Fund revert to or inure to the benefit of any Employer, any Employer association, or the Union, either directly or indirectly.

Confidentiality and Protection of Your Health Information: The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers or any other entity as required by the law. Protected health information will only be disclosed to the extent authorized by the patient, as necessary for the administration of the Plan (including the review and payment of claims and the determination of appeals), or as otherwise authorized or required by law. The Plan has adopted certain written rules and policies to ensure that with regard to its use, disclosure and maintenance of protected health information, it complies with applicable law.

You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund office. You may also cancel any previous written authorization you have provided to the Plan by submitting a written cancellation of authorization to the Fund office. You can request these forms from the Fund office.

The Plan has provided Participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the notice or would like additional information about the Plan's use and disclosure of protected health information or your rights with regard to this information, please contact the Fund office.

Women's Health and Cancer Rights Act of 1998: As explained elsewhere in this booklet, the Plan will provide coverage for you or your eligible Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction surgery in connection with the mastectomy in accordance with the Women's Health and Cancer Rights and of 1998. Such coverage includes: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications of all stages of the mastectomy, including lymphedemas.

Newborns' and Mothers' Heath Protection Act of 1996: Under federal (or state) law, group health plans and health insurers generally may not restrict benefits for length of hospitalization 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you're eligible for health coverage from the Employer for which an employee premium is required, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be

eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Virginia, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Savings Clause: If any provision of this Plan is held to be unlawful, or unlawful as to a particular person or circumstance, such finding shall not adversely affect the application of the other provisions of the Plan as they are described in this booklet, unless the illegality makes the continued operation of the Plan impossible.

STATEMENT OF ERISA RIGHTS

As a Participant in the Heating, Piping and Refrigeration Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants are 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 worksites and Union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security 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 request 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

▪ Continue health care coverage for yourself, your spouse and your Dependents if there is a loss in coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You should review the sections of this booklet for more information on the rules governing your COBRA continuation 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 a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire 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 or ignored, 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 a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $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 suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may sue 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, if, for example, it finds your claim frivolous.

Assistance With Your 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, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, listed in your local telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

THIS BOOKLET CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS UNDER THE HEATING, PIPING AND REFRIGERATION MEDICAL PLAN. PLEASE READ THE INFORMATION CONTAINED IN THIS BOOKLET VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS REGARDING YOU ELIGIBILITY OR COVERAGE UNDER ANY OF THE PROVISIONS OF THIS PLAN PLEASE CONTACT THE FUND OFFICE AT THE FOLLOWING ADDRESS:

PO Box 21427, Eagan, MN 55121
(800) 618-2879
http://HPRBenefitFunds.com

THE FUND OFFICE WILL BE HAPPY TO HELP YOU WITH ANY QUESTIONS YOU MAY HAVE.

PLEASE NOTE THAT THE INTERPRETATIONS REGARDING PARTICIPATION IN THE PLAN AND ELIGIBILITY FOR BENEFITS, STATUS OF EMPLOYERS AND EMPLOYEES, OR ANY OTHER MATTER RELATING TO THE MEDICAL PLAN SHOULD ONLY BE OBTAINED THROUGH THE FULL BOARD OF TRUSTEES OR THE FUND OFFICE. THE TRUSTEES ARE NOT OBLIGATED BY, RESPONSIBLE FOR, OR BOUND BY OPINIONS, INFORMATION, OR REPRESENTATIONS FROM ANY OTHER SOURCES.