STEAMFITTERS WELFARE FUND

LOCAL UNION No. 475

Summary Plan Description and Plan Document

For Active and Retired Participants

Effective January 1, 2009
BOARD OF TRUSTEES AS OF JULY 1, 2009

For the Union

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SCHEDULE A

BASIC PLAN OF BENEFITS
FOR ACTIVE PARTICIPANTS WITH ONE QUARTER
BUT LESS THAN FOUR CONSECUTIVE QUARTERS
OF CREDITED SERVICE
For Eligible Participants Only

Natural Death Benefit ...................................................... $ 10,000.00
Accidental Death Benefit .................................................... $ 20,000.00
Accidental Dismemberment Benefit:
   Loss of Two or More Members (Hand, Foot, Eye) .................. $ 20,000.00
   Loss of Speech or Hearing and Loss of One Member (Hand, Foot, Eye) $ 20,000.00
   Loss of Both Hearing and Speech ..................................... $ 20,000.00
   Loss of One member Only (Hand, Foot, Eye) ...................... $ 10,000.00
   Loss of Speech or Hearing ............................................. $ 10,000.00
   Loss of Thumb and Index Finger (same Hand) .................... $ 5,000.00

Basic Hospital, Surgical-Medical Benefits – Detailed in Section 6

Behavioral Health Benefits – Detailed in Section 7

Transplant Benefits – Detailed in Section 8
SCHEDULE B

EXPANDED PLAN OF BENEFITS
FOR PARTICIPANTS WITH FOUR OR MORE CONSECUTIVE QUARTERS OF CREDITED SERVICE
For Eligible Participants Only

NATURAL DEATH BENEFIT

| Four but less than Eight Service Credits | $ 20,000.00 |
| Eight but less than Twelve Service Credits | $ 30,000.00 |
| Twelve but less than Sixteen Service Credits | $ 40,000.00 |
| Sixteen or More Service Credits | $ 50,000.00 |

ACCIDENTAL DEATH BENEFIT

| Four but less than Eight Service Credits | $ 20,000.00 |
| Eight but less than Twelve Service Credits | $ 40,000.00 |
| Twelve but less than Sixteen Service Credits | $ 60,000.00 |
| Sixteen but less than Twenty Service Credits | $ 80,000.00 |
| Twenty or More Service Credits | $ 100,000.00 |

ACCIDENTAL DISMEMBERMENT BENEFIT

| Loss of Two or More Members (Hand, Foot, Eye) | Principal Sum |
| Loss of Speech or Hearing and Loss of one Member (Hand, Foot, Eye) | Principal Sum |
| Loss of Both Speech and Hearing | Principal Sum |
| Loss of One Member Only (Hand, Foot, Eye) | 50% Principal Sum |
| Loss of Speech or Hearing | 50% Principal Sum |
| Loss of Thumb and Index Finger (same Hand) | 25% Principal Sum |

1. Dependents and Retired Participants are ineligible for Death, Accidental Death and Dismemberment Benefits.
2. Principal Sum is dependent upon Service Credits and is shown under the Accidental Death Benefit Schedule (above).

SUPPLEMENTAL DISABILITY INCOME BENEFIT
For Active Participants Only

<table>
<thead>
<tr>
<th>Consecutive Quarter of Eligibility</th>
<th>First Week</th>
<th>2 to 26 Weeks</th>
<th>27 to 52 Weeks</th>
</tr>
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<tbody>
<tr>
<td>Four to Seven</td>
<td>0</td>
<td>$75.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Eight to Eleven</td>
<td>0</td>
<td>105.00</td>
<td>140.00</td>
</tr>
<tr>
<td>Twelve to Fifteen</td>
<td>0</td>
<td>120.00</td>
<td>160.00</td>
</tr>
<tr>
<td>Sixteen or More</td>
<td>0</td>
<td>150.00</td>
<td>200.00</td>
</tr>
</tbody>
</table>

Maximum Benefit Period 51 Weeks in any 104 Week Period

Benefit payable during the first twenty six (26) weeks subject to Social Security Withholding Tax. The benefits shown above are net after payment of Participants and Employer’s share of Social Security taxes, which are assumed by the Fund.

All plan benefits are subject to Coordination of Benefits and Subrogation.

HOSPITAL AND MEDICAL BENEFITS
Detailed in Section 6

OTHER BENEFITS

Behavioral Health Benefits:
Detailed in Section 7

Transplant Benefits:
Detailed in Section 8

Dental Expense Benefits:
Maximum Covered Charges per Calendar Year $ 2,000.
Maximum Benefit per Calendar Year $ 1,700.
Plan Payments (based on UCR charges) at 85% of UCR Employee Co-Payment 15%
Orthodontic Expense Benefit:
Maximum Lifetime Benefit $2,500.

Benefit payment Based on UCR
First $75 of Charges at............................................................ 100%
Excess charge over $75 at....................................................... 50%

Vision Care Benefit:
Maximum Per Calendar Year.................................................... $150.

Lasik or PRK Surgery:*
Benefit payment based on 85% of UCR
Maximum Lifetime Benefit (per eye) $1,700.

* For those (Active/Retired) Participants eligible for Plan B Benefits **where vision cannot be corrected to better than 20/60** through eyeglasses or contact lenses, the cost of Lasik or PRK Surgery will be a covered benefit administered by the Steamfitters Welfare Fund, Local #475 and subject to the following conditions and limitations:

- A Participant is eligible for the benefit only once during his lifetime.
- A Participant must precertify the surgery in writing, through an independent and duly licensed ophthalmologist, that his vision cannot be corrected to better than 20/60 through eyeglasses or contact lenses. The Welfare Fund reserves the right to obtain a second opinion at its cost and expense as to the satisfaction of this condition prior to certifying the surgery.

Prescription Safety Glasses Active Participants Only
(thru Winchester Optical Only).................................................. 100% coinsurance Maximum of $90

Prescription Drug Benefits:
Retail (30 day supply)
Participant Co-Payment Generic Drugs ........................................ -0-
Participant Co-Payment Preferred Brand Drugs .............................. $15.00
Participant Co-Payment Non-Preferred Brand Drugs ........................ $30.00

Mail Order (90 day supply)
Participant Co-Payment Generic Drugs........................................... -0-
Participant Co-Payment Preferred Brand Drugs................................. $30.00
Participant Co-Payment Non-Preferred Brand Drugs ........................... $60.00

Annual Maximum (per individual per calendar year) ....................... $10,000.
SECTION 1
DEFINITIONS

1.1 **Association**: The Term “Association” shall mean the Mechanical Contractors Association of New Jersey, Inc. with offices presently located at 211 Mountain Avenue, Springfield, NJ 07081-0390.

1.2 **Benefits**: The Plan covers only those benefits specifically described herein, or which are subsequently adopted by the Trustees after the effective date of this Plan. If an eligible Participant incurs a medical expense that is not specifically described as being a covered medical expense, such expense shall be excluded even though not specifically excluded under the exclusion section of the benefit provision. Further, the Trustees reserve the right to interpret the Plan provisions where the language or intent are not clear or where there may appear to be a conflict in terms.

1.3 **Covered Charges**: For benefits administered by the Steamfitters Welfare Fund, Local #475, it means the usual, customary, and reasonable charges specifically covered by this Plan which were incurred for necessary medical care, services, or supplies received by an eligible Participant or Dependent upon the recommendation and approval of a physician who is attending such person, and to the extent such charges are not otherwise excluded or limited by the terms of this plan.

1.4 **Covered Employment**: Means hours worked for an Employer who is obligated to make contributions to the Fund pursuant to a Collective Bargaining Agreement or other written agreement with the Trustees.

1.5 **Custodial Care**: Means care comprised of services and supplies, which are provided to an individual primarily to assist him in the activities of daily living.

1.6 **Dependent’s Benefits**: Refers to the benefits provided an Eligible Employee’s or Retiree’s Eligible Dependent Spouse. It also refers to the coverage provided for an Eligible Employee’s Dependent Child (as defined in the Plan) where such coverage is provided under the Schedule of Benefits.

1.7 **Effective Date of Coverage**: A Participant’s coverage will become effective on the date he satisfies the eligibility requirements set forth in Section 2, providing that on such date he is either actively employed or available for employment. A Participant who, on the date he would become eligible, is unable to work because of an injury or illness incurred prior to such date, shall have his coverage under the plan deferred until the date he either returns to work or is available to return to work.

A Dependent who is in a hospital on the date he or she would become an Eligible Participant will not be covered for any Dependent’s benefits under the plan until such Dependent has been finally discharged from the hospital. However, if a newborn Dependent child incurs charges for services over and above the usual cost of nursery charges for routine well baby care, because of sickness, injury, congenital defects, or premature birth, coverage begins from birth.

1.8 **Effect of Divorce or Legal Separation**: In the event of legal divorce or separation, the Participants must notify the Fund office immediately as to the legal obligations regarding any Dependent Spouse or Child as defined above. If there is a court order specifying that the member has the financial responsibility for the health care expenses of a Dependent Child or Spouse, such order must be immediately filed with the Fund Office in accordance with the terms of Section 1.19.

1.9 **Eligible Dependents**: For the purpose of determining the eligibility of any Dependent hereinafter defined, the Trustees shall consider only those Dependents of an Eligible Participant who are enrolled on the Fund records, providing they satisfy the requirements of one of the following definitions:

a) **Dependent Spouse**: An eligible Participant’s lawful spouse providing she is dependent on the Participant for support and maintenance. If such spouse is employed or self-employed, and is covered under a Health Insurance Plan by her employer or through such self-employment, the coverage provided under this Welfare Plan shall be limited to the extent that such Spouse’s Plan shall be primary, and the benefits provided by this Welfare Plan shall be secondary, as further provided under the Coordination of Benefits hereinafter set forth under Section 17 (see page 62). The Dependent Spouse of an eligible Participant shall cease to be a dependent if the Participant and spouse are legally divorced.

b) **Dependent Child**: The term “Dependent Child” shall mean each unmarried dependent child through eighteen years of age or younger, except that “dependent child” shall also be construed to mean full-time student children through age twenty-four while they are attending a school, college, or university or trade or training school as a full-time student. The term “dependent child” as used herein shall include natural, stepchild, adopted child (including the period pending finalization of the adoption), and foster child provided such child is totally dependent upon the eligible Participant for support and maintenance. However, “dependent child” shall not mean the child of a dependent child. The Trustees shall have the right to require the Participant to furnish proof of such child’s dependency, upon request.
i) Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

ii) If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

c) **Newborn Children:** The newborn natural child of an eligible active Participant shall be covered from the date of birth (see Section 1.7).

Notwithstanding anything to the contrary, those dependents who are eligible for benefits as Employee or Retiree under the plan shall not be considered Eligible Dependents hereunder.

1.10 **Eligible Employee or Participant:** The term “Eligible Employee or Participant” means a Person who has satisfied the Eligibility Requirements of the Plan and is entitled to benefits at the time a claim is incurred.

1.11 **Eligible Retiree:** Refers to formally active Participant of the Steamfitters Welfare Fund, Local No. 475, who has retired from active employment, and who has applied and has satisfied the eligibility requirement under Section 13 of the Plan.

1.12 **Employees - Participants:** The term “Employees” or “Participants” as used herein shall mean the Employer’s Employees who have been, who are, or who may be employed in the heating, piping and air conditioning industry and who have been, are, and may be represented in the future by the Union doing collectively bargained work. The term “Employees” or “Participants” as used herein shall also mean the full time salaried employees of the Union, the Steamfitters Welfare, Surety, Pension and Education Funds of Local Union No. 475, provided contributions are made to the Welfare Fund at the same rates or for the same percentage amounts as Employers contributing pursuant to collective bargaining agreements with the Union, in accordance with the terms of a written agreement between the Trustees and such organizations as herein described.

1.13 **Employer:** The term “Employer” as used herein shall mean any Employer who is a contractor engaged in the heating, piping, and air conditioning industry and who enters into and maintains a collective bargaining agreement with the Union and in accordance therewith assents and consents to participate in and contribute such sums of money to the Welfare Fund as determined in the collective bargaining agreements. The term “Employer” shall also mean each of the present and future employer members of the aforementioned Association on whose behalf the Association shall become a party to the Agreement and Declaration of Trust. The term “Employer” shall also mean an Employer who may now have or will have a collective bargaining agreement in existence with the parent International Union, namely the United Association of Journeymen & Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, but who does not still have a written collective bargaining agreement with the Union but who, however, adheres to the hours of work, working conditions, rates of pay, and the required contributions by the Employer to this Welfare Fund on behalf of the Employees of the Employer represented by the Union. The term “Employer” shall also mean the Union, the Steamfitters Welfare, Surety, Pension and Education Funds of Local Union No. 475, provided contribution are made to the Welfare Fund at the same rate or for the same percentage amounts as Employers contributing pursuant to collective bargaining agreements with the Union.

1.14 **Employer Contributions:** The term “Employer Contributions” shall mean payments to the Welfare Fund by an Employer as defined in Section 1.13 of amounts as set forth in the collective bargaining agreement or agreements with the Union.

1.15 **Handicapped Child:** If an unmarried Dependent Child, as defined under Section 1.9 (b), is incapable of self-sustaining employment because of a physical handicap or mental retardation, and such child is totally dependent upon an Eligible Employee of the Plan for support and maintenance, such child’s eligibility under the Plan will be continued beyond 18 years of age, provided (1) his incapability commenced before the attainment of age 19, and (2) proof of the child’s incapability is furnished to the Welfare Fund within the thirty-one (31) days after attainment of such age. Proof of the continued existence of such incapability must be furnished to the Welfare Fund from time to time at its request. Notwithstanding anything herein to the contrary, such Dependent Child’s coverage shall be subject to the termination provision of Section 2.
1.16 **Home Health Care Agency:** Means an agency or organization which meets each of the following requirements:

a) it is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services,

b) its policies are established by a professional group associated with such agency or organization,

c) includes at least one physician and at least one registered nurse, to govern the services provided,

d) it provides for full-time supervision of such services by a physician or by a registered nurse,

e) it maintains a complete medical record on each patient, and

f) it has an administrator.

1.17 **Hospital:** The term Hospital means:

a) an institution licensed as a hospital, which:

   i) maintains, on the premises, all facilities necessary for medical and surgical treatment;

   ii) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and

   iii) provides 24-hour service by Registered Graduate Nurses;

b) an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

c) an institution which:

   i) specializes in treatment of Mental Health and Substance Abuse or other related illness;

   ii) provides residential treatment programs; and

   iii) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

1.18 **Physician:** Shall mean a duly licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his practice.

1.19 **Qualified Domestic Relations/Medical Child Support Orders:** The Plan shall provide benefits in accordance with the applicable requirements of either a Qualified Domestic Relations Order or a Qualified Medical Child Support Order as such terms are defined under ERISA. For such orders to be operative, the orders must be filed on a timely basis with and approved in writing by the Trustees.

1.20 **Quarterly Period:** The term “Quarterly Period” shall mean any one of the following calendar periods in any given year: (a) January 1 through March 31 inclusive; (b) April 1 through June 30 inclusive; (c) July 1 through September 30 inclusive; or (d) October 1 through December 31 inclusive.

1.21 **Retiree:** Retiree refers to a Participant who has withdrawn from:

a) active employment at the trade or industry and has applied for normal or early retirement benefits under the Steamfitters Pension Fund, Local No. 475 Plan, and

b) who applies and qualifies for retirement benefits in accordance with eligibility provisions herein set forth (see pages 46 thru 48).

1.22 **Retiree’s Benefits:** Refers to the benefits provided to an eligible retiree.

1.23 **Self Contributions:** The term “Self Contributions” shall refer to payments made by an Eligible Participant for the purpose of maintaining eligibility under the plan.

1.24 **Trust Agreement:** The term “Trust Agreement” shall mean the Agreement and Declaration of Trust Steamfitters Welfare Fund, Local Union No. 475 made and entered into as of October 10, 1950 including any amendments or modifications thereto executed by and between the Union, the Association and the Trustees then serving.
1.25 **Trustees:** The term “Trustees” shall mean the Trustees designated by the Trust Agreement, their alternate, if any, or their successors designated in accordance with the provisions of the Trust Agreement.

1.26 **Union:** The term “Union” shall mean Local 475 of the United Association of Journeymen and Apprentices of the Pipefitting Industry of the United States and Canada, AFL-CIO, with offices presently located at 136 Mt. Bethal Road, Warren, New Jersey 07059.

1.27 **Usual, Customary, and Reasonable Charge:** Means the prevailing fee or fees most frequently charged by the providers with similar training and experience for similar or comparable services, in the locality where such service was performed. The Trustees retain the right to determine what constitutes “a usual, customary and reasonable charge” in connection with the payment of any benefit.

1.28 **Welfare Fund:** The term “Welfare Fund,” “Trust Fund” or “Fund” shall mean the Steamfitters Welfare Fund, Local Union No. 475 established pursuant to the Trust Agreement. It shall consist of all contributions to the trust estate received under the aforementioned collective bargaining agreement or agreements and any additional contributions thereto that may hereafter be agreed upon by the Union and Association under the then existing collective bargaining agreement or agreements by reason of any modification, amendment, revision or extension thereof, together with all income, increments, earnings and profits therefore and all other funds (as otherwise defined in this trust indenture) received by the Trustees for uses, purpose and trust set forth in the Trust Agreement.

1.29 **Welfare Plan:** The term “Welfare Plan” shall mean the plan, program, method and procedure for the provision and payment from the Welfare Fund of benefits for Eligible Participants in accordance with such rules and regulations relating to eligibility requirements, amounts of benefits, general administration and operation of the Fund as the Trustees may from time to time adopt and promulgate. The Welfare Plan document refers to this document or as may be hereafter amended or changed from time to time by the Trustees.
SECTION 2
ELIGIBILITY RULES FOR ACTIVE PARTICIPANTS

2.1 Purpose: This section sets forth the basis upon which a Participant becomes an eligible Participant, continues his eligibility or is terminated. A Participant's eligibility is based upon the hours he is credited with as a result of employment with a Contributing Employer in the jurisdictional area of the Plan or by Reciprocal Agreement. In certain instances, a Participant may also receive credit during periods of temporary disability or unemployment, providing he has accumulated the required number of Credited Quarters of service, as hereinafter provided.

2.2 Definition of Hour of Credited Service: A Participant will be credited with one hour of Credited Service for each hour of employment with a Contributing Employer which is performed with the jurisdictional area of the plan, and for which the Plan receives such required employer contribution. Credit will also be given for hours of work transferred under the terms of a Reciprocal Agreement.

2.3 Definition of Credited Service: A Participant who works in covered employment, or who otherwise receives credit for at least four hundred (400) hours of service during a WORK QUARTER shall earn one quarter of Credited Service.

2.4 Definition of Work Quarter: A Work Quarter is defined as the three consecutive calendar months commencing each January 1, April 1, July 1 and October 1. The hours of Credited Service earned and credited during such Work Quarter will be used to determine an employee’s eligibility in the following BENEFIT QUARTER.

2.5 Definition of Benefit Quarter: A Benefit Quarter is defined as the three consecutive calendar months in which a Participant or a dependent is covered for the benefits provided under the Plan. Eligibility during a Benefit Quarter will be based on Hours of Credited Service earned or credited in the Work Quarters (based on contributions received) immediately preceding the Benefit Quarter in which a claim is incurred. Benefit Quarters commence each January 1, April 1, July 1, and October 1.

2.6 Initial Eligibility: An Employee shall become eligible on the first day of the Benefit Quarter following a Work Quarter in which he has been credited with at least four hundred (400) hours of credited service with a contributing employer.

2.7 Continued Eligibility: Once a Participant becomes eligible, his eligibility for benefits will be continued in the succeeding benefit quarter providing such Participant:
(a) has 400 hours of Credited Service in the immediately preceding Work Quarter, or
(b) has 1600 hours of Credited Service in the immediately preceding four (4) consecutive Work Quarters.

<table>
<thead>
<tr>
<th>BASIC ELIGIBILITY REQUIREMENTS</th>
</tr>
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<tbody>
<tr>
<td>To be Eligible in the Current Benefit Quarter</td>
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<td></td>
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</tbody>
</table>

2.8 Disability Credit Hours: An eligible Participant who has four (4) or more consecutive Quarters of Credited Service in the period immediately preceding the date of disability, and who becomes disabled as a result of an accidental bodily injury or illness while eligible hereunder, shall be granted one hour of Credited Service during a period of disability:
(a) for each hour that such disabled Participant received benefits for temporary disability in accordance with New Jersey Temporary Disability Benefits Law, or Workers Compensation provided that in no event shall a Participant receiving benefits under either of the foregoing plans be credited with more than eight (8) hours of Credited Service for any one day nor more than four hundred (400) hours of Credited Service (including hours of actual employment) in any one Work Quarter.

(b) for each hour that such disabled Participant receives Supplemental Disability Income Benefits pursuant to this Welfare Plan, provided that in no event shall a Participant receiving benefits under Supplemental Disability Income Benefits provisions of this Welfare Plan be credited with more than eight (8) hours of Credited Service for any one day nor more than four hundred (400) hours of Credited Service (including hours of actual employment) in any one Work Quarter; and provided further that in the event a Participant receives benefits under New Jersey’s Temporary Disability Benefits Law, or Workers Compensation and at the same time receives benefits pursuant to the Welfare Plan’s Supplemental Disability Benefit, such Participant shall not be entitled to receive more than eight (8) hours of credited Service for any one Work Day nor more than four hundred (400) hours of Credited Service (including hours of actual employment) in any one Work Quarter.

Notwithstanding anything herein to the contrary, no more than sixteen hundred (1600) disability credit hours will be granted during any one continuous period of disability. Successive periods of disability caused by the same or related injuries or illness shall be deemed as one continuous period of disability unless said successive periods of disability are separated by at least three (3) months (90) days during which the Participant either returned to work or was available for work at the area of the Welfare Fund.

2.9 Temporary Unemployment Credit Hours: A Participant who has sixteen (16) or more consecutive Benefit Quarters Of Service immediately preceding the date he becomes unemployed shall be entitled to receive eight (8) hours of Credited Service for each Work Day he is registered and available for work, (as evidenced by enrollment on the Registration and Referral Records of the Union), but no more than four hundred (400) hours of Credited Service for any Work Quarter (including hours actually employed), and not more than sixteen hundred (1600) hours of Temporary Unemployment Credits in any twenty-four (24 ) month period.

2.10 Work Days: For the purpose of Section 2.08 and 2.09, Work Days are defined as Monday through Friday, and specifically excludes all Saturdays and Sundays of any week, as well as all regularly scheduled holidays provided for under the Collective Bargaining Agreement of Steamfitters Local Union No. 475.

2.11 Termination: A Participant’s eligibility and that of his Dependents will terminate on the last day of a Benefit Quarter in which such Participant fails to meet the foregoing requirements of Section 2.07. Further, a Dependent’s eligibility for benefits will terminate when the Participant’s eligibility terminates, or when such Dependent ceases to be a dependent as defined herein.

2.12 Survivor Benefits: If termination of the Dependent’s coverage is due to the death of an eligible Participant such Participant’s dependents coverage will be continued on the following basis:

For those surviving dependents of a deceased Participant who had less than (4) quarters of credited service in effect on the date of death, coverage will be continued for a period not to exceed 180 days following the date of such Participant’s death.

For those surviving dependents of a deceased Eligible Participant who had a minimum of four (4) quarters but less than eighty (80) quarters of credited service in effect on the date of death, coverage will be continued for a period not to exceed 365 days following the date of such Participant’s death.

For the surviving spouse, age 50 or over, of a deceased eligible Participant who had a minimum of eighty (80) or more quarters of credited service in effect on the date of death, full coverage will be continued until the earlier or (a) the date she remarries, or (b) qualifies for Medicare, at which time coverage will be limited to the Supplementary Medicare coverage provided by the Plan. The Dependent Children of such deceased Participant will also be covered until they cease to be Dependent Children as provided for under Section 2.19 (h).

2.13 Entrance in the Armed Forces: A Participant’s eligibility for benefits will also terminate upon his entrance into the Armed Forces of any country.

2.14 Reinstatement: If a Participant whose eligibility for benefits has been terminated receives credit for at least four hundred (400) hours in any one of the four (4) consecutive calendar quarters immediately following his date of termination, the benefits in effect at date of termination will be reinstated in full as of the first day of the month following the calendar quarter he had at least four hundred (400) hours of credit.

Any Participant whose eligibility for benefits has been terminated and who is not reinstated as provided above shall be considered as a new Participant and shall be eligible for benefits upon fulfillment of the
condition set forth in Section 2.6.

### 2.15 Active Employees Age 65 Who Become Eligible For Medicare:

(a) **Continued Coverage After Attainment of Age 65 for Active Employees.** Under TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982)/DEFRA (the Deficit Reduction Act of 1984) and COBRA (the Consolidated Omnibus Budget Reconciliation Act), full benefits are provided by the Welfare Plan if you, after attaining Age 65, remain an active employee and satisfy the basic eligibility requirements. Your dependent spouse upon attaining Age 65 may also choose this plan as primary while you remain actively employed. However, **no benefits under this Welfare Plan will be provided if Medicare is chosen as primary while you remain in active employment.**

(b) **Continued Coverage for Dependents Who Become Totally Disabled.** Participants who become totally disabled while eligible under the Welfare Plan and who qualify for Medicare, are required under the terms of the Omnibus Budget Reconciliation Act of 1986 (COBRA) to make an election with the Fund Office as to their primary Health Provider. If a Participant or a covered dependent chooses Medicare as their primary provider, that Participant or that dependent will no longer be covered under this Welfare Plan. If this Welfare Plan is chosen as the primary provider, the Participant’s eligibility under the Plan will be continued until the Participant ceases to meet the Plan’s standard eligibility requirements.

### 2.16 End Stage Renal Disease (“ESRD”) Beneficiary: Benefits shall be payable under the Plan without regard to an Eligible Employee’s or Eligible Dependant’s entitlement to Medicare if such Employee or Dependent is entitled to Medicare as an “End Stage Renal Disease” beneficiary, and not more than 30 months has elapsed since the earliest of the following months:

(a) the month in which the Employee or Dependent began a regular course of renal dialysis;

(b) the month in which the Employee or Dependent received a kidney transplant;

(c) the month in which the Employee or Dependent was admitted to the Hospital in anticipation of kidney transplant that was performed within the next two months; or

(d) the second month before the month in which the kidney transplant was performed, if performed more than two months after admission.

### 2.17 Qualified Medical Child Support Order (QMSCO): Benefits will be provided in accordance with the applicable requirements of a Qualified Medical Child Support Order.

The process begins when the Plan receives a medical child support order (MCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

(a) Issues from a court of competent jurisdiction pursuant to a state’s domestic relations law;

(b) Requires a Participant to provide only the group health coverage available under the Plan for the Participant’s Dependent children, even though the Participant no longer has custody; and

(c) Clearly specifies:

   i) The Participant’s name and last known mailing address and the names and addresses of each Dependent Child covered by the order,

   ii) A reasonable description of the coverage to be provided, and

   iii) The length of time the order applies,

The Plan will provide written notification to the Participant and each identified Dependent Child that it has received a court order requiring coverage. If the order meets the above requirements, the Plan will also provide written notification to the Participant and each Dependent Child that the order is a QMSCO and their eligibility for coverage. The foregoing is conditioned upon the order being filed on a timely basis and approved in writing by the Trustees.

### 2.18 Family and Medical Leave Act: If a Participant qualifies for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) such Participants eligibility will be continued under the plan provided his employer makes the required contribution on his behalf. Eligibility may be continued for up to twelve (12) weeks during the twelve (12) month period, for any of the following reasons:

(a) to care for the Participant’s child after the birth or placement of a child for adoption or foster care; so long as such leave is completed within twelve (12) months after the birth or placement of the child;
COBRA

2.19 Consolidate Omnibus Reconciliation Act: The Consolidate Omnibus Reconciliation Act (COBRA) requires the Trustees of the Plan to offer eligible Employees and Dependents whose Hospital, Surgical and other Medical Benefits are scheduled to be terminated because of certain “Qualifying Events” the opportunity of continuing their Group Health Benefits through a series of monthly direct payments for a limited period of time.

(a) Qualifying Event: A “Qualifying Event” is defined as any of the following events which would result in either an employee or dependent losing their Hospital, Surgical and Medical Benefits under the Plan:

1) Termination of an Employee’s eligibility due to failure to meet the Plan’s eligibility requirements (i.e., due to failure to work the required number of hours or other similar reasons).
2) Termination of a Dependent’s coverage in event of the employee’s death.
3) Termination of a Spouse’s coverage due to legal separation or divorce.
4) Termination of a Dependent’s coverage following an Employee’s retirement.
5) Termination of a Dependent child’s coverage due to either attainment of maximum age; change in dependent status as a result of marriage; or failure to maintain full time student status.

(b) Coverage and Evidence of Insurability: An Eligible Person, whose coverage is scheduled to be terminated as a result of one of the foregoing “Qualifying Events”, may elect to continue the same Hospital, Surgical and other Medical coverage provided all other employees and dependents in the same classification. No evidence of insurability will be required in order to continue this coverage, however, the Employee or Dependent(s) will be required to make Direct Payments to the Fund.

(c) Eligible Persons: Individuals entitled to COBRA continuation coverage are qualified beneficiaries and include the Employee, his Spouse and Dependent children. In order to be a qualified beneficiary, such individuals must generally be covered under Welfare Plan on the day before the event that causes a loss of coverage (such as a termination of employment, divorce, or death of the Eligible Employee). Effective January 1, 1997, a child who is born to the Eligible Employee, or who is placed for adoption with an Eligible Employee, during a period of COBRA continuation is also a qualified beneficiary.

(d) Maximum period of Coverage: An Employee, Spouse or Dependent child (where applicable) will have the option to continue Group Health Benefits for the period below:

<table>
<thead>
<tr>
<th>Person</th>
<th>Reason for Termination</th>
<th>Months*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Failure to Work the Required Number of Hours in Covered Employment</td>
<td>18</td>
</tr>
<tr>
<td>Spouse</td>
<td>Death of the Employee</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Divorce or Legal Separation</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Employee becomes eligible for Medicare</td>
<td>36</td>
</tr>
<tr>
<td>Dependent</td>
<td>No longer qualifies as a dependent child under the Plan</td>
<td>36</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As an Employee, in the event of termination due to failure to work the required number of hours, the maximum period that a Participant may continue coverage is 18 months. If, however, a Participant is disabled on the date of termination, or becomes disabled with the first 60 days of the COBRA coverage period, and
such disability qualifies the Participant for a Social Security Disability Benefit, the COBRA coverage period may be extended from 18 months to 29 months, or until eligibility for Social Security Benefits commences if prior to the expiration of the 29 month period. To qualify for this extension, a Participant must furnish the Plan Administrator with a copy of the notice of the Social Security Disability Award within 60 days of the determination date.

(e) **Election Period:** An election period of at least 60 days will be given to a Participant to decide whether or not to continue coverage. This election period will begin on the date a Participant’s coverage would otherwise terminate due to a qualifying event. The election period will end:

1) 60 days following the date coverage would otherwise terminate due to a qualifying event; or if later,

2) 60 days following the date either a Participant or a Participant’s Dependents are notified of continuation rights because a Qualifying Event took place.

A Participant’s election to continue coverage will be deemed to include continuation for the Employee’s Spouse and Dependent children. A Spouse’s election to continue coverage will be deemed to include continuation for any Dependent children who are covered by the Welfare Plan.

(f) **Notices:** The Fund will notify a Participant when the Participant is to be terminated as a result of failure to work the required number of hours to maintain eligibility. At the same time, the Participant will also be notified of the right to elect continuation coverage. However, it is the Participant’s responsibility to notify the Fund Office in the event of a divorce, legal separation, or when one of the Participant’s dependents no longer qualifies as an Eligible Dependent under the Welfare Plan. Failure to give proper notice to the Fund Office within 60 days following a “Qualifying Event” shall be deemed as an election not to continue coverage.

(g) **Cost of Continuation Benefits:** An Employee who elects continuation coverage under this new provision must pay the full cost of such coverage, plus 2% for administrative expenses. If either the Participant or Dependent elects to continue the coverage after the date coverage would otherwise terminate, a period of 45 days from the date of the election will be given to pay for retroactive coverage. At that time, payment for up to five months of coverage may be due. This would include the payment for: (1) coverage before either the Participant or Dependent was notified of their continuation rights; plus (2) coverage during the 60 day election period, plus (3) coverage during the 45 day payment period; and (4) monthly payments for coverage will be due on or before the fifteenth day of the month preceding the month for which the payment are being made.

(h) **Dependents of Deceased Participants - Waiver of Initial Monthly Payments.**

1) Of those surviving Dependents of a deceased Participant who had less than four (4) quarters of credited service in effect on the date of death, self payments will be waived for the first six months following the death of the employee.

2) For those surviving Dependents of a deceased Eligible Participant who had a minimum for four (4) quarters but less than eighty (80) quarters of credited service in effect on the date of death, self payments will be waived for the first 12 months following the death of the Participant. For the surviving spouse, age 50 or over, of a deceased Eligible Participant who had a minimum of eight (80) or more quarters of credited service in effect on the date of death, all Self Payments will be waived and full coverage will be continued until the earlier of (a) the date he/she remarries, or (b) qualifies for Medicare, at which time coverage will be limited to the Supplementary Medicare coverage provided by the Plan. The Dependent Children of such deceased Participant will also be covered until they cease to be Dependent Children as provided for under Section 1.9 (b).

(i) **Termination of Coverage:** Continuation coverage under COBRA self Payment Regulations will automatically be terminated before the end of the maximum self-payment period:

1) if the required Self-Payment for the coverage is not received on a timely basis;

2) if the person or dependent becomes covered by another group Plan through employment

3) if the person becomes entitled to Medicare benefits; or

4) if the Trustees of the Plan terminates or eliminates all or any part of the benefits for all Participants in that classification;

5) when a former spouse of a covered employee becomes covered by another group Plan through remarriage.

Under the provision of HIPAA Act of 1996, COBRA coverage may be terminated for any qualified beneficiary when he or she becomes covered under another health plan, even when that plan includes a “pre-
existing condition” limitation or exclusion. However, those plans that do have a “pre-existing condition limitations or exclusions” must now conform to the HIPAA Regulations which limit the exclusion period to a maximum waiting period of 12 months. It also requires all plans to give credit for any prior period of continuous health care coverage under another plan. A continuous period of health care is any prior period of health care under another plan in which there was less than a 63 day break in coverage between the prior plan and the current plan. When coverage is not continuous, no credit for prior coverage is required. Where coverage is continuous, the period of coverage under the old plan will be credited to satisfy the waiting period for pre-existing conditions.
3.1 **Natural Death Benefits:** Upon timely receipt by the Trustees of due proof that an Eligible Employee shall have died of natural causes (other than accidental injury) during a Benefit Quarter in which he was eligible, the Trustees shall pay to the beneficiary of record the Death Benefits set forth below:

<table>
<thead>
<tr>
<th>Consecutive Quarters of Credited Service</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>One, but less than Four</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Four, but less than Eight</td>
<td>$20,000.00</td>
</tr>
<tr>
<td>Eight, but less than Twelve</td>
<td>$30,000.00</td>
</tr>
<tr>
<td>Twelve, but less than Sixteen</td>
<td>$40,000.00</td>
</tr>
<tr>
<td>Sixteen, or More Service Credits</td>
<td>$50,000.00</td>
</tr>
</tbody>
</table>

3.2 **Definition of Natural Death:** Natural death shall mean a death resulting directly from a physical illness or causes other than accidents for which this plan provides Accidental Death Benefit either insured or uninsured.

3.3 **Exclusions:** Notwithstanding anything herein to the contrary, no Natural Death Benefit shall be payable for deaths resulting from:

(a) intentional self-inflicted injuries, suicide or any attempt thereof while sane or insane, if such incident results in death within the first twelve months of eligibility under the Plan.

(b) if death is the result of an act of war, either declared or undeclared.

(c) if death occurs while Participant is serving on full-time duty in the armed services of any country or international authority.

(d) if death occurs as the results of injuries received while in the act of committing a felony.

3.4 **Beneficiary:** Each Participant shall designate the person to whom the proceeds of the Death Benefits are to be paid. A Participant may designate his beneficiary by filling in his or her name on the “Participant Enrollment Card” which may be obtained by contacting the Fund Office.

Upon written request, the beneficiary may be changed at any time and as often as desired. The designation of such beneficiary shall take effect upon receipt of such notice in the Fund Office. If the beneficiary dies before the Eligible Participant, the interest of such beneficiary shall thereupon terminate unless otherwise provided by such written notice.

If there is no beneficiary designated or surviving at the death of the Eligible Participant, payment will be made in a lump sum to the first surviving of the following classes of preferential beneficiaries: (a) the widow or widower; (b) the surviving children; (c) the surviving parents; (d) the surviving sisters or brothers; (e) the executors or administrators of the estate. If there be more than one surviving beneficiary in such class, each such beneficiary shall share equally in such lump sum payment.

3.5 **Filing for Death Benefits:** Written proof of the natural death of an Eligible Participant must be filed at the Fund Office by the deceased employee’s beneficiary within 120 days from the date of the Participant’s death. Failure to furnish such proof within 120 days shall not invalidate the claim if it shall be shown not have been reasonably possible to furnish such proof within the time required. However, all liability on the part of the Fund and the Trustees shall cease and any person’s claim to benefits shall be forfeited unless notice and required proofs are submitted within 36 months from the date of death.

3.6 **Assignment of Benefits:** No assignment by an Eligible Participant of the benefits under this provision shall be valid.
SECTION 4
ELIGIBLE EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

4.1 Benefit: If within one year from the date of an accident which was incurred while eligible under the Welfare Plan, an active Participant sustains an injury which results in either death, dismemberment, loss of sight, speech or hearing, one of the following benefits will be paid; that one being the largest applicable amount for all such losses resulting from one accident:

<table>
<thead>
<tr>
<th>Loss:</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Sight of both Eyes</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Loss of Two Hands, Two Feet, or One</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Hand and One Foot</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Both Speech and Hearing</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One Hand or One Foot, or One Eye</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Loss of Speech or Hearing</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Thumb and Index Finger of the Same Hand</td>
<td>25% of Principal Sum</td>
</tr>
</tbody>
</table>

4.2 Principal Sum: The “Principal Sum” will be determined in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Participant Classification:</th>
<th>Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>One but less than Four Service Credits</td>
<td>$20,000.00</td>
</tr>
<tr>
<td>Four but less than Eight Service Credits</td>
<td>$20,000.00</td>
</tr>
<tr>
<td>Eight but less than Twelve Service Credits</td>
<td>$40,000.00</td>
</tr>
<tr>
<td>Twelve but less than Sixteen Service Credits</td>
<td>$60,000.00</td>
</tr>
<tr>
<td>Sixteen but less than Twenty Service Credits</td>
<td>$80,000.00</td>
</tr>
<tr>
<td>Twenty or More Service Credits</td>
<td>$100,000.00</td>
</tr>
</tbody>
</table>

4.3 Definition of Loss (Dismemberment): With respect to hands, “loss” shall mean severance of the entire four (4) fingers of the same hand through or above the metacarpal-phalangeal joints. With respect to foot, “loss” shall mean actual severance through or above the ankle joint. With respect to eyesight, speech or hearing, loss shall mean the entire and irrecoverable loss of sight, speech or hearing. With respect to Thumb and Index Finger, loss shall mean severance through or above the metacarpal-phalangeal joints.

4.4 Permanent and Total Disability Benefit: If within 180 days from the date of an accident to an Eligible Participant, such injuries totally and continuously disable and prevent such Participant from performing each and every duty of his occupation for a period of one year (as measured from the date such disability commenced), and if such injuries continue to totally and permanently disable and prevent such Participant from engaging in any occupation or employment for which he is fitted by reason of education, training or experience for the remainder of his life, the Principal Amount for which he was covered at the time of such accident will be paid, less any amount otherwise payable for dismemberment, loss of sight, speech or hearing because of the same accident.

4.5 General Exclusions: Losses caused by or resulting from any one or more of the following circumstances are specifically excluded:

(a) loss from intentionally self-inflicted injuries, suicide or any attempt while sane or ill;

(b) loss attributable to declared or undeclared war or act thereof;

(c) loss occurring while serving on full-time active duty in the Armed Forces of any country or International Authority;

(d) loss resulting from illness, disease, pregnancy, childbirth, miscarriage or any bacterial infection other than bacterial infection occurring in consequence of an accidental cut or wound;

(e) loss incurred while traveling or in flight in any vehicle or device for aerial navigation in which the Participant is

1) acting in the capacity of pilot or crew member, or

2) being used for fire fighting, pipe or power line inspection, aerial photography, or exploration, or
3) a passenger or crew member on a plane or craft which does not have an unrestricted air
worthiness certificate, or which is operated by other than a properly certified pilot,
(f) any loss resulting or incurred while participating in commission of a felony.

4.6 **Assignment of Benefits:** No assignment by an eligible Participant of the benefits under this provision shall
be valid.

4.7 **Termination:** Upon the termination of eligibility of any employee, all rights and entitlement to benefits
hereunder shall cease.
SECTION 5
ELIGIBLE EMPLOYEE SUPPLEMENTAL DISABILITY BENEFITS

5.1 **Benefit:** Supplemental Disability Benefits are designed to provide a supplemental income to replace loss of wages for those Participants who are unable to work at the trade during periods of temporary disability. Accordingly, an Eligible Participant who has at least four (4) consecutive Quarters of Credited Service becomes temporarily disabled as a result of an accidental bodily injury or illness, such Participant will be eligible for the benefits outlined below:

**SCHEDULE OF SUPPLEMENTAL DISABILITY PAYMENTS***

<table>
<thead>
<tr>
<th>Consecutive Quarters of Credited Service</th>
<th>2nd thru 26th Week</th>
<th>27th thru 52nd Week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gross Benefit</td>
<td>Net Payment*</td>
</tr>
<tr>
<td>4 but less than 8</td>
<td>$80.78</td>
<td>$75.00</td>
</tr>
<tr>
<td>8 but less than 12</td>
<td>$113.09</td>
<td>$105.00</td>
</tr>
<tr>
<td>12 but less than 16</td>
<td>$129.24</td>
<td>$120.00</td>
</tr>
<tr>
<td>16 or More Quarters</td>
<td>$161.55</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

5.2 **Definition of Disability:** A Participant shall be deemed to be disabled if, on the basis of medical evidence satisfactory to the Trustees, he is found to be physically unable, as a result of a bodily injury or illness, to be able to engage in gainful employment. The Trustees retain the right to make the sole and final judgment as to whether the Participant meets the criteria for disability in the determination and entitlement to Supplemental Disability payments. The Trustees may accept as proof of disability an award for disability from either the State Disability Insurance Fund or a Worker’s Compensation Carrier.

5.3 **Benefit Periods:** Benefit payments begin with the eighth day of disability due to accident or bodily injury. The maximum period during which Supplemental Disability Benefits will be paid is 51 weeks in any consecutive twenty-four (24) month period, or fifty-one (51) weeks during any one (1) period of disability. Successive periods of disability caused by the same or related injury or illness shall be deemed as one continuous period of disability unless such successive period of disability is separated by at least a three month period during which the Participant either returned or was available to work. However, in no event, will the Supplemental Disability Benefits payments exceed fifty-one (51) weeks in any continuous twenty-four (24) month period.

A Participant who has received less than 51 consecutive Weekly Payments, who again becomes disabled, shall be entitled to receive the balance of such payments, but not more than a total of 51 payments in any twenty-four (24) month period (as measured from the first day of disability).

If it is a new or unrelated disability, there will be a one-week waiting period before benefits begin and the amount of the benefit will be based on the Schedule shown above. If the claim is for the same condition related to the initial cause of disability, it would be treated as a continuation of the original claim.

A Participant who has received 51 consecutive Weekly Payments shall have a twenty-four (24) month waiting period (such waiting period commencing with the last day of disability payment) before he is again to apply for a new disability payment.

5.4 **Social Security Withholding Tax:** The Fund will withhold the employee’s portion of the Federal Social Security tax on all Supplemental Disability payments made during the first 26 weeks of disability.
5.5 **Proof of Disability:** To obtain Supplemental Disability Benefits, a disabled Participant must submit a completed claim form on a timely basis. The Participant’s attending physician must certify that the Participant was totally disabled and unable to work, and show the dates of all examinations and treatments.

For those Participants receiving State Disability Benefits or Worker’s Compensation Benefit, the Trustees may request proof of such disability benefit (either copy of check and/or letter) prior to the payment of any Supplemental Disability Benefit provided hereunder. Further, in the event that State Disability or Worker’s Compensation checks are payable for more than 26 weeks because of the type of employer’s Disability Plan, the increased weekly payment that would have been payable on the 27th week shall be deferred until after the last week payable on the employer’s plan and the basic weekly payment will be continued during the extension period.

5.6 **Assignment:** No assignment by an eligible Participant of the benefits under this provision shall be valid.

5.7 **Medical Examination:** The Trustees reserve the right to have any claimant referred to a physician of their choice for examination or re-examination. Failure without good excuse to report to the Fund’s physician within 48 hours after notice to do so may result in suspension of Supplemental Disability payments.

5.8 **Exclusions and Limitations:** Supplemental Disability Benefits will not be paid,

(a) during any week that a Participant is receiving Unemployment Insurance benefits.

(b) during any week or month in which a Participant is receiving a Normal, Early or Disability Retirement Benefit from an employer sponsored Retirement Plan or the Federal Social Security System.

(c) for period of disability directly resulting from injury sustained in the commission of a felony.

(d) for any disability period of less than seven days (partial week).

5.9 **Claim Denial Procedures:** Please refer to Section 20 of the Plan.
6.1 **CIGNA Healthcare:** The Steamfitters Welfare Fund, Local No. 475 has contracted with CIGNA to provide network and administrative services. When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

6.2 **Utilizing the Network:** An Eligible Participant or Dependent has the choice of utilizing a participating physician or provider when in need of medical care. The Welfare Fund Identification Card must be shown to the physician or any other Health Provider before any services are rendered. Network Provider lists are furnished automatically, without charge, as a separate document from the Welfare Plan. Information concerning the Network physicians and providers is located in the Provider Network Booklet provided to each Eligible Participant. Information concerning the Network can also be obtained via the CIGNA website or by contacting the Fund Office.

6.3 **Pre-Admission Certification/Continued Stay Review for Hospital Confinement:** Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

1. as a registered bed patient;
2. for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
3. for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any nonemergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement. Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

4. Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
5. any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

6.4 **Prior Authorization/Pre-Authorized:** The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

1. inpatient Hospital services
2. inpatient services at any participating Other Health Care Facility
3. residential treatment
4. nonemergency ambulance

6.5 **Case Management:** Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary
resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis. Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

(1) You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your fund, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

(2) The Review Organization assesses each case to determine whether Case Management is appropriate.

(3) You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

(4) Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

(5) The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).

(6) The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

(7) Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs. While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

6.6 CIGNA Healthcare Benefit Summary:

<table>
<thead>
<tr>
<th>CIGNA HealthCare Benefit Summary</th>
<th>Steamfitters Welfare Fund Local Union No. 475</th>
<th>Open Access Plus Copay Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFIT HIGHLIGHTS</strong></td>
<td>Plan B and Plan A</td>
<td>Plan B</td>
</tr>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td>OUT-OF-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td><strong>Coinsurance Levels</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Deductible Accumulators</strong></td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family Maximum Deductible Calculation</td>
<td>Individual Deductible</td>
<td>Individual Deductible</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>Plan B and Plan A</td>
<td>Plan B</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum Accumulators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross Accumulation Between In-Network and Out-of-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Deductible</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Includes Copays</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Does not apply to</td>
<td>Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits.</td>
<td>Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits or charges in excess of Maximum Reimbursable Charge</td>
</tr>
<tr>
<td>Benefits for accident or sickness (excludes mental health, alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$12,000 per person</td>
<td>$12,000 per person</td>
</tr>
<tr>
<td>Individual</td>
<td>Individual only</td>
<td>Individual only</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>Individual OOP</td>
<td>Individual OOP</td>
</tr>
<tr>
<td>Family Maximum OOP Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Automated Annual Reinstatement</strong></td>
<td>Not Applicable</td>
<td>80% Percentile of R/C</td>
</tr>
<tr>
<td><strong>Reasonable and Customary Percentile</strong></td>
<td>Not Applicable</td>
<td>80% Percentile of R/C</td>
</tr>
<tr>
<td><strong>Physician's Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician's Office visit</td>
<td>100% coinsurance after $20 PCP per office visit copay; 100% coinsurance after the PCP per office visit copay if only x-ray and/or lab services performed and billed.</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Specialty Care Physician's Office Visit Office Visits Consultant and Referral Physician's Services</td>
<td>100% coinsurance after $20 Specialist per office visit copay; 100% coinsurance after the Specialist per visit copay if only x-ray and/or lab services performed and billed.</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Performed In the Physician's Office</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Second Opinion Consultations (services will be provided on a voluntary basis)</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>100% coinsurance after either the PCP or Specialist per office visit copay or the actual charge, whichever is less</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the physician in the office)</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>Plan B and Plan A IN-NETWORK</td>
<td>Plan B OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% coinsurance after PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and/or lab services performed and billed. <strong>Note:</strong> x-ray and/or lab services performed and billed by an independent diagnostic facility or outpatient hospital are covered under the plan’s x-ray/lab benefit.</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist). <strong>Note:</strong> Charges for lab and radiology services, when billed by the physician’s office, will be subject to the plan’s Preventive Care dollar maximum if applicable. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan’s Preventive Care dollar maximum.</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% coinsurance; no plan deductible</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Mammograms, PSA, Pap Smear</td>
<td>100% coinsurance if billed by an independent diagnostic facility or outpatient hospital. <strong>Note:</strong> If the optional Preventive Care benefit is selected, the associated wellness exam will be covered at 100% coinsurance after the PCP or Specialist per visit copay.</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Notes if applicable:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preventive care related Mammogram charges do not accumulate to the plan’s Preventive Care dollar maximum, regardless of place of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preventive care related PSA and Pap smear charges, when billed by the physician’s office, will be subject to the plan’s Preventive Care dollar maximum.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preventive care related PSA and Pap smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan’s Preventive Care dollar maximum.</td>
<td></td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>Plan B and Plan A</td>
<td>Plan B</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Up to a maximum of 60 days per calendar year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi Private Room and Board</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
</tr>
<tr>
<td>Private Room</td>
<td>Limited to semi-private room negotiated rate</td>
<td>Limited to semi-private room rate</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>Limited to semi-private room negotiated rate</td>
<td>Limited to semi-private room rate</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
</tr>
<tr>
<td><strong>Note:</strong> Non-surgical treatment procedures are not subject to the facility copay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Surgeon</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multiple Surgical Reduction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Highlights

<table>
<thead>
<tr>
<th>Emergency and Urgent Care Services</th>
<th>Plan B and Plan A</th>
<th>Plan B</th>
<th>Plan A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and lab services performed</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and lab services performed (except if not a true emergency, then 80% coinsurance).</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and lab services performed (except if not a true emergency, then 50% coinsurance).</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>100% coinsurance</td>
<td>100% coinsurance (except if not a true emergency, then 80% coinsurance)</td>
<td>100% coinsurance (except if not a true emergency, then 50% coinsurance)</td>
</tr>
<tr>
<td>Outpatient Professional services</td>
<td>100% coinsurance (if the ER facility benefit is subject to coinsurance and plan deductible)</td>
<td>100% coinsurance (if the ER facility benefit is subject to coinsurance and plan deductible) (except if not a true emergency, then 80% coinsurance)</td>
<td>100% coinsurance (if the ER facility benefit is subject to coinsurance and plan deductible) (except if not a true emergency, then 50% coinsurance)</td>
</tr>
<tr>
<td>(radiology, pathology and ER Physician)</td>
<td>100% coinsurance* (except if not a true emergency, then 80% coinsurance)</td>
<td>100% coinsurance* (except if not a true emergency, then 50% coinsurance)</td>
<td>100% coinsurance* (except if not a true emergency, then 50% coinsurance)</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>100% coinsurance</td>
<td>100% coinsurance (except if not a true emergency, then 80% coinsurance)</td>
<td>100% coinsurance (except if not a true emergency, then 50% coinsurance)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Services at Other Health Care Facilities</th>
<th>Plan B and Plan A</th>
<th>Plan B</th>
<th>Plan A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>60 days combined maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory and Radiology Services (includes pre-admission testing)</th>
<th>Plan B and Plan A</th>
<th>Plan B</th>
<th>Plan A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance after PCP or Specialist per visit copay</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</td>
<td>100% coinsurance (if the ER/UC facility is covered subject to plan coinsurance and deductible)</td>
<td>100% coinsurance (if the ER/UC facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 80% coinsurance)</td>
<td>100% coinsurance (if the ER/UC facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 50% coinsurance)</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>Plan B and Plan A</td>
<td>Plan B</td>
<td>Plan A</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab facility</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>100% coinsurance</td>
<td>100% coinsurance (if the ER facility is covered subject to plan coinsurance and deductible)</td>
<td>100% coinsurance (if the ER facility is covered subject to plan coinsurance and deductible)</td>
</tr>
<tr>
<td></td>
<td>100% coinsurance (if the ER facility is covered subject to plan coinsurance and deductible)</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)</td>
<td>100% coinsurance</td>
<td>100% coinsurance (unless not a true emergency then 80% after scan deductible and plan deductible)</td>
<td>100% coinsurance (unless not a true emergency then 50% after scan deductible and plan deductible)</td>
</tr>
<tr>
<td>Physician's Office</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scans are subject to the applicable place of service coinsurance and plan deductible.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture – Must be administered by MD or Certified Acupuncturist</td>
<td>100% up to a $400 annual maximum per calendar year</td>
<td></td>
<td>Not Covered for Plan A Participants</td>
</tr>
<tr>
<td>Up to a $400 annual maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitative Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 days combined maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Cardiac Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% coinsurance after the PCP or Specialist per office visit copay, 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Service</th>
<th>Plan B and Plan A IN-NETWORK</th>
<th>Plan B OUT-OF-NETWORK</th>
<th>Plan A OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>100% up to a $600 annual maximum per calendar year</td>
<td>Not Covered for Plan A Participants</td>
<td></td>
</tr>
<tr>
<td>Up to a $600 annual maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Unlimited Calendar year maximum.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Excludes maternity for dependent children)</td>
<td>100% coinsurance after PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Subsequent Prenatal Visits, Postnatal Visits, and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Delivery – Facility (Inpatient Hospital, Birthing Center)</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective procedures only</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance after $20 per office visit copay</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>Gastric Bypass Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Must meet AMA guidelines for morbid obesity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>Plan B and Plan A IN-NETWORK</td>
<td>Plan B OUT-OF-NETWORK</td>
<td>Plan A OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
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<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance after $20 per office visit copay</td>
<td>80% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Orthotic arch supports, Corrective Orthopedic shoes and Support stockings</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Wigs (after chemotherapy)</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>One per lifetime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical treatment of Varicose veins, Rhinoplasty and Removal of skin tags</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Unlimited maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Appliances</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Unlimited maximum per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Bony impacted wisdom teeth extractions are covered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor’s Office</td>
<td>100% coinsurance after the PCP or Specialist per office visit copay; 100% coinsurance after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% coinsurance</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Admission Certification - Continued Stay Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Health Solutions+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*CIGNA’s PAC/CSR is not necessary for Medicare Primary individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

| Inpatient Pre-Admission Certification - Continued Stay Review (required for all inpatient admissions) | Coordinated by Provider/PCP | Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:  
- No penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission unless stay is denied. If stay is not certified by CIGNA Healthcare then stay is denied.  
- Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified.  
- Benefits are denied for any additional days not certified by CIGNA Healthcare. |
|---|---|---|
| Outpatient Prior Authorization (required for selected outpatient procedures and diagnostic testing) | Coordinated by Provider/PCP | Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:  
- Certain outpatient procedures must be pre-certified through CIGNA Healthcare. Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA Healthcare and not certified. |
| Case Management | Coordinated by CIGNA Healthcare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient’s quality of life. |

### Covered Expenses:

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes an Eligible Participant under the Welfare Plan. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. Any applicable Copayments, Deductibles or limits are shown in The Schedule. Covered Expenses include:

1. charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
2. charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
3. charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
4. charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
5. charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
6. charges made for Emergency Services and Urgent Care.
7. charges made by a Physician or a Psychologist for professional services.
8. charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
9. charges made for anesthetics and their administration.
10. diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
11. charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
12. charges made for an annual Papanicolaou laboratory screening test.
(13) charges made for an annual prostate-specific antigen test (PSA).
(14) charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
(15) charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
(16) charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
(17) office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.
(18) charges made for Routine Preventive Care from age 3 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.
(19) charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child’s life, including immunizations.
(20) charges made for surgical or nonsurgical treatment of TMJ Dysfunction.
(21) charges made for acupuncture.
(22) charges made for orthotic arch supports, corrective orthopedic shoes and support stockings.
(23) orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
   (a) the deformity or disfigurement is accompanied by a documented clinically significant functional impairment,
   (b) and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
   (c) the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
   (d) the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
   (e) Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

6.8 Exclusions, Expenses Not Covered and General Limitations: Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this Welfare Plan:
(1) expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
(2) to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
(3) to the extent that payment is unlawful where the person resides when the expenses are incurred.
(4) charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
(5) for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
(6) charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
(7) assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
(8) for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
(a) not demonstrated, through existing peer-reviewed,
(b) evidence-based, scientific literature to be safe and
c(f) effective for treating or diagnosing the condition or sickness for which its use is
proposed;
d(d) not approved by the U.S. Food and Drug Administration (FDA) or other appropriate
regulatory agency to be lawfully marketed for the proposed use;
(e) the subject of review or approval by an Institutional Review Board for the proposed use
except as provided in the “Clinical Trials” section of this plan; or
(f) the subject of an ongoing phase I, II or III clinical trial, except as provided in the
“Clinical Trials” section of this plan.

(9) cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed
to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial
complaints related to one’s appearance.

(10) regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty /
panniculectomy; rhinoplasty; blepharoplasty; acupressure; craniosacral/cranial therapy; dance therapy;
movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave
lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

(11) for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
(a) charges made for a continuous course of dental treatment started within six months of an
Injury to sound natural teeth;
(b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies;
(c) charges made by a Free-Standing Surgical Facility or the outpatient department of a
Hospital in connection with surgery.

(12) for medical and surgical services intended primarily for the treatment or control of obesity. However,
treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the
National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through
peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for
treatment of the condition.

(13) unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization
not required for health reasons including, but not limited to, employment, insurance or government
licenses, and court ordered, forensic or custodial evaluations.

(14) court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed
as covered in this plan.

(15) infertility services including infertility drugs, surgical or medical treatment programs for infertility,
including in vitro-fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer
(ZIFT), variations of these procedures, and any costs associated with the collection, washing,
preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of
donor sperm and eggs are also excluded from coverage.

(16) reversal of male and female voluntary sterilization procedures.

(17) transsexual surgery including medical or psychological counseling and hormonal therapy in preparation
for, or subsequent to, any such surgery.

(18) any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited
to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

(19) medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is
otherwise eligible under this plan.

(20) nonmedical counseling or ancillary services, including but not limited to Custodial Services, education,
training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep
therapy, employment counseling, back school, return to work services, work hardening programs,
driving safety, and services, training, educational therapy or other nonmedical ancillary services for
learning disabilities, developmental delays, autism or mental retardation.
(21) therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

(22) consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

(23) private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.

(24) personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

(25) artificial aids including, but not limited to, garter belts, corsets and dentures.

(26) hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

(27) aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

(28) medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

(29) charges made for or in connection with eye exercises and for surgical treatment for the correction of radial keratotomy, when eye glasses or contact lenses may be worn.

(30) all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

(31) routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

(32) membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

(33) genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

(34) dental implants for any condition.

(35) fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

(36) blood administration for the purpose of general improvement in physical condition.

(37) cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

(38) cosmetics, dietary supplements and health and beauty aids.

(39) nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

(40) medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

(41) medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
(42) for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

(43) telephone, e-mail, and Internet consultations, and telemedicine.

(44) massage therapy.

(45) for charges which would not have been made if the person had no insurance.

(46) to the extent that they are more than Maximum Reimbursable Charges.

(47) expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

(48) charges made by any covered provider who is a member of your family or your Dependent’s family.

(49) to the extent of the exclusions imposed by any certification requirement shown in this plan.
## SECTION 7.0
### Behavioral Health Network

### 7.1 CONCERN PLUS: The Trustees have contracted with CONCERN PLUS to provide Behavioral Health Care benefits for Participants and Dependents of the Steamfitters Welfare Fund, Local Union No. 475. All Participants requiring Behavioral Health Care treatment must contact CONCERN PLUS. Please see Section 2.0 to determine eligibility.

### 7.2 Eligibility: Participants or Dependents under the Steamfitters Welfare Fund, Local Union No. 475 (see Section 2.0) are eligible for Network Benefits by utilizing a CONCERN PLUS participating physician or provider.

### 7.3 Utilizing the Network: When you or one of your Dependents need Behavioral Health Care, you will have to contact CONCERN PLUS to arrange a session under the Behavioral Health Management Program. The Program provides up to ten (10) free counseling sessions with a CONCERN therapist per year for each Participant under the Plan. The counselors have expertise in dealing with family, marital, psychological, vocational and chemical dependency problems. Confidential access must be made by calling:

1-800-242-7371

Identifying yourself as an Eligible Participant or Dependent of the Welfare Fund for coverage.

### 7.4 Pre-certification: Please note that CONCERN PLUS must approve all treatment (both in and out of hospital) for behavioral or substance abuse conditions. No benefits will be payable for treatment without prior assessment and pre-certification by CONCERN PLUS.

### 7.5 Behavioral Health Benefit Summary:

<table>
<thead>
<tr>
<th>Bereavement Counseling</th>
<th>100% coinsurance</th>
<th>90% coinsurance</th>
<th>50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided as part of Hospice Care</td>
<td>100% coinsurance</td>
<td>90% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient (same coinsurance level as Inpatient Hospice Facility)</td>
<td>Covered under Mental Health benefit</td>
<td>Covered under Mental health benefit</td>
<td>Covered under Mental health benefit</td>
</tr>
<tr>
<td>Outpatient (same coinsurance level as Outpatient Hospice)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Bereavement Counseling:
- Services provided as part of Hospice Care
- Inpatient (same coinsurance level as Inpatient Hospice Facility)
- Outpatient (same coinsurance level as Outpatient Hospice)

### Mental Health/Substance Abuse
- Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:
  - Substance Abuse includes Alcohol and Drug Abuse services.
  - Transition of Care benefits are provided for a 90-day time period.

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>100% coinsurance</th>
<th>90% coinsurance</th>
<th>50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Up to 30 days per calendar year</td>
<td>100% coinsurance after $30 per visit copay</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Acute: Based on a ratio of 1:1</td>
<td>100% coinsurance after $20 per visit copay</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Partial: Based on a ratio of 2:1</td>
<td>100% after $50 per program copay</td>
<td>80% after $50 per program deductible</td>
<td>50% after $50 per program deductible</td>
</tr>
</tbody>
</table>

### Mental Health
- Outpatient Up to a 50 Visit maximum per calendar year
- Outpatient Group Therapy (one group therapy session equals one individual therapy session)
- Intensive Outpatient Maximum: Up to 3 programs per calendar year Based on ratio of 1:1
**Substance Abuse (Alcohol & Drug)**

Inpatient
Up to 30 day combined maximum per calendar year

**Acute Detox:** Requires 24 hour nursing; Based on a ratio of 1:1

**Acute Inpatient Rehab:** Requires 24 hour nursing; Based on a ratio of 1:1

**Partial:** Based on a ratio of 2:1

**Residential:** Based on a ratio of 2:1

<table>
<thead>
<tr>
<th></th>
<th>100% coinsurance</th>
<th>90% coinsurance</th>
<th>50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% coinsurance after $20 per visit copay</td>
<td>80% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% after $50 per program copay</td>
<td>80% after $50 per program deductible</td>
<td>50% after $50 per program deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single deductible per program</td>
<td>Single deductible per program</td>
</tr>
<tr>
<td><strong>Note:</strong> The Intensive Outpatient per program deductible will be taken prior to any payment</td>
<td><strong>Note:</strong> The Intensive Outpatient per program deductible will be taken prior to any payment</td>
<td><strong>Note:</strong> The Intensive Outpatient per program deductible will be taken prior to any payment</td>
<td></td>
</tr>
</tbody>
</table>

**MH/SA Service Specific Administration**

Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- **Partial Hospitalization:** MH and/or SA partial hospitalization services maximum is 50% of the inpatient benefit maximum; e.g. day limits are combined (2:1 ratio). The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- **Standard Option for Residential Treatment:** MH and/or SA Residential Treatment at 50% of Inpatient benefit; day limits are combined (2:1 ratio). Coverage only if approved through CBH Case Management.
- **Intensive Outpatient Program (IOP):** MH and/or SA Intensive Outpatient Program at 1 to 1 Outpatient visits. Visit limits are combined with Outpatient Visit limits (1:1 ratio). Coverage only if approved through CBH Case Management.

**MH/SA Utilization Review & Case Management**

Inpatient and Outpatient Management (CAP):
- CBH provides utilization review and case management for In-network and Out-of-network Inpatient Services and In-network Outpatient Management services.
- Includes Lifestyle Management Program (Stress & Tobacco)

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**IMPORTANT NOTICE**

The Behavioral Health Network benefits described above are subject to the terms, conditions, limitations and exclusions of the contract issued by CONCERN PLUS and CIGNA. If a difference exists between the information shown above and the actual applicable contract, the contract governs. Please see Section 6.8 for a list of possible exclusions.
8.1 **Transplant Benefits:** Transplants are provided through an independent third party in accordance with the terms of a contract between the Trustees and such provider. A special attachment regarding human organ and tissue benefits explains in full the AIG Life Insurance Company Organ & Tissue Transplant Policy. The terms of the contract, the general provisions relating to the benefits to be provided, employee co-insurance, and rules under which coverage is defined are set forth in the contract and summarized hereinafter. All Eligible Participants requiring human organ and tissue transplant services will have transplant-related charges covered under this separate policy, according to its terms and conditions, from the date of their evaluation through 365 days post transplant operation. After this specified benefit has elapsed, all transplant-related medical benefits will revert to the terms and conditions of health coverage under this health plan document. The Steamfitters Welfare Fund, Local No. 475 does not cover Organ and Tissue Transplants. AIG Life Insurance Company (hereinafter known as AIG) will assign a Transplant Case Manager to assist and coordinate the employee or dependent’s continuing transplant related needs.

8.2 **Benefits available for Human Organ and Tissue Transplants:** Benefits are subject to the following:

Participants are eligible for medical benefits under the separate contract if,

(a) the Participant meets all the terms and conditions outlined in the AIG Organ and Tissue policy / certificate

(b) the Participant does not have a pre-existing condition as defined in the AIG Organ and Tissue Transplant Policy / Certificate

Those Participants who are initially excluded from human organ and tissue transplant coverage under the AIG Organ & Tissue Transplant policy (due to a pre-existing condition) will continue to receive health care benefits as they relate to transplantation according to the terms and conditions of the Steamfitters Welfare Fund, Local No. 475 plan document and until eligible for benefits under the separate AIG Organ and Tissue Transplant policy.

8.3 **Covered Transplants:**

(a) Heart
(b) Lung
(c) Heart/Lung
(d) Liver
(e) Kidney
(f) Pancreas
(g) Kidney/Pancreas
(h) Small Bowel
(i) Bone Marrow / Stem Cell

8.4 **Transplant Benefit Period:** AIG provides coverage for claims that are incurred within the coverage period and reported within twelve months of the later of the end of the coverage period and the end of the transplant benefit period. No transplant benefit can begin prior to the policy/certificate effective date or prior to the Participant’s first day of coverage under the AIG policy if the Participant first becomes covered after the policy/certificate effective date. Benefits for a Participant continue beyond the Policy Expiration Date only if the Participant:

(a) has established a Transplant Benefit Period prior to the Policy Expiration Date, and
(b) has undergone transplantation prior to the Policy Expiration Date, and
(c) the established Transplant Benefit Period has not been exhausted, and
(d) the Participant’s Lifetime Limit has not been reached.

8.5 **Schedule of Insurance:** Benefits will be payable for Covered Charges as follows:

(a) Participating Transplant Facility: 100% of Covered Charges for Covered Transplant Services provided through a Participating Transplant Facility with respect to the type of Covered Transplant Procedure performed.
(b) Nonparticipating Transplant Facility: 80% of Covered Charges for the Covered Transplant Services provided through a Nonparticipating Transplant Facility with respect to the type of Covered Transplant Procedure performed.

Benefits paid are 80% of Covered Charges and cannot exceed the Maximum Amount stated below for the type of Covered Transplant Procedure performed.

<table>
<thead>
<tr>
<th>Covered Transplant Procedure</th>
<th>Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Heart</td>
<td>$ 243,000</td>
</tr>
<tr>
<td>2) Kidney</td>
<td>$  89,000</td>
</tr>
<tr>
<td>3) Lung</td>
<td>$ 206,000</td>
</tr>
<tr>
<td>4) Heart/Lung</td>
<td>$ 241,000</td>
</tr>
<tr>
<td>5) Pancreas</td>
<td>$   91,000</td>
</tr>
<tr>
<td>6) Kidney / Pancreas</td>
<td>$ 111,000</td>
</tr>
<tr>
<td>7) Liver</td>
<td>$ 196,000</td>
</tr>
<tr>
<td>8) Small Bowel</td>
<td>$  379,000</td>
</tr>
<tr>
<td>9) Autologous Bone Marrow / Peripheral Stem Cell Including High Dose Chemotherapy</td>
<td>$ 116,000</td>
</tr>
<tr>
<td>10) Allogeneic Bone Marrow / Peripheral Stem Cell Including High Dose Chemotherapy – related</td>
<td>$ 186,000</td>
</tr>
<tr>
<td>11) Allogeneic Bone Marrow / Peripheral Stem Cell Including High dose chemotherapy – unrelated</td>
<td>$ 235,000</td>
</tr>
</tbody>
</table>

8.6 **Lifetime Limit:** The maximum dollar amount payable for any Participant is $1,000,000. The limit for transportation costs is included in and accrues towards this Lifetime Limit.

8.7 **Covered Transplant Services:** The following services when provided to a Participant, performed within a transplant facility, and which are directly related to a Covered Transplant Procedure:

(a) Inpatient and outpatient hospital services.

(b) Services of a Physician for diagnosis, treatment, and surgery.

(c) Diagnostic Services.

(d) Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, compatibility testing, procurement expenses, donor’s surgical procedure to remove the organ or tissue, and inpatient and outpatient services.

(e) Reasonable and necessary transportation costs, as determined by AIG, for travel related to a Covered Transplant Procedure for the Transplant Recipient and one companion during a Transplant Benefit Period, subject to a limit of $200.00 per day for lodging and meals per Covered Transplant Procedure and $10,000.00 for all transportation, lodging, and meals, per Covered Transplant Procedure. The Participant shall submit itemized receipts in a form satisfactory to AIG when claims are filed. If the Participant is a minor, transportation costs for two companions will be covered.

(f) Rental of durable medical equipment for use outside the Hospital, subject to a limit of the purchase price of such equipment.

(g) Prescription drugs, including immunosuppressive drugs.

(h) Oxygen.

(i) Speech Therapy, Occupational Therapy, Physical Therapy, and Chemotherapy.

(j) Services and supplies for and related to High Dose Chemotherapy and bone marrow tissue transplantation when provided as part of a treatment plan which includes bone marrow transplantation and High Dose Chemotherapy.

(k) Surgical dressings and supplies.

(l) Home health care.
8.8 **Exclusions:** The AIG Tissue and Organ Transplant Policy provides no coverage for any of the following:

(a) Any service or supply not directly related to Covered Transplant Procedures (including any service or supply rendered to treat the underlying disease that is not part of the actual Covered Transplant Procedure).

(b) Services and supplies for treatment of complications related to a Covered Transplant Procedure, unless such complications are determined by AIG to be the immediate and direct result of a Covered Transplant Procedure.

(c) Charges for any transplant related services or supplies incurred before the Effective Date of this Policy.

(d) Services and supplies for immunizations.

(e) Animal organ or artificial organ transplants.

(f) Stand-by charges of a Physician.

(g) Services of a Provider who is a member of Participant’s immediate family.

(h) Services, supplies, or Hospital care which, in the judgment of the Company’s medical consultants, are not medically necessary for the treatment illness, injury, diseased condition, or impairment, except as specifically stated as covered.

(i) Custodial care.

(j) Charges for any Experimental Treatment, except as specifically stated in this Policy.

(k) Charges paid or payable under Workers’ Compensation.

(l) Preventive or routine care, including physicals, premarital examinations, and any other routine or periodic examinations, except as specifically stated as covered.

(m) Research studies or screening examinations.

(n) Treatment of any illness or injury sustained as a result of an act of war or terrorism.

(o) Services or supplies to the extent Participant is not legally obligated to pay for them.

(p) Expenses incurred before the Policy Period begins or after it ends, except as stated as covered.

(q) Rest cures or sanitarium care.

(r) Services or supplies furnished by any Provider acting beyond the scope of such Provider’s license.

(s) Any service or supply that is a Medicare Part A or Part B liability.

(t) Services or supplies received from a dental or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust, or similar person or group.

(u) Services provided by any governmental agency to the extent that Participant is not charged for them, except when this exclusion conflicts with state or federal law.

(v) Services or supplies not specifically stated as covered.

(w) Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.

(x) Recreational or diversional therapy.

(y) Materials used in occupational therapy.

(z) Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a Provider prescribes such items.

(aa) Hospitalization for environmental change and all related charges.

(bb) Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.

(cc) Services and supplies for treatment of complications arising from a live donor procedure.

(dd) Immunosuppressive drugs for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period. This Policy will no longer pay benefits following the end of the Transplant Benefit Period.
(ee) Services and supplies of any Provider located outside the United States of America, except for procurement services.

(ff) Biological and/or Mechanical devices used as a bridge to transplant unless specifically included on the Declarations Page.

(gg) Charges for any transplant-related services or supplies incurred during the Policy Period when the transplant procedure occurred prior to the Effective Date of this Policy, except for Covered Charges pursuant to a Covered Transplant Procedure the Participant received under a previous Organ and Tissue Transplant Policy issued by the Company to the Insured and where such Coverage Charges were for services or supplies that were incurred within the Transplant Benefit Period for the Covered Transplant Procedure.
The Following Section Describes

The

EXPANDED MEDICAL BENEFITS

FOR PLAN B PARTICIPANTS

WITH FOUR OR MORE CONSECUTIVE

QUARTERS OF CREDIT SERVICE

Dental Expense Benefit .....................................................Section 9.0

Prescription Drug Benefit...................................................Section 10.0

Vision Service Benefits .....................................................Section 11.0
SECTION 9
DENTAL EXPENSE BENEFIT

9.1 **Benefit:** If while eligible, a Participant with four (4) or more Quarters of Credited Service or his Eligible Dependent, incurs expenses in connection with a Covered Dental Services, he will be reimbursed on the following basis:

**Dental Benefit per Calendar Year Payment Basis**

Percent of Covered Charge paid by Plan .................................................. 85 %
Percent of Covered Charge paid by Employee ........................................... 15 %
Maximum Benefit Payable per Calendar Year ............................................. $ 2,000.00

9.2 **Routine Oral Examination and Cleaning (Prophylaxis):** Covered benefits include charges for Routine Oral Examinations, Prophylaxis, X-rays, Diagnosis and Preparation of Treatment Plan.

9.3 **Basic Dental Benefit:** Benefit designed to cover the cost of treatment and services in connection with the following:

- (a) Routine fillings and Restorations
- (b) Root Canal Therapy
- (c) Crowns, Jackets and Bridges
- (d) Extractions
- (e) Oral Surgery Performed by Dental Surgeon
- (f) Periodontal Treatment
- (g) Initial preparation and placement of partial or complete dentures for Participant and Dependents who have been covered for at least one year under this Welfare Plan.

9.4 **Orthodontic Benefit:** Orthodontic Benefits will be payable for those covered dental Charges for necessary orthodontic treatments which begin and are provided and charged for while eligible under the Plan. The maximum benefit applicable during the individual’s entire lifetime is $2,500.00.

9.5 **The method of payment of orthodontic benefits is as follows:**

- (a) The maximum allowance for all orthodontic services is as follows: 100% of the first $ 75.00, plus 50% of the excess over $ 75.00, subject to a lifetime maximum of $2,500.00
- (b) The first payment will be based on the amount billed by the orthodontist, not to exceed 100% of the first $ 75.00 of charges plus 50% of the excess over $ 75.00.
- (c) Subsequent payments will be based on 50% of the amount billed until the maximum benefit of $2,500.00 has been reached.

9.6 **Exclusions:** No benefit shall be paid for dental care and service:

- (a) for any injury resulting from or relating to the patient’s occupation, or for which benefits are payable under any Worker’s Compensation Act or similar legislation;
- (b) paid for, or furnished by, any government agency (to the extent so paid or furnished);
- (c) rendered solely for cosmetic purposes, unless resulting form accidental bodily injuries sustained while covered hereunder;
- (d) paid by the Welfare Fund under any other part of the Welfare Plan;

9.7 **Claims:** All claims for Dental Benefits must be filed with the Fund Office on a timely basis and in accordance with the provisions of Section 22.
SECTION 10
PRESCRIPTION DRUG BENEFITS

10.1 **Benefit:** The Prescription Drug Benefit is designed to cover certain costs of medically necessary drugs and medications prescribed by the Participants medical doctor in connection with the treatment of non-occupational injury or illness. Prescription Drugs are provided through an independent third party in accordance with the terms of a contract between the Trustees and such provider. The terms of the contract, as well as the general provisions relating to the benefits to be provided, employee co-payments and rules under which drugs are to be dispensed are set forth in the contracts and summarized hereinafter. The Trustees retain the right to change, alter or terminate the benefits or contract at any time without advance notice to Participants or providers.

10.2 **Covered Prescription Drugs:** Covered prescription drugs are defined as:

(a) Legend Drugs (i.e., any medical substance whose label bears the legend “Caution: Federal Law prohibits dispensing without a prescription”), or injectable insulin which is prescribed in writing.

(b) A compound medication, which contains at least one ingredient, which includes a Prescription Drug.

(c) Retinoids (all dosage forms, e.g. Retin A) for individuals through age 25.

(d) Any other drug required by law to be dispensed only by written prescription.

Benefits are provided for those covered prescription drugs ordered by a doctor in connection with medical care of an active Eligible Participant or Dependent.

10.3 **Payment of Claims:** There are three methods by which an Eligible Participant can obtain prescription drugs:

(a) **Use of an InformedRx Pharmacy.** Eligible Participants will be issued a plastic identification card authorizing InformedRx participating pharmacies to fill prescriptions, which come within the scope of the Welfare Plan. Such Participant need only to:

1) Present the InformedRx card to any InformedRx pharmacy with the prescription each time he needs to have a prescription filled or refilled;

2) Then, sign the pharmacy claim voucher, and

3) Pay the co-pay ($0.00 per Generic Drug, $15.00 per Preferred Brand Drug, and $30.00 per Non-Preferred Brand Drug).

(b) **Purchase of Prescriptions at a non-participating InformedRx Pharmacy.** If it is not possible to use a InformedRx member Pharmacy, a special Prescription Drug Claim Form must be obtained from the Welfare Fund Office. This Claim Form must be completed by the Participant and the dispensing pharmacist, and then forwarded to InformedRx. Upon review of the Claim, reimbursement to the Participant will be authorized at the Fund’s discretion.

(c) **Mail Order Maintenance Drugs.** The Mail Order Program was designed to allow members to receive quantities of maintenance medication for treatment of chronic or long-term conditions (e.g. diabetes, arthritis, heart conditions, high blood pressure, etc.) for periods longer than 30 days. If you are on maintenance medication, you must utilize the Mail Order Program. When you receive a maintenance prescription, you can obtain the first two months of the medication at a retail pharmacy, but thereafter, you will have to utilize either RxDn or InformedRx Mail to obtain your maintenance prescription drugs. You can obtain a 90-day supply of your prescription. The co-payment per prescription will be $0.00 for each Generic Drug obtained, $30.00 for each Preferred Brand Drug, and $60.00 for each Non-Preferred Brand name drug obtained. The Fund has contracted with two Mail Order companies to provide convenient service to the members, RxDn and InformedRx Mail. Standard shipping is FREE on all mail orders containing prescriptions. Special Direct Mail Forms may be obtained from the Fund Office or the mail order provider. The mail order providers can be contacted at:

- RxDn 1-800-800-8769
- P.O. Box 137
- Bristol, PA 19007
- www.rxdn.com

- InformedRx Mail 1-800-881-1966
- P.O. Box 407096
- Ft. Lauderdale, FL 33340-7096
- www.nmhcmail.com
(d) **Injectable Drugs.** Injectable Drugs will be covered by the Plan at 10%, requiring a 90% co-pay. The injectable drugs will only be available through the InformedRx Ascend Pharmacy or the RxDn Mail Order facility. The RxDn provider is listed above. The Ascend Pharmacy can be contacted at:

Ascend Pharmacy  
53 Darling Avenue  
South Portland, ME 04106  
800-850-9122  
www.ascendspecialtyrx.com/

(e) **Injectable Vaccinations.** Injectable Vaccinations will be covered by the Plan subject to a copay of $30.00.

(f) **Benefit Limitation:** The Prescription Benefit is subject to an annual maximum of $10,000 per individual, per calendar year (Welfare Plan cost). When the Plan has paid out $10,000 in prescription drug benefits in a calendar year, all remaining prescription drug charges within that calendar year will have to be paid in full by the Participant.

10.4 **Dispensing Limitation:** Eligible Participants and Dependents will be entitled to the amount of prescription drugs or injectable insulin usually prescribed by the attending physician but not to exceed a 34-day supply (except for those maintenance drugs supplied under the Mail Order Maintenance Drug Program). However, for practical purposes only, certain drugs may be dispensed in maximum quantities of the lesser of a 30-day supply or 100 unit doses.

10.5 **Mail Order Only:** Insulin related supplies which include insulin syringes, needles, test tables, sticks and tape designed to test for sugar and acetone, strips for measuring blood sugar may be obtained only through Mail Order.

10.6 **Coordination of Benefits:** If a Participant has primary insurance elsewhere, InformedRx will not process the claim. The pharmacist will immediately receive a rejection of the claim with the indication of primary coverage elsewhere. INFORMEDRX will process any unpaid balance of the claim less the applicable co-payment provided the Participant submits the primary insurance “Explanation of Prescription Benefits” along with copies of the prescription receipts and a Direct Reimbursement Claim Form.

10.7 **Illegal Use of the I.D. Card:** Ineligible Participants are required to return the I.D. card to the Welfare Fund Office. The use of the plastic I.D. card by an ineligible person constitutes fraud.

10.8 **Exclusions:** No payment will be made for

(a) Contraceptive, oral or other, whether medication device, regardless of intended use.

(b) Growth Hormones.

(c) Immunization agents, biological sera, blood or blood plasma.

(d) Infertility Medications.

(e) Levonorgestrel (Norplant).

(f) Minoxidil (Rogaine) for the treatment of alopecia.

(g) Non-legend drugs other than insulin.

(h) Smoking Deterrent Medications or any other smoking cessation aids.

(i) Retinoids, all dosage forms (e.g. Retin-A) for individuals 26 years of age or older.

(j) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use.

(k) Charges for the administration or injection of any drug.

(l) Prescriptions, which an Eligible Participant is entitled to receive without charge from any Worker’s Compensation Laws.

(m) Drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual.
(n) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

(o) Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician’s original order.

(p) Any charge where the usual, customary, and reasonable charge is less than the Participant’s copayment.

(q) Any charge above the usual, customary, and reasonable advertised or posted price, whichever is less than the scheduled amount.

(r) Diet medications.

(s) Genetically Engineered Drugs.

(t) Diabetic Supplies (through card program).

(u) Bee sting kits.

(v) Botox, unless prescribed for treatment of a quantifiable neurological condition confirmed in writing by a neurological specialist.

(w) Medications used for the treatment of erectile dysfunction including oral medications, such as Viagra, Cialis, and Levitra, as well as injectable treatments, such as Edex, Caverject, and Muse.
SECTION 11
VISION CARE BENEFIT

11.1 Benefit: This Vision Care Benefit is designed to provide reimbursement to Participants and their Dependents for the expense associated with eye examinations and corrective glasses or contact lenses. The Welfare Fund will provide a benefit of up to $150 per calendar year in reimbursement for the following services and items when provided by a licensed optometrist or ophthalmologist.

(a) Eye Examination, including charges for glaucoma screening.
(b) Charges for clear single bifocal lenses.
(c) Frame Costs including fittings and adjustment.
(d) Repair of frame or replacement of lenses.

11.2 Claims: Participants have the option to choose any licensed optometrist or ophthalmologist and the Welfare Fund assumes no responsibility for choice of provider or for the services rendered by such provider. To obtain reimbursement for a claim, a Participant must simply submit a claim form and a copy of the receipts to the Fund Office.

11.3 Exclusions: No benefits will be paid for cosmetic, tinted, or sunglasses, or any glasses without lenses or which are not designed to correct a vision abnormality of the patient.

11.4 Prescription Safety Glasses For Active Participants Only: Eligible Active Participants working at the trade who are required to wear prescription glasses while working will be provided one pair of Poly Carbonate Safety Prescription Eye Glasses per calendar year, at a maximum cost of $90. Winchester Optical will provide Safety Glasses through an optician located in Somerville. To obtain glasses, a Participant must contact Somerville Family Eyecare at (908) 725-0144.

The Plan Safety Glasses can only be obtained thru Somerville Family Eyecare.

11.5 Lasik or PRK Benefit: Eligible Participants who have vision that cannot be corrected to better than 20/60 through eyeglasses or contact lenses can have their vision corrected through Lasik or PRK Surgery subject to the following conditions and limitations:

(a) The benefit will be paid at 85% of the usual, customary and reasonable charges but not under any circumstances to exceed $1,700 per eye;
(b) An eligible Participant (Plan B) is eligible for the benefit only once during his/her lifetime;
(c) An eligible Participant must precertify the surgery in writing, through an independent and duly licensed ophthalmologist, that his/her vision cannot be corrected to better than 20/60 through eyeglasses or contact lenses. The Welfare Fund reserves the right to obtain a second opinion its cost and expense as to the satisfaction of this condition prior to certifying the surgery.

The Lasik or PRK Benefit is administered by the Steamfitters Welfare Fund, Local Union No. 475.
PART II

THE FOLLOWING SECTION DESCRIBES

THE

ELIGIBLE REQUIREMENTS AND BENEFITS

FOR

RETIREES AND THEIR DEPENDENTS

Section 12  Definitions for Retirees ................................................................. 46
Section 13  Eligibility Rules for Retirees ............................................................ 47
Section 14  Schedule of Benefits for Eligible Retirees

  Plan B (Full Hospital, Medical, Drug,
  Eye, and Dental) ............................................................... 49

  Plan C (Supplemental Medicare, plus Drug,
  Eye, and Dental) ............................................................. 50

  Plan E (Supplemental Medicare Benefits) ................................. 50
12.1 **Retiree:** Retiree refers to a Participant age 52 or older, who has withdrawn from active employment at the trade or industry or who has applied and is eligible for normal or early retirement benefits under the Steamfitters Local Union No. 475 Pension Plan, and such Participant qualifies for retirement benefits in accordance with eligibility provisions herein set forth (see pages 46 thru 48).

12.2 **Eligible Retiree:** A former Participant of the Steamfitters Local Union No. 475, who has retired from active employment, and who has applied and has satisfied the Eligibility Requirements herein. There are several different categories of requirements for Retirees based on age, service, eligibility status, etc. **All** requirements must be met to be eligible for the applicable benefits.

12.3 **Retirees’ Benefits:** Refers to the benefits provided an Eligible Retiree with respect to himself.

12.4 **Dependent’s Benefits:** Refers to the coverage for Eligible Retiree’s dependent spouse. It also refers to an Eligible Retiree’s dependent child (as defined in the Plan) where such coverage as set forth under the Schedule of Benefits for the Retiree.

12.5 **Covered Charges:** Means the usual, customary, and reasonable charges specifically covered by this Welfare Plan which are incurred for necessary medical care, services, or supplies received by an eligible Participant or Dependent upon the recommendation and approval of a Physician who is attending such person, and to the extent such charges are not otherwise excluded or limited by the terms of this Plan.

12.6 **Usual, Customary, and Reasonable:** Means the prevailing fee or fees most frequently charged by the providers with similar training and experience for similar or comparable services, in the locality where such service was performed. The Trustees retain the right to determine what constitutes “a usual, customary, and reasonable charge” in connection with the payment of any benefit.

12.7 **Other Applicable Definitions:** The definitions in this section basically apply to Retirees and their Welfare Dependents. Notwithstanding anything to the contrary, the Definitions set forth in Section 1 of this Welfare Plan also apply to Retirees in all instances where applicable.
SECTION 13
ELIGIBILITY RULES FOR RETIREES

13.1 PLAN B BENEFITS: For Participants Retiring On or After:
   (a) Attaining Age 62 (But Before Age 65) meeting the following criteria:
       1) Forty (40) Consecutive Benefit Quarters of Credited Service in effect at the time of Retirement.
       2) One Benefit Quarter of Credited Service earned in the twelve (12) month period immediately prior to the date of retirement.
       3) Must be receiving a Retirement or Total and Permanent Disability Pension under the Steamfitters Pension Fund, Local Union No. 475 Plan.
       4) Must make a monthly Self Pay Premium according to the Premium for continuation coverage schedule shown in Section 13.4.
   (b) Prior to Age 62 and eligible for unreduced Early Retirement Benefits [Rule of 90] from the Steamfitters Pension Fund, Local Union No. 475 (Effective for Participants retiring On or After July 1, 1992) MAY ELECT to continue coverage under Plan B by meeting the following criteria:
       1) Forty (40) Consecutive Benefit Quarters of Credited Service in effect at the time of Retirement.
       2) One (1) Benefit Quarter earned in the twelve (12) month period immediately prior to the date of retirement.
       3) Must make a quarterly Self Contribution Payment based on four hundred (400) hours at the prevailing Welfare Fund Contribution Hourly Rate (Rate subject to change in accordance with changes in the Collective Bargaining Agreement).
       4) The quarterly Self Contribution Payment may be paid on a monthly pro-rata basis.

13.2 PLAN C BENEFITS: For Participants and Eligible Retirees / Spouses:
   (a) Participants Retiring On or After Age 65 meeting the following criteria:
       1) Forty (40) Consecutive Benefit Quarters of Credited Service in effect at the time of retirement.
       2) One (1) Benefit Quarter of Credited Service earned in the twelve (12) month period immediately prior to the date of retirement.
       3) Must make a monthly Self Pay Premium according to the Premium for continuation coverage schedule shown in Section 13.4.
   (b) Eligible Retirees / Spouses Upon Attainment of Age 65 and Totally Permanent Disabled Participants Under Age 65 Who Qualify for Medicare meeting the following criteria:
       1) Must be a retired Participant or Dependent.
       2) Must qualify for Medicare Benefits due to the attainment of Age 65. OR
       3) Must be a retired Participant or Dependent Under Age 65 who qualifies for Medicare Benefits due to a Total Disability Award by Social Security.
       4) Must make a monthly Self Pay Premium according to the Premium for continuation coverage schedule shown in Section 13.4.

13.3 PLAN E BENEFITS: For Participants who were Age 52, but less than Age 62 and who retired between October 1, 1984 and June 30, 1992 meeting the following criteria:
   (a) Participants who were covered under Plan E prior to Age 65:
       1) Upon attainment of Age 65.
       2) Continue to make Self Contribution Payments.

1 Participant’s qualifying under Section 13.1 (b) who subsequently attain age 62 will be deemed to have met the eligibility requirements of Section 13.1 (a).
2 Note: If Participant’s Dependent Spouse is Under Age 65, coverage under Plan B will be continued until such Dependent Spouse attains Age 65. Upon attainment of Age 65, spouse will be continued under Plan C.
Participants who elected to continue coverage for themselves and/or their eligible Dependents under Plan E.

1) 40 Consecutive Benefit Quarters of Credited Service in effect at the time of Retirement.
2) One Benefit Quarter earned in the twelve (12) month period immediately prior to the date of retirement.
3) Continue to make Self Contribution Payments.

13.4 Continuation Coverage Schedule:

<table>
<thead>
<tr>
<th>Retired</th>
<th>Years of Benefit Credits</th>
<th>Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 1/1/2004</td>
<td>N/A</td>
<td>$25.00</td>
</tr>
<tr>
<td>On or After 1/1/2004</td>
<td>10 Years or more but less than 15 years of Benefit Credits</td>
<td>$200.00</td>
</tr>
<tr>
<td>On or After 1/1/2004</td>
<td>15 Years or more but less than 20 years of Benefit Credits</td>
<td>$150.00</td>
</tr>
<tr>
<td>On or After 1/1/2004</td>
<td>20 Years or more but less than 25 years of Benefit Credits</td>
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</tr>
<tr>
<td>On or After 1/1/2004</td>
<td>25 Years or more but less than 30 years of Benefit Credits</td>
<td>$100.00</td>
</tr>
<tr>
<td>On or After 1/1/2004</td>
<td>30 Years or more of Benefit Credits</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

13.5 Regulations pertaining to self-contribution payments:

(a) Self Contribution can be made only by former participants who satisfy the Eligibility Rules of Section 13. Such participants (Retirees) may continue their eligibility for retiree benefits only, providing they make the proper application at the time of retirement (within 30 days from the date of termination of active employment), and agree to make the required Self Contribution Payments.

(b) Dependent Coverage is elective and not mandatory. Election of such coverage must be made at the time of retirement. Participants electing single coverage may not elect Dependent coverage at a later date.

(c) All payments must be made on or before the beginning of any Benefit Period. NO LATE PAYMENTS WILL BE ACCEPTED. Failure to make the required Self Contribution Payment on a timely basis will result in termination of all benefits under the Welfare Plan.

(d) All checks and money orders should be made payable to the Steamfitters Welfare Fund, Local Union No. 475.

(e) THE TRUSTEES RETAIN THE RIGHT TO CHANGE THE AMOUNT OF SELF-CONTRIBUTION PAYMENTS AT ANY TIME.

(f) The term “Consecutive Benefit Quarter in effect” shall mean consecutive quarterly periods during which the Participant maintains continuous eligibility for coverage without any intervening termination of coverage.

13.6 Note: Retiree benefits are not vested and the Trustees retain the right to change, modify, or terminate the benefits at any time without advance notice to Participants or providers.
SECTION 14
SCHEDULE OF BENEFITS FOR RETIREES

This section briefly describes the different Welfare Benefit Plans to which an eligible Participant may apply at the time of retirement. It should be noted that the different Benefit Plans are based upon a Participant’s age and the number of consecutive Quarters of Credited Service earned and in effect at the time of retirement as described in Section 13, and when the date when they retired.

Plan B which provides full Hospital, Medical, Drug, Eye and Dental Benefits, applies to those Participants who have met the requirements of Section 13.1.

Dependents under Age 65 may also be covered under Retiree Plan B benefits. The election to cover eligible dependents must be made at the time of retirement.

Plan C sets forth the Supplemental Medicare Benefits for Eligible Participants who meet the requirements of Section 13.2.

Plan E sets forth the Supplemental Medicare benefits for those Retired Participants who meet the requirements of Section 13.3.

Benefit Payments. All benefits payments made by the Welfare Fund will be based on the usual, customary and reasonable fees charged for the specific services rendered:

The “usual fee” is that fee which the individual doctor or provider of medical services most frequently charges to a majority of patients for the procedure or service rendered.

The “customary fee” is the range of fees which most doctors or other providers of services would charge in the general geographic area, taking into account the training, experience, expertise of such provider service.

Trustees shall have the sole prerogative to determine the reasonableness of any fee charged by the doctor, hospital or other provider of medical service however, in those instances where supplemental Medicare benefits are provided, the Trustees shall rely on the determination made by Medicare. All such determination shall be consistently applied in all similar situations, and shall be in accordance with the benefit provisions hereinafter set forth.

14.1 Retiree Plan B Benefits – Please refer to the appropriate Section of the Plan.

CIGNA Hospital & Medical Network and Program ........................................ Section 6.0 page 19
Behavioral Health Network ................................................................. Section 7.0 page 33
Transplant Benefit .............................................................................. Section 8.0 page 35
Dental Expense Benefit ................................................................. Section 9.0 page 40
Prescription Drug Benefit ................................................................. Section 10.0 page 41
Vision Benefit .................................................................................. Section 11.0 page 44

*Maximum Lifetime Benefit for all Hospital and Comprehensive Medical Benefits. $ 1,000,000.
14.2 Retiree Plan C and E - Schedule of Benefits

Behavioral Health Network ................................................................. Section 7.0 page 33
Transplant Benefit ................................................................. Section 8.0 page 35

CIGNA HealthCare Benefit Summary
Steamfitters Welfare Fund Local Union No. 475
Supplemental Medicare Plan - PLAN C and PLAN E
Member must be enrolled in Medicare for Primary coverage

<table>
<thead>
<tr>
<th>Benefit Highlight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
</tr>
<tr>
<td><strong>Coinsurance Levels</strong></td>
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<td><strong>Calendar Year Deductible</strong></td>
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<td>Individual</td>
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<td>Family Maximum</td>
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<tr>
<td>Family Maximum Deductible Calculation</td>
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<td><strong>Out-of-Pocket Maximum Accumulators</strong></td>
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<tr>
<td>Includes Plan Deductible</td>
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<tr>
<td>Includes Copays(deductibles)</td>
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<tr>
<td>Does Not Apply To</td>
</tr>
<tr>
<td>Benefits for accident or sickness (excluding mental health, alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family Maximum</td>
</tr>
<tr>
<td>Family Maximum OOP Calculation</td>
</tr>
<tr>
<td><strong>Automated Annual Reinstatement</strong></td>
</tr>
<tr>
<td><strong>Physician's Services</strong></td>
</tr>
<tr>
<td>Primary Care Physician's Office visit</td>
</tr>
<tr>
<td><strong>Note:</strong> OB/GYN is considered a Specialist</td>
</tr>
<tr>
<td>Specialty Care Physician's Office Visit</td>
</tr>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td>Consultant and Referral Physician's Services</td>
</tr>
<tr>
<td>Surgery Performed In the Physician's Office</td>
</tr>
<tr>
<td>Second Opinion Consultations (services will be provided on a voluntary basis)</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
</tr>
<tr>
<td>Allergy Serum (dispensed by the physician in the office)</td>
</tr>
</tbody>
</table>

50
## Supplemental Medicare Plan – PLAN C and PLAN E
### BENEFIT HIGHLIGHTS

### Adult Preventive Care
Routine Preventive Care for children and adults from age 3; subject to an unlimited maximum per calendar year (including routine immunization)

**Note:** Well-woman visits are considered Specialists visits

**Note:** Charges for lab and radiology services, when billed by the physician’s office, will be subject to the plan’s Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan’s Preventive Care dollar maximum.

### Immunizations
100% coinsurance

### Mammograms, PSA, Pap Smear
**Note:** Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.

**Notes if applicable:**
- Preventive care related Mammogram charges do not accumulate to the plan’s Preventive Care dollar maximum, regardless of place of service.
- Preventive care related PSA and Pap smear charges, when billed by the physician’s office, will be subject to the plan’s Preventive Care dollar maximum.
- Preventive care related PSA and Pap smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan’s Preventive Care dollar maximum.

### Inpatient Hospital - Facility Services
**Up to a 45 day calendar year maximum**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi Private Room and Board</td>
<td>100% coinsurance, if billed by a separate outpatient diagnostic facility such as a hospital</td>
</tr>
<tr>
<td>Private Room</td>
<td></td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Facility Services
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room

**Note:** Non-surgical treatment procedures are not subject to the facility deductible.

### Inpatient Hospital Physician’s Visits/Consultations
100% coinsurance

### Inpatient Hospital Professional Services
Surgeon, Radiologist, Pathologist, Anesthesiologist

### Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

### Outpatient Professional Services
Surgeon, Radiologist, Pathologist, Anesthesiologist

100% coinsurance
## BENEFIT HIGHLIGHTS

### Emergency and Urgent Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Outpatient Professional services</td>
<td>100% after plan deductible (if the ER facility benefit is subject to coinsurance and plan deductible)</td>
</tr>
<tr>
<td>(radiology, pathology and ER physician)</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% coinsurance</td>
</tr>
</tbody>
</table>

### Inpatient Services at Other Health Care Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>60 days combined maximum per calendar year</td>
<td>Note: If plan includes an inpatient hospital deductible, the inpatient hospital deductible does not apply.</td>
</tr>
</tbody>
</table>

### Laboratory and Radiology Services (includes pre-admission testing)

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Emergency Room/Urgent Care Facility</td>
<td>100% after plan deductible (if the ER/UC facility is covered subject to plan coinsurance and deductible)</td>
</tr>
<tr>
<td>( billed by the facility as part of the ER/UC visit)</td>
<td></td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>100% after plan deductible (if the ER facility is covered subject to plan coinsurance and deductible)</td>
</tr>
</tbody>
</table>

### Advanced Radiological Imaging (i.e. MRI’s, MRAs, CAT Scans, PET Scans, etc.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Emergency Room ( billed by the facility as part of the ER visit)</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Physician's Office</td>
<td>100% coinsurance</td>
</tr>
</tbody>
</table>

**Notes:**
- Scans are subject to the applicable place of service coinsurance and plan deductible.
**Supplemental Medicare Plan – PLAN C and PLAN E**

**BENEFIT HIGHLIGHTS**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coinsurance Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Short-Term Rehabilitative Therapy, Cardiac</strong></td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
<tr>
<td>Rehabilitation and Chiropractic Care Services</td>
<td><strong>Note:</strong> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day.</td>
</tr>
<tr>
<td>Includes:</td>
<td>Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Therapy (includes Chiropractors), Pulmonary Rehab, Cognitive Therapy</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Unlimited days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)</td>
<td><strong>Note:</strong> The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td><strong>Note:</strong> If plan includes an inpatient hospital deductible, the inpatient hospital deductible does not apply</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td><strong>Note:</strong> OB/GYN provider is considered a Specialist</td>
</tr>
<tr>
<td>All Subsequent Prenatal Visits, Postnatal Visits, and Delivery (i.e. global maternity fee)</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Office Visits in addition to the global maternity fee when performed by an OB or Specialist.</td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
<tr>
<td>Delivery – Facility (Inpatient Hospital, Birthing Center)</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Non-elective procedures only</td>
<td><strong>Inpatient Facility</strong></td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
<tr>
<td>Office Visits, Tests and Counseling</td>
<td><strong>Note:</strong> Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan’s x-ray/lab benefit.</td>
</tr>
<tr>
<td>No coverage for Contraceptives or Contraceptive devices.</td>
<td></td>
</tr>
</tbody>
</table>

53
### Surgical Sterilization Procedure
for Vasectomy/Tubal Ligations (exclude reversals)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Inpatient Physician’s Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Outpatient Physician’s Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
</tbody>
</table>

### Infertility Treatment - Standard Benefit

Services not covered include:
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).

**Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

### Organ Transplant
Includes all medically appropriate, non-experimental transplants

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Travel Services Maximum</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

### Durable Medical Equipment
Unlimited maximum per calendar year

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% coinsurance</td>
</tr>
</tbody>
</table>

### External Prosthetic Appliances
Unlimited maximum per calendar year

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% coinsurance</td>
</tr>
</tbody>
</table>

### Dental Care
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.

Bony Impacted Wisdom teeth extractions are covered

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s Office</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>100% after plan deductible</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100% coinsurance; 100% coinsurance if only x-ray and/or lab services performed and billed.</td>
</tr>
</tbody>
</table>

### TMJ - Surgical and Non-surgical
Not Covered

### Routine Foot Disorders
Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.

### Mail order or Retail Pharmacy
Not covered under CIGNA
Supplemental Medicare Plan – PLAN C and PLAN E

BENEFIT HIGHLIGHTS

Personal Health Solutions

* CIGNA's PAC/CSR is not necessary for Medicare Primary individuals

14.3 Plan C and E Medical Benefit Exclusions: The Welfare Plan provides coverage for medically necessary services. The Welfare Plan does not provide coverage for the following except as required by federal law:

(a) Care for health conditions that are required by state or local law to be treated in a public facility.

(b) Care required by state or federal law to be supplied by a public school system or school district.

(c) Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

(d) Treatment of an illness or injury which is due to war, declared or undeclared.

(e) Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.

(f) Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

(g) Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the “Clinical Trials” section of “Section IV. Covered Services and Supplies,” or The subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of “Section IV. Covered Services and Supplies.”

(h) Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.

(i) The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

(j) Treatment of TMJ disorder.

(k) Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

(l) Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

(m) Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
(n) Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under “Section IV. Covered Services and Supplies.”

(o) Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intralFallopian transfer (GIFT), zygote intralFallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

(p) Reversal of male and female voluntary sterilization procedures.

(q) Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

(r) Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasia, and premature ejaculation.

(s) Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.

(t) Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

(u) Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

(v) Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or “Breast Reconstruction and Breast Prostheses” sections of "Section IV. Covered Services and Supplies."

(w) Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Section IV. Covered Services and Supplies”.

(x) Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.

(y) Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

(z) Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

(aa) Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

(bb) Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).

(cc) Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy and Lasik surgery.

(dd) All Contraceptives and Contraceptive devices including IUD’s and Diaphragms.

(ee) Treatment by acupuncture.

(ff) All Prescription drugs, non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies.”

(gg) Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

(hh) Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
(ii) Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

(jj) Dental implants for any condition.

(kk) Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

(ll) Blood administration for the purpose of general improvement in physical condition.

(mm) Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

(nn) Cosmetics, dietary supplements and health and beauty aids.

(oo) All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.

(pp) Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Welfare Plan as a Retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.

(qq) Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.

(rr) Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

(ss) Telephone, e-mail & Internet consultations and telemedicine.

(tt) Massage Therapy

Benefits are administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Expense Benefits:</td>
<td>Maximum Covered Charges per Calendar Year $ 2,000. Plan payments (based on UCR charges) at 85% Employee Co-Payment 15%</td>
</tr>
<tr>
<td>Vision Care Benefit</td>
<td>Maximum per Calendar Year $ 150.00</td>
</tr>
<tr>
<td>Prescription Drug Benefits:</td>
<td>Retail (30 day supply): Participant Co-Payment Generic Drugs -0- Participant Co-Payment Preferred Brand Drugs $15.00 Participant Co-Payment Non-Preferred Brand Drugs $30.00 Mail Order (90 day supply): Participant Co-Payment Generic Drugs -0- Participant Co-Payment Preferred Brand Drugs $30.00 Participant Co-Payment Non-Preferred Brand Drugs $60.00</td>
</tr>
<tr>
<td>Annual Maximum (per individual per calendar year)</td>
<td>$ 10,000.00</td>
</tr>
</tbody>
</table>

The following benefits are for Plan C Retirees, Plan E Retirees are not eligible for these benefits.
PART III Personal Benefit

SECTION 15
PERSONAL BENEFIT

15.1 **Purpose**: Benefits provided under the Personal Benefit are designed to provide a supplemental income to replace loss of wages and to protect against contingencies that interrupt or impair a Participant’s earning power or for those Participants who are not currently employed and;
(a) Safeguard or improve health of Participant/Dependent
(b) Protect against interruption or impairment of Participant earning power or estate
(c) Provision of voluntary life, sickness and accident benefit opportunities
(d) Severance pay

* This benefit is not intended to be a savings account and does not accrue interest.

15.2 **Eligibility**: If you were previously employed by an Employer who signed or was bound to the Collective Bargaining Agreement with the Steamfitters, Pipefitters and Apprentices Local Union No. 475 and you did work covered by the Agreement, the Employer was required to make contributions for the Personal Benefit on your behalf.

15.3 **Contributions**: The entire cost of the Personal Benefit is met by Employer Contributions under the provisions of the Collective Bargaining Agreement.

15.4 **Individual Account**: An Individual Account is established and maintained for each Participant upon receipt of Employer Contributions. The Account is reconciled annually on the reconciliation date and a statement will be sent to each Participant informing him of the status of this Account.

In general, your Individual Account shall include:
(a) The sum of all contributions made on your behalf minus
(b) Your share of the expenses of running the Personal Benefit minus
(c) Benefit payment(s)

15.5 **Reconciliation Date**: The reconciliation date is March 1st of each calendar year on which all of the factors (contributions, expenses and benefit payments) are applied to fix the value of each Individual Account.

15.6 **Payment of Personal Benefit**: You are eligible to receive benefits from your Individual Account if one or more of the following apply:

(a) You have collected state unemployment checks for two (2) weeks, at which point you will be eligible to receive supplemental unemployment benefits from your Individual Account at the rate of $150.00, $300.00 or $450.00 per week, whichever amount you designate in your application for benefits, until the earlier of
   1) the commencement of employment covered by the Collective Bargaining Agreement; or
   2) your Individual Account Balance has been reduced to zero.

(b) You have collected state disability or workmen’s compensation unemployment checks for Two (2) weeks, at which point you will be eligible to receive supplemental disability benefits from your Individual Account at the rate of $150.00, $300.00 or $450.00 per week, whichever amount you designate in your application for benefits, until the earlier of
   1) the disability release; or
   2) your Individual Account Balance has been reduced to zero.
(c) You or one of your dependents’ has expenses for medical care not otherwise paid for by the Welfare Fund. Unless services and payment have already been rendered and paid for, the benefits will be payable directly to the medical provider in the amount not otherwise reimbursed or paid by the Welfare Fund. Benefits can be paid until your Individual Account Balance has been reduced to zero.

1) Expenses for Medical Care means amounts paid for hospitalization, medical and dental services, prescription drugs [other medicines & drugs] and medical supplies that are eligible for tax-free reimbursement and corrective lenses and eyeglass frames. Eligible expenses are those that are defined in IRS Code §213(d).

(d) Your Dependent Child has tuition payments for post elementary education. Benefits can be paid until your Individual Account Balance has been reduced to zero.

(e) You have insurance premium payment for yourself or family member, including COBRA, long term care, term life or Universal life; or you are a Retiree between the age of 52 and 62 and qualify under Rule of 90 in Section 4.11 of the Steamfitters Pension Fund Local Union No. 475 and have elected to continue coverage under Plan B for Retirees under the Welfare Plan and you need to make a quarterly Self Contribution Payment based on four hundred (400) hours at the prevailing hourly rate for Employer contributions to the Welfare Fund. Benefits can be paid until your Individual Account Balance has been reduced to zero.

15.7 **Severance Benefit:** Should there have been no contributions to your Individual Account for 24 consecutive months, the entire Account balance will be paid to you.

15.8 **Death of a Participant:** If a Participant dies and his Individual Account has a balance, it shall be paid to his designated beneficiary as set forth under the Steamfitters Pension Fund, Local Union No. 475.

15.9 **Information Required and Standard of Proof:** Every Participant shall furnish, at the request of the Trustees, any information or proof required for the administration of the Personal Benefit or for the determination of any matter that the Trustees may have before them. The falsity of any statement material to an application or the furnishing of fraudulent information or proof shall be sufficient reason for the denial, suspension or discontinuance of benefits under the Personal Benefit; and in such case the Trustees shall have the right to recover any benefit payments made in reliance thereon. Such denial, suspension or discontinuance of benefits may be rescinded and payments may be restored if the Participant, furnishes or corrects to the satisfaction of the Trustees, lacking or incorrectly stated information. The Trustees shall have full discretion in the interpretation of the provisions of the Personal Benefit and are the sole judges of the standard of proof required in any case. In the application and interpretation of the provisions of this Personal Benefit, the decisions of the Trustees shall be final and binding on all parties including Employees, Employers, the Union, Participant and Beneficiaries.

15.10 **Taxes:** The Fund will withhold all required Federal and State payroll tax on all benefits paid out. IRS Form 1099 will be issued to each Participant who draws on these benefits for the particular tax year.

15.11 **Assignment:** No assignment by an eligible Participant of the benefits under this provision shall be valid.

15.12 **Exclusions and Limitations:** Personal Benefit will not be paid:

(a) For any period of non-employment or disability resulting from the commission of a felony or a crime of greater degree.

(b) When the Individual Account Balance is zero.

(c) In the case of unemployment and disability, when receiving retirement benefits from Steamfitters Pension Fund Local Union No. 475, age 62 or older (other than severance).

(d) Any medical expense not described as eligible under IRS Code Section 213(d).
PART IV

THE FOLLOWING SECTION CONTAIN

THE GENERAL PLAN PROVISIONS RELATING TO

Federal Requirements ................................................................. Section 16
Coordination of Benefits .......................................................... Section 17
General Exclusion and Limitations ............................................ Section 18
Subrogation of Benefits ........................................................... Section 19
Denial and Appeal Procedures ................................................ Section 20
Medical Eligible/Election of Benefits ...................................... Section 21
Claim Procedures ................................................................ Section 22
Participants Rights and Protections Under ERISA .................... Section 23
SECTION 16
Federal Requirements

16.1 Notice of Provider Directory/Networks: Because the Welfare Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers. You may also have access to a list of Providers who participate in the network by visiting www.mycigna.com; mycigna.com or by calling the toll-free telephone number on your ID card. Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare.

16.2 Obtaining a Certificate of Creditable Coverage Under This Plan: Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.
Coordination of Benefits - Hospitalization Benefits: Coordination of benefits is applicable to Participants who are covered under another group hospitalization benefit plan in addition to this plan. Its purpose is to conserve funds allocated for health care by preventing individuals from receiving more in benefits than the actual cost of such care.

When an Eligible Participant receives services, which are covered under this Welfare Fund or another group Plan, a determination will be made as to which plan is “primary” and which is “secondary”. The primary plan will pay its benefits without regard to the secondary plan. The secondary plan will then pay for any covered services which have not been paid for by the primary plan.

The primary plan will be determined in the following order:

First, the plan covering the patient as a Participant will be considered the primary plan,

NEXT, where the patient is a Dependent Child and where both the father and mother are covered under separate Plans, the PRIMARY PLAN would be that Plan whose Participant’s birthday (month and day) falls earliest in the calendar year. For example, if you have a Dependent Child who is hospitalized and both you and your spouse are covered under separate plans providing dependent coverage, but you were born on December 15 and your spouse was born on February 29 your spouse’s plan would be considered the PRIMARY PLAN. Conversely, if you were born on January 22 and your spouse was born on February 2, your plan would be considered PRIMARY. (Please note that the determination is not based on age but on the month and day of birth).

Where the patient is a foster child or stepchild, and the child is covered by his natural father’s plan, the plan covering such child’s natural father shall be considered primary.

Where the determination cannot be made in accordance with either of the foregoing, the plan, which has covered the patient for the longer period of time, will be considered the primary plan.

When another plan does not contain a Coordination of Benefit provision, that plan will always be considered the PRIMARY plan. Payment under the SECONDARY plan is made after the amount payable under the primary plan has been determined.

This foregoing Coordination of Benefits Provision does not apply to individual, nongroup, or group conversion policies, issued directly to an eligible Participant or dependent.

Whenever this Welfare Plan is considered the secondary plan and a claim payment is reduced because of this provision, the amount of the reduction will be carried for the balance of the calendar year as a credit for the person for whom the claim was made. This amount may be used for other claims, due to any cause, in the same calendar year, if the person has an out-of-pocket allowable expense after the normal benefits under both plans have been paid. A claim record is maintained only for a calendar year, and a new record starts as of January 1.

For Private or Individual Plans

Where the “other plan” is an individual or private Health Insurance Plan for which the employee pays the full cost,

(a) this Fund will be considered primary (and all claims must be filed and processed by this Fund before application is made to the Participant’s individual Health Insurance carrier), and

(b) all claims will be paid (at the discretion of the Trustees) directly to the provider of medical services, except where such provider refuses assignments. Where the provider does not accept assignments, payments may be made directly to the Participant.

(c) in the event the Participant fails to comply with the foregoing, this Fund will reimburse the individual Participant in an amount not to exceed the lesser of:

(1) the premiums such individual paid in the three month period immediately preceding the date of the claim, or

(2) the amount that the Fund would have paid had not the benefits of this Plan been coordinated with those of the individual or group plan.
SECTION 18
GENERAL EXCLUSIONS AND LIMITATIONS

The plan does not cover injuries, losses or expenses resulting from any of the following:

18.1 **Occupational Injuries:** Loss caused by accidental bodily injury (except as specifically provided under the Accidental Death and Dismemberment provisions of the Group Insurance Policy and Weekly Disability provisions of this Plan) which arise out of or occurs in the course of any occupation or employment for wage or profit, or sickness for which you are entitled to benefits under any Workmen’s Compensation and Occupational Disease Law or similar legislation.

The exception to the foregoing will occur where hospital confinement is necessary for the treatment of asbestosis, emphysema, cancer or other related diseases which are alleged to have been the result of the your occupation or employment, and for which you are seeking legal redress from either your employer under Workman’s Compensation or from third parties. Hospital coverage may be extended by the Trustees in such situations, providing you agree to pursue your legal remedies and also to notify the Fund Office of the progress of any actions. Further, you will have agree in writing to reimburse the Welfare Fund for any award, judgment or settlement. The Welfare Fund will require that it have a first lien or charge upon such funds as provided under Section 19.

18.2 **Care Rendered by Governmental Agencies:** Expenses resulting from care rendered by or within any facility or provided by the United States Veterans Administration, nor will payment be made for services or supplies furnished by any other Governmental Agency or Facilities, unless required by Federal Law.

18.3 **Injuries Related to Hazardous Sports, Hobbies, Recreational Activities or Employment:** Losses resulting from self employment for which contributions are not made or required to be made to the Welfare Fund or any form of employment for which contributions are not required to be made to the Welfare Fund or losses resulting from participation (other than as a spectator) in hazardous or high risk sports, hobbies or recreational activity or entertainment will not be covered. Such limitations shall apply specifically, but shall not be limited to such activities as sky diving, amateur, semi-professional or professional racing of motorcycles, cars, ski mobiles and airplanes, professional or semi-professional boxing, wrestling, football, soccer, hockey or other organized competitive sports that provide forms of compensation other than trophies or medals, and activities shall be considered to Participants for the purpose herein, as semi-professional and injuries resulting from such activities shall be excluded from coverage hereunder.

18.4 **Injuries Sustained In Commission of Crime:** Loss resulting from the participation in a commission of a crime, regardless of whether such participation results in prosecution or conviction.

18.5 **War, Insurrection, Riot or Military Service Related Injuries or Illness:** Loss caused by war or any act of war (declared or undeclared), insurrection, riot or military or naval service of any country.

18.6 **Motor Vehicle Accident Medical Expense:** Loss resulting from accidental personal injuries as well as any medical expense deductibles sustained or incurred:

(a) while operating, occupying, entering into, alighting from or being transported by a vehicle as defined herein, or

(b) sustaining accidental injuries as a pedestrian, caused indirectly or directly by a vehicle (as defined herein) or by an object propelled by such vehicle.

The term vehicle shall include, but not be limited to, an automobile, van, truck, motorcycle or other similar vehicle, motorized or self-propelled.

18.7 **Implants and Transplants:** All charges due to or related to implants (either natural or artificial) except that special consideration will be given to transplants of the eye, bone marrow and other routine operations of similar frequency and common practice as determined by the Trustees.

18.8 **Other:** Procedure and/or Expense that is not specifically described as being covered.
SECTION 19
SUBROGATION

19.1 Subrogation of Hospitalization Surgical, Medical Benefits: Subrogation seeks to conserve the assets of the Fund by imposing the expense for accidental injuries suffered by eligible Participants or their dependents on those responsible for causing them. Accordingly, if an eligible Participant or dependent, qualifies for hospital surgical or other medical benefits for injuries caused by someone else, the Fund, through subrogation, will seek repayment from the other party or his insurance company.

a) If you or your dependent have the opportunity to recover monies in connection with an illness, injury, accident, occurrence, condition or other loss for which Fund benefits are payable, through a claim against any third party the Fund has a lien against, is subrogated to, and has the right to reimbursement from such monies up to the full extent of benefits paid by the Fund. A "claim against any third party" includes but is not limited to a claim of any type whatsoever, whether the claim exists or may exist, or the monies are or may be recovered, from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, Workers Compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by you, by compromise, or in any other way from any third party, person, agency, organization or fund of money.

b) The Fund is entitled to its full lien and its full recovery of the total amount of benefits which are payable, regardless of the amount of monies paid or awarded to you by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. The Fund’s right of recovery shall be a prior lien against any proceeds recovered by the Participant or dependent, which right shall not be defeated or reduced by the application of any so-called “Make-Whole Doctrine,” “Rimes Doctrine,” or any other such doctrine purporting to defeat the Fund's recovery rights by allocating the proceeds exclusively to non-medical expense damages. No reduction of the Fund's full right to recover the total amount of Fund benefits is effective without the Fund's written consent. The Fund retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested. The Fund has a constructive trust over and an equitable right to and lien with regard to any monies received by a Participant or beneficiary and his or her attorney or representative from a third party.

c) This provision applies to any type of payment, which in any way arises from or in connection with the illness, injury, accident, occurrence, loss or condition, whether or not the payor caused or is legally responsible or liable for it. It is applicable regardless of whether such liability or responsibility is or is not denied or is in dispute.

d) The Fund has sole and final discretion to determine whether to assert its rights under this provision as a lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, or through any combination or variation of these methods. The determination of which method(s) will be used in a particular case will be made to protect the interests of the Fund and its Participants, is in the Fund's sole and final discretion.

e) If any claim exists or may exist by you or your dependent against any third party, you must notify the Fund within 30 days of the date such claim becomes apparent in writing, stating the name, address, telephone number and basis for the claim against the third party, and the name, address and telephone number of the attorney, representative or other agent handling the claim on behalf of you or your dependent. You must also notify the third party and its counsel or representative in writing of the Fund's lien within 30 days of the date you assert your claim against the third party.

f) You, your dependent, and any attorney, representative or agent who is representing you in connection with any claim against any third party, are required to sign a written statement provided by the Fund saying that they acknowledge, agree to and will adhere to the Fund's lien, right of subrogation and reimbursement and this provision of the Plan. The existing form, which the Fund requires you and any such attorney to complete, includes this entire provision and will be provided by the Fund. The Fund may modify this form at any time without further notice, in its sole and exclusive discretion, and will
provide you with a copy of any new or revised form to be executed and returned to the Fund within 10 days of notification. The Fund also may, in its sole and final discretion, require you, your dependent and any such attorney, representative or agent to execute such other documents the Fund deems necessary, helpful or appropriate to protect the Fund's rights under the provision. You may also be required to permit the Fund to intervene in any proceeding, and you may be required to file a lien or Consent to Lien, assignment or other such forms, to protect the Fund's interests. Failure to procure said forms will not preclude the Fund from enforcing its rights under this Reimbursement and Subrogation provision.

g) The Fund may withhold or suspend payment of any, or all benefits in case a claim against any third party exists pending reimbursement, pending guaranteed recognition of the Fund's reimbursement, or pending court order, as the Fund may decide in its sole and final discretion. If you, your dependent, attorney, representative or agent fail or refuse to cooperate with this provision and with the Fund's rights by disputing the Fund's lien, fail to advise the Fund of the status of the claim against the third party, withhold necessary information, fail to execute the Consent to Lien form described above, or in any other way interfere with the Fund's rights, the Fund will withhold, suspend and exclude payment of any benefits which would otherwise be payable under the Plan. This is a specific exclusion and limitation of the Plan, and is in addition to any other legal rights, which the Fund may have, or any other action the Fund may take to protect its rights.

h) You, your dependent, your attorney, a representative or agent must advise the Fund as to the status of any claim against any third party, including providing the Fund with information as to the third party, insurers, lawsuits or any other data related to the claim or to the existence of a claim. Such information must be provided at the initiation of the claim, every 12 months thereafter, whenever a settlement is proposed, and whenever requested by the Fund.

i) No claim against any third party may be settled or resolved, and no payment may be accepted from any third party, without the written consent of the Fund. Unless and until the Fund has received full reimbursement, no monies from or through a third party may be distributed to you, your dependent, your attorney, representative or agent without the Fund's written consent, and these monies are, to the extent of benefits payable or paid by the Fund, assets of and debts owed to the Fund. The Fund's decision on whether to grant or withhold its consent is a final decision, made in the sole discretion of the Fund.

j) The Fund may, by written notice given to you, require that any other person comply with this provision, in order to secure the Fund's rights in the exercise of its sole and final discretion.

k) Full cooperation with this provision is a condition to payment of any benefits under this Plan. In case of any failure to cooperate, or violation of this provision, you, your dependent, attorney, representative or agent will be liable to the Fund for full reimbursement and for its loss, including costs, interests and fees.

l) This provision covers not only you as Participant, but also your dependents, spouses, attorneys, representatives, agents and their heirs, guardians, executors, successors and assignees.

m) No other liens may be superior to the Fund's lien or rights under this provision. The Fund may in its discretion and in an appropriate case, agree to a reduction of its lien for the payment of a portion of attorneys' fees and costs of a legal proceeding, if all terms of this provision have been and are being observed. However, no Participant or dependent shall incur any expenses on behalf of the Fund in pursuit of the Fund’s right hereunder, and specifically no court costs or attorney’s fees may be deducted from the Fund’s recovery, without express written consent of the Fund. This right shall not be defeated by any so-called “Fund Doctrine,” “Common Fund Doctrine,” or “Attorney’s Fund Doctrine.”

n) Any disputes arising under or in connection with this Section, including disputes over liens, their amount, reimbursement or withholding of benefits, or reductions or compromises in the Fund's lien shall, if not resolved with the Fund Administrator, be taken up in accordance with the procedure for disputed claims contained in this Plan Document including appeal to and review by the Fund Board of Trustees as set forth in this Plan Document. The Board of Trustees may delegate a Committee of its members to decide upon such disputes. Wherever the discretion of the Fund is noted in this Section, it refers to the discretion of the Fund personnel and the Board of Trustees or its delegated Committee.
The following Denial and Appeal Claim Procedures will be effective January 1, 2008.

The Fund is administered by a Board of Trustees pursuant to an Agreement and Declaration of Trust, which may be amended from time to time. The Board of Trustees has authority and discretion to determine benefits, and may, in its discretion, revise, discontinue, improve, reduce, modify or make changes in the plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Welfare SPD and Plan, and Trust Agreement, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees, whose determinations are final and binding.

A claim is a request for a benefit under this Welfare Plan made in accordance with this claim procedure. A request for a benefit under this Welfare Plan will be considered a claim only if it is submitted to the appropriate Claim Administrator identified below. The Fund may recoup the amount of any erroneous payment, with interest, against pending or future benefits in accordance with law and regulation. In addition to the information provided on each benefit, information on submitting a claim is shown in Section 22.

20.1 Claim Administrators:

(a) **Inpatient Hospital and Medical**: The Claim Administrator for inpatient hospital administration is CIGNA Healthcare. Claims for inpatient hospital administration must be pre-certified as shown in Section 6.3. You or your authorized representative may contact the Fund Office if you require further information.

(b) **Behavioral Health**: The Claim Administrator for the treatment of behavioral health conditions is found in Section 7. All treatment must be pre-certified as indicated in Section 7. You or your authorized representative may contact the Fund Office if you require further information.

(c) **Prescription Drug**: The Claim Administrator for prescription drugs is INFORMEDRX as shown in Section 10. Claims for prescription drugs at participating pharmacies will be processed at the time your prescription is filled. You or your authorized representative may contact INFORMEDRX by calling the number shown in Section 10.

(d) **Dental, vision, temporary disability benefits, and other claims not covered by CIGNA Healthcare**: The Claim Administrator for dental, vision, temporary disability benefits, and other claims not covered by CIGNA Healthcare is the Steamfitters Welfare Fund, Local No. 475. You or your authorized representative may contact the Fund Office if you require further information.

(e) **Life Insurance and Accidental Death**: The Claim Administrator for life insurance and accidental death and dismemberment benefits can be found in Section 3 and 4.

20.2 Initial Claim Determination:

(a) Definitions:

1) **Urgent claims** are requests for eligibility status or for medical care or treatment of an emergency nature, which could seriously jeopardize the life or health or the claimant or would subject the claimant to severe pain.

2) **Pre-service claim** is a request for eligibility status or for benefits for which a Plan requires pre-approval, such as pre-admission certification for a hospital admission or a predetermination of benefits for major dental care.

3) **Post-service claim** is a request for a benefit following the claimant’s receipt of services.

4) **Disability claim** is a request for a disability benefit as described in sections 2.8, Section 5, and Schedule B.

5) **Life Insurance claim** is a request for life insurance or accidental death and dismemberment benefits under the Welfare Plan.

(b) **Time Limits for Initial Claim Determinations**:
(1) **Urgent Care Claim:** A decision and notification to you with respect to an *urgent care claim* will be made within seventy-two (72) hours or sooner if possible (whether adverse or not). If the claim is not complete, the Plan will so notify you of the additional information required within twenty-four hours. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with the Appeal and Denial procedures (described in Section 20). The Plan Administrator shall notify the claimant of the plan’s benefit determination as soon as possible, but in no case later than 48 hours after the earlier of

i) The plan’s receipt of the specified information

ii) The end of the period afforded the claimant to provide the specified additional information

(2) **Pre-Service Claim:** A decision and notification to you on a *pre-service claim* will be made within fifteen (15) days from receipt of the claim. The Plan may take an additional fifteen (15) days, if it is determined an extension is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension, prior to the expiration of the fifteen (15) day period, and the date by which the Plan expects to render a decision. The Plan will advise of a defective or incomplete filing of a pre-service claim within five (5) days of receipt. If the extension is due to failure to submit necessary information to decide the claim, you shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the information.

(3) **Post-Service Claim:** A decision and notification to you on a *post-service* claim will be made within thirty (30) days from receipt of the claim. This determination period may be extended one time for fifteen (15) days for reasons beyond the Plan’s control, in which case the Plan will notify you in writing within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least forty-five (45) days from receipt of the notice to provide the necessary information.

(4) **Disability Claim:** A decision and notification to you on a *disability* claim will be made within forty-five (45) days from receipt of the claim. This determination period may be extended two times for thirty (30) days for reasons beyond the Plan’s control, in which case the Plan will notify you in writing within the first forty-five (45) day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least forty-five (45) days from receipt of the notice to provide the necessary information. The deadline for the claim determination will be suspended for forty-five (45) days or until the information is received.

(5) **Life Insurance Claim:** A decision and notification to you on a *Life Insurance* claim will be made within ninety (90) days from receipt of the claim. One ninety (90) day extension is permitted if required by special circumstances, in which case the Plan will notify you in writing within the first ninety (90) day period of the circumstances requiring an extension and the expected date of a decision.

(b) **Concurrent Care Decisions:**

1) If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the Plan of such course of treatment before the end of the period or number of treatments previously agreed to will be considered a denial. The Plan will notify you of this action in advance of the application of the reduction or termination and advise of the appeal rights to permit a review prior to the date the benefit is reduced or terminated.

2) A decision to extend the previously agreed to course of treatment for an *urgent care claim* will be acted upon as soon as possible. The Plan will notify you of the determination within twenty-four (24) hours of receipt, provided the claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

20.3 **Claim Denial Procedures:** If your claim is denied or partially denied, you will be notified in writing and provided an opportunity for a review.
(a) The written notice of denial will provide:

1) The specific reason(s) for the denial;
2) The specific Plan provision on which the determination is based;
3) A description of additional information or information necessary for you to perfect the claim and an explanation of why this additional information is necessary;
4) A statement that the specific rule, guideline, protocol or other criterion relied upon in making the determination, if applicable, will be provided at no cost upon request;
5) A statement advising that an explanation of the scientific or clinical judgment relied upon and the names of the individuals from whom opinion(s) were secured, if a determination is based upon medical necessity or experimental treatment, or similar exclusion or limit, will be provided at no cost; and
6) A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under section 502(a) of ERISA.

7) For urgent care claim denials, a description of the expedited review process applicable to urgent care claims.

20.4 Claim Appeal Procedures for Hospital and Medical Claims (all claims administered by CIGNA Healthcare): For any claim denial issued by CIGNA Healthcare, the Participant will be afforded two appeals, first to CIGNA Healthcare, then, if denied upon appeal, to the Board of Trustees as outlined in 20.8. Prior to appealing directly to the Board of Trustees, the Participant will have to file an appeal with CIGNA Healthcare. CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write CIGNA Healthcare at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

(a) Level-One Appeal: Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. CIGNA Healthcare will respond in writing with a decision within the time frame outlined in Section 20.2.

(b) Level-Two Appeal: If dissatisfied with the level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the process for a Level-One Appeal stated in 20.4 (a). Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

1) For level-two appeals CIGNA Healthcare will acknowledge in writing that the request was received and schedule a Committee review. The review will be completed in the time frames outlined in Section 20.2.

(c) Independent Review Procedure: If not fully satisfied with the decisions of CIGNA Healthcare’s level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA Healthcare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant’s rights to any other benefits under the plan. There is no charge for you to initiate this Independent Review Process. CIGNA Healthcare will abide by the decision of the Independent Review Organization. In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA Healthcare. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

1) To request a review: The Appeals Coordinator must be notified with 180 days of your receipt of CIGNA Healthcare’s level-two appeal review denial. CIGNA Healthcare will then forward the file to the Independent Review organization. The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CIGNA Healthcare’s
Physician reviewer, the review shall be completed in 3 days. The Independent Review Program is a voluntary program arranged by CIGNA Healthcare.

(d) **Notice of Benefit Determination on Appeal:** Every notice of a determination on appeal will be provided in writing or electronically. An adverse determination will include all the items outlined in 20.6.

(e) **Second Appeal to Board of Trustees:** A Participant will be afforded the right to appeal to the Board of Trustees upon receipt of an Adverse Appeal Determination from CIGNA Healthcare. The Participant will have had to complete the CIGNA Level-One and Level-Two Appeal process. The optional appeal to the Independent Review Procedure outlined in 20.4(c) is not required. To appeal the Adverse Appeal Determination from CIGNA Healthcare, the Participant should follow the steps outlined in Section 20.5.

20.5 **Claim Appeal Procedures for Behavioral Health, Prescription Drug, Dental, Vision, Temporary Disability Benefits, Life Insurance and Accidental Death and other claims not covered or denied by CIGNA Healthcare:**

(a) Filing an Appeal: If your claim has either been denied or partially denied and you are not satisfied with the decision, you may appeal the decision and request a review of the claim. The appeal:

1) Must be in writing and can be made by you or your duly authorized representative;
2) Should be mailed or delivered to the Fund address shown in the Summary Plan Description;
3) Should state the reasons you believe the initial determination was incorrect
4) Should include any written comments, documents, records and other information relating to the claim for benefits; and
5) Must be submitted within one hundred eighty (180) days of the date you receive the notice of denial or partial denial.

You will be provided access to and copies of, at a reasonable charge, all documents, records, and other information relevant to your claim.

(b) Timeframe for Claim Appeal Determinations:

1) A determination of an **urgent care claim** will be made within seventy-two (72) hours after receipt of your request for review.
2) A determination of a **pre-service claim** will be made within thirty (30) days of receipt of your request for review.
3) A determination of a **post-service claim** will be made during the course of the regular quarterly Trustees’ meeting following receipt of the request for review and you will be notified of the decision within five (5) days of the date of such meeting. (If the request for review is received within thirty (30) days of the next regular quarterly Trustees’ meeting, the decision on review will be made not later than the date of the second meeting following the Plan’s receipt of the request for review). If special circumstances require an extension of time, a decision will be rendered not later than the next following quarterly Trustees’ meeting. You will be advised of the special circumstances and the date the decision is expected to be made.
4) A determination of a **disability claim** will be made within forty-five (45) days from receipt of your appeal. One forty-five (45) day extension is permitted if the Claims Administrator provides you with notice and an explanation of the circumstances resulting in the delay prior to the expiration of the initial forty-five (45) day period.
5) A determination of a **life insurance claim** will made within sixty (60) days from receipt of your appeal. One sixty (60) day extension is permitted if the Claims Administrator provides you with notice and an explanation of the circumstances resulting in the delay prior to the expiration of the initial sixty (60) day period.

20.6 **Claim Reviewers:**

(a) **Initial Claim Review** for Behavioral Health, Prescription Drug, Dental, Vision, Temporary Disability Benefits, Life Insurance and Accidental Death and other claims not covered or denied by CIGNA Healthcare will be conducted by the Fund Administrator or staff. If medical judgment is required, a qualified medical reviewer will be consulted.
(b) A review of the claim upon appeal will be conducted by the Board of Trustees. If medical judgment is required, a qualified medical reviewer will be consulted. The qualified medical reviewer will be not be connected in any way with the medical reviewer utilized in 20.5.

20.7 Adverse Appeal Determinations: If you receive an adverse appeal determination, you will be notified in writing and advised of the following:

(a) The specific reason for the adverse determination;
(b) Reference to the specific plan provisions on which the determination is based;
(c) That a copy of any internal rule guideline, protocol, or similar criteria which was relied upon is available without cost upon request;
(d) That a copy of the scientific or clinical judgment relating to a claim denial for medical necessity, experimental treatment or similar exclusion or limit is available without cost upon request;
(e) The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan;
(f) That you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.
(g) A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement regarding your right to bring a civil action under section 502(a) of ERISA.
SECTION 21
MEDICARE ELIGIBLE ELECTION OF BENEFITS

21.1 **TEFRA/DEFRA AND COBRA:** Under TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982)/DEFRA (the Deficit Reduction Act of 1984) and COBRA (the Consolidated Omnibus Budget Reconciliation Act,) full benefits are provided by this plan if you, after attaining age 65, remain an active employee. Your dependent spouse upon attaining age 65 may also choose this plan as primary providing you remain actively employed at the trade and under the collective bargaining agreement. However, no benefits under this plan will be provided if Medicare is chosen as primary while you remain in active employment.

21.2 **OBRA:** Under OBRA (the Omnibus Budget Reconciliation Act of 1986), the plan’s coverage may be chosen as primary by you, as an active employee, and by your covered dependents should they become eligible for Medicare because of total disability. If you or a covered dependent chooses Medicare as primary, you or that dependent will no longer be covered under this plan, but a hospital and medical policy for Medicare subscribers is available on a direct-payment basis from Empire Blue Cross and Blue Shield.

21.3 **End Stage Renal Disease (“ESRD”) Beneficiary:** Benefits shall be payable under the Plan without regard to an Participant’s or Dependant’s entitlement to Medicare as an “End Stage Renal Disease” beneficiary, and not more than twelve (12) months has elapsed since the earliest of the following months:

(a) the month in which the Participant of Dependent began a regular course of renal dialysis;
(b) the month in which the Participant of Dependent received a kidney transplant;
(c) the month in which the Participant or Dependent was admitted to the Hospital in anticipation of kidney transplant that was performed within the next two months; or
(d) the second month before the month in which the kidney transplant was performed, if performed more than two months after admission.
SECTION 22
CLAIM PROCEDURES

22.1 **Filing Claims:** Only a Participant can file a claim (except for Death Benefits) even though a Dependent is involved. All claims must be filed within ninety (90) days after the claim has arisen. Claim forms may be obtained from the Provider of Service or the Fund Office.

22.2 **Claim Forms:** The Trustees will accept the AMA approved Health Insurance Claim Form RRB-1500 for non-dental medical expense.

The Trustees will accept the Form approved by the American Dental Association (ADS 85) for dental claim expense.

22.3 **Completing Claims (Proof of Loss):** All questions on the Claim Form must be correctly completed and must show:

a) Person or organization providing the service or supply.
b) Diagnosis or nature of illness or injury (ICD-9).
c) Procedures, Services, or Supplies (CPT/HCPCS).
d) Date the service was rendered.
e) Amount charged.
f) Name and Social Security Number of Participant.

22.4 **Private Duty Nursing Bills:** (a) Must contain the shifts worked. (b) Charge per day, (c) Professional status of the nurse, (d) Signature of doctor prescribing the service.

22.5 **Physicians' Bills:** Must show diagnosis (ICD-9), the services rendered (CPT), specific treatment dates, the amount charged, and the name and social security number of the Participant.

22.6 **Other Medical Bills:** (a) Must set forth diagnosis (ICD-9), (b) must describe the service provided (CPT/HCPCS), (c) the date services were provided, (d) the name and social security number of the Participant, and (e) the detailed bill for such services. A Participant's attending physician must certify that he prescribed all services by signing his name on all bills, except doctor bills, hospital bills, or prescription bills. Some bills requiring signature of physician are: ambulance, prosthetic devices, rental of durable equipment, private duty nursing, etc. Itemized bills cannot be returned.

The completed claim form, with all itemized bills or itemized receipts attached, must be forwarded to the Fund Office.

22.7 **Proof of Loss:** Written proof of loss must be furnished to the Trustees within ninety (90) days from the date of loss. Proof of Loss shall consist of the Completed Claim Form, together with all itemized bills or other necessary documents, signed and certified by the claimant and the doctor, or in the case of claimant’s death, his or her beneficiary.

Failure to furnish notice or proof within the time provided in this Plan shall not invalidate nor reduce any claims if the claimant can demonstrate or show that such notice or proof was furnished as soon as was reasonably possible. The Trustees retain the right to reject any late claim where failure to file on a timely basis was due to culpable negligence or unreasonable delay.

22.8 **Physical Examination:** The Trustees, at their expense, shall have the right and opportunity to have any Participant or Dependent examined when and as often as it may reasonably require during the pendency of a claim hereunder. Failure without reasonable cause to report to the physician designated by the Trustees after notice to do so may, at the Trustees’ discretion, disqualify a claimant for further benefit payments.

22.9 **Payment of Claims:** The Trustees of the Fund retain the right to pay all or any part of the benefits either directly to the Participant, or to the provider of the service except in those instances – (a) where there is a valid legal court order directing payment to a third party, or - (b) the Participant has completed an assignment (which has been filed with the Fund Office) which specifically directs payment to the provider of service. In such situations, payments will be made to the court designated third party, or in the case of an
assignment, to the designated assignee. However, in no event may a Participant assign Death, Accidental Death or Weekly Disability Benefits under this Welfare Plan.

In the event that benefits are payable to a Participant who is deceased, then the benefits will be paid to the named beneficiary, if living. If the beneficiary shall have pre-deceased the Participant, then the benefits shall be payable to the first surviving class of the following classes of successive beneficiaries:

a) widow or widower
b) surviving children
c) surviving parents
d) surviving brothers and sisters
e) executors or administrators

22.10 Basis of Payment for all Hospital, Surgical, Medical, Dental, and other health related benefits:

All benefit payment made by the Welfare Fund will be based on the usual, customary and reasonable fees charged for the specific services rendered in connection with the necessary care and treatment of a nonoccupational illness or injury.

The “usual fee” is that fee which the individual doctor or provider of medical services most frequently charges to a majority of patients for the procedure or service rendered.

The “customary fee” is that range of fees which most doctors or other providers of services would charge in the general geographic area, taking into account the training, experience, expertise of such provider of service.

Notwithstanding anything herein to the contrary, the Trustees shall have the sole prerogative to determine the reasonableness of any fee charged by any doctor, hospital or other provider of medical service, and such determination shall be consistently applied in all similar situations, and shall be in accordance with the benefit provisions hereinafter set forth.

22.11 Errors in Benefit Payment: The Trustees specifically retain the right to recover all moneys paid in error to, or on behalf of any person, from such person. Upon the discovery of a payment “made in error,” the Trustees shall notify the recipient or beneficiary of such payment, indicating the circumstances and amount of such payment, together with a request for re-payment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary, or in the case of a Participant of the Fund, the amount of the payment made in error may be deducted from any future benefit payment which such Participant or his Dependents or beneficiary may become entitled to under this Plan.

22.12 Fraud: Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Fund, may be prosecuted in such manner as the Trustees deem advisable or at the Trustees discretion, terminated from participation in the Plan until full restitution has been made by the Participant.
SECTION 23
Amendment and Termination

The Trustees reserve the right to amend or change the Plan Provisions at any time including terminating the Plan and cease all benefits provided through the plan at any time. Provisions of benefits under this plan is no guarantee that benefits will be continued, except as required by law.

In the event the Steamfitters Welfare Fund, Local 475 terminates the plan and ceases to provide any benefits through the plan, the Plan Administrator will notify Participants and their beneficiaries in writing at least sixty (60) days prior to the effective date of termination of the plan and benefits.

All previous Steamfitters Welfare Fund, Local 475 contributions shall continue to be available to pay benefits under plan terms with respect to claims arising before the plan termination effective date, or shall be used to provide similar health benefits to Participants until all contributions are exhausted. Participants and beneficiaries will be required to continue elected contributions within thirty (30) days of the effective date of termination of the plan and benefits. No reimbursements or coverage will be available for any claims incurred after the effective date of the plan termination. Participants and beneficiaries with claims incurred prior to the plan termination effective date and whose claims have not been paid or reimbursed will have ninety (90) days following the plan termination effective date to submit claims. No claims submitted more than ninety (90) days following the effective date of the plan termination will be paid or reimbursed.

Any Participant and beneficiary contributions remaining at the close of the plan will be returned on a pro-rata basis within ninety (90) days of receipt of funds by the Steamfitters Welfare Fund, Local Union No. 475.

The Trustees, by appropriate action also reserve the right to change any amounts contributed toward the cost of providing benefits, the level of benefits provided, and the class or classes of Participants eligible for Plan benefits. The Trustees, pursuant to the Agreement and Declaration of Trust have the sole and exclusive authority to interpret the terms and conditions of the Plan and this Summary Plan Description including but not limited to eligibility, participation and the benefits to be provided.
As a Participant in the Steamfitters Welfare Fund, Local Union No. 475 you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each Participant with a copy of this annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting coverage exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under this Plan or exercising your rights under ERISA. If your claim for a welfare benefit under this Plan is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan which you are entitled to receive, and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored in whole or in part, you may file suit in a federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may 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 the 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.

If you have any questions about your Plan, you should contact the Plan administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.