

Plumbers & Steamfitters Local 141 Health and Welfare Fund

Summary Plan Description

**For Active Employees,
COBRA Participants and
Pre-Medicare Retirees**

January 1, 2016 Edition

FOR ADDITIONAL INFORMATION AND ASSISTANCE

For information on:	Contact:
Fund Office • Eligibility for All Benefits • Dental Benefits • Dental and Prescription Drug Claims and Appeals • COBRA and Extended Self Pay Information and Premium Payments • HIPAA Certificate of Creditable Coverage • HIPAA Notice of Privacy Practice • Medicare Part D Notice of Creditable Coverage • Second Level Appeal	Plumbers & Steamfitters Local 141 Health and Welfare Fund 7113 West Bert Kouns Ind Loop Shreveport, LA 71129 Telephone: (318) 688-6990 Fax: (318) 688-6997
Medical Coverage, including: • Medical Network Provider Directory • Utilization Review • Claim Filing Procedures and Appeal Procedures - First Level Prescription Drug Coverage • ID Cards • Locate A Retail Network Pharmacies • Prescription Drug Information • How To Find Out If A Drug You Are Taking Is On The Formulary • To Receive Prior Authorization for Required Drugs	Blue Cross and Blue Shield of Louisiana (BCBS) P.O. Box 98029 Baton Rouge, LA 70898-9029 www.bcbsla.com
Life and Accidental Death & Dismemberment Benefits	MetLife (800) 708-5434 Ext. 3614 Call the Fund Office if you wish to change your beneficiary designation, or if you need additional information on filing a claim.

To All Covered Persons:

We are pleased to provide you with this booklet, that together with the BCBS booklet describing the medical and prescription drug benefits, and the MetLife booklet describing the life benefits and accidental death and dismemberment benefits, comprise the Summary Plan Description ("SPD") and Plan document for the Plumbers and Steamfitters Local 141 Health & Welfare Plan ("Plan"). This booklet has been updated to include all amendments and changes made through June 2016. We urge you to read this SPD carefully so that you will understand the benefits offered by the Plan, the eligibility rules, and procedures for filing and appealing claims. It includes certain changes made to comply with the new federal health care legislation.

The Trustees strive to provide the most appropriate benefits that will contribute to your security, health and well-being. The changing economic conditions require a constant assessment of the Plan and benefits that are offered to maintain its financial stability. Your help is also critical to effectively combat the rising costs and ensure future coverage availability.

If you have questions about the Plan after reading this booklet, please contact the Fund Office. We will continue to do everything possible to maintain the Health & Welfare Fund on a sound financial basis so that meaningful benefits can be available for you and your family. However, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a convenient place where you and your family can find and refer to them.

Sincerely,

Board of Trustees

IMPORTANT!

Please note that the Board of Trustees has the exclusive authority, in its sole discretion, to determine all questions of coverage, eligibility and benefits, methods of providing or arranging for benefits and other Plan matters, and to construe the SPD, Plan and Plan documents (including any ambiguous or conflicting provisions that may exist). For benefit claims filed in accordance with the Plan's claim and appeal procedures, the person(s) or entity designated by the Board of Trustees may decide the claim or appeal. The Trustees, Plan and Fund are not obligated by, responsible for, or bound by opinions, information, or representations from any other sources.

BOARD OF TRUSTEES

EMPLOYER TRUSTEES

Chris FitzGerald
FitzGerald Contractors, LLC
P.O. Box 6600
Shreveport, LA 71136
cfitzgerald@fitzgeraldcontractors.com

Ken Payne
The Payne Company
P.O. BOX 19130
Shreveport, LA 71149-0130
ken@thepayneco.com

William Hamm
517 W. 61st St.
Shreveport, LA 71106
318.828.2345
whamm@hammmechanical.com

UNION TRUSTEES

Michael Hale, Co-Chairman
Plumbers & Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
michael@local141.com

Daniel T. Walker, President Local 141
Plumbers and Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
dwalker@dmrmechanical.com

James “Casey” Olden
Plumbers and Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
casey057@yahoo.com

FUND OFFICE STAFF

Jocelyn Shane, Administrative Manager
Wendy McCalister, Assistant Administrator

CONSULTANTS & ACTUARIES

Robin Dusang
The Segal Company

FUND COUNSEL

Maria C. Cangemi
Robein, Urann, Spencer, Picard & Cangemi, PLC

FUND AUDITOR

Harris Hutto
Dennis G. Jenkins, CPA

TABLE OF CONTENTS

FOR ADDITIONAL INFORMATION AND ASSISTANCE	i
BOARD OF TRUSTEES AND PLAN PROFESSIONALS	iii
SCHEDULE OF BENEFITS	viii
ARTICLE I DEFINITIONS	1
Section 1.1 – “Administrative Manager”	1
Section 1.2 – “Agreement and Declaration of Trust”	1
Section 1.3 – “Allowable Charge”	1
Section 1.4 – “Alternate Recipient”	1
Section 1.5 – “Beneficiary”	1
Section 1.6 – “Break in Coverage”	1
Section 1.7 – “COBRA”	1
Section 1.8 – “Collective Bargaining Agreement”	1
Section 1.9 – “Competitive Employment”	2
Section 1.10 – “Covered Employment”	2
Section 1.11 – “Dentist”	2
Section 1.12 – “Dependent”	2
Section 1.13 – “Employee”	3
Section 1.14 – “Employer”	3
Section 1.15 – “Employer Contributions”	3
Section 1.16 – “ERISA”	4
Section 1.17 – “Family and Medical Leave or FMLA Leave”	4
Section 1.18 – “Fund Office”	4
Section 1.19 – “HIPAA”	4
Section 1.20 – “Illness”	4
Section 1.21 – “Medically Necessary”	4
Section 1.22 – “Open Enrollment Period”	5
Section 1.23 – “Participant”	6
Section 1.24 – “Participation Agreement”	6
Section 1.25 – “Physician”	6
Section 1.26 – “Plan”	6
Section 1.27 – “Plan Administrator”	6

Section 1.28 – “Plan Sponsor”	6
Section 1.29 – “Qualified Medical Child Support Order”	6
Section 1.30 – “Retiree”	7
Section 1.31 – “Schedule of Benefits”	7
Section 1.32 – “Trustees” or “Board of Trustees”	7
Section 1.33 – “Trust Fund” or “Fund”	7
Section 1.34 – “Union”	8
Section 1.35 – “USERRA”	8
ARTICLE II ELIGIBILITY, TERMINATION AND REINSTATEMENT	9
Section 2.1 - General Eligibility	9
Section 2.2 - Initial Eligibility- New Employees	9
Section 2.3 - Continuing Eligibility for Employees and Reserve Account.....	9
Section 2.4 – Termination of Employee Coverage	10
Section 2.5 - Reinstatement of Employee’s Eligibility	11
Section 2.6– Eligibility of Dependents.....	11
Section 2.7 – Automatic Coverage Period for Newborn Dependent Children.....	11
Section 2.8 - Termination of Dependent’s Coverage	13
Section 2.9 – Special Enrollment Rules.....	13
Section 2.10 - Continued Eligibility during Disability Periods.....	14
Section 2.11 – Uniformed Services Leave of Absence	14
Section 2.12 – Reciprocity	16
Section 2.13 - Eligibility and Coverage during Family and Medical Leave	16
Section 2.14 - Qualified Medical Child Support Orders (QMCSOs)	17
Section 2.15 – COBRA Continuation of Coverage Option	18
Section 2.16 - Special Self-Pay Rules for Retirees and Dependents who are not Eligible for Medicare.....	23
Section 2.17 - Supplemental Medicare Plan for Medicare Eligible Retirees and Their Dependents	25
Section 2.18 - Special Eligibility Rules for Employees of Contributing Employers with Collective Bargaining Agreements Providing for Immediate Eligibility.	26
ARTICLE III MEDICAL AND PRESCRIPTION DRUG BENEFITS.....	29
Section 3.1 – Medical Benefits.....	29
Section 3.2 – Prescription Drug Benefits	29

ARTICLE IV LIFE BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	30
Section 4.1 - Life Benefit	30
Section 4.2 - Accidental Death and Dismemberment Benefit.....	30
ARTICLE V DENTAL BENEFITS	32
Section 5.1 - Dental Expense Benefits	32
Section 5.2 - Calendar Year Deductible	32
Section 5.3 - Reimbursement Percentage	32
Section 5.4 - Calendar Year Maximum Benefit	32
Section 5.5 - Eligible Dental Expense.....	32
Section 5.6 - Dental Exclusions	35
Section 5.7 Dental Opt Out	36
ARTICLE VI COORDINATION OF MEDICAL BENEFITS	37
Section 6.1 - General	37
Section 6.2 - Order of Benefit Determination	37
ARTICLE VII CLAIMS AND CLAIMS REVIEW PROCEDURES, ADMINISTRATION OF PLAN AND MISCELLANEOUS FOR DENTAL CLAIMS	39
Section 7.1 – Claims Procedure and Claims Review Procedure	39
Section 7.2 – Right to Withhold Payment and Recovery of Improper Payments.....	43
Section 7.3 – Facility of Payment.....	44
Section 7.4 - Physical Examination and Autopsy	44
Section 7.5 – Administration of Plan	44
Section 7.6 – Miscellaneous.....	45
Section 7.7 – Time Limit On Legal Action	45
ARTICLE VIII AMENDMENT AND TERMINATION	47
Section 8.1 - Right to Amend or Terminate.....	47
Section 8.2 – Eligibility and Benefits Not Guaranteed	47
Section 8.3 – Circumstances Under Which Plan May Terminate	47
Section 8.4 – Procedures on Termination	48
ARTICLE IX YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)	49
Section 9.1 - Receive Information about Your Plan and Benefits	49
Section 9.2 - Continue Group Health Plan Coverage	49
Section 9.3 - Prudent Actions by Plan Fiduciaries.....	50

Section 9.4 - Enforce Your Rights	50
Section 9.5 - Assistance with Your Questions	51
ARTICLE X PRIVACY AND SECURITY RULE	52
ARTICLE XI IMPORTANT INFORMATION ABOUT THE PLAN	54
Section 11.1 - Official Name of Plan	54
Section 11.2 - Type of Plan	54
Section 11.3 - Plan Sponsor, Plan Administrator, and Named Fiduciary	54
Section 11.4 - Employer Identification Number and Plan Number	54
Section 11.5 - Plan Year End	54
Section 11.6 - The Names and Business Addresses of the Plan's Trustees	55
Section 11.7 - Name and Address for Agent for service of Legal Process	55
Section 11.8 - Source of Contributions	55
Section 11.9 - Identity of Funding Medium Used for Accumulation of Assets	56
Section 11.10 - Fund Administrative Manager	56
Section 11.11 - Type of Administration	56
Section 11.12 - Collective Bargaining Agreements, Plan Documents and Reports	56
Section 11.13 - Consultant and Actuary	57
Section 11.14 - Accountants	57
Section 11.15 - Health Insurance Issuer	57
Section 11.16 - Participating Employers	57
Section 11.17 - Selection of Physicians and Facilities	58
Section 11.18 - Qualified Medical Child Support Orders	58
ARTICLE XII MISCELLANEOUS	59

**PLUMBERS AND STEAMFITTERS LOCAL 141
HEALTH AND WELFARE FUND**

SCHEDULE OF BENEFITS

EFFECTIVE JANUARY 1, 2016

(except as otherwise stated)

BENEFITS FOR ACTIVE EMPLOYEES	
LIFE BENEFIT	
If you die before age 70	\$20,000*
If you die on or after age 70	\$10,000*
*Subject to terms, conditions and exclusions of MetLife insurance contract. Accelerated benefit available; if paid, Life Benefit will be reduced. Continuation of Life Benefit coverage during Total Disability available. Right to convert to individual life insurance policy available.	
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	
Covered losses:* life; any combination of a hand, a foot or sight of an eye; speech and hearing; quadriplegia	Full Benefit (\$20,000)
Covered losses:* a hand; a foot; sight of an eye; speech or hearing in both ears; paraplegia; hemiplegia	One-half of Full Benefit (\$10,000)
Covered losses:* thumb and index finger of same hand	One-quarter of Full Benefit (\$5,000)
*Subject to terms, conditions and exclusions of MetLife insurance contract and payable prior to age 70; benefits are reduced by 50% on or after age 70. An additional 10% of Full Benefit is payable for covered loss of life resulting from automobile accident involving private passenger car if seat belt was properly fastened. For all covered losses sustained in one accident, not more than Full Benefit will be paid. Only Retirees who are not Medicare eligible and who self-pay to continue their health coverage are eligible for the Life and AD&D Benefit.	
DENTAL BENEFITS	
Calendar Year Deductible (applies to all services)	\$100 per person
Calendar Year Maximum for all Dental Benefits to all Participants aged 21 or older and Major Restorative Dental Benefits to Dependents under the age of 21.	\$1000 per person
Calendar Year Maximum for all Dental Benefits other than Major Restorative Dental Benefits to Participants under age 21	Unlimited
Reimbursement Percentages	
Oral Surgery	70%
Diagnostic and Preventative	70%
Simple Restorative	70%
Periodontics	70%
Major Restorative (crowns only)	50%

ARTICLE I DEFINITIONS

The following terms, whenever appearing in the Plan as capitalized terms, shall have the meaning specified in this Article unless the context requires otherwise:

Section 1.1 – “Administrative Manager” is the person appointed by the Trustees to manage and support the ministerial and clerical duties of the Plan and keep record of and report to the Trustees any action taken.

Section 1.2 – “Agreement and Declaration of Trust” means the Trust Agreement of the Plumbers and Steamfitters Local 141 Health and Welfare Fund, initially adopted effective May 1, 1976, as amended and supplemented from time to time.

Section 1.3 – “Allowable Charge” means the amount of a provider’s charge that the Plan recognizes as payable for services or supplies that are covered by the Plan (subject to any applicable deductible or limitation). The Allowable Charge will be the lowest of the following amounts: (i) the actual charge; (ii) the contractually agreed upon discounted rate for a Network Provider; and (iii) for a non-Network Provider, the allowed amount as determined by the Board of Trustees in a reasonable and uniform manner in accordance with the methodology, fee schedule, percentile and/or adjustment for the geographical area and nature and severity of the condition being treated, as approved for use by the Board. It is anticipated that the Allowable Charge for a non-Network Provider will be lower than the Allowable Charge for a Network Provider.

Section 1.4 – “Alternate Recipient” means any child of a Participant who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Plan as the Participant’s Dependent.

Section 1.5 – “Beneficiary” means a person or persons validly designated in writing by a Participant or, in the absence of a valid designation, determined in accordance with the terms of the Plan or applicable law, who is or may become entitled to receive a benefit under the Plan because of the Participant’s death.

Section 1.6 – “Break in Coverage” means a period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but which does not include any waiting periods. A leave of absence under FMLA or USERRA is not counted as a Break in Coverage.

Section 1.7 – “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations issued pursuant thereto, as amended.

Section 1.8 – “Collective Bargaining Agreement” means any written agreement (as amended, extended, renewed or replaced from time to time) between an Employer and the Union, in

relation to wages, hours and working conditions, which requires the Employer to make contributions to the Trust Fund.

Section 1.9 – “Competitive Employment” means any work as a Plumber or Pipefitter with an employer who is not signatory to the terms of a Collective Bargaining Agreement or Participating Agreement with any UA local union.

Section 1.10 – “Covered Employment” means employment for which an Employer is obligated to contribute to the Trust Fund on behalf of an Employee.

Section 1.11 – “Dentist” means a person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD), who satisfies the following requirements at the time the services are rendered:

- A. Is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered;
- B. Acts within the scope of his or her license; and
- C. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Section 1.12 – “Dependent” means any of the following:

- A. The spouse of the opposite sex to whom the Participant is legally married (not including a “common law” spouse), provided the spouse is recognized as such under federal tax laws;
- B. Natural-born child, stepchild unless legally emancipated;
- C. Adopted child, or child placed for adoption unless legally emancipated;
- D. Dependent foster child or other child within Participant’s legal custody;
- E. Stepchild, provided the Participant and stepchild’s biological parent are legally married;
- F. Disabled child who was eligible as a Dependent on the day before his 26th birthday and became disabled prior to turning 26; and
- G. Any recognized children you are required to cover under the Plan due to a Qualified Medical Child Support Order (QMSCO).

The Plan may require proof of a Dependent’s eligible status, including but not limited to the following: (1) certified copies of birth certificates and marriage licenses; (2) adoption, or foster care

court decrees; (3) physician statements attesting to a child's disability; and (4) Qualified Medical Child Support Orders.

A "Dependent" shall not include a divorced spouse, or a Dependent who enters military duty in the armed forces of any country. If both husband and wife are eligible under the Plan as Employees, their child(ren) may be covered as Dependent(s) of either parent, but not both. A "Dependent" shall also not include the child of a Dependent.

Section 1.13 – "Employee" means:

- A. An employee who is covered by a Collective Bargaining Agreement that requires periodic contributions to the Trust Fund on behalf of his or her employment;
- B. A full-time salaried employee of the Union, who is covered by a Participation Agreement with the Trustees, which requires the Employer to make contributions to the Trust Fund on behalf of his or her employment;
- C. A full-time salaried employee of the Apprenticeship Fund, who is covered by a Participation Agreement with the Trustees, which requires the Employer to make contributions to the Trust Fund on behalf of his or her employment;
- D. A full-time salaried employee of the Trust Fund, who is covered by a Participation Agreement with the Trustees, which requires the Employer to make contributions to the Trust Fund on behalf of his or her employment; and
- E. Any other employee of an Employer, who is covered by a Participation Agreement between the Employer and the Trustees, which obligates the Employer to make contributions to the Trust Fund on behalf of his or her employment, provided the employee participates on the basis of contributions for 40 hours of work per week.

Section 1.14 – "Employer" means any person or entity that has a Collective Bargaining Agreement with the Union, as well as the Union, Apprenticeship Fund, Trust Fund and any other person or entity, that signs a Participation Agreement which obligates him or it to make periodic contributions to the Trust Fund on behalf of its Employees and is bound by the terms of the Plan as an Employer, provided the Participation Agreement is accepted by the Trustees. For Employers of non-bargaining unit employees that have a Participation Agreement, the Employer must report and make contributions at the rate of 40 hours per week for its non-bargaining unit Employees.

Section 1.15 – "Employer Contributions" means payments to the Trust Fund by an Employer on behalf of an eligible Employee, at the applicable contribution rate in accordance with the Collective Bargaining Agreement or Participation Agreement accepted by the Trustees, or as otherwise required by the Agreement and Declaration of Trust.

Section 1.16 – “ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and any regulations issued pursuant thereto.

Section 1.17 – “Family and Medical Leave or FMLA Leave” means a leave of absence, intermittent leave or leave on a reduced schedule, not to exceed twenty-six work weeks, that an Employer is required to extend to an Employee under the provisions of the Family and Medical Leave Act of 1993 (“FMLA”), the regulations issued pursuant thereto and the Trust Fund’s FMLA policies and procedures, as amended.

Section 1.18 – “Fund Office” means the person, persons or entity retained by the Trustees and to whom the Trustees have delegated their authority to make eligibility determinations, to pay and process claims, and to perform other administrative functions authorized by the Trust Agreement and applicable law.

Section 1.19 – “HIPAA” means the Health Insurance Portability and Accountability Act of 1994 and the regulations issued pursuant thereto, as amended.

Section 1.20 – “Illness” means any bodily sickness or disease, including pregnancy, and any congenital abnormality, as diagnosed by a Physician and compared to the person’s previous condition.

Section 1.21 – “Medically Necessary” means that a medical or dental service or supply satisfies the following requirements:

- A. Is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it, or a Dentist if a dental service or supply is involved;
- B. Is determined by the Plan or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- C. Is determined by the Plan or its designee to meet all of the following requirements:
 - 1. It is consistent with the symptoms or diagnosis and treatment of an Illness or injury; and
 - 2. It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, health care provider, or health care facility; and
 - 3. It is an “appropriate” service or supply given the patient’s circumstances and condition; and
 - 4. It is a “cost-efficient” supply or level of service that can be safely provided to the patient; and

5. It is safe and effective for the Illness or injury for which it is used.

A medical or dental service or supply will be considered to be “appropriate,” for purposes of this definition, if:

- A. It is a diagnostic procedure that is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the Illness or injury involved and the patient’s overall health condition; or
- B. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or injury involved and the patient’s overall health condition.

A medical or dental service or supply will be considered to be “cost-efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that a Physician or Dentist may provide, order, recommend, or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

A hospitalization or confinement to a health care facility will not be considered to be Medically Necessary if the patient’s Illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can be safely and appropriately furnished in a Physician’s or Dentist’s office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or health care facility or other more costly facility.

The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services, will not result in a determination that continued confinement in a Hospital or other health care facility is Medically Necessary.

A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or Dentist or other licensed health care practitioner, or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any health care practitioner, or any health care facility.

Section 1.22 – “Open Enrollment Period” means the sixty-day period every calendar year beginning on January 1. In order to cover any newly acquired Dependents, you must complete and sign an Enrollment Form available from the Fund Office, and submit it to the Fund Office.

The application must be turned in within 60 days from the date you acquired the Dependent(s) for coverage to be effective; otherwise, your Dependent(s) will not be eligible for coverage until the Plan's next Open Enrollment Period.

Section 1.23 – “Participant” means any Employee or former Employee of an Employer, when covered by the Plan.

Section 1.24 – “Participation Agreement” means a written agreement, including any extensions, renewals or amendments thereof, by an Employer and accepted by the Trustees, that obligates the Employer to make contributions to the Trust Fund on behalf of Employees who are covered by the agreement, and evidences the commitment of the Employer to be bound by the Agreement and Declaration of Trust and the Plan.

Section 1.25 – “Physician” means a person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO), who is authorized to practice medicine, perform surgery and administer drugs under the laws of the state or jurisdiction where the services are rendered, and who acts within the scope of his or her license at the time and place the services are rendered. For purposes of this Plan, the term “Physician” includes a person legally licensed as a Physician Assistant who acts within the scope of his or her license and acts under the supervision of a Physician.

Section 1.26 – “Plan” means these Rules and Regulations of the Plumbers and Steamfitters Local 141 Health and Welfare Fund, initially adopted effective May 1, 1976, as amended and restated from time to time, and that Plan document issued by Blue Cross/Blue Shield, as amended from time to time.

Section 1.27 – “Plan Administrator” refers to the Board of Trustees.

Section 1.28 – “Plan Sponsor” refers to the Union and the Employers who are signatory to a Collective Bargaining Agreement with the Union which requires contributions to the Plan.

Section 1.29 – “Qualified Medical Child Support Order” (“QMCSO”) means a medical child support order that qualifies as a QMCSO or a National Medical Support Notice that is deemed to be a QMCSO, within the meaning of ERISA Section 609(a), and as determined in accordance with the following and any written procedures adopted by the Trustees from time to time. A “QMCSO” creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Dependent is eligible under the Plan.

A “medical child support order” is any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or (2) enforces a law relating to medical child support described in Social Security Act Section 1908 with respect to a group health plan.

In order to qualify as a QMCSO, the medical child support order must clearly specify the following information:

- A. The name and last known mailing address, if any, of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
- B. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient or the manner in which such type of coverage is to be determined;
- C. The period of coverage to which the order applies; and
- D. The name of this Plan.

In addition, the medical child support order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of a state law relating to medical child support orders for Medicaid eligible children as described in Section 1908 of the Social Security Act.

A “National Medical Support Notice” is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a QMCSO, that directs the Plan to effectuate coverage for an Alternate Recipient as the Dependent child of the noncustodial parent who is (or will become) a Participant in the Plan, pursuant to a domestic relations order that includes a provision for health care coverage.

Section 1.30 – “Retiree” means a Participant who is receiving a pension from the Plumbers and Steamfitters National Pension Fund and is a retired member of the Plumbers and Steamfitters Local 141.

Section 1.31 – “Schedule of Benefits” means, with respect to a covered charge or loss, the Schedule of Benefits in effect on the date the charge is incurred or the loss giving rise to the claim occurs. The Schedule of Benefits, as amended from time to time, is incorporated as an addendum to the Plan. Each Schedule of Benefits shall become effective on the date described and shall remain in effect unless and until replaced by a Schedule of Benefits with a later effective date.

Section 1.32 – “Trustees” or “Board of Trustees” means the persons appointed from time to time pursuant to the Agreement and Declaration of Trust to serve as the Fund’s administrator, and who are serving, as the “Employer Trustees” and “Union Trustees” for the Trust Fund.

Section 1.33 – “Trust Fund” or “Fund” means the Plumbers and Steamfitters Local 141 Health and Welfare Fund, created and maintained pursuant to the Agreement and Declaration of Trust, and its entire trust estate, which shall consist of all monies received by the Trustees as contributions or otherwise, all investments thereon, and all other things of value which comprise the corpus and additions to the Trust Fund.

Section 1.34 – “Union” means the Plumbers and Steamfitters Local Union 141, and any other labor organization which is or shall become a party to the Agreement and Declaration of Trust and which has a Collective Bargaining Agreement with an Employer requiring periodic contributions to the Trust Fund, provided that such other labor organization is accepted by the Trustees for participation in the Trust Fund.

Section 1.35 – “USERRA” means the Uniformed Services Employment and Re-Employment Rights Act of 1994 and the regulations issued pursuant thereto, as amended.

ARTICLE II

ELIGIBILITY, TERMINATION AND REINSTATEMENT

Section 2.1 - General Eligibility

An Employee will become eligible to participate in the Plan when he satisfies the qualifying rules as to the minimum number of hours worked in Covered Employment. Upon qualifying for coverage, the Employee must complete the Plan's enrollment and medical information form and return it to the Fund Office. The Plan will not verify coverage or pay benefits under the Plan until the completed form is received. Every Employee is required to notify the Fund Office of any change in address or change affecting coverage under the Plan, including but not limited to the addition of a new Dependent or a change in Dependent status due to divorce, or a child ceasing to qualify as a Dependent, no later than 90 days following the change or, if earlier, the date of the filing of a claim affected by the change.

Section 2.2 - Initial Eligibility - New Employees

A new Employee who is not eligible under the existing rules shall initially become covered for one month of coverage under the Plan, beginning on the first day of the second calendar month following a six or less consecutive month period during which he is credited with at least 400 hours of Covered Employment. Thereafter, an Employee's continuing eligibility shall be determined in accordance with the following Section 2.3.

Section 2.3 - Continuing Eligibility for Employees and Reserve Account

All hours an Employee works in Covered Employment shall be accumulated in a Reserve Account maintained on his behalf. However, if he is employed by the Union, the Apprenticeship Fund or the Trust Fund, and covered by a Participation Agreement, he is not eligible for Reserve Accounts unless he qualifies as a Bargaining Unit Alumni. A "Bargaining Unit Alumni" is an Employee who worked under a Collective Bargaining Agreement immediately prior to his full-time employment with the Union, Apprenticeship Fund, Trust Fund or other Employer in a non-bargaining unit position.

The accumulated hours in an Employee's Reserve Account shall be used to satisfy the initial and continuing eligibility requirements. Withdrawal will be made from the Employee's Reserve Account as follows:

- A. 400 hours of Covered Employment on the first day of the month for which the Employee initially becomes eligible; and
- B. 130 hours of Covered Employment at the beginning of each month thereafter.

An Employee must have at least 130 hours of Covered Employment accumulated in his Reserve Account, or if he is not eligible for a Reserve Account, he must be credited with at least 130 hours of Covered Employment, at the beginning of each month after the month in which the Employee initially becomes eligible in order to be covered for that month. There is a one (1) month lag between the time he works and the time the corresponding hours are credited to his Reserve Account. **For example**, if you have 130 hours accumulated in your Reserve Account or credited to you on February 1, for Covered Employment through December 31, you will be covered under the Plan for the month of February. If you do not have the 130 hours required at the beginning of a month, your coverage will end as of the last day of the prior month, subject to any continuation of coverage rights through self-pay under COBRA or the Plan. If you are eligible for a Reserve Account, you will be allowed to accumulate up to a maximum of 720 hours of Covered Employment in your Reserve Account after the withdrawal for the current month's eligibility. Any accumulated hours remaining in your Reserve Account at the time your coverage ends may not be used to offset any self-payment amount required to continue coverage pursuant to COBRA, USERRA or any other self-payment provision under the Plan.

Section 2.4 – Termination of Employee Coverage

An Employee's coverage under the Plan shall terminate on the earliest of the following dates to occur, subject to the right, if any, to continue coverage through self-pay under USERRA, COBRA or any other self-pay provision of the Plan:

- A. On the last day of the last month for which the Employee worked or accumulated the number of hours in Covered Employment required to qualify for coverage for the month;
- B. The date of the Employee's death;
- C. The last day of the month in which the Employee takes a Uniformed Services leave of absence; or
- D. The date the Plan and/or Trust Fund is terminated or amended to exclude coverage for the Employee.
- E. If an Employee engages in Competitive Employment, as defined in Section 1.59, his Reserve Account will be forfeited and his eligibility will terminate as of the first day of the Calendar Month following his beginning such employment. To become eligible for benefits in the future, he will be required to fulfill all of the Initial Eligibility requirements for New Employees, as outlined in Section 2.2.

To become covered under the Plan in the future, he must either satisfy the requirements for Reinstatement of Eligibility described in Section 2.5, or again satisfy the Initial Eligibility requirements for new Employees described in Section 2.2.

Section 2.5 - Reinstatement of Employee's Eligibility

If you lose coverage because you are not credited with the minimum number of hours of Covered Employment required for continuing eligibility at the beginning of any month (after taking into account any accumulated hours in a Reserve Account available to you), your coverage will be reinstated if you are credited with the minimum number of hours of Covered Employment required for continuing eligibility within the six-month period following the date coverage terminated (taking into account any accumulated hours in a Reserve Account available to the Employee). However, reinstatement of coverage will not be effective until the first day of the second calendar month following the month in which this requirement is met.

If an Employee does not earn or accumulate in his Reserve Account the minimum number of hours of Covered Employment required for continuing eligibility during the six month period following the date coverage terminated, any hours of Covered Employment earned or accumulated in the Reserve Account will be forfeited, and he will be required to satisfy the Initial Eligibility requirements for new Employees.

Section 2.6– Eligibility of Dependents

An Employee's eligible Dependent(s) will become covered under the Plan, without cost to him, on the latest of the following dates to occur, provided the Fund Office receives a completed enrollment form and any additional documentation required by the Fund Office (including but not limited to a marriage license, birth certificates, social security numbers and medical information) for the Dependent(s) within 60 days of such date:

- A. The date the Employee's coverage becomes effective;
- B. The date the Employee first acquires the Dependent; or
- C. If applicable, the date specified in a Qualified Medical Child Support Order.

If an eligible Dependent is not enrolled within 60 days of the date on which the Dependent first qualifies for coverage as described above, the Dependent will only be eligible for coverage on the first day of the second month following the month in which a completed enrollment form is filed with the Fund Office. The Plan will not verify a Dependent's coverage or pay benefits to or for the Dependent until the Fund Office receives a timely completed enrollment form and any required documentation for the Dependent.

Section 2.7 – Automatic Coverage Period for Newborn Dependent Children

Notwithstanding enrollment requirements in Section 2.6 and 2.8, there may be a thirty (30) day period of automatic coverage for Newly-Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period

for adding these infants to this Benefit Plan. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied, except as provided in Sections 2.6 and 2.8.

A. Automatic Coverage Period for Newly Born Infants (Newborns)

1. If a child is born to a Plan Participant holding Employee Only coverage or Employee and Spouse coverage, the following will apply:
 - a. Such child will be covered automatically for thirty (30) days from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Coverage for the child will continue in effect thereafter, only upon the Plan's receipt of a completed enrollment form prior to the expiration of the period of automatic coverage.
 - b. If the completed enrollment form is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at Open Enrollment or under a special enrollment provision.
2. If a child is born to a Plan Participant holding coverage which includes Dependent children (Employee and Family coverage or Employer and Child(ren) coverage) and the signed enrollment form is timely received by the Plan, the Effective Date for coverage for such child will be the date of birth.

B. Automatic Coverage Period for Newly Born Adopted Infants

3. For a Plan Participant holding Employee Only coverage or Employee and Spouse coverage:

If within thirty (30) days of the birth of a child, the child is either: legally placed into the Plan Participant's home for adoption following a voluntary act of surrender to the custody of the Plan Participant or his legal representative, which becomes irrevocable, or is subject to a court order awarding custody to a Plan Participant, the following will apply:

- a. The child will be covered automatically for thirty (30) days from the date of legal placement into the Plan Participant's home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Plan Participant's home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special

Care Unit, whichever is longer. The infant will not be covered from birth. Coverage for the infant will continue in effect thereafter, only upon the Plan's receipt of a completed enrollment form prior to the expiration of the period of automatic coverage.

- b. If the completed enrollment form is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at Open Enrollment or under a special enrollment provision.

Section 2.8 - Termination of Dependent's Coverage

A Dependent's coverage under the Plan will terminate on the earliest of the following dates to occur, subject to the Dependent's right, if any, to continue coverage under COBRA or any other self-pay provision of the Plan:

- A. The last day of the month in which the Dependent ceases to be an eligible Dependent;
- B. The date the Employee's coverage under the Plan terminates other than by reason of death;
- C. If the Employee dies, the date the Employee's coverage would have terminated had the Employee stopped working as of the date of death and exhausted any hours remaining in his Reserve Account;
- D. The date specified in a Qualified Medical Child Support Order;
- E. The last day of the month in which the Employee takes a Uniformed Services leave of absence unless he continues coverage for the Dependent(s) under USERRA; or
- F. The date the Plan is terminated or amended to terminate coverage for the Dependent.

Section 2.9 – Special Enrollment Rules

The Plan shall provide special enrollment rights to Participants and Dependents to the extent required under HIPAA. The special enrollment rights, which are described in this Section, are in addition to the general enrollment rights available under the Plan. Individuals with both general enrollment and special enrollment rights will become enrolled as of the earliest date for which they qualify.

If an Employee acquires a Dependent by reason of marriage, birth, adoption or placement for adoption, he may enroll that newly acquired Dependent, if any, who is not already enrolled in the Plan. If the Fund Office receives a completed enrollment form and all required documentation (including but not limited to a marriage license, birth certificates and medical information) for

such Dependent(s) within 60 days after the date of the marriage, birth, adoption or placement for adoption, the Dependent(s)' coverage will be effective as follows: (1) retroactive to the date of the birth, adoption or placement for adoption; or (2) for a marriage, as of the first day of the calendar month beginning after the date the Plan receives the completed enrollment form and required documentation. If the Fund Office receives a completed enrollment form and all required documentation more than 60 days after the marriage, birth, adoption or placement for adoption, the Dependent shall not be eligible for coverage. The Employee shall have the opportunity to enroll such Dependents during the Plan's next Open Enrollment Period.

If an Employee does not enroll a Dependent spouse or child(ren) for coverage under this Plan when they first become eligible because they have other group health coverage maintained by an employer, and the other coverage terminates because of loss of eligibility or because the employer stops contributing towards the other coverage, or if the other coverage is COBRA coverage because the COBRA coverage is exhausted, the Employee may enroll such Dependent(s) for coverage under this Plan effective as of the date the other coverage terminates if the Fund Office receives a completed enrollment form and all required documentation for the Dependent(s) within 60 days after the date the other coverage terminates. Coverage that terminates because of failure to pay a premium or required self-payment timely or for cause does not qualify for this special enrollment right.

Section 2.10 - Continued Eligibility during Disability Periods

If, after an Employee becomes eligible, he is unable to work in Covered Employment because of a Certified Disability, he will be credited with 30 hours of Covered Employment for each full week of Certified Disability solely for the purpose of maintaining his eligibility to participate in the Plan. In no event, however, may he receive credit for more than 390 hours of Covered Employment during a 12-consecutive month period by reason of a Certified Disability.

A "Certified Disability" is a disability for which he submits satisfactory evidence to the Plan of receiving Worker's Compensation Benefits as a result of an accident on a job for which contributions are paid to the Trust Fund.

Section 2.11 – Uniformed Services Leave of Absence

As an Employee, if you or your spouse who is a member of the Uniformed Services, is called to active duty, which causes a leave of absence during which you are unable to work in Covered Employment, any hours in Covered Employment you have earned shall, to the extent required under USERRA and the Plan's policies and procedures related thereto, be protected during the period of such leave if you return to work or seeks re-employment with an Employer following an honorable discharge within the minimum time period required.

The "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or

emergency.

If you do not return to Covered Employment or seek re-employment with an Employer within the time period required, you will forfeit your credited hours of Covered Employment and contributions. You are obligated to notify the Plan as soon as you or your spouse is called up for the Uniformed Services to ensure protection of your rights under USERRA.

If you are covered under the Plan as an Employee at the time the Uniformed Services leave of absence begins, your coverage and your Dependent(s)' coverage will terminate on the last day of the month in which such leave of absence begins, unless you notify the Plan of your election to continue coverage for the period of the leave of absence, up to a maximum of 24 months. This right to continue coverage extends to medical and dental benefits only. If the leave does not exceed 31 days, there is no cost to continue such coverage. If the leave exceeds 31 days, you must self-pay to continue coverage. This right to continue coverage will generally be subject to the Plan's payment, notification, cancellation and other administrative procedures, time frames and rules for COBRA coverage, as long as they do not conflict with USERRA. Under USERRA, only you may elect to continue coverage for your Dependents. The hours of Covered Employment, if any, credited to you and/or accumulated in your Reserve Account will be kept on the Plan's records during the Uniformed Services leave of absence and reinstated upon your re-employment with an Employer within the time period protected under USERRA.

Your Dependent(s) may be eligible for health care coverage under TRICARE (formerly known as the Civilian Health & Medical Program of the Uniformed Services or CHAMPUS). This Plan will coordinate coverage with TRICARE. Coverage will not be available for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the Uniformed Services leave of absence.

When you or your spouse is discharged (not less than honorably) from the Uniformed Services, you must return to Covered Employment or seek re-employment with an Employer within the following time periods in order to have your eligibility or hours of Covered Employment reinstated:

- A. 90 days from the date of discharge if the period of service was more than 180 days; or
- B. 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- C. At the beginning of the first full regularly scheduled work 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 incurred during service in the Uniformed Services, these time limits will be extended for the period of such recovery up to a maximum of two years.

Section 2.12 – Reciprocity

Recognizing that for various reasons an Employee may from time to time perform work in geographical areas outside the jurisdiction of the Plumbers and Steamfitters Local 141 Health and Welfare Fund, the Trustees have entered into, and may in the future enter into, certain reciprocal agreements (“Reciprocal Agreements”) with the trustees of other welfare benefit trust funds similar in purpose to the Trust Fund, which permits Employees to elect to have all contributions received by such other funds or by this Trust Fund transferred to the other under certain circumstances. The Trustees shall transfer or accept contributions made on behalf of you as directed in writing by you but only to the extent permitted or required pursuant to the terms of a Reciprocal Agreement binding upon the Trustees. If you perform work outside the jurisdiction of the Trust Fund and wish to have contributions transferred to or from the Trust Fund on your behalf, you may obtain, upon request, additional information regarding the existence and requirements of any Reciprocal Agreement pertaining to such employment.

This Trust Fund will credit an Employee hours on a pro-rata basis based on the actual contribution rate in effect in this Plan’s jurisdiction at the time the hours are worked in a related Plan’s jurisdiction. This Plan will grant credit to you, upon receipt of contributions from another reciprocating welfare fund, pro-rated based on the following in accordance with the following formula:

$$\frac{\text{Amount of Contributions Received}}{\text{Contribution rate for this Plan pursuant to the Collective Bargaining Agreement}} = \text{Hours of Credit under this Plan}$$

Section 2.13 - Eligibility and Coverage during Family and Medical Leave

If you are covered as an Employee under the Plan and eligible for Family and Medical Leave, you shall be eligible to continue your medical and dental benefits coverage and your Dependent(s)’ medical and dental benefits coverage during the period of the FMLA Leave in accordance with the following provisions:

- A. Your Employer must certify to the Trust Fund, in accordance with the Plan’s administrative procedures, that you are subject to the FMLA requirements and that you are eligible for FMLA Leave;
- B. The Employer and you must timely notify the Plan of the type and duration of FMLA Leave, which has been requested and timely furnish the necessary information to support your eligibility for FMLA Leave;
- C. The Employer must submit contributions to the Trust Fund, on your behalf, during the period of the FMLA Leave to the extent required by the Plan’s FMLA policies and procedures;
- D. Upon your return to Covered Employment following termination of the FMLA Leave, you

shall be entitled to a grace period during the FMLA Leave such that you will continue eligibility just as if your work in Covered Employment had continued without interruption. You *will not* be required to use your Reserve Account to maintain coverage during the FMLA Leave. If, prior to the end of the FMLA leave, you notify your Employer that you do not intend to return to work at the end of the FMLA Leave, coverage will end at the time of such notification;

- E. For purposes of this Section only, if your eligibility is being maintained pursuant to the transfer of contributions by another welfare fund to this Trust Fund in accordance with a Reciprocity Agreement, the welfare fund submitting the reciprocal contributions on your behalf shall be regarded as the Employer. In that event, the reciprocating welfare fund shall be required to fulfill all obligations of the Employer and to furnish all certifications, information and documentation required by the Plan to procure coverage for you during the FMLA Leave; and
- F. The Employer shall furnish information to, and cooperate with, the Plan in administering these rules to comply with FMLA. The Plan shall have the right to request and require additional information from the Employer and/or you before extending coverage during the FMLA Leave. The Plan shall be entitled to rely on information provided by the Employer and shall not be responsible in any way for the Employer's failure to furnish information or to provide correct information to the Plan or you under FMLA.

Section 2.14 - Qualified Medical Child Support Orders (QMCSOs)

If the Plan receives a medical child support order, the Plan shall, as soon as administratively possible, take the following action: (1) notify the Participant and each Alternate Recipient covered by the order (at the address included in the order) of its receipt of the order and the Plan's procedures for determining whether it qualifies as a Qualified Medical Child Support Order ("QMCSO"); (2) make an administrative determination as to whether the order qualifies as a QMCSO; and (3) notify the Participant and each affected Alternate Recipient of its determination. Alternate Recipients may designate a representative for receipt of notices that are sent to the Alternate Recipient with respect to the order. Any determinations made by the Plan regarding QMCSO status will be binding on all parties concerned.

If an Employer receives a National Medical Support Notice, the Employer shall promptly provide it to the Plan for handling. The Plan shall, as soon as administratively possible, take the following action: (1) notify the state or local agency issuing the notice whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Plan and either the effective date of coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage; and (2) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Section 2.15 – COBRA Continuation of Coverage Option

Each Employee and eligible Dependent has the right to continue health care coverage under the Plan, on a self-payment basis, when it would otherwise end because of a qualifying event, to the extent required by the federal law known as COBRA.

The health care coverage available under the Plan during the COBRA coverage period is the same medical and dental coverage being provided by the Plan to similarly situated Participants with respect to whom a COBRA qualifying event has not occurred. If there is a change in the health care coverage provided by the Plan to similarly situated Employees and Dependents, that same change will be made to the COBRA coverage.

A. Eligibility for COBRA Coverage (Qualifying Events)

1. For Employees:

A covered Employee who would otherwise lose health care coverage under the Plan due to one of the following qualifying events shall be entitled to elect COBRA coverage:

- a. Failure to work or be credited with the required number of hours of Covered Employment to maintain coverage under the Plan; or
- b. Termination of employment for any reason other than gross misconduct.

2. For Dependents:

A covered Dependent who would otherwise lose health care coverage under the Plan due to one of the following qualifying events shall be entitled to elect COBRA coverage:

- a. The Employee fails to work or be credited with the required number of hours of Covered Employment to maintain coverage under the Plan;
- b. The Employee terminates employment for any reason other than gross misconduct;
- c. The Employee dies, divorces or becomes legally separated; or
- d. A Dependent child ceases to qualify as an eligible Dependent under the Plan.

3. Qualified Beneficiary(ies) and Special Enrollment Rights

After a qualifying event, COBRA coverage is available to each person who is a “qualified beneficiary.” A “qualified beneficiary” is any Employee or Dependent who, on the day before the qualifying event, has health coverage under the Plan and would otherwise lose such coverage due to the qualifying event. In addition, any Dependent child who is born to or placed for adoption with a covered Employee during a period of COBRA

coverage is also a qualified beneficiary.

If a qualified beneficiary with COBRA coverage acquires a family member who could be enrolled in the Plan as a Dependent if the qualified beneficiary was an active Employee, the qualified beneficiary may add the family member to his or her COBRA coverage for the remainder of the COBRA coverage period; however, the family member is not a qualified beneficiary with independent COBRA rights. In addition, if a qualified beneficiary with COBRA coverage has a Dependent: (1) who was eligible but did not enroll in the Plan at the time of the qualified beneficiary's initial enrollment because the Dependent had other group health coverage; and (2) who lost the other coverage due to exhaustion of COBRA, loss of eligibility or termination of Employer Contributions (but not due to the Dependent's failure to pay timely any required premium or self-payment or termination of coverage for cause), the qualified beneficiary may add that Dependent to his or her COBRA coverage for the remainder of the coverage period, within 30 days after termination of the Dependent's other coverage. If COBRA coverage ceases for a qualified beneficiary, it will end for any family members of the qualified beneficiary who are also enrolled but are not qualified beneficiaries in their own right.

4. Notification Requirements

The Fund Office is assigned the COBRA administrative responsibility to notify you and your Dependent(s) of your rights to elect COBRA coverage whenever health care coverage would otherwise end due to your death, termination of employment, failure to work or be credited with enough hours of Covered Employment or, if applicable, Medicare entitlement. The Fund Office must notify you and/or your Dependent(s) COBRA continuation of coverage rights within 30 days of the date coverage will otherwise terminate due to such qualifying event. Employers are not required to submit notice of a qualifying event to the Plan due to an Employee's death, termination of employment or failure to work or be credited with sufficient hours.

You and your Dependents are required to provide the Fund Office with timely notice of the following events in order to protect your rights to elect COBRA coverage: (a) your divorce or legal separation; (b) a Dependent child ceasing to qualify for eligibility under the Plan as a Dependent; (c) the occurrence of a second qualifying event after an individual has become entitled to COBRA coverage with a maximum of 18 or 29 months; (d) when an individual entitled to COBRA coverage for a maximum of 18 months is determined by the Social Security Administration to be disabled; and (e) when the Social Security Administration determines that a disabled individual receiving COBRA coverage is no longer disabled.

In order to give notice of the above events, you or your Dependent(s) must send a letter to the Fund Office containing the following information: (a) your name; (b) the qualified beneficiary(ies)' name; (c) the type of event for which notice is being provided; (d) the date of the event; (e) for a divorce or legal separation, a copy of the divorce or legal

separation decree; and (f) for a Social Security Administration disability determination, a copy of the determination.

For the required notice of a divorce or legal separation, a Dependent ceasing to qualify for Dependent status or a second qualifying event, the Notice must be postmarked or hand delivered no later than 60 days after the later of: (a) the date on which the relevant qualifying event occurs; or (b) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

For the required notice of a Social Security Administration ("SSA") determination relating to disability, the Notice must be postmarked or hand delivered prior to the end of the first 18 months of COBRA coverage and no later than 60 days after the latest of:

- a. the date of determination by the SSA;
- b. the date on which the qualifying event occurs; or
- c. the date on which the individual loses or would lose coverage under the Plan because of the qualifying event.

If the Fund Office is not timely notified, in writing, by you and/or your Dependent(s) of the occurrence of any of the events listed above for which you are required to give Notice, you and/or your Dependent(s) will forfeit your right to elect continuation of coverage under COBRA.

Notice may be provided by you, a Dependent or a representative acting on behalf of the you or your Dependent. Notice from one individual will satisfy the notice requirements for all individuals affected by the same qualifying event. If an individual provides notice to the Fund Office relating to a qualifying event but is not entitled to COBRA coverage, the Plan will send written notice to the individual explaining why he or she is not entitled to COBRA coverage, within the same time period required for sending a COBRA election notice if the individual was entitled to COBRA coverage.

B. How to Elect COBRA Coverage

Within 30 days after receiving timely notice of a qualifying event from you and/or your Dependent(s), or within 30 days after you and/or your Dependent(s) lose coverage due to your death, termination of employment, insufficient hours worked or Medicare entitlement, the Fund Office will furnish you and/or your Dependent(s) with specific information on when and how to elect COBRA coverage including the amount of the required self-payment. Notice given to you or your Dependent spouse will be deemed to be notice to all affected Dependent children living with you or your Dependent spouse. You and your Dependent(s) will then have 60 days after the later of (1) the date coverage would otherwise end due to the qualifying event, or (2) the date of notification of the

right to continue coverage, in which to elect to continue coverage under COBRA.

Each qualified beneficiary will have an independent right to elect COBRA coverage. COBRA coverage may be elected by some qualified beneficiaries and not others and regardless of whether the Employee elects it. You may elect COBRA coverage on behalf of your Dependent spouse, and a parent may elect COBRA coverage on behalf of Dependent children living with him or her. If a qualified beneficiary waives COBRA coverage during the 60-day election period, he or she may revoke the waiver and elect COBRA coverage at any time during the 60-day election period; however, COBRA coverage may be provided only from the date of revocation and not retroactive to the date coverage terminated.

C. Cost of COBRA Coverage and Self-Payment

Qualified beneficiaries who elect COBRA coverage must pay the amount of the required self-payment determined by the Plan on an after-tax basis. The self-payment amount may not exceed 102% of the Plan's cost of the coverage; however, for COBRA coverage extended from 18 to 29 months due to total disability, the self-payment amount may not exceed 150% of the Plan's cost of coverage for the 11-month extension period. The Fund Office will notify you and/or your Dependent(s) of the cost of COBRA coverage at the time notice of entitlement to COBRA coverage is distributed. The COBRA self-payment amounts shall be reviewed and established periodically by the Trustees and shall remain constant for a 12-month period to the extent required by COBRA.

There will be an initial grace period of 45 days measured from the date COBRA coverage is elected in which to make the first required self-payment. The amount of the initial self-payment must cover the cost of coverage from the date it would otherwise terminate through the end of the month in which payment is made. If the initial self-payment is not made by the end of this grace period, COBRA coverage will not take effect.

All subsequent self-payments are payable on a monthly basis and due on the first day of each month. There will be a 30-day grace period measured from the first day of the month in which to make the required self-payment. If the self-payment is not made by the first day of the month, coverage will be terminated; however, it will be reinstated retroactively to the first day of the month if the self-payment is received within the 30-day grace period. If payment of the required self-payment is not made by the end of the 30-day grace period, coverage will terminate as of the end of the last month for which payment was made timely, and the qualified beneficiary will forfeit all rights to receive COBRA coverage.

D. Duration of COBRA Coverage

Continuation coverage under COBRA is available for the following periods depending on the nature of the qualifying event. The period of COBRA coverage available to a qualified

beneficiary begins on the date of loss of coverage and continues for the following period:

1. 18 Months: If health care coverage is lost due to your failure to work or be credited with the number of hours required to maintain coverage or termination of employment (unless due to gross misconduct), the available period of COBRA coverage is 18 months;
2. 29 Months: If you or your Dependent is entitled to COBRA coverage for an 18-month period, that period can be extended for up to 11 additional months (29 months total) if one of the qualified beneficiaries with COBRA coverage is determined by the Social Security Administration to be totally disabled within the first 60 days of COBRA coverage, and notifies the Fund Office of that determination no later than 60 days after it is received and before the end of the initial 18-month COBRA period. If one qualified beneficiary is disabled, the entire family receiving COBRA coverage is entitled to receive the additional 11 months of COBRA coverage;
3. 36 Months: If health care coverage is lost due to your death, divorce, legal separation or entitlement to Medicare, or a Dependent's loss of status as an eligible Dependent under the Plan, the available period of COBRA coverage is 36 months;
4. 36 Month Maximum for Multiple Qualifying Events: If a qualified beneficiary experiences an additional qualifying event while he or she is receiving 18 or 29-months of COBRA coverage, the maximum period of COBRA coverage available to the qualified beneficiary(ies) affected by both qualifying events shall be 36 months measured from the earliest date of eligibility for COBRA coverage due to the first qualifying event; and
5. Special Rule for Termination of Employment/Reduction in Hours After Medicare Entitlement: If you experience a termination of employment or insufficient hours qualifying event less than 18 months after you first becomes entitled to Medicare (enrollment in Medicare Part A or Part B), the period of COBRA coverage available to your Dependents shall last until 36 months after the date you first became entitled to Medicare.

E. Earlier Termination of COBRA Coverage

Notwithstanding the length of COBRA coverage available to qualified beneficiaries based on the nature of the qualifying event as described above (18, 29 or 36 months), an individual's COBRA coverage will terminate earlier upon the first, if any, of the following events to occur:

1. The last day of the last month for which the required COBRA self-payment was made timely (taking into account the applicable grace period);
2. The date on which the Plan and Trust Fund terminate as permitted under COBRA;

3. The date, after the COBRA election, on which the individual first becomes eligible for coverage under Medicare or covered another group health plan that does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the individual has (or if it does, the first day on which the limitation or exclusion no longer affects the individual);
4. If the individual is extending COBRA coverage from 18 to 29 months due to disability, the last day of the month that includes the 30th day following a Social Security Administration determination that the individual is no longer disabled; or
5. Failure to follow the Plan's policies and procedures and taking action that would result in termination of coverage for cause for a similarly situated active Employee or Dependent (such as submission of false claims to the Plan).

In the event of an earlier termination of COBRA coverage for one of the reasons set forth above, the Plan will send written notice to the affected individual(s), as soon as practicable after the Plan determines that such coverage will terminate, setting forth the reason for termination, the date of termination and the individual's rights, if any, to alternative coverage.

F. Health Insurance Marketplace

Qualified Beneficiaries may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA Continuation Coverage. The Marketplace allows Qualified Beneficiaries to find and compare private health insurance options. In the Marketplace, Qualified Beneficiaries could be eligible for a new kind of tax credit that lowers monthly premiums and cost-sharing reductions so that a decision about whether to enroll can be made. Through the Marketplace, Qualified Beneficiaries can learn if they qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). The Marketplace can be accessed at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA Continuation Coverage. Being offered COBRA Continuation Coverage will not limit a Qualified Beneficiary's eligibility for coverage or a tax credit through the Marketplace.

Section 2.16 - Special Self-Pay Rules for Retirees and Dependents who are not Eligible for Medicare

The right to continue your health coverage on a self-payment basis as provided in this Section shall be available only to Retirees and/or their Dependents who exhaust the COBRA coverage available to them at your retirement and are not Medicare eligible when their COBRA coverage is exhausted, subject to the following terms and conditions:

- A. There can be no gap in coverage under the Plan for any month. Any individual who fails

to be covered in any month under the self-pay provisions of COBRA, this Section or the Supplemental Medicare Plan, shall lose all rights to self-pay for coverage under any provision of the Plan, including COBRA, this Section and the Supplemental Medicare Plan;

- B. If an Employee with coverage under the Plan is not Medicare eligible at the time of retirement, he or she may elect and self-pay for COBRA coverage until the earlier of the following: (1) eligibility for Medicare, or (2) exhaustion of COBRA coverage.
 - 1. If the Retiree does not become eligible for Medicare prior to exhaustion of COBRA coverage, he or she may self-pay for coverage under this Section, immediately following exhaustion of COBRA coverage, until becoming eligible for Medicare. At that time, the right to self-pay for coverage under this Section shall end, and the Retiree shall have the option to self-pay for coverage under the Supplemental Medicare Plan, if he otherwise meets the eligibility requirements of that Plan.
 - 2. If the Retiree becomes eligible for Medicare while self-paying for COBRA coverage (and prior to exhaustion of COBRA coverage), he or she must then choose between the following:
 - i. continuing to self-pay for COBRA coverage for the remainder of the COBRA period. If the Retiree chooses to continue to self-pay for COBRA coverage, he or she shall lose the right to participate in the Supplemental Medicare Plan; or
 - ii. self-paying for coverage under the Supplemental Medicare Plan, which is available in lieu of COBRA coverage, provided he otherwise meets the eligibility requirements of that Plan.
- C. The Retiree's Dependent(s) shall have the same self-payment options as the Retiree (as described in the above paragraph), except that the Dependent(s)' right to be covered under the self-pay provisions of this Section and the Supplemental Medicare Plan is contingent upon the Retiree simultaneously being covered under the self-pay provisions of the Plan (COBRA coverage, this Section or the Supplemental Medicare Plan), and also upon the Retiree self-paying for coverage under this Section or the Supplemental Medicare Plan when the Retiree is eligible to do so. If, for any month, the Retiree is eligible to self-pay for coverage under this Section or the Supplemental Medicare Plan and fails to do so, the Retiree's Dependent(s) shall lose the right to self-pay for coverage under this Section of the Plan and the Supplemental Medicare Plan;
- D. Self-payments for coverage under this Section are payable monthly and due on the first day of the month, subject to a 30-day grace period measured from the first day of the month for which coverage is sought. If the Fund Office is closed on the last day of the 30-day grace period because it is a weekend, a legal or scheduled holiday or natural disaster, the deadline for payment will be extended to the next regular business day. If a Retiree or Dependent fails to make the required monthly self-payment by the last day of the grace

period, his or her coverage shall terminate as of the end of the last month for which timely self-payment was made and cannot be reinstated (or if the failure relates to the first required self-payment, coverage shall never take effect);

- E. The health care coverage available to Retirees and Dependents under this Section will be the same coverage that is being provided to active Employees under the Plan;
- F. If a Retiree dies while covered under this Section, his or her surviving Dependent who is also covered under this Section may continue to self-pay for coverage under this Section until the first of the following to occur: (1) death; (2) remarriage; (3) the failure to make a required self-payment timely; (4) amendment of the Plan to terminate the coverage available under this Section; or (5) termination of the Plan;
- G. The amount of the required self-payment shall be determined by the Trustees from time to time and is subject to change; and
- H. The right of Retirees and Dependents who are not eligible for Medicare to self-pay for coverage under this Section may be amended or terminated at any time at the discretion of the Trustees, regardless of the age or retirement status of the affected individuals. The granting of medical coverage for Retirees and their Dependents is neither a vested nor contractual right.

Section 2.17 - Supplemental Medicare Plan for Medicare Eligible Retirees and Their Dependents

Retirees and Dependents of Retirees who are eligible for Medicare have the option to participate in the Plumbers & Steamfitters Local 141 Supplemental Medicare Plan ("Supplemental Medicare Plan") as briefly explained in this Section 2.16 and in more complete detail in the Plan document entitled Plumbers & Steamfitters Local 141 Supplemental Medicare Plan, a copy of which is available from the Administrative Manager. Benefits under the Supplemental Medicare Plan shall be available only to Retirees and/or their Dependents who elect to continue medical coverage through the Plan when they first become eligible for Medicare and otherwise meet the definition of Retiree as set forth in §1.29, and subject to the terms and conditions set forth in the Supplemental Medicare Plan document.

There can be no gap in coverage under the Plan for any month. Any individual who fails to be covered in any month under the self-pay provisions of COBRA, Section 2.15 or this Section 2.16, shall lose all rights to self-pay for coverage under any provision of the Plan, including COBRA, Section 2.15 or this Section 2.16.

If an Employee with coverage under the Plan is Medicare-eligible at retirement, he or she shall have the following two options for continuing coverage on a self-payment basis: (1) continue his or her active Employee health care coverage under COBRA in accordance with Section 2.14; or (2) participate in the Supplemental Medicare Plan, as described in that Plan document, which is available in lieu of COBRA coverage. If the Retiree chooses COBRA coverage, he or she shall lose

the right to participate in the Supplemental Medicare Plan and his or her coverage under the Plan shall end when the COBRA coverage ends. If the Retiree chooses to participate in the Supplemental Medicare Plan, he or she must waive the right to elect COBRA coverage in the form required by the Plan in order to enroll in the Supplemental Medicare Plan.

Before making his election, the Retiree should carefully review the provisions of the Supplemental Medicare Plan document. The Retiree must request from the Administrative Manager a copy of the Supplemental Medicare Plan document in sufficient time to review it and make his election so that he may timely elect his coverage to avoid a gap in coverage.

The Retiree's Dependent(s) shall have the same self-payment options as the Retiree (including the obligation to waive COBRA coverage where applicable) as described in the above paragraphs, except that the Dependent's right to be covered under the self-pay provisions of Sections 2.15 and 2.16 is contingent upon the Retiree simultaneously being covered under the self-pay provisions of the Plan (COBRA coverage, Section 2.15 or Section 2.16), and also upon the Retiree self-paying for coverage under Section 2.15 and/or Section 2.16 when the Retiree is eligible to do so. If, for any month, the Retiree is eligible to self-pay for coverage under Section 2.15 or 2.16 and fails to do so, the Retiree's Dependent shall lose the right to self-pay for coverage under Sections 2.15 and 2.16 of the Plan.

Section 2.18 - Special Eligibility Rules for Employees of Contributing Employers with Collective Bargaining Agreements Providing for Immediate Eligibility.

A. Initial Eligibility Rules for Employees of Contributing Employers whose Collective Bargaining Agreements Provide for Immediate Eligibility

Contributing Employers with Collective Bargaining Agreements providing for immediate eligibility for their Employees are employers who have never been signatory to a Collective Bargaining Agreement with the Plumbers and Steamfitters Local 141. Employees of Contributing Employers that enter into a special Collective Bargaining Agreement with the Union providing for immediate eligibility shall be eligible beginning at 12:01 a.m. on the effective date set forth in the Employer's Collective Bargaining Agreement with the Union, without regard to the minimum service requirement under the general rule for initial eligibility for New Employees as stated in §2.2, provided the Employee is actively at work with the Employer on the effective date of the Collective Bargaining Agreement, and subject to the following terms and conditions:

1. Employees of such a Contributing Employer will initially be granted three months of coverage under the Plan beginning on the effective date set forth in the Collective Bargaining Agreement;
2. A copy of the executed Collective Bargaining Agreement between the Employer and the Union providing for immediate eligibility for the Employer's Employees shall be provided to the Fund Office;

3. The Employer must provide to the Fund Office a list of all Bargaining Unit Employees, including their names, addresses, telephone numbers and Social Security numbers;
4. In order to effect immediate eligibility under the Plan, the Fund will establish a “negative” Reserve Account for each Employee. Each Employee will be credited with 390 negative hours in his Reserve Account;
5. Once an Employee has been covered for the initial three-month period, his continuing eligibility for subsequent months shall be determined in accordance with the following subsection B;
6. An Employee may initially qualify for Plan coverage under this special eligibility rule only once; and
7. If an Employee does not qualify under this special rule, he will be required to meet the Plan’s eligibility rules contained in Sections 2.1 et seq. of the Plan.

B. Continuation of Eligibility for Employees of Contributing Employers whose Collective Bargaining Agreements provide for Immediate Eligibility

1. Following an Employee’s initial three-month eligibility period, he shall continue to be eligible during each succeeding Benefit Month, provided he works at least 130 hours in Covered Employment in the corresponding Contribution Month. Contribution Months and Benefit Months are determined in accordance with the following schedule:

CONTRIBUTION MONTH

Hours Worked In:

January
February
March
April
May
June
July
August
September
October
November
December

BENEFIT MONTH

Earn Eligibility For:

March
April
May
June
July
August
September
October
November
December
January
February

2. Any hours of Covered Employment in excess of 130 hours in a given month will be applied to the Employee's negative Reserve Account until the negative Reserve Account reaches zero. Thereafter, the provisions of Sections 2.3 and 2.5 shall apply to the Employee for purposes of Continuing and Reinstatement of Eligibility. Until an Employee's negative Reserve Account reaches zero, the Employee will not be eligible for the "Continued Eligibility During Disability Periods," as described in Section 2.9.

C. Termination of Employees' Coverage

If an Employee terminates employment with the Employer while his Reserve Account still has a negative balance, his Reserve Account hours will be forfeited and his eligibility will terminate as of the last day of the month in which he earned eligibility through hours worked. Thereafter, Employees shall be subject to the provisions of Section 2.4.

ARTICLE III

MEDICAL AND PRESCRIPTION DRUG BENEFITS

Section 3.1 – Medical Benefits

For information about the medical benefits provided under the Plan, please refer to the separate booklets entitled Plumbers and Steamfitters Local 141 Health & Welfare Fund Comprehensive Medical Benefit Plan **or** Plumbers & Steamfitters Local 141 Supplemental Medicare Plan that correspond to your category of eligibility. They summarize the medical benefits and are incorporated by reference with this Summary Plan Description (“SPD”) as part of the Plan. There is a booklet for active Employees and their Dependents and a separate booklet for Retired Medicare-eligible employees and/or Medicare-eligible Dependents of Retirees. The separate booklets provide the information you need to know about the medical coverage for you and your covered Dependents, including eligible expenses, covered health services, annual deductibles, maximum benefit limitations, utilization review requirements, other limitations and exclusions, and the procedures for filing a claim and appealing a claim decision.

Section 3.2 – Prescription Drug Benefits

For information about the prescription drug benefits provided under the Plan, please refer to the separate booklet entitled Plumbers and Steamfitters Local 141 Health & Welfare Fund Comprehensive Medical Benefit Plan, which summarizes the prescription drug benefits and are incorporated by reference with this Summary Plan Description (“SPD”) as part of the Plan. This separate booklet will provide the information you need to know about the prescription drug coverage for you and your covered Dependents, including deductibles, limitations and exclusions.

ARTICLE IV

LIFE BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Section 4.1 - Life Benefit

The Life Benefits provided by the Plan are insured by a policy offered by MetLife, and are governed by a separate policy. The following section summarizes those benefits.

If an Employee dies while covered for the Life Benefit under the Plan, a Life Benefit in the amount shown in the Schedule of Benefits shall be paid to the Employee's surviving Beneficiary upon MetLife's receipt of satisfactory proof of death. The amount of the Life Benefit otherwise payable is reduced by 50% for death occurring on or after age 70. Covered Employees who retire and are eligible for Medicare are not eligible for Life Benefit coverage. Covered Employees who retire prior to eligibility for Medicare and qualify as Retirees are eligible for Life Benefit coverage only if and while they are not eligible for Medicare and continue their health care coverage under the Plan through self-pay under COBRA or the special self-pay rules (Sections 2.14 and 2.15); their Life Benefit coverage shall terminate at the time they become eligible for Medicare or, if earlier, when their health care coverage through self-payment terminates.

NOTICE OF DISCLAIMER: IN THE EVENT OF A DISCREPANCY BETWEEN THE METLIFE BOOKLET OR THIS BOOKLET AND THE GROUP LIFE INSURANCE POLICY OR CERTIFICATE OF INSURANCE ISSUED BY THE INSURER OF THE BENEFIT, THE INSURER'S DOCUMENTS WILL PREVAIL.

Section 4.2 - Accidental Death and Dismemberment Benefit

The Accidental Death and Dismemberment Benefits provided by the Plan are insured by a policy offered by MetLife, and are governed by a separate policy. The following section summarizes those benefits.

If you suffer death or dismemberment solely due to, and within one year after, an accident which occurs while you are covered for the Accidental Death and Dismemberment Benefit, a benefit in the amount shown in the Schedule of Benefits (as in effect on the date of the accident) shall be paid to your surviving Beneficiary (for an accidental death), or to you (for an accidental dismemberment), upon the Plan's receipt of notice and satisfactory proof of loss. The amount of the Accidental Death and Dismemberment Benefit otherwise payable under the Plan is reduced by 50% once you attain age 70. Covered Employees who retire after becoming eligible for Medicare are not eligible for Accidental Death and Dismemberment Benefit coverage. If you retire prior to becoming eligible for Medicare and qualify as a Retiree, you are eligible for Accidental Death and Dismemberment Benefit coverage only if and while you are not eligible for Medicare and you continue your health care coverage under the Plan through self-pay under COBRA or the special self-pay rules (Sections 2.14 and 2.15); your Accidental Death and Dismemberment Benefit coverage shall terminate at the time you become eligible for Medicare or, if earlier, when your

health care coverage through self-pay terminates.

NOTICE OF DISCLAIMER: IN THE EVENT OF A DISCREPANCY BETWEEN THE METLIFE BOOKLET OR THIS BOOKLET AND THE GROUP ACCIDENT DEATH AND DISMEMBERMENT POLICY OR CERTIFICATE OF INSURANCE ISSUED BY THE INSURER OF THE BENEFIT, THE INSURER'S DOCUMENTS WILL PREVAIL.

ARTICLE V DENTAL BENEFITS

Section 5.1 - Dental Expense Benefits

The dental coverage has been designed to provide you and your Dependents with benefits for dental care, based on the Allowable Charges incurred for dental services, supplies and/or treatment provided by a Dentist and covered under this Article.

Section 5.2 - Calendar Year Deductible

Before the Plan begins to pay Dental Benefits under this Article, each covered person must pay a portion of the Allowable Charges incurred for eligible dental expenses during the calendar year, known as a deductible.

The Calendar Year Deductible for Dental Benefits, as shown in the Schedule of Benefits, is the amount of eligible dental expenses that a covered person must incur and pay during a calendar year before his or her eligible dental expenses incurred during the calendar year are payable under the Plan. The Calendar Year Deductible for Dental Benefits is separate from the Calendar Year Deductible for Comprehensive Major Medical Expenses Benefits. A separate Calendar Year Deductible applies to each covered person each calendar year.

Section 5.3 - Reimbursement Percentage

The Reimbursement Percentages, as shown in the Schedule of Benefits, are the percentages of eligible dental expenses payable under the Plan, after satisfaction of the Calendar Year Deductible, up to the Calendar Year Maximum and subject to any other limitations set forth in this Article.

Section 5.4 - Calendar Year Maximum Benefit

The Calendar Year Maximum Per Person is the maximum amount of Dental Benefits, as shown in the Schedule of Benefits, payable on behalf of a covered person during a calendar year. Once a covered person reaches the Calendar Year Maximum Per Person for a calendar year, no further Dental Benefits will be payable on behalf of such covered person for dental claims incurred during the calendar year.

Section 5.5 - Eligible Dental Expense

Eligible dental expenses, for purposes of Dental Benefits payable under this Article, are the Allowable Charges incurred by a person while covered under the Plan, for any of the following dental services, supplies or treatment, unless excluded from coverage under Section 6.6, Dental Exclusions:

A. ORAL SURGERY:

Simple surgical extractions with local anesthetic, including routine post-operative care;
Complicated procedures for surgical extractions (such as sectioning flaps) and residual root recovery) with local anesthetic, including routine post-operative care;
Re-implantation following traumatic exfoliation;
Removal of impacted teeth (soft tissue, partial bony, or complete bony);
Apicoectomy;
Root recovery (surgical recovery of residual root);
Alveolectomy of edentulous areas;
Alveolectomy following the removal of teeth;
Alveoloplasty (surgical preparation of ridge for dentures); and
Stomatoplasty including revision of soft tissue, ridge extension, muscle reattachment, and manipulation of other intraoral tissue.

SURGICAL EXCISIONS:

Excision of reactive inflammatory tissue, including hyperplastic/hypertrophic tissue and scar tissue;
Removal of exostoses;
Excision of cysts from soft or osseous tissue;
Excision of benign tumors from soft or osseous tissue;
Excision or resection of malignant tumors from soft or osseous tissue; and
Radical resection of mandible with bone graft.

SURGICAL INCISIONS, TISSUE REPAIR, AND FRACTURES:

Sialolithotomy (intraoral or extraoral);
Incision and drainage of abscess or cellulitis (intraoral or extraoral);
Incision and removal of foreign body from soft or osseous tissue;
Frenulectomy (frenectomy or frenotomy);
Suture of soft tissue wound or injury;
Oral antral fistula closure and/or antral root recovery;
Injection of Trigeminal Nerve for destruction closure of salivary fistula;
Treatment of fractures (simple or compound of the orofacial structures);

TEMPOROMANDIBULAR JOINT DYSFUNCTIONS:

Open reduction of dislocation;
Manipulation under anesthesia;
Condylectomy;
Meniscectomy; and
Dental anesthesia when Medically Necessary.

B. DIAGNOSTIC AND PREVENTATIVE:

Emergency Treatment, Palliative;
Initial oral examination and treatment planning;

Periodic oral examination (limited to 2 per calendar year);
 Emergency oral examination;
 Special consultation fee by specialist for case presentation when diagnostic procedures have been performed by a general Dentist;
 Diagnostic models;
 Pulp vitality test;
 Biopsy of soft tissue;
 Oral smear;
 Bacteriologic culture for determination of oral pathologic agents;
 Microscopic examination of pathogens and/or oral tissue;
 Intraoral periapical x-rays;
 Complete intraoral series of periapical x-rays (14 or more x-rays) (limited to once in a 2-year period);
 Bite-wings (Caries Detector) x-rays (limited to once in a 6-month period);
 Cephalometric x-rays;
 X-rays of Temporomandibular Joint;
 Intraoral-occlusal x-rays;
 Extraoral - x-rays of T.M.J., lateral head antero-posterior, postero anterior;
 Panoramic type x-rays (limited to once in a 3-year period);
 Plaque Control Program (limited to once in a 3-year period);
 Training in oral hygiene (limited to once in a 3-year period);
 Occlusal Equilibration (limited to once in a 3-year period);
 Dental Prophylaxes (limited to 2 per calendar year);
 Topical application of fluoride (limited to once yearly to Participants under 19 years of age);
 Space maintainers (limited to replacement of same maintainer once in a 3-year period);
 and
 Dietary prescription and counseling (limited to once in a 3-year period).

C. SIMPLE RESTORATIVE:

Amalgam restorations of permanent and primary teeth;
 Cement bases;
 Calcium hydroxide or zinc-oxide-eugenol bases;
 Silicate cement (synthetic porcelain) restorations;
 Acrylic or plastic restorations;
 Composite resin restorations;
 Pins for reinforced pin restorations (maximum 3 pins);
 Etched Composites/Nuva Lite System (not for Fissure Sealant);
 Pulp cap (excluding restoration);
 Recalcification (treatment restoration);
 Therapeutic apical closure (apical calcification technique);
 Pulpotomies (excluding restoration); and
 Extirpation of pulp and root canal fillings (excluding restoration).

D. PERIODONTICS:

Emergency palliative treatment;
Sub-gingival curettage;
Gingivectomy and/or gingivoplasty;
Osseous surgery including flap entry and closure;
Mucogingivoplastic surgery;
Periodontal scaling and root planning;
Periodontal scaling and root planning with sub-gingival curettage;
Provisional splinting;
Occlusal guards; and
Occlusal Equilibration Treatment of hypersensitive teeth.

E. MAJOR RESTORATIVE:

Crowns and build up for crowns (only when tooth cannot be restored adequately with a filling).

Section 5.6 - Dental Exclusions

Notwithstanding any provision in this Article to the contrary, no Dental Benefits are payable for any of the following:

- A. Dental care received from a dental or medical department maintained by or on behalf of any Employer, a Mutual Benefit Association, Labor Union, Trustee, or similar person or group;
- B. Services for which the covered person incurs no charge or for which the covered person would have no legal obligation to pay;
- C. Dental care, treatment or services covered, in whole or part, by Worker's Compensation, occupational disease, or disability benefits laws;
- D. Services for which indemnification is available under the laws of the United States, any state or political subdivision thereof or the Veterans Administration, or treatment for which the Employee would have no legal obligation to pay unless otherwise prohibited by law;
- E. Services for diseases contracted or injuries sustained as a result of war or any act of war;
- F. Expenses incurred after the termination of Dental Benefits coverage under the Plan regardless of the cause of termination;
- G. Expenses incurred for or in connection with transplants, bone graphs or implants, except as specifically covered under Oral Surgery;
- H. Services not specifically listed as covered under the Plan;

- I. Orthodontic care and treatment;
- J. Fissure sealants;
- K. Charges for dental procedures, services or supplies which are Experimental in nature or otherwise do not meet accepted standards of dental practice;
- L. Charges made by a Dentist for the patient's failure to appear as scheduled for an appointment; and
- M. Prosthetic appliances, including Bridges and partial or complete Dentures.
- N. Expenses for oral surgery that are covered under the Plumbers and Steamfitters Local 141 Health and Welfare Medical Plan.

Section 5.7 Dental Opt Out

Although the Plumbers and Steamfitters Local 141 Health & Welfare Plan provides dental coverage as set forth in this Article V to all eligible Participants and Dependents, you may opt out of such coverage for yourself and your eligible Dependents.

In order to opt out, you must contact the Fund office to request and sign an Opt-Out Form. Once you opt-out of dental coverage under the Plan, you may reinstate your dental coverage and that of any eligible Dependent on a prospective basis by submitting a written request to the Fund office. Your coverage will then become effective on the first day of the following month.

ARTICLE VI

COORDINATION OF BENEFITS

Section 6.1 - General

If you or your Dependents are covered by other group health plans, this Plan will coordinate its dental benefits with the benefits that are available under the other group health plans. The following rules will be applied to determine which plan is primary and which plan is secondary. Benefits provided under this Plan will not be payable to the extent benefits are provided under another group health plan that is considered the “primary” plan. In no event will you or your Dependent be paid benefits under this Plan and the other plan that total more than 100% of your “Allowable Expenses.” “Allowable Expenses” means your necessary and reasonable medical and dental expenses, part or all of which are covered under any of the plans. When a claim is made, the primary plan will pay its benefits first without regard to the benefits provided by the other plan. The secondary plan will then adjust its benefits so that the total benefits available do not exceed the Allowable Expenses. No plan will pay more than it would without the Coordination of Benefits (“COB”) provision.

Section 6.2 - Order of Benefit Determination

If the other plan does not have a COB provision, it will be treated as the primary plan and will pay benefits first. If both plans have a COB provision or limitation against duplicate benefits, the order of benefit determination will be made as follows:

- A. Non-Dependent/Dependent. The plan which covers the patient as an employee, rather than a dependent, is the primary plan, and the other plan is the secondary plan.
- B. Dependent Child/Parents Not Separated or Divorced. If the patient is a dependent child who is covered under separate plans provided to the parents, the plan of the parent whose birthday occurs earlier in the calendar year will be the primary plan. If both parents have the same birthday, the plan which has covered the parent longer will be the primary plan.
- C. Dependent Child/Separated or Divorced Parents. If two or more plans cover the patient as a dependent child of separated or divorced parents, benefits for the child will be determined in the following order: i) if a court order places financial responsibility for the child’s health care on one of the parents, the plan covering that parent is the primary plan, and the plan covering the other parent is secondary; ii) if there is no such court order, the plan of the parent with custody of the child is primary; the plan of the spouse of the parent with custody, if any, pays next; the plan of the parent without custody pays next; and the plan of the spouse of the parent without custody, if any, pays next.

- D. Active/Inactive Employee. The plan that covers the patient as an active employee (that is an employee who is neither laid-off nor retired), or a dependent of that active employee, is the primary plan, and the plan that covers the patient as a laid-off or retired employee, or a dependent of that employee, pays second. If the other plan does not have this rule and as a result the plans do not agree on the order of benefits, this rule is ignored. If the patient is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined under the Non-Dependent/Dependent rule.
- E. Legally Mandated Continuation of Coverage. If the patient is covered by a plan under a right of continuation under federal or state law in addition to being covered under another plan, the other plan is the primary plan, and the plan providing continuation of coverage is secondary. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- F. Default. If none of the COB rules described above apply in a particular case, the plan which has covered the patient for a longer period of time is the primary plan, and the plan which has covered the person for a shorter period of time is secondary.
- G. Coordination with HMOs. If this Plan is secondary to a HMO, benefits will be payable under this Plan for reimbursement of the co-payments under the HMO, subject to any deductibles and reimbursement percentages payable under this Plan, provided the charges were covered under the other plan. If the charges are not covered under the HMO (but are covered under this Plan), benefits will be payable for those charges under this Plan as if it is the primary plan.
- H. Coordination with Medicare. If the patient is an active Employee or Dependent of an active Employee and is eligible for Medicare, the plan covering the patient as the active Employee or Dependent will be the primary plan, and the balance of unpaid expenses may then be submitted to Medicare for reimbursement. Benefits for Retirees and Dependents who are eligible for Medicare and enrolled in the Supplemental Medicare Plan under this Plan will be paid first by Medicare, and the balance of unpaid expenses which are covered by Medicare but not reimbursed by Medicare may then be submitted to this Plan for reimbursement.

ARTICLE VII
CLAIMS AND CLAIMS REVIEW PROCEDURES,
ADMINISTRATION OF PLAN
AND MISCELLANEOUS
FOR DENTAL CLAIMS

Section 7.1 – Claims Procedure and Claims Review Procedure

A. Definitions

The following terms, whenever used as capitalized terms in this Section, shall have the meaning specified below unless a different meaning is clearly and plainly implied by the context:

“Adverse Benefit Determination” means any denial, reduction, or termination of, or a failure to provide or make payment for a benefit, including “rescissions,” regardless of whether there is an adverse effect on any particular benefit at the time of the claim. A “rescission” is generally a cancellation or discontinuance of coverage with a retroactive effect for reasons other than a failure by you to timely pay premiums.

“Authorized Representative” means that you or your beneficiary may appoint an Authorized Representative to file claims, request reviews, receive correspondence, and act on behalf of you with respect to the claims procedure and claims review procedure. To do so, you must complete and submit to the Plan an acceptable form.

“Claim” means a request for a benefit made by you in accordance with the Plan’s reasonable procedures. The following inquiries and requests shall not qualify as Claims: (a) casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan; (b) requests for a determination of whether an individual is eligible for benefits under the Plan (but not the filing of a Claim for a specific benefit that is denied because the individual is not eligible for benefits under the Plan); and (c) requests for prior approval of a benefit that does not require prior approval by the Plan.

“Named Fiduciary” is the fiduciary designated by the Trustees in the Plan document.

“Post-Service Claim” means a Claim for benefits for services that have already been rendered.

“Relevant Documents” means documents pertaining to a Claim if they (a) were relied upon in making the benefit determination; (b) were submitted, considered or generated in the course of making the benefit determination; (c) demonstrate compliance with the administrative processes and safeguards required by the applicable regulations for minimum requirements of benefit claims procedures; or (d) constitute the Plan’s policy or guidance with respect to the denied treatment option or benefit, without regard to whether they were relied upon in making the benefit determination.

B. Determinations on Claims for Benefits

Post Service Claims. The Administrative Manager shall notify you of a benefit determination within 30 days after the Plan's receipt of the claim.

If additional time is required due to matters beyond the Plan's controls, you will be notified before the expiration of the 30-day period of the circumstances requiring the extension of time, and of the date by which the Plan expects to render the benefit determination. The extension shall not exceed 15 days beyond the initial 30-days period. If an extension is necessary due to your failure to submit sufficient information, the notice shall describe the required information and afford you at least 45 days from receipt of the notice to provide the information.

Accidental Death and Dismemberment Benefit Claims. You, your Beneficiary, or representative of the decedent's estate must file a Death Benefit Claim or Accidental Death and Dismemberment Benefit Claim in writing with adequate proof of loss to the Administrative Manager, within 15 months after the date of loss covered by the Plan. Claims filed after this 15-month deadline will not be covered under the Plan. A claim is considered filed when the claim is received by the Administrative Manager, at its administrative offices, during normal business hours on a regularly scheduled workday.

Notwithstanding any provision of this Section to the contrary, the claims procedure for Life Benefits and Accidental Death and Dismemberment Benefits shall be governed by the terms of the insurance contract purchased by the Trustees on behalf of the Plan to insure such benefits, and the related insurance certificate-booklet, in effect at the time of death or, for an accidental death or dismemberment, the accident causing the accidental death or dismemberment. Notice of the claims procedure shall be provided to Participants. Claims for Life Benefits and Accidental Death and Dismemberment Benefits shall be determined by the insurance company insuring such benefits or its designee, unless otherwise provided by the insurance contract.

C. Full and Fair Review

You shall be provided, free of charge and before an Adverse Benefit Determination is issued, with (a) any new or additional evidence considered, generated or used by the Plan with regard to the claim, and (b) any new or additional rationale on which the Adverse Benefit Determination will be based. The new or additional evidence or rationale must be provided as soon as possible, and sufficiently before an Adverse Benefit Determination is due, in order to give you a reasonable opportunity to respond to the new information before the Adverse Benefit Determination issues.

D. Adverse Benefit Determination

The Fund's Administrator shall provide you with written or electronic notification of any Adverse Benefit Determination (or orally for Urgent Care Claims, provided that written or electronic notification is provided to you within 3 days thereafter). The notification shall include each of the following items:

The specific reason for the Adverse Benefit Determination;

1. Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;
2. A description of any additional material or information necessary for you to perfect the claim and an explanation why such material or information is needed;
3. A description of the time limits applicable to the procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other criterion or statement that such rule, guideline, protocol or other criterion was relied upon in making the Adverse Benefit Determination, and that a copy will be provided free of charge to you, upon request;
5. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
6. Confirmation that the Plan shall continue to provide coverage to you pending the outcome of your internal review and appeal. This means that the Plan will not reduce or terminate coverage for an ongoing course of treatment without an opportunity for advance review; and
7. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relied upon in making the Adverse Benefit Determination.

E. Appeals Procedure for Adverse Benefit Determination

You shall be given 180 days following the receipt of an Adverse Benefit Determination to appeal the determination.

The review shall not give deference to the initial Adverse Benefit Determination. A Named Fiduciary of the Plan must conduct the review. This Named Fiduciary can neither be the individual who made the Adverse Benefit Determination subject to appeal, nor a subordinate of that individual.

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or other similar matters) shall not be made on the basis of whether that person is likely to support a denial of benefits.

If an appeal is based in whole, or in part, on medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Named Fiduciary shall consult with a health care professional with the appropriate training and experience in the medical field. Any health care professional used for purposes of consultation must be an individual who is neither an individual who was consulted in the initial Adverse Benefit Determination that is subject to appeal, nor a subordinate of that individual.

Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an initial Adverse Benefit Determination shall be identified to you, without regard to whether the advice was relied upon in making the benefit determination.

F. Final Internal Claims Determination on Appeal

The Fund's Administrative Manager shall notify you of the Plan's final internal benefit determination no later than the date of the Trustees' meeting that immediately follows the receipt of your request for review, unless such request for review is filed within 30 days before the date of such meeting. In such case, the Plan Trustees may delay the decision until the second meeting following the Administrative Manager's receipt of the request for review. If special circumstances require a further extension of time for processing the appeal by the Plan's Trustees, the decision on the appeal shall be made no later than the third meeting of the Board of Trustees or any Trustee Subcommittee that immediately follows the Plan's receipt of your request for review. If an extension of time for review is required because of special circumstances, the Trustees' designee shall provide you with a written notice of the extension describing the special circumstances and the date on which the benefit determination will be made, before the commencement of the extension. The Trustees' designee shall notify you in writing of its decision on your appeal as soon as possible, but no later than five days after the final determination is made.

G. Decision on Appeal

The decision on appeal shall be made no later than the date of the Board of Trustees' meeting that immediately follows the receipt of your request for review, unless such request for review is filed within 30 days before the date of such meeting. In such case, the Plan Trustees may delay the decision until the second meeting following the Administrative Manager's receipt of the request for review.

If special circumstances require a further extension of time for processing the appeal by the Plan's Trustees, the decision on the appeal shall be made no later than the third meeting of the Board

of Trustees any or Trustee Claims Subcommittee that immediately follows the Fund's Administrator's receipt of your request for review. If an extension of time for review is required because of special circumstances, the Administrative Manager shall provide you with a written notice of the extension describing the special circumstances and the date on which the benefit determination will be made, before the commencement of the extension.

The Administrative Manager shall notify you in writing of the Trustees' decision on your appeal as soon as possible, but no later than five days after the final internal determination is made.

For purposes of the foregoing, the period of time within which a decision on your appeal must be made shall begin at the time the appeal is filed without regard to whether all information necessary to make a benefit determination has accompanied the filing. If a period of time is extended as permitted by these rules and regulations due to your failure to submit the information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Section 7.2 – Right to Withhold Payment and Recovery of Improper Payments

The Plan may withhold or deny payment of any claim that it reasonably believes is based on erroneous, false or misstated facts or representations by any covered person, Beneficiary or provider of services or supplies. In the event the Plan pays a claim in error, overpays a claim or makes an improper payment on a claim for any reason, the Plan has the right to recover such improper payment or overpayment and secure reimbursement for such improper payment or overpayment directly from the person for whom the claim was made or from any third party to whom payment was made, and such person or third party is obligated to reimburse the Plan for such payment. The Plan also has the right to secure reimbursement through an offset of any related or unrelated existing or future benefits due to the covered person for whom the claim was made or any covered family member.

If a covered individual fails to comply with the notification requirements under the Plan, including but not limited to the failure to notify the Plan timely of a change in address, change in Dependent status or other change affecting coverage under the Plan, and as a result (1) the Plan makes an erroneous or improper payment or overpayment, including but not limited to payment to or for an individual who is no longer covered or payment that is mailed to the wrong address and then cashed by an unauthorized person, and (2) does not recover such payment after notice and demand, the covered individual and any third party receiving payment shall be obligated to reimburse the Plan for such payment, and the Trustees shall have the right to secure reimbursement for such payment directly from the covered individual or third party or through an offset of any related or unrelated existing or future benefits due to the covered individual or any covered family member.

Section 7.3 – Facility of Payment

If benefits are payable under the Plan to the estate of an eligible Employee or to an eligible person or Beneficiary who is a minor or otherwise not competent or capable of executing a valid receipt, the Plan may, in the absence of a duly appointed legal representative, pay all or any portion of such benefits to the parent, spouse or a relative by blood, or to any other person or entity that, in the Trustees' opinion, is entitled to receive payment on behalf of such person. Any payment so made by the Trustees in good faith will fully discharge the Plan, the Trust Fund and the Trustees to the extent of such payment.

Section 7.4 - Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or illness is the basis of a claim for benefits under the Plan, when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death unless prohibited by law.

Section 7.5 – Administration of Plan

The Plan shall be administered by the Board of Trustees for the Trust Fund. The Trustees are the fiduciaries for the Plan, and unless and except to the extent delegated, shall have full and exclusive authority to interpret, control and manage the operation and administration of the Plan, in their sole discretion, consistent with the Agreement and Declaration of Trust. The Trustees shall be free to use their own judgment and discretion in all things pertaining to the affairs of the Plan and shall not be personally liable for any action done or omitted to be done when acting in good faith and in the exercise of their best judgment, and the fact that such actions or omissions are based upon advice of counsel employed by the Trustees shall be evidence of their good faith and best judgment to the extent not prohibited by ERISA. For purposes of carrying out their responsibilities and duties, the Trustees shall have all necessary and appropriate powers including but not limited to the following:

- A. Interpret the provisions of the Plan, determine all questions of coverage and eligibility, all methods of providing and arranging for benefits and all claims for benefits, decide any ambiguities, inconsistencies or omissions in the Plan, and determine any other matters arising under the Plan, and all such determinations, constructions and interpretations adopted by them in good faith shall be binding on all persons and parties concerned;
- B. Establish, from time to time as needed, administrative rules and procedures relating to the administration of the Plan and the carrying out of their duties and powers, including the delegation of duties as they see fit;
- C. Employ, appoint or retain such persons or entities as they deem necessary or desirable in connection with administration of the Plan, including but not limited to certified public accountants, actuaries, consultants, legal counsel, and insurance companies;

- D. Require covered individuals or other persons to furnish such information and complete such forms as the Trustees may require for the proper administration of the Plan and as a condition to receiving any benefit under the Plan;
- E. Provide Plan documents and information as permitted or required under ERISA and, if permitted and deemed appropriate, charge for the related costs;
- F. Determine the facts affecting eligibility to participate in the Plan or receive benefits under the Plan;
- G. Determine the manner in which benefits shall be paid under the Plan, if discretionary, and the persons who are entitled, and authorize and direct the payment of benefits and other sums due under the Plan;
- H. Employ personnel if and as needed to carry out the daily functions of the Plan;
- I. Enter into insurance contracts if and as deemed necessary or desirable to provide for the benefits under the Plan; and
- J. Authorize the reimbursement of expenses incurred on behalf of the Plan.

Section 7.6 – Miscellaneous

- A. **Law Applicable:** This Plan is created and accepted in the State of Louisiana, and all questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Louisiana to the extent not preempted by ERISA and except as to matters governed by federal law.
- B. **Savings Clause:** Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions of the Plan or the application of said provision to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.
- C. **Headings:** All article and section headings in the Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

Section 7.7 – Time Limit on Legal Action

In no event may legal action be brought by or on behalf of any individual to receive benefits under the Plan unless the individual or his or her legal representative has first fully complied with and timely exhausted all of the requirements of the Claims Procedure and Claims Review Procedure under the Plan, and in no event may any such legal action be brought later than one year following a final determination of a claim under the Plan. Solely with respect to Life Benefits and Accidental Death and Dismemberment Benefits, the time limits for starting lawsuits to obtain such benefits shall be governed by the terms of the insurance contract and related insurance certificate-booklet governing the payment of such benefits, if and to the extent they provide for

such time limits.

ARTICLE VIII

AMENDMENT AND TERMINATION

Section 8.1 - Right to Amend or Terminate

The Trustees expressly reserve the right, in their sole discretion, at any time and for any reason, to amend or terminate the Plan, in whole or part, and any such amendment or termination authorized by the Trustees will take effect on the date specified by the Trustees and will apply to all affected persons regardless of status, illness or injury sustained prior to the effective date. The right to amend or terminate the Plan shall include, but is not limited to, the right to do any of the following:

- A. To terminate, amend or reduce the benefits or coverage under the Plan or to modify the eligibility conditions;
- B. To alter or postpone the method of payment of any benefit;
- C. To enter into a merger with one or more other group plans, provided such merger is accomplished pursuant to applicable law;
- D. To terminate the Plan in whole or part; and
- E. To amend the Plan in whole or part at any time, consistent with all applicable provisions of the Agreement and Declaration of Trust.

Section 8.2 – Eligibility and Benefits Not Guaranteed

Eligibility and benefits under the Plan are not guaranteed and may be amended or terminated at any time, regardless of retirement, disability or self-payment status, and regardless of the effect on any illness, injury or condition sustained prior to the effective date of change.

Section 8.3 – Circumstances Under Which Plan May Terminate

Circumstances under which the Plan may be terminated include, but are not limited to, the following:

- A. When there are no longer sufficient assets to continue the benefits of the Plan;
- B. When there are no longer any Employers that are required to make contributions under the appropriate Collective Bargaining Agreement;
- C. When there are no longer any persons covered by the Plan; and
- D. With respect to a particular Employer, when that Employer ceases to be a contributing

Employer according to the Agreement and Declaration of Trust.

Section 8.4 – Procedures on Termination

- A. In the event of a Plan termination, the Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations under the Plan and to provide that all remaining assets be used in a manner which best carries out the basic purpose for which the Plan was established, or to otherwise be disposed of in a manner consistent with applicable law. In no event, however, may any amendment or termination cause any part of the Fund to revert to an Employer.
- B. In the event of a Plan termination, only claims and expenses incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used. In no event will the Board of Trustees or any individual Trustee, Employer, Union or other individual or entity be liable to provide the payment of benefits over and beyond the Plan assets in the Fund available for such purpose.

ARTICLE IX

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”)

This statement of your rights under ERISA is required by federal law and regulation.

As a Participant in the Plumbers and Steamfitters Local 141 Health and Welfare Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended, (“ERISA”). ERISA provides that all Participants shall be entitled to:

Section 9.1 - Receive Information about Your Plan and Benefits

You have the right to:

Examine, without charge, at the Fund Administrator's office and other specified locations such as worksites and union halls, all documents governing the Plan including insurance contracts, 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 Fund Administrator, copies of documents governing the operation of the Plan including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Section 9.2 - Continue Group Health Plan Coverage

You have the right to:

Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this booklet and the other benefit booklets comprising the Summary Plan Description and Plan for the rules governing your COBRA Coverage rights.

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer: (1) when you lose coverage under the plan; (2) when you become entitled to elect COBRA Coverage; (3) when your COBRA Coverage ceases; (4) if you request it before losing coverage; or (5) if you request it up to 24 months after losing coverage. Without

evidence of creditable coverage, you may be subject to an exclusion of coverage for a pre-existing condition for 12 months (18 months for late enrollees) after your coverage enrollment date.

Section 9.3 - Prudent Actions by Plan Fiduciaries

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

Section 9.4 - Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or 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 Fund 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 Fund Administrator.

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

However, in all cases including those described in the above paragraph, a person must first exhaust his administrative remedies under the Plan, by following the Plan’s Claim and Appeal Procedures described in this booklet or the separate benefit booklet for the benefit to which the claim relates, before the person may file a lawsuit in any court. The person will then have one year from the date a final decision on appeal is reached under the Plan in which to start a lawsuit. In no event may legal action be brought in court, by or on behalf of the person, later than this one-year period.

Section 9.5 - Assistance with Your Questions

If you have questions about your Plan, you should contact the Fund Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should: (1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or (2) call EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or (3) write to EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW,
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

ARTICLE X

PRIVACY AND SECURITY RULE

The Plan has the right to release to or obtain from another person or entity, information relating to your claim or the claim of your Dependent which the Plan considers reasonably necessary for administering the Plan and determining and paying benefits that may be due. However, what the Plan does with your health information is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The federal law known as "HIPAA" resulted in federal privacy and security rules that require health plans, such as this Plan, to protect the confidentiality of your protected health information (also referred to as "PHI"). These privacy and security rules also apply to your Dependent's PHI. PHI is defined under HIPAA and generally includes health information, including demographic information, that is collected from you or created received by the Plan in any form (oral, written or electronic), from which it is possible to individually identify you. In addition, the information must relate to your past, present or future health or condition (physical or mental), to providing health care to you, or to paying for your health care. A complete description of your privacy rights can be found in the Plan's Privacy Notice, which was distributed to you upon enrollment. You may also request a copy of the Privacy Notice at any time by contacting the Fund Office.

We will not use or disclose your PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you. We have also required all of our business associates, such as the Claims Administrator, that create or receive PHI on our behalf to observe the privacy and security rules with respect to such PHI.

We will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any of our other benefits or employee benefit plans. If someone other than you, even a friend or relative, contacts us and wants to discuss a claim or matter involving the information, your authorization will first be required unless the discussion is otherwise permitted under HIPAA. **Written explanations of benefits (EOBs) for Dependents under age 18 will be mailed to the participating Employee through whom the Dependent has coverage, unless the Dependent provides other written instructions to the Plan.**

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and to amend the information in certain circumstances. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Your rights are explained in greater detail in the Plan's Notice of Privacy Practices.

If you have questions about the privacy or security of your health information or wish to file a complaint under HIPAA, please contact the Administrative Manager at the Fund Office. The Administrative Manager also serves as the Plan's Privacy and Security Officer.

Written explanations of benefits (EOBs) for Dependent spouses and children age 18 or older will be mailed to the spouse or child unless he or she provides other written instructions to the Fund Office.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE PLUMBERS AND STEAMFITTERS LOCAL 141 HEALTH AND WELFARE PLAN, THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE THE PLAN, IN WHOLE OR IN PART, AT ANY TIME AND IN THEIR SOLE DISCRETION.

ARTICLE XI

IMPORTANT INFORMATION ABOUT THE PLAN

Section 11.1 - Official Name of Plan

The name of the Plan is the Plumbers and Steamfitters Local 141 Health and Welfare Fund.

Section 11.2 - Type of Plan

The Plan is a group health plan that provides comprehensive medical benefits, prescription drug benefits, and also provides life benefits, accidental death and dismemberment benefits.

Section 11.3 - Plan Sponsor, Plan Administrator, and Named Fiduciary

This collectively bargained Plan is sponsored and administered by a joint Board of Trustees consisting of up to three Union representatives and up to three Employer representatives. The Trustees may be contacted at the following address and telephone number:

Board of Trustees
Plumbers and Steamfitters Local 141 Health and Welfare Fund
7113 W. Bert Kouns Industrial Loop
Shreveport, Louisiana 71129
Phone (318) 688-6990

A copy of the collective bargaining agreement as well as a complete list of the employers and/or employee organizations sponsoring or participating in the Plan are available for inspection without charge at the Fund Office, and a copy may be obtained by Employees, Dependents, Retirees or Beneficiaries upon written request to the Board of Trustees for a minimal copying fee.

Section 11.4 - Employer Identification Number and Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees for the Plan is: **72-0800067**. The Plan number assigned by the Board of Trustees to the Plan is **501**.

Section 11.5 - Plan Year End

The records of the Plan are kept on the basis of a fiscal year which begins on May 1 and ends on the following April 30. This fiscal year is also known as the Plan Year. Benefits under the Plan are provided on the basis of the 12-month period from January through December 31.

Section 11.6 - The Names and Business Addresses of the Plan's Trustees

Chris FitzGerald
FitzGerald Contractors, LLC
P.O. Box 6600
Shreveport, LA 71136
cfitzgerald@fitzgeraldcontractors.com

Ken Payne
The Payne Company
P.O. BOX 19130
Shreveport, LA 71149-0130
ken@thepayneco.com

William Hamm
517 W. 61st St.
Shreveport, LA 71106
318.828.2345
whamm@hammmechanical.com

Michael Hale, Co-Chairman
Plumbers & Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
michael@local141.com

Daniel T. Walker, President Local 141
Plumbers and Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
dwalker@dmrmechanical.com

James "Casey" Olden
Plumbers and Steamfitters Local 141
7111 W. Bert Kouns Ind. Loop
Shreveport, LA 71129
(318) 671-1175
casey057@yahoo.com

Section 11.7 - Name and Address for Agent for service of Legal Process

The Board of Trustees for the Plan has been designated as the agent for service of legal process. Service of process may be made at the address listed above, upon any of the individual Plan Trustees, or upon the Plan's legal counsel, as follows:

Maria C. Cangemi
Robein, Urann, Spencer, Picard & Cangemi
2540 Severn Avenue, Suite 400
Metairie, LA 70002

Section 11.8 - Source of Contributions

All contributions to the Plan are made primarily by Employers in accordance with Collective Bargaining Agreements or other written agreements between the Plumbers and Steamfitters Local 141 and signatory Employers, which require contributions to the Fund at fixed rates per hour worked. Contributions may also be made to the Fund by Employers of non-collectively bargained employees in accordance with written participation agreements. The Administrative Manager will provide you, upon written request, with information as to whether or not a

particular Employer or employee organization is contributing to the Fund on behalf of Employees working under the Collective Bargaining Agreement or written participation agreement.

Employees and their Dependents are generally not allowed to contribute to the Fund except under certain circumstances for which continuation of coverage on a self-payment basis is permitted by the Plan. In all such cases the Trustees will determine the amount of the required self payments based upon the cost of providing the coverage and any additional amounts for related administrative costs permitted by law.

Section 11.9 - Identity of Funding Medium Used for Accumulation of Assets

The Plan's assets are accumulated under the provisions of the Collective Bargaining Agreements, Participation Agreements and Trust Agreement, and held in a trust fund account for the purpose of providing benefits to Covered Persons and defraying reasonable administrative expenses of the Plan. All medical and prescription drug benefits are provided on a self-funded basis and are payable out of the Fund's assets. All Life Benefits and Accidental Death and Dismemberment Benefits are provided through a group insurance policy purchased by and issued to the Fund, and payable by the insurance issuer in accordance with the terms of the policy.

Section 11.10 - Fund Administrative Manager

The Trustees have delegated certain responsibilities for the Plan's day-to-day operations to a Fund Administrator. The Fund Administrative Manager is:

Jocelyn Shane
Plumbers & Steamfitters Local 141 Health & Welfare Fund
7113 West Bert Kouns Ind Loop
Shreveport, LA 71129
Telephone: (318) 688-6990
Fax: (318) 688-6997

Section 11.11 - Type of Administration

The Plan is administered by a joint Board of Trustees consisting of no more than three Union representatives and no more than three Employer representatives. The Board of Trustees has appointed a Fund Administrative Manager, identified above, to handle certain day-to-day operations of the Plan and Fund, including but not limited to matters related to eligibility and COBRA Coverage. The Board of Trustees may, in its sole discretion, contract with outside parties to arrange for the provision of other administrative services.

Section 11.12 - Collective Bargaining Agreements, Plan Documents and Reports

The Plan is maintained pursuant to one or more Collective Bargaining Agreements and Participation Agreements, which require the signatory Employers to make contributions to the

Fund on behalf of their Employees. Contributions are required on the basis of fixed rates for each hour in Covered Employment or other specified basis. You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- A. Agreement and Declaration of Trust;
- B. Collective Bargaining Agreements and Participation Agreements;
- C. Plan documents and all amendments;
- D. Form 5500 and full Annual Report filed with the Internal Revenue Service and the Department of Labor; and
- E. List of Contributing Employers.

You may also obtain copies of these documents by writing for them and paying the reasonable cost of duplication. You should find out what the charge will be before requesting copies. If you prefer, you can arrange to examine these reports, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. A summary of the Annual Report which give details of the financial information about the Plan's operation is furnished free of charge to all Participants.

Section 11.13 - Consultant and Actuary

The consultant and actuary for the Plan is The Segal Company.

Section 11.14 - Accountants

The accountant for the Plan is Dennis Jenkins, CPA.

Section 11.15 - Health Insurance Issuer

The Life Benefits, Accidental Death and Dismemberment Benefits are provided through a group insurance policy issued through MetLife to the Fund. Please contact MetLife (800) 708-5434 Ext. 3614.

Section 11.16 - Participating Employers

A complete list of the Employers and/or employee organizations participating in the Plan is available for inspection without charge at the Fund Office upon ten days' written notice. A copy may also be obtained upon written request to the Administrative Manager for a minimal copying fee. You may want to ask the amount of the fee before requesting copies. Alternatively, you may obtain, upon written request to the Fund Office, information as to whether a particular employer participates in the Plan and, if so, its address.

Section 11.17 - Selection of Physicians and Facilities

The Plan provides benefits for certain health care expenses, but the Plan does not provide hospital or medical services. You have the right to use the provider(s) of your choice. The Plan is not responsible for any acts or omissions by hospitals, medical facilities, Physicians or medical professionals, or any facility staff member or employee thereof.

Section 11.18 - Qualified Medical Child Support Orders

Upon written request to the Administrative Manager, you may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

ARTICLE XII

MISCELLANEOUS

IT IS IMPORTANT that you and your Dependents notify the Fund Office whenever:

- A. You have a change in home address or marital status (marriage, divorce or physical separation);**
- B. You wish to change a beneficiary (a new beneficiary card must be turned in to the Fund Office);**
- C. You acquire a new Dependent (a new beneficiary card must be turned in to the Fund Office); or**
- D. You suffer an injury resulting in disability.**

This booklet is a summary of the most important features of the Plan. If you or your Dependents have any questions about the terms of the Plan or about proper payment of benefits, please contact the Fund Office for more information. The Board of Trustees for the Fund has full and exclusive authority, in their sole discretion, to determine all questions of coverage and eligibility, the level and type of benefits provided and the methods of providing for such benefits, and to construe and interpret the terms of the Plan. All such determinations, constructions and interpretations adopted by the Trustees in good faith shall be binding on all entities and persons.

The Trustees reserve the right, in their sole and absolute discretion and at any time, to change, modify, reduce and/or terminate any and all eligibility requirements, coverage, benefits and/or other provisions of the Plan, retroactively or otherwise, for any persons including any class of Employees, Dependents or Retirees. Any changes authorized by the Trustees will take effect on the date specified by the Trustees, and will apply to all affected persons regardless of status, and to any injury or illness sustained prior to the date of change as well as to any medical services which may be required for an illness or injury sustained prior to the date of change. Eligibility and benefits under the Plan are not guaranteed and are subject to change. Except for the Life Benefit and Accidental Death and Dismemberment Benefits, which are provided through the group insurance policy purchased by the Trustees out of the assets of the Fund, all benefits provided under the Plan are self-insured by the Fund, and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and above the amount in the Fund available for the payment of benefits under the Plan.

IN WITNESS WHEREOF, the Plumbers and Steamfitters Local 141 Health and Welfare Fund Restated Rules and Regulations are hereby adopted and executed in Shreveport, Louisiana, on the 17th day of May, 2016, to be effective January 1, 2016 except as otherwise stated.

BOARD OF TRUSTEES

PLUMBERS AND STEAMFITTERS LOCAL 141 HEALTH AND WELFARE FUND

UNION TRUSTEES:

MANAGEMENT TRUSTEES:

Michael Hale, Co-Chairman

Chris FitzGerald

Daniel T. Walker

Ken Payne

James "Casey" Olden

William Hamm

