

Automatic Sprinkler Local 281, U.A. Welfare Fund

Summary Plan Description and Plan Document

As Amended and Restated Effective as of January 1, 2018

AUTOMATIC SPRINKLER LOCAL 281, U.A. WELFARE FUND SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Effective January 1, 2018

To All Participants:

We are pleased to provide you with this updated Summary Plan Description and Plan of Benefits (referred to as the SPD or Plan). Unless expressly stated otherwise, this SPD is effective as of January 1, 2018. You've received this SPD based on your work in employment covered by the Automatic Sprinkler Local 281, U.A. Welfare Fund. However, you must satisfy the eligibility requirements shown on the following pages in order to qualify for benefits. Since the purpose of the Automatic Sprinkler Local 281, U.A. Welfare Fund is to benefit you and your family, we urge you to read this SPD carefully so that you will understand the complete Plan of Benefits, as well as the eligibility rules and procedures for filing claims.

We strive to offer a Plan of Benefits that makes meaningful contributions to your security, health and well-being. Nevertheless, changing economic conditions require a constant assessment of the Plan to maintain the Fund's financial stability. Within this framework, we will continue to monitor the Fund's resources in an effort to ensure that it will provide high-quality health coverage to members and their families for years to come.

Very truly yours,

The Board of Trustees

IMPORTANT

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to interpret the Plan and to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees' exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan's provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment. Decisions made by the Board of Trustees are final and binding on all parties. Judicial review of any decision made by the Board of Trustees will be limited to determine only whether the decision was arbitrary and capricious.

Interpretations concerning eligibility for benefits, claims, status of Participants and Employers, or any other matter relating to the Welfare Fund should be obtained through the Board of Trustees or the Administrative Manager. The Trustees are not bound by, responsible for, or obligated by opinions, information or representations from other sources. All the provisions of the Plan are very important, and we encourage you to read them carefully. For additional information and assistance, feel free to contact the Fund Office:

Automatic Sprinkler Local 281, U.A. Welfare Fund
11900 South Laramie Avenue
Alsip, Illinois 60803
P: (708) 597-1832
F: (708) 371-7562

TABLE OF CONTENTS

CHAPTER 1 – DEFINITIONS	1-1
Section 1.01 – General Definitions	1-1
Section 1.02 – Medical Definitions	1-2
CHAPTER 2 – ELIGIBILITY FOR EMPLOYEES	2-1
Section 2.01 – In General.....	2-1
Section 2.02 – Initial Eligibility for Employees.....	2-1
Section 2.03 – Continuing Eligibility for Employees	2-1
Section 2.04 – Eligibility for Dependents.....	2-2
Section 2.05 – Termination of Eligibility.....	2-4
Section 2.06 – Reinstatement of Eligibility.....	2-5
Section 2.07 – Eligibility During & After Periods of Military Service	2-5
Section 2.08 – Eligibility During FMLA Leave.....	2-6
Section 2.09 – Eligibility for Sole Proprietors Partners Shareholders Officers Relatives	2-6
Section 2.10 – Your Obligation to Report Important Events to the Fund Office	2-9
CHAPTER 3 – ELIGIBILITY FOR RETIREES IMPACT OF MEDICARE	3-1
Section 3.01 – Eligibility for Retirees.....	3-1
Section 3.02 – Opting Out Opting Back In	3-1
Section 3.03 – Termination and Reinstatement of Retiree Coverage.....	3-1
Section 3.04 – Medicare-Eligible Participants Coverage and Coordination of Benefits.....	3-2
CHAPTER 4 – RIGHT TO COBRA CONTINUATION COVERAGE	4-1
Section 4.01 – COBRA Continuation Coverage.....	4-1
Section 4.02 – COBRA Rules for Employees	4-1
Section 4.03 – COBRA Rules for Dependents.....	4-1
Section 4.04 – Notice Requirements for COBRA	4-2
Section 4.05 – Electing COBRA	4-2
Section 4.06 – Required Premiums	4-3
Section 4.07 – Termination of COBRA.....	4-3
Section 4.08 – Notification of Unavailability or Early Termination of COBRA.....	4-3
Section 4.09 – Obligation to Notify the Plan of a Divorce.....	4-4
CHAPTER 5 – MAJOR MEDICAL BENEFITS	5-1
PART A – GENERAL INFORMATION REGARDING YOUR MEDICAL BENEFITS	5-1
Section 5.01 – Blue Cross Blue Shield of Illinois.....	5-1
Section 5.02 – In-Network Out-of-Network.....	5-2
Section 5.03 – Coinsurance Copayments Deductibles Maximums.....	5-3
PART B – SCHEDULE OF MAJOR MEDICAL BENEFITS	5-5
Section 5.04 – Deductible & Maximums.....	5-5
Section 5.05 – Schedule of Benefits.....	5-5
PART C – DETAILED INFORMATION REGARDING SPECIFIC COVERED BENEFITS	5-6
Section 5.06 – Alcoholism, Substance Abuse, or Drug Addiction	5-6
Section 5.07 – Ambulance Service	5-7
Section 5.08 – Anesthesia	5-7
Section 5.09 – Convalescent Facility Room.....	5-7
Section 5.10 – Dental Implants	5-7

Section 5.11 – Drugs and Medicines.....	5-7
Section 5.12 – Durable Medical Equipment	5-7
Section 5.13 – Emergency Room Visits.....	5-8
Section 5.14 – Home Health Agency.....	5-8
Section 5.15 – Hospice Care.....	5-8
Section 5.16 – Hospital	5-8
Section 5.17 – Infertility Treatment.....	5-8
Section 5.18 – Mental Illness and Nervous Disorder	5-9
Section 5.19 – Occupational Therapy	5-9
Section 5.20 – Ophthalmologist.....	5-9
Section 5.21 – Organ Transplant Benefit	5-9
Section 5.22 – Oxygen.....	5-9
Section 5.23 – Physical Therapy.....	5-10
Section 5.24 – Prophylactic Mastectomy Benefit.....	5-10
Section 5.25 – Registered Nurse	5-10
Section 5.26 – Speech Therapy	5-10
Section 5.27 – Surgical	5-11
Section 5.28 – X-Ray and Laboratory Services	5-11
PART D – EXCLUSIONS AND CASE MANAGEMENT.....	5-11
Section 5.29 – Major Medical Benefit Exclusions	5-11
Section 5.30 – Case Management.....	5-11
Section 5.31 – The Benefit of Calling the Case Manager	5-11
CHAPTER 6 – EXCLUSIONS.....	6-1
Section 6.01 – In General.....	6-1
Section 6.02 – General Exclusions	6-1
Section 6.03 – Specific Exclusions	6-2
CHAPTER 7 – PRESCRIPTION DRUG BENEFITS	7-1
Section 7.01 – Schedule of Prescription Drug Benefits	7-1
Section 7.02 – Pharmaceutical Benefit Managers.....	7-1
Section 7.03 – Smoking Cessation Benefit	7-3
Section 7.04 – Prescription Drug Benefit Exclusions	7-3
CHAPTER 8 – DENTAL BENEFITS	8-1
Section 8.01 – In General.....	8-1
Section 8.02 – Dental Care Provider Network.....	8-1
Section 8.03 – Schedule of Dental Benefits	8-1
Section 8.04 – Dental Care Coverage	8-1
Section 8.05 – Dental Care Exclusions.....	8-2
Section 8.06 – Precertification for Medical Necessity.....	8-3
Section 8.07 – Employees Retiring Before January 1, 1998	8-3
CHAPTER 9 – VISION BENEFITS.....	9-1
Section 9.01 – In General.....	9-1
Section 9.02 – In-Network Coverage.....	9-1
Section 9.03 – Out-of-Network Coverage	9-1
Section 9.04 – Schedule of Vision Benefits	9-1
Section 9.05 – Vision Benefit Exclusions	9-2

CHAPTER 10 – DEATH AD&D BENEFITS	10-1
Section 10.01 – In General	10-1
Section 10.02 – Schedule of Death AD&D Benefits	10-1
Section 10.03 – Designated Beneficiary	10-1
Section 10.04 – Conflict.....	10-2
CHAPTER 11 – ACCIDENT & SICKNESS BENEFITS.....	11-1
Section 11.01 – In General	11-1
Section 11.02 – Schedule of Accident & Sickness Benefits	11-1
Section 11.03 – Duration of Payments.....	11-1
Section 11.04 – Exclusions.....	11-1
CHAPTER 12 – ADDITIONAL BENEFITS	12-1
Section 12.01 – Chiropractic Benefit	12-1
Section 12.02 – Hearing Aid Benefit.....	12-1
Section 12.03 – Member Assistance Program (MAP).....	12-1
Section 12.04 – Health Fairs	12-2
Section 12.05 – Sleep Study Benefit.....	12-3
Section 12.06 – Preventive Services	12-3
CHAPTER 13 – COORDINATION OF BENEFITS	13-1
Section 13.01 – Coordination of Benefits in General	13-1
Section 13.02 – How Benefits Are Coordinated	13-1
Section 13.03 – Right to Information	13-2
Section 13.04 – Right to Correct Erroneous Payments	13-3
CHAPTER 14 – REIMBURSEMENT & SUBROGATION	14-1
Section 14.01 – Right to Recovery.....	14-1
Section 14.02 – Reimbursement of Conditional Benefit Payments	14-2
Section 14.03 – Subrogation.....	14-4
CHAPTER 15 – CLAIMS & APPEALS PROCEDURES	15-1
Section 15.01 – In General	15-1
Section 15.02 – Time Limits Where to File	15-2
Section 15.03 – Applicable Definitions.....	15-3
Section 15.04 – Timeframes for Making Initial Claims Decisions.....	15-4
Section 15.05 – Content of Initial Denial Notices.....	15-6
Section 15.06 – Your Right to Appeal.....	15-8
Section 15.07 – Timing of Notification of Decision on Appeal	15-9
Section 15.08 – Content of Notice of Decision on Appeal	15-10
Section 15.09 – External Review of Medical Benefit Appeals.....	15-11
Section 15.10 – Expedited External Review of Medical Benefit Appeals.....	15-13
Section 15.11 – Optional Pre-Service Evaluation of Medical Services	15-14
Section 15.12 – Policies, Determinations or Actions.....	15-15
Section 15.13 – Decisions of the Trustees are Final and Binding.....	15-15
CHAPTER 16 – IMPORTANT MISCELLANEOUS PROVISIONS	16-1
Section 16.01 – Exclusive Discretionary Authority of the Board of Trustees.....	16-1
Section 16.02 – No Vesting.....	16-1
Section 16.03 – Exclusive Right to Benefits	16-2
Section 16.04 – No Assignment or Attachment of Benefits.....	16-2

Section 16.05 – No Liability for Practice of Medicine.....	16-2
Section 16.06 – Workers’ Compensation	16-2
Section 16.07 – Overpayments and Reimbursements	16-3
Section 16.08 – Allocating / Delegating Trustee Authority; Actions in Accordance With Trust.....	16-3
Section 16.09 – Preservation of Plan Provisions	16-3
Section 16.10 – Forum Selection Clause	16-3
Section 16.11 – Governing Law	16-3
CHAPTER 17 – GENERAL INFORMATION & YOUR ERISA RIGHTS	17-1
Section 17.01 – Name of the Plan	17-1
Section 17.02 – Plan Administration	17-1
Section 17.03 – Name of Plan Sponsor	17-1
Section 17.04 – Agent for Service of Legal Process.....	17-1
Section 17.05 – Plan Number and Employer Identification Number (EIN)	17-1
Section 17.06 – Type of Plan	17-1
Section 17.07 – Plan Year	17-1
Section 17.08 – Source of Financing.....	17-1
Section 17.09 – Service Providers.....	17-2
Section 17.10 – Compliance with Privacy Standards.....	17-3
Section 17.11 – Your Rights Under ERISA.....	17-4
Section 17.12 – Newborns’ & Mothers’ Health Protection Act Women’s Health & Cancer Rights Act	17-5

CHAPTER 1—DEFINITIONS

The following terms have special meaning when used in this SPD.

1.01 GENERAL DEFINITIONS

(a) Active Employee

The term Active Employee means a person who is eligible for benefits pursuant to Employer contributions, COBRA Continuation Coverage payments, or other self-payment method, and is not retired.

(b) Collective Bargaining Agreement

The term Collective Bargaining Agreement means the labor agreement in force and effect between Sprinkler Fitters Local Union No. 281 and the National Fire Sprinkler Association or another Employer, together with any modifications, supplements or amendments.

(c) Employee

The term Employee means an employee of a participating Employer covered by a Collective Bargaining Agreement between that Employer and Sprinkler Fitters Local Union No. 281 affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the U.S. and Canada AFL-CIO. Employee also means an employee covered by a Participation Agreement between his or her Employer and the Trustees. Work performed as an Employee for which contributions are required is considered covered employment.

(d) Employer

The term Employer means:

- (1) An employer who is a member of, or is represented by, the National Fire Sprinkler Association, and who is bound by a Collective Bargaining Agreement with Sprinkler Fitters Local Union No. 281 providing for the establishment and maintenance of the Trust Fund and for the payment of contributions to the Trust Fund.
- (2) An employer who is not a member of the National Fire Sprinkler Association but whose Employees are represented by Sprinkler Fitters Local Union No. 281 and who satisfied the requirements for participation in the Plan as established by the Board of Trustees. Such employer will, by the making of a payment to the Trust Fund on behalf of any Employee, be deemed to have become a party to any agreement between Automatic Sprinkler Local Union No. 281 and the National Fire Sprinkler Association.
- (3) Sprinkler Fitters Local Union No. 281 as the employer of Employees of the Local Union on whose behalf the Local Union makes contributions to the Trust Fund.
- (4) The Board of Trustees as the employer of the Employees of this Welfare Fund on whose behalf the Board of Trustees makes contributions to the Trust Fund.
- (5) Any other employee benefit fund or other entity that is obligated to make contributions to this Fund in accordance with an agreement accepted by the Board of Trustees.

(e) Eligible Dependent

The term Eligible Dependent means your lawful Spouse and your children under age 26 who meet the eligibility requirements of this Plan.

(f) Fund

The term Fund or Trust Fund means the Automatic Sprinkler Local 281, U.A. Welfare Fund.

(g) Participant

The term Participant means a person who is eligible for benefits under the Plan.

(h) Participation Agreement

The term Participation Agreement means a written agreement with the Board of Trustees that requires an Employer to make contributions to the Fund in accordance with the rules of the Trustees.

(i) Plan

The term Plan means the Summary Plan Description and Plan Document of the Automatic Sprinkler Local 281, U.A. Welfare Fund, describing the program of benefits offered by the Fund.

(j) Plan Year

The term Plan Year means the period beginning on January 1 and ending on December 31 of each year.

(k) Retired Employee

The term Retired Employee means an Employee who has retired from active employment, is drawing a pension from the National Automatic Sprinkler Industry (NASI) Pension Fund, and who meets the Retired Employee eligibility requirements of Chapter 3.

(l) Spouse

The term Spouse means the person who is legally married to you while you are covered under this Plan.

(m) Trustees

The term Trustees or Board of Trustees refers to the Board of Trustees of the Automatic Sprinkler Local 281, U.A. Welfare Fund. The Board of Trustees is the plan sponsor and plan administrator as those terms are defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Trustees have delegated authority for day-to-day plan administration to an Administrative Manager, Tim Morrin.

(n) Union

The term Union means Sprinkler Fitters Local Union No. 281.

1.02 MEDICAL DEFINITIONS

(a) Accident

The term Accident means an injury, such as a cut, break, sprain, bruise, or wound, occurring from an unexpected, undesirable, and unavoidable act. Injuries incurred in the commission of a felony are excluded from coverage as well as intentionally self-inflicted injuries, unless the injury is a result of a "medical condition" as that term is defined within the Health Insurance Portability and Accountability Act (HIPAA) regulations at 29 CFR 2590.701-2 and as used in 29 CFR 2590.702.

(b) Convalescent Facilities

The term Convalescent Facilities means an institution that is licensed to keep patients regularly overnight. The facility must provide supervision by a legally qualified Physician or a registered professional nurse, 24-hour skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse, and training in self-care for the essential activities of daily living.

The institution must also maintain a complete medical record on each patient and have a utilization review plan for all of its patients. An institution is not a Convalescent Facility if it is used principally for the care of mental retardation or any other form of mental disorder. Institutions such as clinics, or places for rest, educational care, care of the aged, Custodial Care, care of drug addicts or alcoholics do not qualify as Convalescent Facilities. To qualify for coverage, confinement in a Convalescent Facility must occur within 14 days after a minimum three-day Hospital confinement for the same Sickness.

(c) Covered Expense

The term Covered Expense means a charge to the extent it is within the Usual and Customary Charge that is allowable under the Plan for a service or supply that is Medically Necessary for diagnosis, treatment, mitigation or cure of a Sickness or injury to a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply will be considered a Covered Expense.

(d) Covered Loss

The term Covered Loss means a loss for purposes of the Accidental Death and Dismemberment Benefit resulting from bodily injury caused solely by an Accident.

(e) Custodial Care

The term Custodial Care means the services and supplies, including room and board and other institutional services, which are provided whether or not you are Disabled, primarily to assist you in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed. Room and board and skilled nursing services, when provided in a Hospital or other institution for which coverage is specifically provided, are not Custodial Care when such services must be combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards to establish a program of medical treatment, which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition and is not merely the maintenance or stabilization of such individual's medical condition.

(f) Developmental Care

The term Developmental Care means services, supplies or prescription drugs, regardless of where or by whom provided, which meet one of the following criteria:

- (1) Are provided to a Participant who has not previously reached the level of development expected for his age in areas of major life activity such as intellectual, receptive and expressive language, learning, mobility, self-direction, capacity for independent living; or
- (2) Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or Sickness); or
- (3) Are educational in nature.

(g) Disabled

The term Disabled or Disability means there is medical proof, acceptable to the Trustees, that you are temporarily unable to perform your normal duties because of Accident, injury, Sickness or pregnancy. In addition, you must be under the regular care of a medical doctor who certifies the Disability.

(h) Hospital

The term Hospital means an institution which has permanent, full-time facilities for bed care of five or more resident patients; has a Physician in regular attendance; provides 24-hour-a-day service by

registered nurses; primarily provides diagnostic and therapeutic facilities for the medical and surgical care of patients; and is NOT a rest home, nursing home, Convalescent Facility, or a place for the aged or for the treatment of alcoholism, drug addiction or substance abuse.

(i) Inpatient

The term Inpatient means a person receiving room and board while undergoing treatment in a Hospital or treatment facility.

(j) Medically Necessary

The term Medically Necessary or Medical Necessity means the services or supplies that are: (1) furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected Sickness or injury; (2) consistent with the diagnosis and treatment of the patient's condition; (3) in accordance with standards of good medical practice; (4) required for reasons other than the convenience of the patient, Physician, or other licensed provider; and (5) the most appropriate level of service or supply that can be provided safely for the patient.

When the term Medically Necessary is used to describe Inpatient care in a Hospital, it means that your medical symptoms and condition are such that the service or supply cannot be provided safely on an Outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are Medically Necessary. The Trustees have sole discretion to determine if a service or supply is Medically Necessary.

(k) Mental Illness

The term Mental Illness means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(l) Outpatient

The term Outpatient means a patient who goes to a Hospital, clinic, doctor's office or treatment facility for diagnostic services and/or treatment, but does not occupy a bed or stay overnight.

(m) Outpatient Facility

The term Outpatient Facility means a clinic or other establishment that provides surgery, diagnosis, and treatment on an Outpatient basis. The facility must have an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist under the supervision of a Physician). Outpatient Facilities include alternative care facilities such as Emergency Centers or 24-hour clinics. The following are not Outpatient Facilities: Convalescent Facilities, nursing homes, homes for the needy, homes for nursing and domiciliary care, infirmaries or orphanages, sanatoriums, maternity homes for pre-natal or post-natal care, mental health facilities, or other homes or institutions primarily providing Custodial Care. Other facilities, not otherwise covered by the Plan, may be approved in advance by the Fund if they fall within standard medical practice and treatment is recommended by a Physician.

(n) Physician

The term Physician means a person who is licensed to practice medicine or to perform surgery in the state in which he or she practices, who is practicing within the scope of his or her license, and who is providing a service covered by the Plan. Physician includes a doctor of medicine, osteopathy, dental surgery, or podiatry. Physician charges also include the services of a qualified professional chiropractor, physiotherapist, psychologist, optometrist, nurse-midwife, nurse anesthetist, and any health care

provider who is acting within the scope of that provider's license or certification under applicable state law.

(o) Sickness

The term Sickness means any disease or illness that is the basis of a claim and resulting in a loss covered by the Fund. The term "Sickness" also includes any disease or illness not caused by an Accident.

(p) Total Disability

The term Total Disability or Totally Disabled means that you are completely unable to engage in substantial, gainful activities because of a medically determinable physical or mental impairment that is expected to last permanently or indefinitely. Proof of your eligibility for a Social Security Disability Award is proof of Total Disability. For an Eligible Dependent, Total Disability means the complete inability to perform the functions and activities of a person who is in good health, due to a medically determinable physical or mental impairment that is expected to last permanently or indefinitely.

(q) Usual and Customary Charge

The term Usual and Customary Charge or U&C means:

- (1) For a service or supply rendered by a PPO Provider, the amount the PPO Provider has agreed to accept as payment in full under its contract with the PPO.
- (2) For a service or supply rendered by a provider other than a PPO Provider, the amount the Fund would have paid if the provider qualified as a PPO Provider as determined under (1) above.
- (3) For a service or supply where the amount cannot be determined under (1) or (2) above, an amount based on 125% of the amount that would be allowed by Medicare, except as described in (4) below.
- (4) For Outpatient Facility charges and ambulatory surgical center charges where the amount cannot be determined under (1) or (2) above, an amount based on 150% of the Medicare grouper rate.

Notwithstanding the foregoing, the Board of Trustees, in their sole and absolute discretion, may treat an amount in excess of the amount determined under subsections (1), (2), (3) and (4) above as a Usual and Customary Charge.

(r) Workers' Compensation

The term Workers' Compensation means a state fund, agency, or insurance policy to which Employers contribute and which provides coverage for job-related Sicknesses or injuries.

CHAPTER 2—ELIGIBILITY FOR EMPLOYEES

2.01 IN GENERAL

Eligibility is based upon hours worked under Collective Bargaining Agreements or Participation Agreements which obligate Employers to report and pay contributions to this Fund on your behalf and for which contributions have been received.

If the Employer contributions remitted are less than the required number of hours to maintain eligibility, or if you have terminated your active employment due to retirement or disability, you may continue your coverage under the Plan by making monthly payments under certain circumstances. An Active Employee or Eligible Dependent may make monthly payments for coverage provided under COBRA Continuation Coverage for a limited period of time. Retired Employees are allowed to continue their coverage by making quarterly self-payments.

This Fund also has reciprocal agreements with certain other U.A. welfare funds. When contributions are received by this Fund from a reciprocal fund, the greater of the actual hours worked or the reciprocated contributions divided by the contribution rate of this Fund will be credited for eligibility purposes under this Plan. Contributions made to this Fund, which are forwarded to a reciprocal fund, will not be counted for eligibility purposes for this Plan.

Your eligibility is based on payroll reports with monthly cut-off dates determined by each Employer. Contribution reports with hours worked are not due and processed until later in the following month. The Fund Office, therefore, cannot certify in advance when benefits will start or end. Notices are sent as soon as eligibility can be determined.

You should keep track of the hours you work each month. The Fund Office can advise you of your eligibility status if you have a record of your hours worked. However, the final determination of eligibility will be based upon contributions actually received by the Fund Office.

2.02 INITIAL ELIGIBILITY FOR EMPLOYEES

You become eligible for Plan benefits on the first day of a calendar month following a period of 12 consecutive months or less during which you have been credited with a minimum of 600 hours.

2.03 CONTINUING ELIGIBILITY FOR EMPLOYEES

(a) General Rule | 200 Hours Within Two Consecutive Months

You will remain eligible for benefits provided that at least 200 hours are reported on your behalf within a two-consecutive month period. If less than 200 hours are reported within a two-month period, coverage will terminate the first day of the second month following the month for which less than 200 hours have been reported on your behalf within a two-consecutive month period.

For example, for coverage effective April 1, you must have at least 200 total hours reported on your behalf for January and February. If you do not have enough hours during this period, and you do not extend coverage by making self-payments or electing COBRA Continuation Coverage, your coverage will terminate effective April 1.

(b) Self-Payments to Continue Eligibility

If you have at least 150 hours but fail to have sufficient hours reported on your behalf to remain eligible for benefits, you may make a self-payment to the Fund so that your eligibility continues. The amount of the self-payment is calculated by taking the number of hours you are short of 200, up to a maximum

of 50 hours, and multiplying that amount by the applicable Employer contribution rate. (For example, if 195 hours are reported on your behalf during a two-consecutive month period, you may pay for the remaining 5 hours you require to continue coverage.) If you work less than 150 hours you may continue your coverage under COBRA Continuation Coverage.

To be eligible to make a self-payment, the Union must certify that you are available for work in covered employment under this Fund, and that you are not working in the industry for an employer that does not contribute to the Fund. If you are eligible to make a self-payment, you will be notified in writing of the amount owed. The Fund must receive full payment no later than the due date listed on the self-payment notice. It is your responsibility to submit the self-payment on time to prevent termination of eligibility.

You may make self-payments for up to 12 consecutive months of coverage. The Trustees may extend the maximum self-payment period during periods of high unemployment. After exhausting the maximum self-payment period, you may continue your coverage under COBRA.

(c) Maintaining Eligibility While Disabled

- (1) *Six Month Extension.* An Employee who becomes Disabled while eligible for benefits may extend eligibility for up to six additional months while the Disability continues. Regular benefits will continue for you and your Eligible Dependents. In no event can your eligibility under this rule be longer than eight months from the last two consecutive months in which you worked 200 or more hours.
- (2) *You Must Remain Available for Covered Employment.* The Disability coverage extension is not available for Employees who cease to be available for work covered by the Plan as verified by the Union.
- (3) *Evidence of Disability & Other Requirements.* If you qualify for and are receiving Weekly Accident and Sickness Benefits, the Disability coverage extension is automatic while you are receiving these benefits. Otherwise, you must provide satisfactory evidence of your Disability to the Fund Office, in which case you must be under the regular care of a medical doctor who certifies the Disability, or you must provide evidence of on-the-job Workers' Compensation as well as off-the-job Disabilities or Sickness. It is not the responsibility of your doctor, Employer, Workers' Compensation insurance company, Local Union Business Manager or Business Representative to submit evidence of your Disability to the Fund Office, although they may assist you. During this period, the Fund has the right to request evidence of continuing Disability and may require you to have a physical examination by a medical doctor chosen and paid for by the Fund. In addition to being Disabled, you must cease receiving any substantial compensation related to any employment.

(d) COBRA Payments

You may also continue your coverage under the Plan if you make the appropriate COBRA Continuation Coverage premium payments, as set forth in Chapter 4, in the manner and in the amount established, as may be changed from time to time, by the Trustees.

2.04 ELIGIBILITY FOR DEPENDENTS

(a) In General

Your dependents will become eligible for benefits under the Plan upon the later of the effective date of your eligibility, or the date your dependents qualify as Eligible Dependents. The following individuals qualify as Eligible Dependents:

- (1) Your legal Spouse.
- (2) Your children under age 26.
- (3) Your unmarried dependent child who is age 26 or over and is incapable of self-support because of physical or mental Disability that occurred prior to age 19 and who continues to be Disabled. The eligibility for the child will continue as long as the child continues to be incapable of earning a living due to the physical or mental Disability, and the child either: (A) is Totally Disabled, lives with you for more than one-half of the year, and does not provide for more than one-half of his or her own support; or (B) depends on you for more than one-half of his or her financial support, or depends on you for more than one-half of his or her financial support prior to your death. Proof that the child was incapacitated prior to age 19 must be submitted to the Fund Office prior to age 26 and may be required periodically thereafter.
- (4) Your grandchild provided you have legal guardianship of the grandchild.
- (5) The child of an Active Employee whose coverage under this Plan is established in accordance with a QMCSO. However, if your child who is the subject of the QMCSO is not your "dependent" as defined in the Internal Revenue Code Section 105(b) or 152, you may be subject to income tax on the fair market value of the coverage provided to that child by the Plan pursuant to the QMCSO.

Your "child" means a child as defined in Section 152(f)(1) of the Internal Revenue Code, which includes your biological child, legally adopted child, child legally placed with you for adoption, your stepchild or legally-placed foster child. "Child" also means any other child living with you in a parent-child relationship, who depends on you for more than one-half of his or her financial support, and for whom you have a legal obligation to provide health care. An adopted child is considered an Eligible Dependent when he or she is placed with you for adoption. For a foster child to be eligible, no parent can claim the child as a "qualifying child" under the federal tax code and the non-parent Employee must have a higher adjusted gross income (AGI) than any parent.

(b) Continued Eligibility for Eligible Dependents of Deceased Employees

- (1) If an Active or Retired Employee dies while eligible for Fund benefits, his/her Eligible Dependents will remain eligible at no cost for two months, after which they can elect Retiree coverage at the applicable self-payment (premium) rate as determined by the Trustees.
- (2) For Eligible Dependents who were eligible prior to April 1, 2012, if Retiree coverage is not elected, benefits will be continued for a surviving Spouse, at no cost, until the last day of the month in which the surviving Spouse remarries. Benefits will be continued for Eligible Dependent children after the two-month grace period, only if the surviving Spouse or someone acting on behalf of the Eligible Dependent children pays premiums to continue the benefits for the Eligible Dependent children. Premiums are paid quarterly. The premium amount is determined by the Trustees.
- (3) For Eligible Dependents who were eligible on or after April 1, 2012, if Retiree coverage is not elected, benefits will be continued for a surviving Spouse at the premium amount determined by the Trustees. If the surviving Spouse would like to continue benefits for the Eligible Dependent children, the maximum premium amount for all Eligible Dependent children will be the premium for one Eligible Dependent child. Benefits will be continued for Eligible Dependent children after the two-month grace period, only if the surviving Spouse or someone acting on behalf of the Eligible Dependent children pays premiums to continue the benefits for the Eligible Dependent children. Premiums are paid quarterly. The premium amount is determined by the Trustees.

- (4) Eligible Dependent children continue to be covered, as long as the required premiums are received, until they would otherwise lose Eligible Dependent status.

(c) Special Rule for Children Covered by a QMCSO

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order. To be a QMCSO, a judgment, decree, or order must require a child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or to enforce a state law relating to medical child support. To be a QMCSO, an order must include: (1) The name and last known address (if any) of the Participant and the name and mailing address of each child covered by the order; (2) a reasonable description of the type of coverage to which the order pertains as well as the period of coverage; and (3) the name of the Plan.

Such an order is not "qualified" if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan will notify, in writing, the eligible Employee and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the eligible Employee and each affected child in writing of its determination as to whether an order is a QMCSO. A copy of the QMCSO Procedures adopted by the Trustees may be obtained without charge from the Fund Office.

2.05 TERMINATION OF ELIGIBILITY

(a) In General

Except as otherwise provided herein, eligibility for benefits for you and your Eligible Dependent(s) under the Plan will terminate upon the occurrence of any the following:

- (1) The first day of the second month following the month for which less than 200 hours have been reported on your behalf within a two-consecutive month period.
- (2) Exhaustion of any periods of extended benefits otherwise provided by the Plan.
- (3) Exhaustion of COBRA Continuation Coverage or the failure to elect COBRA Continuation Coverage.
- (4) Employment with an employer in the industry that does not maintain this Plan (i.e., is not signatory to a Collective Bargaining Agreement which requires payment of contributions to this Fund or to another health and welfare plan that is party to a reciprocal agreement with this Fund).
- (5) The commission of fraud against the Fund or misrepresenting material facts to the Fund.
- (6) Entry into the Uniformed Services.
- (7) The date the Plan is terminated.

(b) Additional Termination Events for Dependents

Unless otherwise provided by the Plan, an Eligible Dependent will lose coverage under this Plan on the date your Employee coverage terminates. In addition, an Eligible Dependent will lose coverage under this Plan on the date the dependent ceases to qualify as an Eligible Dependent pursuant to either the terms of this Plan or the terms of a Plan amendment.

In the case of your Spouse, this date refers to when you and your Spouse are legally separated or divorced. In the case of a dependent child, this date refers to the last day of the month in which the

dependent child no longer meets the definition of an Eligible Dependent child. In the case of a Disabled child, this date refers to the 60th day after the Plan requests but does not receive proof of his/her incapacity, or when the dependent is no longer physically or mentally Disabled and otherwise fails to meet the definition of an Eligible Dependent.

It is your responsibility to notify the Fund Office immediately if any of the events described above occur. Continued coverage under the Plan through COBRA will not be offered if notification is not made within 60 days of the event giving rise to COBRA eligibility. Any claims paid after the event date due to lack of notification to the Plan will be subject to refund or recovery by offset or other appropriate means as determined by the Trustees.

(c) Effect of Termination of Eligibility

Upon termination of eligibility, benefits will not be payable under the Plan except for Covered Expenses for Covered Services incurred prior to the date eligibility terminates.

2.06 REINSTATEMENT OF ELIGIBILITY

If you have lost your eligibility for benefits under the Plan, you may reestablish eligibility by returning to work for a minimum of 200 hours within two months with a contributing Employer; provided, that the period of ineligibility lasted less than 12 months. The effective date of coverage shall be the first day of the month following the month in which 200 hours or more have been reported on your behalf within a two-consecutive month period. If the period of ineligibility lasted 12 months, or more, you must satisfy the Plans Initial Eligibility requirements to reinstate eligibility for benefits, unless the absence from work was due to a work-related Disability.

2.07 ELIGIBILITY DURING & AFTER PERIODS OF MILITARY SERVICE

If you enter the "Uniformed Services," as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, coverage for you and your Eligible Dependents will terminate when you no longer meet the Plan's Continuing Eligibility requirements (up to two months). If you are discharged from the Uniformed Services, except for a dishonorable discharge, you and your Eligible Dependents will also receive up to two months of coverage at no cost on the day you begin work with an Employer participating in this Fund, until you meet the Plan's Continuing Eligibility requirements. To protect your rights to reinstatement with your Employer prior to Uniformed Service, you must present yourself to that Employer within a time frame established by law as follows:

- (a) *Service Less Than 31 Days.* For service of less than 31 days, you must apply for re-employment with an Employer at the beginning of the next regularly scheduled work period on the first day after your release from service, taking into account safe transportation plus an eight-hour rest period.
- (b) *Service More Than 31 Days But Less Than 181 Days.* For service of 31 days or more but less than 181 days, you must apply for re-employment within 14 calendar days (not work days) after your release from service.
- (c) *Service More Than 181 Days.* For service over 180 days, you must apply for re-employment within 90 calendar days (not work days) after your release from service.

If you or your Eligible Dependents want to purchase COBRA Continuation Coverage through the Welfare Fund to cover you during your period of Uniformed Service, you can do so, so long as you make your election within 60 days of your first day of Uniformed Service. COBRA Continuation Coverage made available because of your service in the Uniformed Services is available for a maximum 24 months, but is otherwise the same as COBRA Continuation Coverage.

2.08 ELIGIBILITY DURING FMLA LEAVE

In addition, hours will be credited if you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993 ("FMLA"). The FMLA entitles Employees eligible under the FMLA to take up to 12 weeks of unpaid job-protected leave each year for the Employee's own Sickness, or to care for a seriously ill child, Spouse or parent; the birth or placement of a child with the Employee in the case of adoption or foster care, or a "Qualifying Exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the Employer and who have provided at least 1,250 hours of service to the Employer. An Employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75-mile radius of the employee is 50 or more.

Employers covered by the FMLA are required to maintain medical coverage for employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the employee had continued to work. This means that an Employer is required to continue making contributions to the Fund on behalf of an Employee on FMLA leave.

Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to report the period of your absence. In addition, if you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. government, Department of Labor, Employment Standards Administration, or visit the Department of Labor's website.

2.09 ELIGIBILITY FOR SOLE PROPRIETORS, PARTNERS, CORPORATE SHAREHOLDERS, CORPORATE OFFICERS AND/OR THEIR RELATIVES

(a) In General

Federal law requires the Plan to be designed and operated for the sole and exclusive benefit of Employees. For purposes of participation in this Plan, an individual will be considered to be an Employee if he or she is employed by an Employer for wages under a Collective Bargaining Agreement which requires contributions to be made to the Fund on his or her behalf.

Certain categories of persons who have an ownership interest in an Employer or who have a special relationship to an Employer may be considered Employees for purposes of participation in the Plan. If such persons participate in the Plan, the Employers of persons in these categories must contribute to the Fund in accordance with the rules described in this Section. The persons subject to these rules are:

- (1) A person who has an ownership interest in an incorporated Employer (hereafter referred to as "Owner" or "Stockholder").
- (2) A person who is an officer of or is otherwise involved in the management of an incorporated Employer (hereafter referred to as an "Officer").
- (3) A person who is a relative; that is, a child, stepchild, spouse, parent, brother, sister, son-in-law, father-in-law, or other relative as determined by the Trustees in specific cases, of a Stockholder, Officer, or a sole proprietor or partner of an unincorporated Employer (hereafter referred to as a "Relative").

(b) Eligibility

- (1) *Stockholders, Officers, and Relatives.* A Stockholder, Officer, or Relative who works in employment covered by this Plan will be eligible to participate in the Plan on the first day of the fifth month following four consecutive months of making required payments pursuant to a Participation Agreement to the Fund on his or her behalf.

A Stockholder, Officer or Relative who established initial eligibility for Plan participation working under a Collective Bargaining Agreement, and is eligible based on work under a Collective Bargaining Agreement at the time he or she becomes a Stockholder, Officer, or Relative, will be eligible as a Stockholder, Officer, or Relative on the first day of the month after his or her Employer makes the first required payment pursuant to a Participation Agreement to the Fund on his or her behalf.

A Stockholder, Officer, or Relative who established initial eligibility for Plan participation working under a Collective Bargaining Agreement, but is no longer eligible based on work under a Collective Bargaining Agreement at the time he or she becomes a Stockholder, Officer, or Relative, will be eligible as a Stockholder, Officer, or Relative on the first day of the month after his or her Employer makes the first required payment pursuant to a Participation Agreement to the Fund on his or her behalf, so long as the first Plan coverage payment is for a month within 12 months from the date his or her eligibility based on work under a Collective Bargaining Agreement ended.

- (2) *Petition for Participation of Relatives as Bargaining Unit Employees.* An Employer may petition the Trustees to accept the participation of a Relative (other than a spouse of a corporate stockholder or officer) under the same terms as unrelated Employees performing work under the Collective Bargaining Agreement. However, the Relative must work exclusively in a job classification covered by a Collective Bargaining Agreement. The burden is on the Employer to establish the type of work performed by the Relative, and the Trustees may require the Employer and the Union to submit documentation concerning the type of work performed by the Relative.
- (3) *Unincorporated Businesses.* A sole proprietor or partner of an unincorporated business is an employer by law and may not participate under the Plan. However, Employees of a sole proprietor or partner of an unincorporated business who are covered by the Collective Bargaining Agreement must be reported to the Fund, and contributions must be made to the Fund on behalf of these Employees as required by the Collective Bargaining Agreement.

Any Employee who is married to an owner of an unincorporated business and who files a joint Federal tax return with that spouse which includes the operation of the business may not participate in the Plan. All other Relatives of sole proprietors or partners of unincorporated businesses are subject to the rules of this Section.

(c) Additional Rules

- (1) *Participation Agreement & Recordkeeping.* The Employer of a Stockholder, Officer, or Relative, who is or will be participating in the Plan, must sign a Participation Agreement and must agree to maintain records for at least seven years (the current year plus the prior six years) to document the total hours worked by each Stockholder, Officer, or Relative, a description of the type of work performed, and the amount of each type of work, including the total hours of work in employment covered by this Plan.
- (2) *Remain Current in Contributions for Collectively Bargained Employees.* The Employer of a Stockholder, Officer, or Relative who is participating in the Plan must contribute to all of the

funds to which contributions are required for collectively bargained Employees under the applicable Collective Bargaining Agreement.

- (3) *Tax Returns.* The owner of an unincorporated business, whose spouse is an Employee participating in the Plan, must annually submit the tax returns filed by the owner and his or her Employee spouse.
- (4) *Termination of Coverage.* Coverage for a Stockholder, Officer, or Relative who is eligible for Plan coverage will terminate on the first day of the month following the last month in which the monthly Plan coverage payment was not received. Such coverage may terminate earlier in the event of a delinquency as described in subsection (d) below. The Plan will not provide additional notification that coverage will be lost for failure to make timely Plan coverage payments.
- (5) *Erroneous Overpayments.* If an erroneous overpayment is made to the Fund, the contributions may be refunded, after the deduction of the costs of correcting the error and the deduction of benefit payments made based on the erroneous overpayment.
- (6) *Retiree Coverage.* A Retired Employee, who participated in the Plan as a Stockholder, Officer, or Relative, has the right to continue certain benefits provided that the Retired Employee makes self-payments as required by the Board of Trustees and otherwise meets the requirements for Retiree coverage under the Plan.

(d) Payment of Contributions

All remittance reports and monthly Plan coverage payments are due in the Fund Office no later than the fifteenth day of each calendar month for the prior month's coverage. However, if an Employer of a Stockholder, Officer, or Relative is repeatedly delinquent in making contributions on behalf of the Stockholder, Officer, or Relative, the Trustees may require that Plan coverage payments be made before the month of coverage as described below.

Example of Special Contribution Rule for Delinquent Employers: For example, if the special contribution requirement for delinquent employers is applied, in order for a Stockholder, Officer, or Relative to receive coverage under the Plan for February, the monthly Plan coverage payments for February must be received in the Fund Office by January 15. If the Employer does not submit any payment for the Employees who are participating as Stockholders, Officers, or Relatives, the coverage of these Employees will terminate on the last day of the month preceding the month for which the monthly Plan coverage payment is late; under the above example, coverage for the Stockholder, Officer, or Relative would terminate on January 31.

If any Employer is delinquent in making payments on behalf of its bargaining unit Employees, the participation of the Employees who are Stockholders, Officers, or Relatives will terminate on the last day of the month in which the delinquent contribution payment is due to the Fund.

If coverage terminates due to a late payment, the coverage may not be reinstated unless the payment of all amounts due, including all contributions, monthly Plan coverage payments, liquidated damages, interest, attorneys' fees, auditors' fees and costs which may be due, is made prior to the expiration of the grace period established by the Trustees. The grace period expires 30 days following the date the contributions are due (the 15th day after the end of each calendar month). The Trustees may change or eliminate this grace period at any time without prior notice.

In general, contributions to the Fund for Stockholders, Officers, and Relatives are not made on an hourly basis. The Trustees have established a monthly Plan coverage payment which applies to each of these Employees regardless of the number of hours the Employee works. The monthly Plan coverage

payment is designed to approximate the actual cost of providing medical benefits. Currently, the monthly Plan coverage payment is equal to 160 hours times the current contribution rate in the Collective Bargaining Agreement. The Trustees may change the amount of the monthly Plan coverage payment at any time.

2.10 YOUR OBLIGATION TO REPORT IMPORTANT EVENTS TO THE FUND OFFICE

You must report to the Fund Office important events such as a divorce, loss of Eligible Dependent status, and any other event that impacts the eligibility of you or your dependent(s). You must reimburse the Fund for any claim paid in error because you failed to report to the Fund Office any of the previously described events. If you fail to reimburse the Fund for any claim paid in error as required by this Section, the Fund may take action in accordance with Chapter 14 to recover the amount paid in error.

CHAPTER 3—ELIGIBILITY FOR RETIREES | IMPACT OF MEDICARE

3.01 ELIGIBILITY FOR RETIREES

Employees who retire through the National Automatic Sprinkler Industry (NASI) Pension Fund while eligible for health coverage under this Fund may continue health coverage under this Fund by making premium payments after a two-month grace period. Premiums are paid quarterly. The amount of each premium is determined by the Trustees.

Employees can choose to continue coverage with generally the same benefits as Active Employees by electing either Retiree coverage or COBRA Continuation Coverage. This choice will be offered when the Employee no longer meets the Plan's Continuing Eligibility Requirements. By accepting Retiree coverage, the Employee waives his or her rights to COBRA Continuation Coverage.

3.02 OPTING OUT | OPTING BACK IN

The Plan permits Retired Employees and their Spouses to opt out of Retiree coverage so long as coverage is available through another group health plan. Proof of such other coverage is required to opt out.

If the coverage available through another group health plan expires, the individual who opted out will be allowed to resume health coverage under this Fund so long as the individual can present a Certificate of Creditable Coverage (or other suitable proof of expiration of the other coverage) within 60 days of the expiration of such other coverage.

Opt out and opt in forms for Retiree coverage are available from the Fund Office.

3.03 TERMINATION AND REINSTATEMENT OF RETIREE COVERAGE

(a) In General

Retiree coverage is available for the lifetime of the Retired Employee and the Retired Employee's Spouse. However, Retiree coverage will terminate earlier than death upon the occurrence of one of the following events:

- (1) The Retired Employee and/or the Retired Employee's Spouse fails to make timely premium payments.
- (2) The Retired Employee returns to covered employment under this Fund, or performs any work in the sprinkler fitting, plumbing, or pipefitting industry.
- (3) The Retired Employee and/or the Retired Employee's Spouse files the appropriate form to opt out of coverage due to coverage being provided through another group health plan.

(b) Reinstating Retiree Coverage

If a Retired Employee returns to covered employment under this Fund and subsequently retires at an additional time, the Retired Employee will be eligible to reinstate Retiree coverage so long as the Retired Employee was eligible for and elected Retiree coverage following his or her first retirement. As previously noted, an individual who opts out of Retiree coverage may opt back in by meeting the conditions of Section 3.02.

(c) Permanent Loss of Retiree Coverage | Work in the Industry with a Non-Contributing Employer

As stated earlier, Retiree coverage will end if the Retired Employee performs any work in the sprinkler fitting, plumbing, or pipefitting industry, regardless of whether such work was performed

in covered employment under this Fund (including work for which contributions are made to this Fund through a reciprocal agreement). However, if Retiree coverage ends because the Retired Employee performs work in the sprinkler fitting, plumbing, or pipefitting industry with an employer that does not contribute to the Fund, Retiree coverage will not be reinstated upon any subsequent retirement.

3.04 MEDICARE-ELIGIBLE PARTICIPANTS / COVERAGE AND COORDINATION OF BENEFITS

(a) Requirement to Enroll in Medicare Parts A and B When First Eligible / Medicare is Primary for Retirees

You and/or your Spouse or Eligible Dependent MUST enroll in Medicare Parts A and B when first eligible. Benefits will be determined as if you and/or your Medicare-eligible Spouse or Eligible Dependent(s) have both Medicare Parts A and B, regardless of whether such individuals actually enroll in Medicare Parts A and B. Therefore, to have adequate coverage, you and/or your Spouse or Eligible Dependent MUST sign up for both Medicare Parts A and B at the earliest possible opportunity. This paragraph applies to you regardless if you or your Eligible Dependent(s) become eligible for Medicare due to age, disability, end-stage renal disease, or any other reason.

Medicare Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Medicare Part B covers Physician services, outpatient Hospital services, and other medical supplies. You must pay a monthly premium for Medicare Part B.

If you are a Retired Employee or an inactive Disabled Employee and become eligible for Medicare, Medicare will be your primary coverage. If you are a Retired Employee, inactive or Disabled Employee not yet eligible for Medicare, but your Spouse or other Eligible Dependent is eligible for Medicare, Medicare will be the primary coverage of your Medicare-eligible Spouse or Eligible Dependent.

(b) Automatic Enrollment in a fully-insured Medicare Advantage Prescription Drug Plan

The Fund will automatically enroll all Medicare-eligible Participants in a fully-insured Medicare Advantage Prescription Drug Plan (MAPD Plan). The premiums for the MAPD Plan will be paid by the Fund.

The MAPD Plan provides benefits as a supplement to Medicare's medical coverage and also provides Medicare Part D prescription drug coverage. Under this arrangement: (1) Medicare will be primarily responsible for paying your healthcare providers; (2) the MAPD Plan—in lieu of the Fund—will cover some or all of any remaining medical charges, as well as your medications; and (3) the Fund Office will continue to handle inquiries related to eligibility, premium payments, vision benefits, death benefits, and all other matters outside the purview of the MAPD Plan. The following paragraphs summarize the benefits of the MAPD Plan and what to expect if you are a Medicare-eligible Participant.

- (1) The MAPD Plan provides additional benefits designed to help Medicare-eligible participants achieve better health outcomes, including wellness and chronic disease management programs.
- (2) Medicare-eligible Participants will receive a new ID card for medical and prescription drug coverage. There will be no separate card for prescription drugs.
- (3) Medicare-eligible Participants will not have to change their current doctor or hospital as long as they accept Medicare Assignment and the plan. "Assignment" means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

- (4) Medicare-eligible Participants must be enrolled in Medicare Parts A and B and continue to pay their Medicare Part B monthly premium to the Social Security Administration, including any income-related surcharges, to be eligible for coverage under the MAPD Plan.
- (5) While the MAPD Plan is intended to replicate the medical and prescription drug benefits currently offered by the Plan, there will be some differences in benefits, as determined by both the insurance carrier for the MAPD Plan and the Centers for Medicare and Medicaid Services (CMS) guidelines. Please refer to literature furnished by the insurance carrier regarding the benefits available under the MAPD Plan.

If you are Medicare-eligible, or will soon be Medicare-eligible, please do not hesitate to contact the Fund Office if you have any questions regarding the MAPD Plan.

(c) Medicare Coordination for Active Employees

If you are Medicare-eligible, but continue or return to covered employment and work enough hours to maintain or reestablish active eligibility, you will be covered under the Plan as an Active Employee.

Under these circumstances, medical benefits provided by the Fund will be your primary coverage (and your Spouse's, if he or she is also eligible for Medicare); Medicare Benefits will be secondary. As long as you remain eligible due to hours worked, you should continue to submit your claims to the Fund. After payment by the Fund, you can submit any remaining expenses to Medicare for possible payment.

Active disabled employees (as defined in federal regulations) also receive primary coverage from the Fund and secondary coverage from Medicare as described above. This provision DOES NOT apply to eligible Employees, their Spouses or Eligible Dependents entitled to Medicare benefits because of Total Disability or end-stage renal (kidney) disease after 18 months.

Medicare is primary if you make COBRA Continuation Coverage payments after age 65.

CHAPTER 4—RIGHT TO COBRA CONTINUATION COVERAGE

4.01 COBRA CONTINUATION COVERAGE

If coverage under this Plan is scheduled to end because of certain events referred to as Qualifying Events, a Participant can pay to continue benefits for a limited period. This extended coverage is called COBRA Continuation Coverage (“COBRA”) and is available to both Active Employees and Eligible Dependents who are covered by this Plan on the day before the Qualifying Event. COBRA includes Major Medical, Dental, Vision Benefits, and the Plan’s Other Benefits as described in Chapter 12.

Individuals who have the right to elect COBRA are called Qualified Beneficiaries. A Qualified Beneficiary who elects COBRA is responsible for paying the full cost of this coverage once all other coverage under this Plan ends. The COBRA rates are established by the Trustees and can change from time to time.

This Chapter explains what COBRA is, when it may become available to you and your family, and what you need to do to protect your right to get it. However, when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse’s plan) even if that plan generally doesn’t accept late enrollees.

4.02 COBRA RULES FOR EMPLOYEES

An Active Employee may choose COBRA for the Active Employee, the Active Employee’s Spouse, and/or the Active Employee’s Eligible Dependent children. COBRA can be continued for up to 18 months from the date the Active Employee would lose coverage under the Plan because the Employee terminates employment covered by this Plan (for reasons other than gross misconduct) or because the Employee does not have sufficient hours for which contributions are received by the Fund to continue eligibility.

Under certain circumstances a disabled person and his or her family may extend coverage for a total of 29 months following termination of employment or a reduction in hours of employment. To qualify for the additional 11 months of coverage, the disabled person must have a determination of disability from the Social Security Administration effective within 60 days of the termination or reduction in hours. The determination from the Social Security Administration must be filed with the Fund Office within 60 days of the date the determination is made. This extended coverage applies to the disabled individual and all covered non-disabled family members.

If individuals receive extended COBRA because of a disability, the disabled person must also notify the Fund Office within 30 days of a final determination by the Social Security Administration that the person is no longer disabled. COBRA ends if Medicare coverage begins before the 29-month period expires or if the disabled person recovers from the disability and has already received 18 months of COBRA.

4.03 COBRA RULES FOR DEPENDENTS

If an Employee chooses not to purchase COBRA, the Employee’s Spouse, and/or Eligible Dependent children may separately purchase COBRA for themselves by making the election and the required monthly premium payments.

COBRA for Eligible Dependents can be continued for up to 18 months (29 months if there is a disabled person electing coverage) if coverage would otherwise end because of the termination of an Employee’s employment or a reduction in the Employee’s hours. However, coverage can be continued for up to 36

months for the Employee's Spouse and Eligible Dependent children if their coverage would otherwise end because of:

- (a) The death of the Employee;
- (b) The divorce of the Employee and Spouse;
- (c) A child's loss of status as an Eligible Dependent under the Plan; or because
- (d) The Employee becomes entitled to Medicare.

The maximum COBRA period under these circumstances is 36 months even if two or more of these events occur.

4.04 NOTICE REQUIREMENTS FOR COBRA

(a) Employee | Eligible Dependent

- (1) An Employee, Spouse, or Eligible Dependent child must notify the Fund Office in writing within 60 days of a divorce or a child's loss of Eligible Dependent status.
- (2) An Employee, Spouse, or Eligible Dependent child must notify the Fund Office in writing of a determination by the Social Security Administration that a Participant was disabled during the 60-day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the initial 18-month continuation coverage period. If, during extended disability coverage, the Social Security Administration determines that the Participant is no longer disabled, the Participant must inform the Fund Office of this redetermination within 30 days of the date it is made.
- (3) A Spouse or Eligible Dependent child of an Employee should notify the Fund Office within 60 days of that Employee's death.

(b) Employer

An Employer must notify the Fund Office within 60 days of an Employee's death or eligibility for Social Security benefits.

(c) Fund Office

The Fund Office will determine when an Employee's eligibility for benefits would end due to a termination of covered employment or reduction in hours of covered employment for which contributions are received by the Fund.

Following the Fund Office's receipt of a notice described in subsections (a) or (b), or after an Employee's loss of eligibility due to termination of covered employment, or reduction in hours of covered employment, the Fund Office will notify Employees and any Eligible Dependents not living with such Employees (whose address is known to the Fund) of their right to elect COBRA.

4.05 ELECTING COBRA

To elect COBRA, an Employee, Spouse, or Eligible Dependent child must complete an election form provided by the Fund and submit it to the Fund Office within 60 days after the later of: (a) the date eligibility for benefits would otherwise end; (b) or the date the Employee, Spouse, or Eligible Dependent child receives the notice of the right to elect COBRA.

Each Qualified Beneficiary who elects COBRA must be named on the election form or a separate election form must be submitted for any person not named. If, for any reason, the completed election form is not received by the Plan within the 60-day period, with respect to any particular Qualified Beneficiary, that

Qualified Beneficiary's eligibility for COBRA will expire and his or her health benefits will terminate as of the date on which he or she first became a Qualified Beneficiary. The Plan is not responsible if a parent or guardian, acting on behalf of a minor Qualified Beneficiary, does not inform the minor Qualified Beneficiary of his or her rights to COBRA coverage within the 60-day period.

4.06 REQUIRED PREMIUMS

The premiums for COBRA are established by the Trustees and can change from time to time. A Participant who has elected COBRA will be notified of the applicable premium(s) and payment options.

The initial premium payment must be received by the Fund within 45 days after the date of the COBRA election. This payment must cover the period of coverage from the date of the COBRA election retroactive to the date of the loss of coverage due to the Qualifying Event. Subsequent payments are due on the first day of each calendar month.

It is the responsibility of each Qualified Beneficiary, or person acting on behalf of a Qualified Beneficiary, to ensure that correct payment is received by the Fund on a timely basis. The Fund is not responsible if the Qualified Beneficiary causes himself or herself to lose COBRA through a failure to submit the correct payment in a timely fashion.

The Fund will return any overpayment of COBRA premiums. This provision applies in all situations, including situations where the Sprinkler Fitters Local Union 281 Unemployment Extension & Retiree Subsidy Plan remits COBRA premiums on behalf of a Participant who would otherwise lose eligibility on the basis of unreported hours and contributions, and the Fund subsequently collects the delinquency, thus negating the need for the COBRA premiums.

4.07 TERMINATION OF COBRA

COBRA may terminate earlier than the maximum period (18, 29 or 36 months) if:

- (a) All health benefits provided by the Plan terminate.
- (b) An Employee, Employee's Spouse, or Eligible Dependent child who has elected COBRA does not pay required premiums to the Fund Office on time.
- (c) An Employee who has elected COBRA becomes covered by Medicare.
- (d) An Employee, Employee's Spouse, or Eligible Dependent child becomes covered by another group health plan after the loss of coverage from this Plan, unless the replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to the Employee, Spouse, or Eligible Dependent child after your coverage under this Plan is taken into account.
- (e) Coverage has been extended for up to 29 months due to disability, and there has been a final determination that the individual is no longer disabled.

Once COBRA terminates, it cannot be reinstated.

4.08 NOTIFICATION OF UNAVAILABILITY OR EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

If a Participant applies for COBRA and the Fund Office determines that the Qualifying Event or, second Qualifying Event, as the case may be: (a) does not entitle the Participant to COBRA; or (b) that the Participant's application or notice of Qualifying Event was not timely, the Fund Office will provide the Participant an explanation why the Participant is not entitled to COBRA.

Furthermore, if a Participant's COBRA is terminated before the end of the maximum COBRA period, then (as soon as practicable) the administrator will provide an explanation of such termination to the Participant. The explanation shall state: (a) the reason why the COBRA has terminated early; (b) the effective date of

termination; and (c) an explanation of any rights the Participant may have under the Plan or under any applicable law to elect an alternative group or individual coverage, such as a conversion right.

4.09 OBLIGATION TO NOTIFY THE PLAN OF A DIVORCE

In addition to the notice requirements under COBRA, Active Employees and Retired Employees have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced spouse and children of the divorced spouse (stepchildren of the Employee) become ineligible for benefits upon the divorce. If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to an ineligible person, the Trustees may decide to recover those benefits by treating such benefits as an advance to the Employee, and deducting such amounts from benefits which become due to the Employee until the entire amount of benefits erroneously paid is recovered. Also, if notice of divorce is not provided to the Fund office within 60 days, an Employee's Spouse and children of the divorced spouse will lose their right to elect COBRA.

CHAPTER 5—MAJOR MEDICAL BENEFITS

PART A – GENERAL INFORMATION REGARDING YOUR BENEFITS

Part A of this Chapter is designed to educate you about how to access medical care covered by the Plan. It is also designed to inform you about how financial responsibility for such care is allocated between you and the Fund. It addresses topics such as:

- How to access medical care through the PPO network.
- The distinctions between In-Network and Out-of-Network care.
- The importance of staying In-Network to minimize your expenses and the Fund’s expenses.
- The meaning of: (a) Deductible; (b) Out-of-Pocket Maximum; (c) Coinsurance; and (d) Copayment.

Part B of this Chapter contains the Schedule of Major Medical Benefits. Part C of this Chapter provides additional information regarding the types of Covered Services included in the Schedule of Benefits. Part D of this Chapter includes information regarding exclusions and case management.

You should note that capitalized terms used in this Chapter and throughout the Plan have special meaning. In most cases, these terms are defined in Chapter 1 of the Plan. However, where a term is specific to a particular type of covered benefit, the term may be defined in the Section of the Plan that describes such benefit. Finally, you should also note that Chapter 6 describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office at (708) 597-1832.

5.01 BLUE CROSS BLUE SHIELD OF ILLINOIS

(a) In General

The Fund is party to a preferred provider organization network administration agreement with Blue Cross Blue Shield of Illinois (BCBSIL or PPO). Pursuant to that agreement, BCBSIL provides Participants with access to health care through a select group of providers (In-Network or PPO Providers). Providers outside of the BCBSIL network are referred to as Out-of-Network providers.

(b) How to Use the BCBSIL Network | Your Identification Card

Participants will each receive a BCBSIL identification (ID) card. Your ID card verifies your participation in the BCBSIL network. It is important to take your ID card with you wherever you go, and you should present your ID card whenever you seek medical care. If any information on your ID card is incorrect, you misplace it, or need a new ID card, please contact the Fund Office.

(c) Finding an In-Network Provider | Managing Your Healthcare Online

You find providers in the BCBSIL network by going to www.bcbsil.com. You may also call 1-800-571-1043 and a customer service associate will help you locate a provider.

Participants 18 years of age and older can conveniently and securely view their benefits and claims information and access several useful online tools at www.bcbsil.com.

(d) Traveling Outside of the BCBSIL Network | The BlueCard PPO Program

Under the BlueCard PPO Program, Participants who require care outside of BCBSIL’s service area may access the preferred network of the Blue Cross Blue Shield company that serves the area where the care is rendered. This means you can travel with peace of mind knowing that, if you need to see a

Physician or go to the Hospital, you can simply present your ID card to any BlueCard PPO provider across the country.

5.02 IN-NETWORK | OUT-OF-NETWORK

(a) You Must Remain In-Network to Receive Maximum Benefits

Covered Services may be provided by either an In-Network or Out-of-Network provider. When a Participant seeks care from an In-Network provider, the Fund will provide benefits at the In-Network Coinsurance and/or Copayment level specified in the Schedule of Benefits. When a Participant seeks care from an Out-of-Network provider, the Fund will provide benefits at the Out-of-Network Coinsurance and/or Copayment level specified in the Schedule of Benefits.

To receive maximum benefits available under the Plan, Participants must obtain Covered Services from an In-Network provider. In other words, Participants must use a provider that participates in the BCBSIL network or qualifies as a BlueCard PPO provider. Participants will save money (and will save the Fund money) if they remain within the BCBSIL network.

(b) You May Pay More if You Use an Out-of-Network Provider | Risk of Balance Billing

If a Participant uses an Out-of-Network provider, the Fund will pay for the Covered Services in accordance with the Plan, but the Participant may incur significantly higher out-of-pocket expenses, including Deductibles and a higher Coinsurance percentage. In certain instances, the Out-of-Network provider also may charge the Participant for the remainder (or “balance”) of the provider’s bill after applying payment from the Fund—this practice is often referred to as *balance billing*. This is true whether the Participant uses an Out-of-Network provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a provider.

(c) Out-of-Network Services Treated as In-Network

In certain cases, services provided by an Out-of-Network provider will be subject to the In-Network cost-sharing levels set forth in the Schedule of Benefits. The following care will qualify for such special treatment.

- (1) Emergency Services for an Emergency Medical Condition. The term “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. The term “Emergency Services” means, with respect to an Emergency Medical Condition: A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under the Social Security Act to stabilize the patient.
- (2) Services provided by an Out-of-Network provider such as a lab, anesthesiologist, or radiologist in an In-Network Hospital when being treated by an In-Network Physician.
- (3) Chiropractic treatment if chiropractors are not included in the BCBSIL network.

- (4) Care provided by a psychologist or psychiatric social worker if these providers are not included in the BCBSIL network.
- (5) Services rendered by a provider which leaves the BCBSIL network during a continuous course of treatment if, as the result of the provider leaving the network, the Participant would be required to change Physicians during the course of treatment. For these purposes, a continuous course of treatment means a limited and specific plan or program of treatment to address a specific Sickness or condition such as a pregnancy or a course of chemotherapy.

Your benefits will also be paid at the In-Network level of benefits if you live in an area covered by the BCBSIL network or the BlueCard PPO Program, but there is not an appropriate In-Network provider within 30 miles of where you live. In addition, if a provider is treated as In-Network because of one of the exceptions listed above, a continuous course of treatment by that provider will also be considered In-Network. For these purposes, a continuous course of treatment means a limited and specific plan or program of treatment to address a specific Sickness or condition such as a pregnancy or a course of chemotherapy.

5.03 COINSURANCE | COPAYMENTS | DEDUCTIBLES | MAXIMUMS

(a) How much is paid under the Major Medical Benefit?

Covered Expenses will be paid at 85% for In-Network services after the satisfaction of the Major Medical In-Network Deductible. Covered Expenses will be paid at 60% for Out-of-Network services after the satisfaction of the Major Medical Out-of-Network Deductible. After you have met the applicable calendar year Out-of-Pocket Maximum, all applicable Covered Expenses will be paid at 100%.

(b) Coinsurance

The term Coinsurance refers to a type of cost-sharing whereby the Participant assumes responsibility for a percentage of the Covered Expenses for a Covered Service. It is the amount a Participant must pay for covered medical services after the Participant has satisfied any applicable Copayment or Deductible. The Coinsurance rates for specific covered services are listed in the Schedule of Benefits.

(c) Copayments or Copays

The term Copayment refers to a type of cost-sharing whereby the Participant pays a flat dollar amount each time a Covered Service is provided. The Copayment rates for specific covered medical services are listed in the Schedule of Benefits.

(d) Deductible

The term Deductible refers to the amount of Covered Expenses that a Participant must pay each calendar year before the Plan pays benefits. There are separate Deductibles for In-Network and Out-of-Network services listed in the Schedule of Benefits.

A Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Deductible, or once the family Deductible has been satisfied for all covered family members combined. Copayments and non-Covered Expenses do not count towards your Deductible; however, Covered Expenses that are applied towards the Deductible are counted towards the Calendar Year Out-of-Pocket Maximum.

Any Covered Expenses incurred and applied to the Deductible amount in the last three months (October, November, December) will be applied to the Deductible amount for both the present and following calendar year.

(e) Maximums

- (1) *Out-of-Pocket Maximum.* The Plan limits your responsibility to pay for Covered Expenses to the Annual Out-of-Pocket Maximums listed in the following Section. After the amount you or your family pays meets the applicable Out-of-Pocket Maximum, the Plan will cover 100% of all applicable Covered Expenses for the remainder of the calendar year.
- (2) *Types of Annual Out-of-Pocket Maximums.* The Plan has three separate annual Out-of-Pocket Maximums. These include: (A) the In-Network Major Medical Benefit Out-of-Pocket Maximum; (B) the Out-of-Network Major Medical Benefit Out-of-Pocket Maximum; and (C) the In-Network Prescription Drug Benefit Out-of-Pocket Maximum. The Plan does not have an Out-of-Pocket Maximum that applies to Out-of-Network Prescription Drug Benefits.
- (3) *Expenses that Apply Towards the Annual Out-of-Pocket Maximums.*
 - (A) In-Network Major Medical Benefit Out-of-Pocket Maximum. In-Network Major Medical Benefit Copayments, Coinsurance payments, and Deductibles apply towards the In-Network Major Medical Benefit Out-of-Pocket Maximum.
 - (B) Out-of-Network Major Medical Benefit Out-of-Pocket Maximum. Out-of-Network Major Medical Benefit Copayments, Coinsurance payments, and Deductibles apply towards the Out-of-Network Major Medical Out-of-Pocket Maximum. However, what you pay in connection with Out-of-Network Prescription Drug Benefits does not apply towards the Out-of-Network Major Medical Benefit Out-of-Pocket Maximum.
 - (C) In-Network Prescription Drug Benefit Out-of-Pocket Maximum. In-Network Prescription Drug Benefit Copayments and Coinsurance payments apply towards the In-Network Prescription Drug Benefit Out-of-Pocket Maximum.
 - (D) Important Note Regarding Non-Covered Expenses. Expenses that do not qualify as Covered Expenses do not apply towards the Annual Out-of-Pocket Maximums.
- (4) *Other Maximums.* The term Maximum refers to a limit on the amount of Covered Services that a Participant may receive. A Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance, and Copayment amounts paid by Participants for the Covered Service to which the Maximum applies. A Maximum may also be expressed in number of days or number of services for a specified period of time.

This Space Is Intentionally Left Blank

PART B – SCHEDULE OF MAJOR MEDICAL BENEFITS

5.04 DEDUCTIBLES & MAXIMUMS

ANNUAL DEDUCTIBLES & MAXIMUMS	IN-NETWORK	OUT-OF-NETWORK
• Non-Medicare Eligible Individual Deductible	\$500	\$660
• Non-Medicare Eligible Family Deductible	\$1,500	\$1,980
• Medicare Eligible Individual Deductible	\$100	\$100
• Medicare Eligible Family Deductible	None	None
• Individual Out-of-Pocket Maximum	\$3,000	\$5,760
• Family Out-of-Pocket Maximum	\$9,000	None
• Overall Annual Maximum	None	None
• Overall Lifetime Maximum	None	None

5.05 SCHEDULE OF BENEFITS

TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
• Alcoholism Substance Abuse Addiction	Plan pays 85%	Plan pays 60%
• Ambulance	Plan pays 85%	Plan pays 60%
• Anesthesia	Plan pays 85%	Plan pays 60%
• Convalescent Facility Room and Board ¹	Plan pays 85%	Plan pays 60%
• Dental Implants (Medically Necessary)	Plan pays 85%	Plan pays 60%
• Durable Medical Equipment	Plan pays 85%	Plan pays 60%
• Emergency Room Visits ²	Plan pays 85% after \$200 Copayment	Plan pays 60% after \$200 Copayment
• Home Health Care	Plan pays 85%	Plan pays 60%
• Hospital Daily Room and Board ³	Plan pays 85%	Plan pays 60%
• Infertility Benefit ⁴	Plan pays 85%	Plan pays 60%
• Mental Illness and Nervous Disorder Benefit	Plan pays 85%	Plan pays 60%
• Occupational Therapy ⁵	Plan pays 85%	Plan pays 60%
• Ophthalmologist	Plan pays 85%	Plan pays 60%
• Organ Transplant Benefit	Plan pays 85%	Plan pays 60%
• Physical Therapy ⁵	Plan pays 85%	Plan pays 60%
• Prophylactic Mastectomy Benefit	Plan pays 85%	Plan pays 60%
• Speech Therapy ⁵	Plan pays 85%	Plan pays 60%
• Surgical Benefit – Non-Physician Charges	Plan pays 85%	Plan pays 60%
• Surgical Benefit – Physician Only	Plan pays 85%	Plan pays 60%

¹ Convalescent Facility Room and Board charges are limited to the lesser of the Convalescent Facility’s most common charge for its standard semi-private room or 50% of the semi-private room rate of the Hospital in which the Participant was confined prior to the Convalescent Facility admission.

² Copayment is waived for moderate to severe conditions as reported by the Emergency Room or if the patient is admitted that day.

³ Hospital Daily Room and Board charges are limited to the semi-private room rate.

⁴ Eligible Dependent children are not eligible for Infertility Benefits. Infertility Benefits are limited to up to four completed oocyte retrievals per person per lifetime.

⁵ If more than 20 visits per type of therapy per Sickness or diagnosis are needed, the case will be reviewed for Medical Necessity before approving additional visits.

PART C – DETAILED INFORMATION REGARDING SPECIFIC COVERED BENEFITS

The Major Medical Benefit covers certain expenses for Accident, Sickness, pregnancy of the Employee or Spouse, voluntary sterilization, or well-baby charges during the Hospital confinement immediately following birth. Part C of this Chapter provides additional information regarding these benefits as well as the types of covered services listed in the Schedule of Benefits. The order of the following Sections generally corresponds with the order in which Covered Services are listed in the Schedule of Benefits (i.e., alphabetically).

As previously noted, capitalized terms used in this Chapter and throughout the Plan have special meaning. In most cases, these terms are defined in Chapter 1 of the Plan. However, where a term is specific to a particular type of covered benefit, the term is defined in the Section of the Plan that describes such benefit. Finally, you should also note that Chapter 6 describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office at (708) 597-1832.

5.06 ALCOHOLISM, SUBSTANCE ABUSE, OR DRUG ADDICTION

(a) In General

The Plan covers treatment for alcoholism or drug addiction. Treatment for alcoholism or drug addiction must have an acceptable treatment plan and be in an approved treatment facility. Accident and Sickness Weekly Benefits under this provision will be paid after the eighth day of an approved confinement. Court ordered treatment does not make the treatment Medically Necessary.

(b) Treatment Plan

Confinement must result from the diagnosis and recommendation of a Physician who certifies that a treatment plan has been established under the Physician's direction for the rehabilitation of the patient. Treatment solely for detoxification or primarily for maintenance care is **NOT** considered an acceptable treatment plan. Detoxification is care aimed primarily at overcoming the after-effects of a specific episode of drinking or drug abuse. Maintenance care consists of providing an environment without access to alcohol or drugs.

(c) Treatment Facilities

To qualify as an approved treatment facility, an institution must meet **ALL** of the following:

- (1) It is primarily engaged in providing, for compensation from its patients and on a full-time basis, a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse, whichever condition is being treated.
- (2) It provides all medical detoxification services necessary as an adjunct to its effective treatment programs continuously on a 24-hour basis.
- (3) It provides all normal infirmary-level medical services required for the treatment of any disease or injury manifested during the treatment period, whether or not related to the alcoholism or drug abuse, continuously on a 24-hour basis. Also, it provides, or has an agreement with a Hospital in the area to provide, any other medical services that may be required during the treatment period.
- (4) It is under the supervision of a staff of Physicians on a continuous 24-hour basis, and it provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.

- (5) It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, physiological, and social needs with documentation that the plan is under the supervision of a Physician.
- (6) It meets any applicable licensing standards established by the jurisdiction in which it is located.

(d) Medical Complications

If you or one of your Eligible Dependents is confined as an Inpatient in a Hospital solely for the treatment of a medical complication of alcoholism or drug abuse (such as cirrhosis of the liver, delirium tremens, or hepatitis) the Plan will pay for the confinement on the same basis as any other confinement. Accident and Sickness Weekly Benefits under this provision will be paid after the eighth day of the **first confinement** only. Disability payments will **NOT** be made until a treatment program has been completed.

5.07 AMBULANCE SERVICE

The Plan covers Ambulance services due to an Accident, Sickness or pregnancy for which a benefit is payable under the Plan, and the transportation is to or from a Hospital.

5.08 ANESTHESIA

The Plan covers Anesthesia, and its administration for a surgical procedure covered under this Plan, including the services of an anesthesiologist.

5.09 CONVALESCENT FACILITY ROOM

The Plan covers Convalescent Facility Room and Board during the first 60 days of confinement, but only while confined as a registered bed patient. Confinement must begin within seven days following termination of a Hospital confinement of at least three days. All periods of Convalescent Facility confinement during any Disability will be considered one confinement. For Convalescent Facility confinement, only the lesser of the following charges will be covered: (a) the Convalescent Facility's most common charge for its standard semi-private room, or (b) 50% of the semi-private room rate of the Hospital from which the covered person was confined prior to the Convalescent Facility admission.

5.10 DENTAL IMPLANTS

The Plan covers Medically Necessary dental implants due to an Accident or congenital defect. The Plan also covers Medically Necessary dental implants for patients that require implants due to cancer treatment in excess of the Plan Year Maximum Dental Benefit.

5.11 DRUGS AND MEDICINES

The Plan covers Drugs and Medicines administered in a Hospital setting or at a Physician's office and not available through the Plan's prescription drug program. Chapter 7 outlines the Plan's prescription drug program.

5.12 DURABLE MEDICAL EQUIPMENT

The Plan covers the rental of Durable Medical Equipment for therapeutic treatment up to the purchase price of said equipment. Durable Medical Equipment must meet each of the following criteria: (a) it is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation, or rehabilitation of a patient; (b) it is clearly related to and necessary for the treatment, habilitation, or rehabilitation of the patient; (c) it must improve the function of a malformed body member or impede further deterioration of the patient's condition; (d) it would NOT be necessary in the absence of a Sickness or physical or mental disability; (e) it is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for

transportation, comfort, or convenience (the fact that the equipment or device is also useful for transportation, comfort, or convenience will NOT serve as a disqualifying factor); (f) it is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe); and (g) it is appropriate for and intended for use in the home.

Examples of Durable Medical Equipment include, but are not limited to, artificial eyes and limbs to replace lost or natural eyes and/or limbs; oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, surgical dressings and bandages, casts, splints, trusses, crutches or braces that stabilize an injured body part, mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions and rental, up to the purchase price of a standard wheelchair, standard Hospital type bed, or an iron lung. Nondurable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with covered Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to covered Durable Medical Equipment.

Requests for Durable Medical Equipment must be accompanied by a Physician's statement describing the Medical Necessity and length of use of the equipment. The cost of these items will be limited to the Usual and Customary Charge as defined by the Plan. Rental of Durable Medical Equipment is covered up to the purchase price. It is recommended that you contact the Fund Office before purchasing or renting any of these items to be advised of the cost that will be covered.

5.13 EMERGENCY ROOM VISITS

The Plan covers Emergency Room Visits pursuant to the Schedule of Benefits.

5.14 HOME HEALTH AGENCY

The Plan covers charges made by an organization or agency which meets the requirement for participation as a Home Health Agency under a Medicare plan for treatment administered within 90 days following a period of five days of Hospital or covered Convalescent Facility confinement.

5.15 HOSPICE CARE

The Plan covers Hospice care. Hospice care is a coordinated program intended to meet the special physical, psychological, spiritual, and social needs of a terminally ill person and the immediate family. A terminally ill person is defined as one who (1) has no reasonable prospect of cure; and (2) as estimated by the Physician, has a life expectancy of less than six months. Hospice services include providing the terminally ill person with palliative and supportive medical nursing and other health services through home or in-patient care.

If Hospice Care is being given at home, short-term respite care is also covered under this benefit as long as it is provided in a Medicare-approved facility. Respite care is given to a hospice patient by another caregiver so that the usual caregiver can rest. This benefit includes transportation to and from the respite facility.

5.16 HOSPITAL

The Plan covers Hospital charges for room and board at the lesser of: (a) the Hospital's most common charge for its standard semi-private room or (b) the Hospital's actual charge for an intensive care, coronary care, or other specialized care unit.

5.17 INFERTILITY TREATMENT

Benefits will be provided to an Employee or Spouse for covered services in connection with the diagnosis and/or treatment of infertility, including but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer. Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer will be provided only when one has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment.

Benefits will be provided for four completed oocyte retrievals per person per lifetime, except that, when one has had a live birth following a completed oocyte retrieval, the benefits will only be provided for two additional oocyte retrievals for that person.

Benefits will **NOT** be provided for the following: (a) reversal of voluntary sterilization; (b) services or supplies rendered to a surrogate for purposes of childbirth; (c) selected termination of an embryo in cases where the person's life is not in danger; (d) cryo-preservation or storage of sperm, eggs, or embryos; (e) non-medical costs of an egg or sperm donor; (f) travel costs for travel within 100 miles of the covered person's home or which is not Medically Necessary or which is not required by the Plan; (g) infertility treatments which are determined to be investigational by a specialist consulted by the Plan; and (h) infertility charges incurred by a dependent child.

5.18 MENTAL ILLNESS AND NERVOUS DISORDER

The Plan covers any Medically Necessary Covered Expenses associated with a Mental Illness and/or a nervous disorder. In order to save both you and the Plan money, you should consider contacting the MAP program prior to consulting with a Physician or therapist. Information regarding the MAP may be found in Section 12.03. Participants are eligible for up to six free visits with a counselor through the MAP program. Treatment for alcoholism, substance abuse or drug addiction is not covered under this Mental Illness and Nervous Disorder Benefit.

5.19 OCCUPATIONAL THERAPY

The Plan covers Occupational Therapy. Occupational Therapy is constructive therapeutic activity by a Physician, licensed occupational therapist, licensed occupational therapy assistant, or any health care provider who is acting within the scope of that provider's license or certification under applicable state law, that is designed and adapted to promote the restoration of a useful physical function when it has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered Expenses do not include educational training or services to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical condition of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or Sicknesses. If a Participant needs more than 20 visits per Sickness or diagnosis, the Plan's case manager will review the expenses for services for Medical Necessity. Pre-determination of Medical Necessity is not required, but is recommended in some cases to prevent financial misunderstandings between you and your provider.

5.20 OPHTHALMOLOGIST

The Plan covers services performed by an ophthalmologist which are not covered under the Vision Benefit.

5.21 ORGAN TRANSPLANT BENEFIT

The Plan covers charges incurred when a Participant undergoes an organ transplant. However, the Plan does not cover any charges associated with experimental procedures for any organ transplant procedure not covered by Medicare.

5.22 OXYGEN

The Plan covers the provision of oxygen.

5.23 PHYSICAL THERAPY

The Plan covers Physical Therapy. Physical Therapy is the treatment of a disease, injury, or condition by physical means by a Physician, licensed physical therapist, licensed physical therapist assistant, licensed pulmonary therapist, or any health care provider who is acting within the scope of that provider's license or certification under applicable state law when designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered Expenses do not include educational training or services designed and adapted to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical conditions of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or Sicknesses. If an Employee or dependent needs more than twenty (20) visits per Sickness/diagnosis, the Plan's case manager will review the expenses for services for Medical Necessity. Pre-determination of Medical Necessity is not required but is recommended in some cases to prevent financial misunderstandings between you and your provider.

5.24 PROPHYLACTIC MASTECTOMY BENEFIT

The Plan covers surgical procedures relating to prophylactic simple mastectomies and post-mastectomy reconstructive surgery when one or more of the following risk factors are present: (a) a strong family history of breast cancer among certain relatives; (b) first generation relative with bilateral pre-menopausal breast cancer; (c) a biopsy diagnosis of lobular carcinoma or atypical hyperplasia and a history of breast cancer among certain relatives or certain medical conditions that prevent follow-up examinations; (d) a family history of hereditary cancer; (e) a positive test for BRCA 1 or BRCA 2 mutant genes; or (f) a significant risk of breast cancer due to prior medical treatment.

Participants must submit proposed procedures and treatment plans to the Fund for advance authorization. The Fund may require you to obtain a second medical opinion at no cost to you, which could require you to submit to a reasonable medical examination in order to obtain the second medical opinion.

Prophylactic Mastectomy Benefit will not provide any payment for charges incurred to have a prophylactic subcutaneous mastectomy performed. BRCA1, BRCA2, and other genetic testing will be paid only if the need for such testing is clearly documented, and there is medical evidence that your family history warrants such treatment.

5.25 REGISTERED NURSE

The Plan covers services rendered by a registered nurse.

5.26 SPEECH THERAPY

The Plan covers Speech Therapy. Speech Therapy is the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes by a Physician, licensed speech therapist, or any health care provider who is acting within the scope of that provider's license or certification under applicable state law when designed and adapted to promote the restoration of a useful physical function that has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time. Covered Expenses do not include educational training or services designed and adapted to develop a physical function, except if such expenses are provided in conjunction with the treatment of a condition that is the result of a Mental Illness or a developmental delay related to the medical conditions of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed, other head trauma, spinal cord injuries, multiple or complicated fractures, other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or Sicknesses. If an Employee or dependent needs more than 20 visits per

Sickness/diagnosis, the Plan's case manager will review the case for Medical Necessity. Pre-determination of Medical Necessity is not required but is recommended in some cases to prevent financial misunderstandings between you and your provider.

5.27 SURGICAL

The Plan covers Physician's charges and non-Physician charges for surgical and obstetrical care, including newborn circumcision.

5.28 X-RAY AND LABORATORY SERVICES

The Plan covers X-Ray and Laboratory services.

In addition, the Trustees are pleased to advise that they have retained Absolute Solutions to make available an expansive network of providers who offer competitive pricing for diagnostic tests such as MRIs, CT scans, and PET scans. **To encourage you to use providers in the Absolute Solutions Network, the Fund will cover 100% of the claims you incur for covered services in the Absolute Solutions Network. No Deductible applies.** Of course, if your current imaging provider is not affiliated with Absolute Solutions, you may continue to use your provider, in which case your diagnostic tests will be covered under the Plan's normal cost-sharing rules after you satisfy the applicable Deductible.

PART D – EXCLUSIONS AND CASE MANAGEMENT

5.29 MAJOR MEDICAL BENEFIT EXCLUSIONS

This Chapter does not cover: (a) any service, supply, or treatment listed under the Plan's general Exclusions in the following Chapter; (b) Hearing aids, as they are covered under the Hearing Aid Benefit; (c) Eyeglasses, as they are covered under the Plan's vision benefits; (d) Expenses covered under the Dental Benefit, such as services and supplies for treatment of the teeth, the gums (other than for tumors), and other associated structures primarily in connection with the replacement of teeth; and (f) Expenses for shipping and handling, sales tax, or lab transfer fees for any covered or non-covered service or supplies.

5.30 CASE MANAGEMENT

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

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

The Fund may request or require participants to use case management services. This is most likely to arise in cases involving claims in excess of \$25,000, but the Trustees reserve the right to require the use of case management services for all conditions or cases, including (but not limited to) the management of chronic or other appropriate conditions. For example, expenses for services for Physical, Occupational, or Speech therapy over 20 visits per Sickness/diagnosis will also need to be reviewed by a case manager to assure the treatments are Medically Necessary.

5.31 THE BENEFIT OF CALLING THE CASE MANAGER

In general, Major Medical Benefit services do not need to be pre-authorized. However, in order to be sure that the service will meet the Plan's Medical Necessity requirement, it is recommended that you contact the

Fund's Case Manager in advance of any Inpatient admission. In the case of an emergency admission, the Case Manager should be contacted as soon as possible after admission. Calling the Case Manager may prevent financial misunderstandings between you and your provider. Contact information for the Case Manager may be found in Section 17.09 of this Plan.

CHAPTER 6—EXCLUSIONS

6.01 IN GENERAL

The Plan provides benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of a service or charge from the Plan of benefits shall be presumed to be an exclusion even though not expressly stated as such.** In addition, the Plan does not cover (or limits) the services and supplies listed in this Chapter. These exclusions are in addition to any other exclusions set forth elsewhere in the Plan.

6.02 GENERAL EXCLUSIONS

(a) Workers' Compensation

The Plan does not cover any Accident or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain which is covered by any Workers' Compensation or occupational disease law.

(b) Supplies or Services for Which No Charge is Made or Required

The Plan does not cover any supplies or services, without cost, for which no charge is made or required, or which are not legally required to be paid in the absence of the Plan.

(c) Charges Incurred Prior to Effective Date of Eligibility

The Plan does not cover expenses incurred prior to the date you or your Eligible Dependents became eligible for benefits under the Plan.

(d) Charges Incurred After the Date of Termination of the Participant's Eligibility

The Plan does not cover expenses incurred after the date the eligibility of you or your Eligible Dependents under the Plan terminates.

(e) Experimental/Investigational Services and Supplies

The Plan does not cover services or supplies, including prescription drugs, considered educational, investigational, or experimental. A drug, device, medical treatment, or procedure is considered experimental or investigational if:

- (1) It is a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing had not been given at the time the drug or device was furnished;
- (2) If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- (3) If reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, "Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or written informed

consent used by the treating facility studying substantially the same drug, device, medical treatment, or procedure.

This general exclusion for educational, investigational, or experimental services or products does not include the routine patient costs for items or services furnished in connection with participation in a clinical trial if those costs would otherwise be covered under the plan. "Routine patient costs" has the same meaning as that term is defined in the Public Health Services Act Section 2709 and includes items or services that are otherwise covered under the plan and are used for the direct clinical management of the patient, but does not include items or services used solely to satisfy the data collection and analysis needs of the clinical trial.

(f) Medical Necessity

The Plan does not cover treatment, services, or supplies which are not Medically Necessary, except for covered Preventive Services.

(g) Services Furnished by Government

The Plan does not cover medical services or supplies furnished in or by a federal, state or local government agency or program, or in or by a Hospital or institution, unless required by law.

(h) Services Furnished by Relative

The Plan does not cover medical services or supplies furnished by an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage.

(i) Services Not Rendered / In Excess of Amount Billed

The Plan does not cover services not rendered, or in an amount more than the amount billed.

(j) Charges in Excess of Usual and Customary

The Plan does not cover charges for services or supplies in excess of Usual and Customary Charges unless specifically provided by the Plan.

(k) Education / Training

The Plan does not cover services rendered primarily for educational or training purposes.

(l) Telephone Consultations, etc.

The Plan does not cover charges for telephone consultations, failure to keep a scheduled appointment, completion of a claim form, or to obtain medical records or other information.

6.03 SPECIFIC EXCLUSIONS

(a) Nursing Home, etc.

The Plan does not cover medical services or supplies, including prescription drugs, furnished in or by a nursing home, sanatorium, rest home, Convalescent Facility, extended care facility or similar establishment.

(b) Private Duty Nursing Care

The Plan does not cover private duty nursing care, unless ordered by a Physician as Medically Necessary.

(c) Custodial Care

The Plan does not cover Custodial Care or domiciliary care regardless of the facility where provided.

(d) Food or Supplements

The Plan does not cover food or supplements.

(e) Developmental Care

The Plan does not cover charges for Developmental Care except as otherwise allowed under the Plan.

(f) Obesity / Diet Control

The Plan does not cover: (1) Charges for surgical correction of obesity or complications thereof; (2) Office visits for diet control or counseling; and (3) Any obesity programs or food supplements for weight loss, diet clinics or any other such programs.

(g) Smoking Cessation

The Plan does not cover smoking cessation treatment except as otherwise allowed under the Plan.

(h) Certain Pregnancy-Related Charges

The Plan does not cover:

- (1) Charges for any expenses related to a surrogate pregnancy for either the mother or the child.
- (2) Charges for elective abortion or complications thereof.
- (3) Pregnancy, childbirth or miscarriage of a dependent child unless treatment is necessary to save the life of the dependent child or the Trustees determine that the pregnancy is the result of a violent or criminal act against the dependent child.
- (4) Birth control pill and appliances (diaphragms, IUDs, etc.), unless: (A) Medically Necessary and specifically prescribed for a diagnosis other than birth control; or (B) allowed as a Preventive Service pursuant to the Affordable Care Act.
- (5) Reversal of voluntary sterilization.
- (6) Penile implants.
- (7) Drugs for the treatment of impotence except as specifically provided by the Plan.
- (8) Expenses incurred for pharmaceuticals prescribed, or normally prescribed, for the treatment of a sexual dysfunction disorder shall be limited to ten doses per month, plus any excess maintenance dose provided through the Plan's Mail Order Service for prescription drugs, if any. Expenses for such pharmaceuticals incurred as prescribed for treatment of non-sexual dysfunction disorders shall be paid only upon presentation of a medical doctor's certification and substantiation of prior treatment history.

(i) Lasik Surgery

The Plan does not cover lasik surgery.

(j) Routine Foot Care

The Plan does not cover routine foot care, unless Medically Necessary.

CHAPTER 7—PRESCRIPTION DRUG BENEFITS

7.01 SCHEDULE OF PRESCRIPTION DRUG BENEFITS

(a) Schedule

Type of Drug	Your Cost If You Use a Retail Pharmacy Up To 30-Day Supply	Your Cost If You Use the Mail Order Service ² 30 to 90-Day Supply
Generic Drugs	\$8 Copayment	\$11 Copayment
Brand – Formulary	\$30 Copayment	\$50 Copayment
Brand – Non-Formulary	\$50 Copayment	\$90 Copayment
Specialty ¹	20% Coinsurance, capped at \$100	20% Coinsurance, capped at \$100

¹ Special rules apply to specialty medications eligible for copay assistance through IPC/EvergreenRX. These special rules may be found in the following pages of this Chapter.

² Mail Order Service is mandatory, when available, after two fills. Any drug deemed to be a maintenance drug (drugs taken for more than 30 days) should be ordered from the Mail Order Service. Mail Order Service order forms are available from the Fund Office.

(b) Limitations

- (1) *Out-of-Network Drug Purchases.* If a Participant purchases a drug at an Out-of-Network retail pharmacy or fails to purchase a drug with his or her prescription drug card, the Participant will be responsible for 40% of the actual charges incurred for the drug, AFTER satisfaction of the applicable Major Medical Benefit Deductible, and AFTER payment of the applicable Copayment amount listed in the Schedule of Prescription Drug Benefits. The Plan does not cover Out-of-Network drugs purchased through a Mail Order Service.
- (2) *Brand-Name or Specialty Drug When Generic Equivalent Is Available.* In order to save you and the Fund money, the Trustees encourage you to use generic prescriptions whenever possible. If a Participant purchases a brand-name or specialty drug when a generic equivalent is available, the Plan will only cover the cost of the drug up to the price of the generic equivalent, unless the Brand Name prescription is Medically Necessary as determined by your Physician and the Fund's Pharmaceutical Benefit Manager.

(c) Out-of-Pocket Maximums

The calendar year Out-of-Pocket Maximum for In-Network prescription drug benefits is \$3,850 per person and \$4,700 for a family. There is no Out-of-Pocket Maximum for Out-of-Network prescription drug benefits. Out-of-Network prescription drug purchases do not accrue towards the Out-of-Network Major Medical Benefit Out-of-Pocket Maximum.

7.02 PHARMACEUTICAL BENEFIT MANAGERS

(a) OptumRx

To help save you and the Fund money, the Trustees have designated OptumRx as the Fund's Pharmaceutical Benefit Manager (PBM) to oversee the Plan's prescription drug program and provide a prescription drug card to Participants. This is a consumer-driven benefit that allows you to obtain prescriptions for generic and brand-name drugs, subject to the Plan's prescription drug program payment rules and limitations. You will need to present your prescription drug card to your pharmacy

for any prescriptions that you and your Eligible Dependents purchase.

To obtain a list of In-Network pharmacies that have partnered with OptumRx, you can either visit the OptumRx website at www.myoptumrx.com, call OptumRx directly at (855) 577-6319, or contact the Fund Office. The OptumRx website also allows you to set up a personal account, refill mail order prescriptions, view claims, research medications, and much more.

(b) BriovaRx

The Trustees have designated BriovaRx as the Fund's PBM for specialty drugs. Specialty drugs are typically used to treat chronic conditions and are often taken via injection. Examples of chronic conditions for which drugs are available through BriovaRx include: conditions requiring a transplant, Multiple Sclerosis, Hepatitis, Rheumatoid Arthritis, and Cancer. BriovaRx is designed to assist patients with the unique care requirements of specialty medications. A care coordinator works closely with the patient to ensure proper delivery, administration, and compliance to the medication. This personalized approach helps reduce medical complications. If you are taking a specialty medication, you will be required to use BriovaRx to fill your specialty medication. Please contact BriovaRx at 1-855-427-4682 prior to your next refill to place your prescription order.

(c) IPC/EvergreenRx – Copay Assistance Program for Specialty Medications

In keeping with their efforts to provide a robust yet cost-effective prescription drug program for you and your family, the Trustees have retained IPC/EvergreenRx to implement a comprehensive copay assistance program for specialty medications.

- (1) *Who is IPC/EvergreenRx?* IPC/EvergreenRx is a company that facilitates the provision of copay assistance from drug manufacturers to participants who purchase certain specialty medications. The copay assistance is used to reduce the out-of-pocket expenses that participants incur for eligible drugs. Consequently, using IPC/EvergreenRx may result in a savings for you and your family.
- (2) *How will IPC/EvergreenRx save me and the Fund money?* In general, the Coinsurance rate for specialty medications is 20%, capped at \$100. However, specialty medications for which copay assistance is available will be subject to a 30% Coinsurance rate, with no payment cap, and the copay assistance you receive from the specialty medication manufacturer is expected to reduce or completely cover your payment for the medication. In any event, your payment will not exceed the old per prescription cap of \$100. This means that the Fund will save money because it will be covering a smaller percentage of the cost of certain specialty medications. Likewise, because you will be receiving copay assistance that will cover all or a portion of your out-of-pocket costs, you may pay less as well.
- (3) *What can I expect from IPC/EvergreenRx?* If you currently take medications for which copay assistance is available, you will receive a welcome letter from IPC/EvergreenRx that provides specific information about the program as it pertains to your medication. After receipt of the initial letter, you will also receive a phone call from IPC/EvergreenRx to help you enroll in one or more copay assistance programs.

If you are not currently taking medications for which copay assistance is available, but are then prescribed one or more of these medications by your physician, you will be contacted by IPC/EvergreenRx. IPC/EvergreenRx has PBM partnerships which permit prior authorization requests for medications for which copay assistance is available to be immediately forwarded to IPC/EvergreenRx. This arrangement allows IPC/EvergreenRx to know very quickly when you are

in a position to receive copay assistance. As a result, IPC/EvergreenRx can move swiftly to enroll you in the drug manufacturer's copay assistance program.

- (4) *What are my reporting obligations as Participant?* **You must report to the Fund if and when you receive copay assistance through IPC/ EvergreenRx.** This will allow the Fund to better monitor the actual out-of-pocket expenses you have incurred when determining whether you have reached the applicable Out-of-Pocket Maximum. Any copay assistance you receive will not qualify for, and cannot be applied to your total Out-of-Pocket Maximum for the year. In addition, if the Fund is not informed of any copay assistance you may have received, the Fund has the right to recover amounts improperly credited to your Out-of-Pocket Maximum, or amounts improperly paid by the Fund under the mistaken belief you have reached your out-of-pocket limit.

(d) Special Programs

- (1) *Review Programs.* To help control prescription drug costs for you and the Fund, the Trustees may authorize the Fund to participate in certain clinical and utilization review programs, including programs similar to the foregoing. Among other things, these programs may require you to obtain certain medications from designated pharmacies or the mail order service. In addition, these programs may impose prior approval requirements or quantity limits on certain medications.
- (2) *Fraud, Waste and Abuse.* The Trustees may authorize the Fund's PBMs to monitor physician and patient prescription drug utilization patterns to help the Fund reduce health risks and unnecessary spending associated with fraud, waste and abuse. Such monitoring enables to the Fund to identify potential problem prescribers and unusual or excessive utilization patterns. When a PBM identifies an unusual or excessive pattern of prescription drug use, the Trustees may authorize the PBM to restrict the filling of that prescription drug to one designated pharmacy or restrict a patient to a single physician for the prescribing of prescription drugs.
- (3) *Dose Optimization.* Many prescription drugs are available at various strengths and their total cost may vary depending on the dosage strength. At times, for example, it may be more cost-effective to receive a daily dose of a 100mg tablet versus a daily dose of two 50mg tablets. Evaluating the cost-effectiveness of a particular drug dosage is referred to as dose optimization. The Trustees may authorize the Fund's PBMs to engage in dose optimization in an effort control prescription drug costs for you and the Fund.

7.03 SMOKING CESSATION BENEFIT

The Plan covers smoking cessation products purchased through OptumRx. Smoking cessation products must be purchased with your prescription drug card in order to be eligible for coverage. This benefit is not available to Eligible Dependent children.

7.04 PRESCRIPTION DRUG BENEFIT EXCLUSIONS

The following items are excluded from coverage under this Chapter:

- (a) Anabolic steroids used for body building.
- (b) Anorexics (diet aids).
- (c) Anti-smoking aids, e.g., gums and patches, except as otherwise allowed under the Plan.
- (d) Drugs determined to be "less-than-effective" by the drug efficiency study implementation (DESI) program.

- (e) Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- (f) Fertility agents except as specifically provided by the Plan.
- (g) Fluoride agents.
- (h) Legend contraceptives, except where prescribed for treatment of medical conditions, or required under the Affordable Care Act.
- (i) Medications covered under Workers' Compensation.
- (j) Medications used to treat or cure baldness.
- (k) Over-the-counter medications and products.
- (l) Products used for unapproved cosmetic indications.
- (m) Vitamins.
- (n) Drugs for the treatment of impotence, except as specifically provided by the Plan.
- (o) Copayments for prescription drugs.

Please keep in mind that this is a partial list and the Fund may add or delete items from this list on a case-by-case basis. Please contact the Fund Office if you have any questions concerning a particular prescription drug.

CHAPTER 8—DENTAL BENEFITS

8.01 IN GENERAL

The Plan covers comprehensive dental care as described in this chapter. If you, or an Eligible Dependent, incur covered dental expenses, the Plan will pay 80% of Usual and Customary Charges made by a legally qualified dentist, after satisfaction of the applicable Deductible amount.

Upon written request to the Fund Office a Participant and/or Eligible Dependent may opt out of (and, if applicable, opt back into) dental care from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after your written request is received by the Fund Office.

8.02 DENTAL CARE PROVIDER NETWORK

The Fund has retained Blue Care Dental to make available an expansive group of dental care providers to Participants. You may find a provider that participates with Blue Care Dental by visiting <https://www.bcbsil.com/member/advantages-of-membership/blue-care-dental-connection>. You may also call Blue Care Dental customer service toll-free at (800) 367-6401.

8.03 SCHEDULE OF DENTAL BENEFITS

<ul style="list-style-type: none">• Calendar Year Deductibles<ul style="list-style-type: none">• Dental Services• Orthodontia and Periodontal Services	<p>\$75 per person \$225 per family</p> <p>\$75 per person \$225 per family</p>
<ul style="list-style-type: none">• Coinsurance Percentages<ul style="list-style-type: none">• Dental Services• Orthodontia and Periodontal Services	<p>20% Coinsurance, after Deductible</p> <p>20% Coinsurance, after Deductible</p>
<ul style="list-style-type: none">• Calendar Year Maximum<ul style="list-style-type: none">• Dental Services• Orthodontia and Periodontal Services	<p>\$1,500 per person</p> <p>\$1,500 per person</p>

Any covered regular dental expenses or orthodontia and periodontal expenses incurred and applied to the applicable Deductible amount in the last three months (October, November, December) of a year will be applied to the applicable Deductible amount for both the present and following calendar years.

8.04 DENTAL CARE COVERAGE

This Chapter covers the following services:

- (a) Initial oral examination and routine periodic examinations, twice per calendar year.
- (b) Diagnostic x-rays – Complete mouth x-rays provided once every three calendar years. Bitewing x-rays provided twice per calendar year.
- (c) Topical fluoride application, limited to Participants ages 19 and younger.
- (d) Dental prophylaxis including cleaning, and polishing of teeth, twice per calendar year.
- (e) Periodontal scaling, limited to once per year per quadrant.

- (f) Palliative emergency treatment of conditions causing dental pain.
- (g) Fillings, consisting of silver amalgam and synthetic tooth color restorations ONLY.
- (h) Extractions, plus local anesthesia – includes fully impacted or surgical extraction of partially impacted teeth.
- (i) Endodontics, including pulpotomy, pulp capping and root canal treatment.
- (j) Repair of existing broken removable dentures, but only if the breakage occurred after your effective date of coverage.
- (k) Inlays (not part of a bridge) and gold fillings to restore diseased or accidentally broken teeth.
- (l) Crowns, onlays and veneers, limited to one per tooth every five years.
- (m) Space maintainers that replace prematurely lost teeth.
- (n) Oral Surgery consisting of the treatment of fractures and dislocations; the diagnosis and treatment of cysts and abscesses, surgical extractions and impaction including local or general anesthesia.
- (o) Apicoectomy (treatment of the apex of tooth and surrounding tissue).
- (p) Dental prosthesis (dentures), once every five years.
- (q) Sealants, limited to Participants ages 19 and younger.
- (r) Periodontal maintenance sessions, limited to two per participant, per year. A review of your periodontal history will be required before a periodontal maintenance session may be considered for approval.
- (s) Localized delivery of the antibiotic known as Arestin to teeth that do not respond to periodontal therapy, subject to the following conditions: (1) a review of your periodontal history and evidence of 5mm depths will be required before localized delivery of Arestin may be considered for approval; (2) the application of Arestin will not be covered if applied on the same day as periodontal therapy; (3) the benefit available for localized delivery of Arestin will be limited to \$175 per quadrant; and (4) the application of Arestin will be limited to once per year, per tooth.

8.05 DENTAL CARE EXCLUSIONS

This Chapter does not cover the following services:

- (a) More than two oral examinations, cleanings, or bitewing x-rays during any calendar year, or more than one complete mouth x-ray during any three calendar years.
- (b) Dental services received from a dental or medical department maintained by or in behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.
- (c) Dental services for which the Participant incurs no charge.
- (d) Dental services for which coverage is available to the Participant, in whole or in part, under any Workers' Compensation law or similar legislation, whether or not the covered person claims compensation or receives benefits thereunder.
- (e) Dental services primarily for cosmetic or aesthetic purposes unless performed within two years after an Accident to repair or alleviate damage from that Accident.
- (f) Replacement of a lost or stolen appliance.
- (g) Dietary planning, oral hygiene instruction, or training in preventive dental care.

- (h) Temporary full prosthesis.
- (i) Adjustment or refining of a prosthesis (crown or any fixed or removable denture) within six months after the prosthesis is initially installed.
- (j) Replacement of a prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under the Plan if the replacement occurs within five years from the date the expense was incurred, unless: (1) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth; (2) the prosthesis is a stayplate or similar temporary partial prosthesis and is being replaced by a permanent prosthesis; (3) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while you were covered for Dental Benefits; or (4) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while you were covered for Dental Benefits. Any supplies furnished in connection with such procedure, except that x-rays and prophylaxis treatment will NOT be considered as the beginning of a dental procedure.

8.06 PRECERTIFICATION FOR MEDICAL NECESSITY

Certain dental care procedures require precertification for Medical Necessity. In addition, the Fund recommends you request optional precertification (regardless of whether precertification is required) on all dental claims which can be expected to involve dental services of \$100 or more.

8.07 EMPLOYEES RETIRING BEFORE JANUARY 1, 1998

Medicare-eligible Employees who retire before January 1, 1998 and their Spouses are eligible for dental coverage under this Chapter, with no required premium payment or Deductible, up to a lifetime maximum of \$800 per person. Alternatively, such Medicare-eligible Retired Employees and their Spouses may make premium payments to continue to the benefits available under this Chapter prior to becoming Medicare-eligible. Premium payment amounts for Retiree dental care as described in this Section are set by the Trustees and are subject to change. The dental coverage for Medicare-eligible Employees who retire on or after January 1, 1998 is included with their overall Retiree premium.

CHAPTER 9—VISION BENEFITS

9.01 IN GENERAL

The Plan covers vision exams, frames, lenses, and contacts (instead of lenses). The Plan will pay benefits for covered vision expenses as provided for in the Schedule of Vision Benefits

Upon written request to the Fund Office, a Participant and/or Eligible Dependent may opt out of (and, if applicable, opt back into) vision care from this Plan. Because contribution rates to the Fund are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant who has opted out will not be reduced. Any such opt out (or, if applicable, opt in) will be effective the first day of the second calendar month after your written request is received by the Fund Office.

9.02 IN-NETWORK COVERAGE

The Fund has retained EyeMed to make available an expansive group of vision care providers to Participants. You may find a provider that participates in the EyeMed network by visiting the EyeMed website at www.eyemedvisioncare.com and entering your Network (“Select”) and Zip Code in the Locate a Provider area. You may also call EyeMed customer service toll-free at (866) 723-0513. When calling EyeMed, please refer to Plan name “Local 281 Welfare” and Plan id 9724543.

9.03 OUT-OF-NETWORK COVERAGE

If you choose to use a provider that is not in the EyeMed Network, you must pay up front the entire cost for your services and materials. However, you may be reimbursed up to the maximum amount stated in the Schedule of Vision Benefits. To be reimbursed, you must complete an Out-of-Network Vision Services Claim Form (available at the Fund Office) and mail it (with your itemized paid receipts) to:

EyeMed Vision Care | Attn: OON Claims
P.O. Box 8504 | Mason, OH 45040-7111

In addition, if you choose an Out-of-Network provider, there is no discount on additional services or materials.

9.04 SCHEDULE OF VISION BENEFITS

TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK
<ul style="list-style-type: none"> Complete Eye Exam (One/Calendar Year) 	Plan pays 100%	Plan pays up to \$35
<ul style="list-style-type: none"> Frames (Once/Calendar Year) 	Plan pays up to \$150. Participant pays balance over maximum allotment less 20%	Plan pays up to \$75
<ul style="list-style-type: none"> Lenses (Once/Calendar Year, Any One Type) <ul style="list-style-type: none"> Single Bifocal Trifocal 	Plan pays 100% Plan pays 100% Plan pays 100%	Plan pays up to \$25 Plan pays up to \$40 Plan pays up to \$55
<ul style="list-style-type: none"> UV Coating, Tint (Solid and Gradient), Standard Scratch-Resistance 	\$15 Copayment	Not Available
<ul style="list-style-type: none"> Standard Polycarbonate 	\$40 Copayment	Not Available

<ul style="list-style-type: none"> • Standard Anti-Reflective Coating 	\$45 Copayment	Not Available
<ul style="list-style-type: none"> • Standard Progressive (Add-on to Bifocal) 	\$45 Copayment	Not Available
<ul style="list-style-type: none"> • Other Add-Ons and Services 	20% off Retail Price	Not Available
<ul style="list-style-type: none"> • Contact Lenses (Once/Calendar Year, instead of Lenses). <ul style="list-style-type: none"> • Conventional • Disposable • Medically Necessary 	<p>For Conventional, the Plan pays up to \$150, and the Participant pays the balance over maximum allotment less 15%.</p> <p>For Disposable, the Plan pays up to \$150, and the Participants pays the balance over maximum allotment.</p> <p>For Medically Necessary, Plan pays 100%.</p>	<p>For Conventional and Disposable, Plan pays up to \$120.</p> <p>For Medically Necessary, Plan pays up to \$200.</p>

9.05 VISION BENEFIT EXCLUSIONS

This Chapter does not cover the following:

- (a) Services received more frequently than the allowed by this Chapter.
- (b) Expenses in excess of the Vision Care Schedule of Benefits.
- (c) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- (d) Charges for services or supplies which are covered in whole or in part under any portion of the Major Medical Benefits Chapter of the Plan, including aniseikonic lenses.
- (e) Services provided as a result of any Workers' Compensation or occupational disease law.
- (f) Benefits for certain frame brands on which the manufacturer imposes a no discount policy.
- (g) Eye exams or corrective eyewear required by an employer as a condition of employment or for which the employer is required to provide by virtue of a labor agreement or those required by law.
- (h) Safety eyewear.
- (i) Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- (j) Services or materials provided by any other group benefit plan providing for vision care.
- (k) Two pair of glasses in lieu of bifocals.
- (l) Services or supplies not listed as Covered Expenses in this Chapter.
- (m) Non-prescription glasses.
- (n) Lasik surgery.

CHAPTER 10—DEATH | AD&D BENEFITS

10.01 IN GENERAL

In order to ensure that you and/or your loved ones are financially secure in the unfortunate event of your death, accidental death, or if you incur a dismemberment, the Trustees have secured a fully-insured life and accidental death & dismemberment (AD&D) policy for your benefit.

Subject to the terms, conditions, and limitations of the policy, the Designated Beneficiary of an Active Employee, or Retired Employee will be eligible for payment in the event of the death of the Active Employee or Retired Employee. Payment is made directly to the Active Employee or Retired Employee in the event of other specified losses incurred by such individuals.

10.02 SCHEDULE OF DEATH | AD&D BENEFITS

(a) Schedule of Benefits

- (1) *Death Benefit.* The Plan's death benefit for Active Employees and Retired Employees who have not reached age 70 is \$12,500. The Plan's death benefit for Active Employees and Retired Employees who have reached age 70 is \$2,500.
- (2) *AD&D Benefit.* The Plan's AD&D benefit for Active Employees and Retired Employees who have not reached age 70 is \$25,000. The Plan's AD&D benefit for Active Employees and Retired Employees who have reached age 70 is \$5,000.

(b) AD&D Benefit Limitations

- (1) *Amount Payable.* The amount payable as shown in the Schedule of Benefits is paid for the loss of life, both hands, both feet, one hand and one foot, entire sight of both eyes, one hand and entire sight of one eye, one foot and entire sight of one eye, one hand, one foot, or entire sight of one eye.
- (2) *Covered Losses.* Loss of hand or foot means loss by severance at, or above the wrist or ankle joint. Loss of sight means irrevocable and complete loss of sight in the eye. In order to be covered, the loss must occur within 90 days after the date of the Accident.
- (3) *Multiple Losses Attributable to One Accident.* If an Active Employee incurs more than one loss due to one Accident, payment will be made only for the loss with the largest benefit. Additionally, payment will be made only for the loss that results from the Accident without regard to any former loss.
- (4) *Eligibility for Benefits.* Death and AD&D benefits are payable on behalf of any Active Employee or Retired Employee who is covered under the Plan at the time of his or her death or loss. Death and AD&D benefits are not payable on behalf of persons ineligible for Plan benefits, Eligible Dependents, or Participants covered under COBRA.

10.03 DESIGNATED BENEFICIARY

(a) In General

Designated Beneficiary means the person(s) properly named to receive benefits under the Plan. Minor children may not be named as Designated Beneficiaries.

(b) Procedure for Naming a Designated Beneficiary

A Designated Beneficiary must be named in writing provided to the Fund Office, and may be changed

from time to time. No designation or change shall be binding unless the Fund Office receives the written instrument making such designation or change prior to the death of the Active Employee, or Retired Employee, as applicable. Consent of the Designated Beneficiary is not required to change the designation.

(c) Failure to Name a Designated Beneficiary

If an Active Employee or Retired Employee does not have a Designated Beneficiary in accordance with the Plan, this benefit will be paid first, to the beneficiary designated with the Sprinkler Industry Supplemental Pension Fund (SIS) and then to the beneficiary designated with the National Automatic Sprinkler Industry Pension Fund (NASI). If the Employee or former Employee has not designated beneficiaries with either related fund, this benefit will be paid to the person responsible for funeral expenses. If the above procedures do not identify a designated beneficiary, the benefit will be paid to any one or more of the following surviving individuals, in descending order:

- (1) In equal shares to the surviving Spouse, if any, of the Active Employee or Retired Employee; but if none, then;
- (2) In equal shares to the surviving parent(s), if any, of the Active Employee or Retired Employee; but if none, then;
- (3) In equal shares to the surviving sibling(s), if any, of the Active Employee or Retired Employee; but if none, then;
- (4) All to the executor or administrator of the estate of the Active Employee or Retired Employee.

10.04 CONFLICT

In the event of a conflict between this Chapter and the policy, the policy will govern.

CHAPTER 11—ACCIDENT & SICKNESS BENEFITS

11.01 IN GENERAL

Accident and Sickness Benefits are intended to provide weekly payments to **Active Employees** who are Disabled and cannot work as a result of a Sickness or Accident that is **NOT** work-related.

11.02 SCHEDULE OF ACCIDENT & SICKNESS BENEFITS

As an Active Employee you are entitled to **\$400 per week**. The daily rate is one-fifth of the weekly rate or \$80. In accordance with federal law, Social Security taxes (FICA) will be deducted from the Accident and Sickness Benefit payments.

11.03 DURATION OF PAYMENTS

(a) Benefit Beginning Date

If you are unable to perform your regular job due to an Accident, your benefit payments will begin with the first day of Disability, if you are under the continuous care and treatment of a Physician. If you are unable to return to your regular job due to a Sickness, your benefit payments will begin with the eighth day of Disability, if you are under the continuous care and treatment of a Physician.

(b) Benefits End Date

When you are physically able to return to your regular job, as certified by a Physician, or you are not being treated by a Physician, or when you have received the benefit payments for 16 weeks, whichever occurs first, benefit payments will end.

(c) New Benefit Period

If you return to work and are Disabled again from the same Sickness, Accident or pregnancy and have worked at least two full weeks, the Plan provides for a new maximum benefit period of 16 weeks, but you must again satisfy any waiting period required for benefit payments to start.

Alternatively, if you are Disabled again by a completely different Sickness, Accident, or pregnancy, and have worked at least one full day, the Plan provides for a new maximum benefit period of 16 weeks, but you must again satisfy any waiting period required for benefit payments to start.

Otherwise, if you return to work and do not meet the requirements listed above, your Disability will be considered as a continuation of your previous Disability.

However, if you return to full-time employment after a period of Disability during which you have received a weekly benefit for two years or longer, a subsequent Disability will be considered a new period of Disability only if it begins after at least six months of continuous full-time active employment.

11.04 EXCLUSIONS

The following exclusions apply to Accident and Sickness Benefits Payments provided by this Chapter: (a) Accidents and Sicknesses which entitle you to benefit payments under any Workers' Compensation or occupational disease law are NOT covered; (b) Accidents and Sicknesses arising from or sustained in the course of any occupation or employment for compensation, profit or gain are NOT covered; and (c) Accidents and Sicknesses while you are NOT under the continuous care and treatment of a Physician are NOT covered.

CHAPTER 12—ADDITIONAL BENEFITS

12.01 CHIROPRACTIC BENEFIT

(a) In General

The Chiropractic Benefit covers charges by a licensed chiropractor for detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation for the purposes of removing nerve interference and the effect thereof in the vertebral column.

(b) Benefit Amount

The Chiropractic Benefit will be payable at 85% of the actual charges (In-Network) or 60% of Usual and Customary Charges (Out-of-Network) after satisfaction of the applicable Major Medical Deductible, subject to a \$35 maximum allowance per visit. It shall be limited to a maximum of 24 visits per person per calendar year. One office visit and one set of X-rays provided by a chiropractor will be allowed per person per calendar year under the Major Medical Benefit and not subject to the maximum allowance per visit.

(c) Exclusions

Unless otherwise provided in this Section, the Chiropractic Benefit does not cover x-ray charges, vitamin and nutrient supplements, blood work, acupuncture, or orthotics. In addition, the Chiropractic Benefit does not cover devices, appliances, and supplies designed to or intended to correct posture, maintain posture or ease pain such as, but not limited to: (1) bed board; (2) cervical collar; (3) foundation garments; (4) orthopedic mattress; (5) sacro ease car seat; (6) heating lamps and pads; (7) cervical bed pillows; (8) back braces; or (9) charges in excess of \$35 per visit.

12.02 HEARING AID BENEFIT

(a) In General

The Hearing Aid Benefit covers expenses for the purchase of a Medically Necessary hearing aid device for Active Employees, Retired Employees, and Eligible Dependents.

(b) Benefit Amount

The In-Network benefit payable under this Section is 85% of actual charges incurred. The Out-of-Network benefit payable under this Section is 60% of Usual and Customary Charges incurred.

(c) Exclusions

The Hearing Aid Benefit does not cover supplies (e.g., batteries or energy cells) necessary to operate the hearing aid device, or expenses in excess of the maximum benefit per **five consecutive calendar year** periods.

12.03 MEMBER ASSISTANCE PROGRAM (MAP)

(a) In General

The Plan provides a Member Assistance Program (MAP) and managed mental health care services to you and your Eligible Dependents through Employee Resource Systems, Inc. These confidential services were developed to help you and your Eligible Dependents cope with personal difficulties that can affect your lives both at home and at work.

The MAP assists people with a variety of life problems including alcohol and drug abuse; stress, anxiety and depression; marital, family and relationship discord; child and adolescent behavioral problems; domestic violence; child care; elder care; financial and legal concerns; and education and career-related problems at no cost to you.

All contact with the MAP is confidential. The MAP counselor will not speak with a supervisor, co-worker or family member without permission from you (or your Eligible Dependent using the MAP). Confidentiality is compromised only when a threat exists (e.g., risk of suicide or homicide, stalking or child abuse). Contacting the MAP can be a first step toward resolution of personal difficulties.

(b) Coverage

Persons eligible to use the MAP have access to up to **six FREE counseling** sessions per problem, situation or issue. Service may include a comprehensive evaluation, brief counseling and a referral, if necessary. Some services not covered under the Plan may be provided by the MAP, at no cost to you.

When you or your Eligible Dependent contacts the MAP, the immediate task of the MAP is to rule out any threat to the life and safety of the caller or any risk caused by the caller. Once safety has been established, the MAP offers an in-person session or provides services over the phone. A thorough assessment of your current situation is conducted. A variety of issues presented to the MAP can be assessed within the scope of up to six in-person counseling sessions. Short-term counseling through the MAP is appropriate for individuals who are experiencing a variety of stressors including a difficult transition, stress, depression, relationship and family conflicts.

(c) Exclusions

The MAP does not address difficulties related to salaries, job assignments or other work-related issues. Should you or your dependent require care beyond the MAP, you will be directed to the best and most appropriate In-Network provider available.

(d) Contact Information

MAP services are available Monday through Friday from 8:30 a.m. to 5:30 p.m. CST by calling (800) 292-2780. Calls are always answered directly by clinical professionals who provide immediate service, even after standard business hours. The 800 number can be used anywhere in the United States.

(e) If the MAP is Inappropriate or Insufficient

If, during the assessment, it becomes apparent that brief counseling is either inappropriate or insufficient to address your concern, the MAP counselor will guide you to the appropriate In-Network provider and the correct level of care. In these situations, the MAP will act as an educator, explaining the benefits that are available and reminding the individual about the importance of selecting In-Network versus Out-of-Network providers.

12.04 HEALTH FAIRS

The Fund may from time to time sponsor a "Health Fair" or a program through which it offers inoculations, blood pressure checks or other routine screenings and/or tests, services and/or health education to Participants. The tests, screenings, services and/or education that may be offered at such a program and the coverage of such screenings, tests and services may vary from time to time as the financial condition of the Fund permits and as the Trustees determine will be most advantageous to the Participants. The tests, screenings, services and education offered will also vary depending on developments such as new screening tests or new vaccines. The tests, screenings, services and education offered at each

such event, the coverage provided by the Fund will be determined by the Trustees, and notice of such coverage will be provided to Participants in connection with the event.

12.05 SLEEP STUDY BENEFIT

(a) In General

The Sleep Study Benefit covers expenses for Medically Necessary sleep studies for Active Employees, Retired Employees, and Eligible Dependents.

(b) Benefit Amount

Covered Expenses will be paid at 85% for other In-Network services, after the satisfaction of the Major Medical In-Network Deductible. Covered Expenses will be paid at 60% for Out-of-Network services, after the satisfaction of the Major Medical Out-of-Network Deductible.

12.06 PREVENTIVE SERVICES

(a) In General

The Plan covers preventive services and supplies in the form of periodic physical exams, routine screening tests, immunizations, and other benefits to the extent required by applicable law. **Preventive services are not subject to the Plan's Deductibles and are paid in full by the Fund when rendered In-Network.** Preventive services provided on an Out-of-Network basis are subject to a 40% Coinsurance rate after satisfaction of the applicable Major Medical Benefit Deductible.

The Plan will adhere to certain federal guidelines in determining the preventive services or treatments it will cover. To the extent not already set forth in the guidelines, the Plan may impose reasonable, recognized rules or other limits with respect to the number of visits or treatments it will cover in any given period of time for any one particular preventive service. To the extent any such limits or other rules are inconsistent with applicable law or the guidelines, applicable law or the guidelines will control.

The types of preventive services the Plan will cover are described as follows:

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

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

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

The types of preventive services required by law may be updated from time to time and will be deemed to have been incorporated in the Plan by reference. Any change or update to the types of preventive services required by law that occur after September 23, 2009 will take effect with respect to the benefits provided under the Plan on the first day of the Plan Year beginning on or after one year following the date the change or update occurs. For example, additions or modifications to the list that occurred during 2017 will take effect on January 1, 2019.

Important Note: To the extent the comprehensive list referenced above is inconsistent with applicable law or the preventive service guidelines, such applicable law or guidelines will control.

(b) Preventive Service Billing Practices

The following rules will apply with respect to charging for Physician office visits that include covered preventive services:

- (1) If a preventive service is billed separately (or is tracked separately) from an office visit, then this Plan will impose the applicable cost-sharing provisions with respect to the office visit but not for the preventive service;
- (2) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then the Plan will not impose the applicable cost-sharing provisions with respect to the office visit; and
- (3) If a preventive service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive service, then the Plan will impose the applicable cost-sharing provisions with respect to the office visit.

The following example demonstrates the application of the Plan's preventive service billing practice rules:

Example. A Participant visits an In-Network provider to discuss recurring abdominal pain. During the visit, the Participant receives a blood pressure screening. Blood pressure screening has in effect a rating of A or B in the current recommendations of the United States Prevent Service Task Force with respect to the Participant and is covered under the Plan as a preventive service. The provider bills the Fund for an office visit and does not bill the blood pressure screening separately.

Conclusion. In this example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver a preventive service. Therefore, because the provider did not bill the blood pressure screening separately from the charge for the office visit, the Participant must pay the charges pursuant to the Plan's cost-sharing provisions he or she would normally incur for the office visit.

(c) Additional Information Regarding Preventive Services

You should also take note of the following restrictions and other conditions related to preventive services:

- (1) Preventive services must be billed correctly under the appropriate services codes.
- (2) Preventive services may be subject to reasonable medical cost management techniques and standards (e.g., treatment, setting, frequency, and medical management standards) as imposed and altered by the Trustees from time to time.

- (3) Preventive services may not be covered depending on the service at issue and the presence of various risk factors.
- (4) Preventive services incurred for non-medical reasons (e.g., to maintain a license or employment, as part of judicial or administrative proceedings, a prerequisite for traveling or education purposes) are not covered under the Plan.
- (5) A service that is provided to monitor or treat an existing condition and not as a Preventive Service will be covered to the extent otherwise covered by the Plan and will be subject to the Plan's applicable cost-sharing provisions.

CHAPTER 13—COORDINATION OF BENEFITS

13.01 COORDINATION OF BENEFITS IN GENERAL

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

Benefits payable for Covered Expenses incurred by a Participant who also is covered under or entitled to benefits from another group health plan must be coordinated so that the total amount payable does not exceed 100% of the expenses actually incurred.

13.02 HOW BENEFITS ARE COORDINATED

(a) Coordination with Other Group Health Plans

If a Participant has duplicate health care coverage, benefits are coordinated by looking first to what is called the “primary plan”. If any charges remain to be paid, then the “secondary plan” pays in accordance with its own provisions.

If another group health plan covering the Participant does not contain a Coordination of Benefits provision, it is the primary plan. If another group health plan covering the Participant contains a Coordination of Benefits provision, primary responsibility is decided by the following rules:

- (1) The plan covering the Participant as a full-time employee will pay benefits before the plan covering the Participant as a part-time employee.
- (2) The plan covering the Participant as an employee will pay benefits before the plan covering the Participant as a dependent or retiree.
- (3) If a child who is covered as a dependent under different plans, and the parents are not separated or divorced, the plan of the parent whose birthday (excluding year of birth) falls earlier in the calendar year is primary, and the plan of the parent whose birthday (excluding year of birth) falls later in the calendar year is secondary. If both parents have the same birthday, the plan that covered the parent longer is primary. The birthday rule described in this paragraph only applies if both plans contain the same rule. If the other plan does not have a birthday rule and instead has a rule based upon gender of the parent, the plan covering the male head of household pays first.
- (4) If a covered child’s parents are separated or divorced, and there is a court decree or other order which designates financial responsibility for the health care expenses of the child, the plan of the person designated as financially responsible for the health care expenses of the child is primary.
- (5) If a covered child’s parents are separated or divorced, and there is no court decree or other order which designates financial responsibility for the health care expenses of the child, benefits for the child are paid: (A) first, by the plan covering the child as a dependent of the parent with custody; (B) second, by the plan of the new spouse of the parent with custody of the child; and (C) finally, by the plan of the parent not having custody of the child.
- (6) For a married dependent who is covered under several plans as an employee, spouse, or dependent, benefits for the dependent are paid: (A) first, by the plan covering the married dependent as an employee; (B) second, by the plan of the married dependent’s spouse; and

(C) third, by the plan of the married dependent's parents as determined by paragraphs (3), (4), (5), and (7), whichever applicable.

(7) If a determination cannot be made, the plan which covered the Participant longer will be primary.

(b) Effect on Benefits

When this Plan is secondary, the benefits payable under the Plan will be reduced. The Fund will pay no more than the difference, if any, between the benefits provided under the primary plan and the total Allowable Expenses incurred by the Participant.

"Allowable Expenses" are any necessary, Usual and Customary Charges for medical, dental, and vision benefits and services covered in full or in part under this Plan and any other plan which covers the person making the claims. For Weekly Accident and Sickness Benefits, Allowable Expenses are two-thirds of your average weekly earnings during the 12-month period before your Disability. Expenses not covered by any plan which covers the person are not Allowable Expenses, such as personal comfort items.

Benefits payable under another plan include benefits that would have been payable had a claim been duly made. In no event will the Fund's payment exceed the amount that would have been payable under the Plan if it were primary. If benefits are reduced under the primary plan because a Participant does not comply with a relevant plan provision, or fails to maximize benefits under the plan, the amount of such reduction will not be covered under this Plan.

(c) Coordination of Benefits for Dual Coverage

If an Employee and the Employee's Spouse are both covered as Participants under this Plan, medical benefits shall be paid so that 100% of all Covered Expenses are paid with no Deductible, Copayments or Coinsurance applied. However, Dental Benefits shall be coordinated pursuant to this Chapter with Deductibles, Copayments and Coinsurance applied.

(d) Coordination with HMOs

If your Eligible Dependent is covered by an HMO, but the HMO does not cover an expense because your Eligible Dependent did not go to an HMO provider, this Plan will pay the claim as if the HMO coverage was provided. Since an HMO typically covers all of the costs of treatment, this will usually mean that this Plan will not pay benefits to your Eligible Dependent.

(e) Coordination with PPOs

If your Eligible Dependent is covered by a group plan that provides lower benefits if services are not provided by a PPO physician or hospital, this Plan will coordinate with the actual amount paid by the other plan.

13.03 RIGHT TO INFORMATION

For purposes of determining the applicability and implementation of this Chapter or a provision of similar purpose of another group health plan, the Board of Trustees, without the consent of or notice to any person, may release to, or may obtain from, any insurance company, organization, or person any information that the Board of Trustees deems necessary for such purposes (to the extent permitted under the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to HIPAA). An individual claiming benefits under the Plan shall furnish, upon request by the Fund, information, in writing, as may be requested to implement this provision.

The Fund, however, is not required to determine the existence of any other plan or the amount of benefits payable under any such plan, and the payment of benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent the Fund is furnished with information relative to such other plans.

13.04 RIGHT TO CORRECT ERRONEOUS PAYMENTS

Whenever a payment that should have been made under the Plan in accordance with this Chapter has been made under another group health plan, the Board of Trustees shall have the right, exercisable alone and at its sole discretion, to pay to the organization making such payment an amount it shall determine to be warranted in order to satisfy the intent of this Chapter. The amount so paid shall be deemed to be a benefit provided under the Plan, and, to the extent of such payment, the Fund shall be fully discharged from liability. The Plan also reserves the right to seek recovery for any excess paid by it over the maximum it should have paid under this Chapter, from any insurance company, other plan(s), or any person to or from whom payments were made.

CHAPTER 14—REIMBURSEMENT & SUBROGATION

14.01 RIGHT TO RECOVERY

(a) Fraudulent Claims

If a fraudulent claim is submitted, benefits will be denied. A Participant must reimburse the Fund for any fraudulent claim paid in error.

(b) Erroneous Payments

A Participant must reimburse the Fund for any claim that is paid in error because of a mistake of law or fact. Also, a Participant must reimburse the Fund for any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, irrespective of to whom paid.

(c) Payments Made Due to Failure to Update Enrollment Status, Etc.

A Participant must report to the Fund Office important events such as a divorce, legal separation, loss of custody, loss of Eligible Dependent status, and any other event that impacts the eligibility of the Participant or the Participant's dependent(s).

A Participant must reimburse the Fund for any claim paid in error because the Participant failed to (1) report to the Fund Office any of the previously described events; (2) update the Participant's enrollment status; or (3) update the status of the Participant's previously enrolled dependents. In addition, a Participant must reimburse the Fund for any claim paid in error by the Fund because the Participant failed to notify the Fund of any copay assistance received through IPC/EvergreenRx for specialty medications.

(d) Improper Payments Described in this Chapter Are Fund Assets

Any payment made by the Fund in error as described in this Chapter, including any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, is due and owing to the Fund and is an asset of the Fund. (In other words, such payment is a "plan asset" as that term is used in ERISA.) The recipient of any such Fund asset will be considered a fiduciary under Section 3(21) of ERISA with respect to such Fund asset to the extent he or she exercises control over such Fund asset. Exercising control over such Fund assets includes, but is not limited to, disposing of such Fund assets. Among other things, the Fund's fiduciaries must act prudently, for the exclusive benefit of the Fund's participants and beneficiaries, and in accordance with the Fund's governing documents (e.g., the Plan, including this Chapter). The recipient of any payment made by the Fund in error as described in this Chapter must promptly return such payment (plan asset) to the Fund.

(e) Recovery of Improper Payments Described in this Section

If the Fund pays a claim in error as described in this Chapter, or makes any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, the improperly paid amount (overpayment) may be deducted from any benefits due to the Participant and his or her Eligible Dependents until the Fund is reimbursed for the amount improperly paid.

The Fund may take any other action it deems appropriate to recover any improperly paid amount against one or more of the following parties: (1) the recipient of the payment; (2) the Participant with respect to whom the payment was made; (3) an insurance company; and (4) any other person, organization or entity. The Participant will be liable to the Fund for all of its expenses, including attorneys' fees, related to the cost of collecting any improperly paid amount.

14.02 REIMBURSEMENT OF CONDITIONAL BENEFIT PAYMENTS

(a) In General

- (1) *Conditional Benefit Payments.*
 - (A) In General. The Plan does not provide benefits to diagnose and treat illnesses or injuries for which a third party may be responsible or liable. However, if a Participant incurs an illness or injury for which a third party may be responsible or liable, the Fund may make one or more conditional benefit payments to or on behalf of the Participant to cover claims arising from such illness or injury. Such payments are conditioned upon the Participant's compliance with this Chapter, including all of the Participant's obligations set forth in this Section.
 - (B) Cases Involving Work-Related Claims. The Plan does not provide benefits to diagnose and treat illnesses or injuries that arise out of the course of employment. However, if a Participant incurs a work-related injury or sickness for which a claim has been filed with a Workers' Compensation insurance carrier or with a federal or state court or agency, and that claim has been initially denied, then the Fund, upon request, may make one or more conditional benefit payments to or on behalf of the Participant to cover claims arising from such illness or injury. Such payments are conditioned upon the Participant's compliance with this Chapter, including all of the Participant's obligations set forth in this Section. (Note: The term *third party* as used in this Chapter includes a Workers' Compensation insurance carrier, a federal or state court or agency, and any other person or entity.)
- (2) *Agreement to Reimburse the Fund.* By accepting conditional benefit payments from the Fund, the Participant agrees to actively pursue his or her claim against the third party and agrees to reimburse the Fund for claims paid up to the full amount of any recovery arising from the illness or injury. The Participant agrees that any amounts recovered by judgment, settlement, or otherwise will be applied first to reimburse the Fund, without reduction for attorneys' fees and other costs, even if the Participant is not made whole, regardless of whether the amounts recovered are designated to cover medical expenses, and regardless of how the amounts recovered are characterized. Finally, the Participant agrees that the Fund's right to reimbursement as described in this Chapter applies irrespective of the Participant's cause of action, demand, claim, right of recovery, judgment, order, award, settlement, or compromise against or with the third party, regardless of whether the Participant actually obtains the full amount of such judgment, order, award, settlement or compromise, and regardless of whether the third party is found responsible or liable (or admits responsibility or liability) for the illness or injury.
- (3) *Equitable Lien.* By accepting conditional benefit payments from the Fund, the Participant agrees that the Fund will have a first priority equitable lien on the amount of any recovery arising from the illness or injury. The Participant further agrees that, except as otherwise provided in paragraph (5) of this subsection: (A) the amount of any recovery arising from the illness or injury is due and owing to the Fund and is an asset of the Fund (in other words, the recovery is a "plan asset" as that term is used in ERISA); (B) the equitable lien on the amount of any recovery arising from the illness or injury is an asset of the Fund (in other words, the equitable lien is a "plan asset" as that term is used in ERISA); and (C) the Participant, or anyone acting on the Participant's behalf, will be considered a fiduciary under Section 3(21) of ERISA with respect to such Fund assets to the extent he or she exercises control over such Fund

assets. Exercising control over such Fund assets includes, but is not limited to, disposing of such Fund assets.

Among other things, the Fund's fiduciaries must act prudently, for the exclusive benefit of the Fund's participants and beneficiaries, and in accordance with the Fund's governing documents (e.g., the Plan, including this Chapter). As previously stated, this Chapter requires Participants who accept conditional benefit payments from the Fund to reimburse the Fund for claims paid up to the full amount of any recovery (plan asset) arising from the illness or injury.

- (4) *Right to Reimbursement Not Impacted by Equitable or Legal Doctrines.* The Fund's right to reimbursement as described in this Section will not be reduced, eliminated or otherwise affected by the make whole doctrine, comparative fault or regulatory diligence, the common fund doctrine, or any other equitable or legal doctrine, rule, or principle.
- (5) *Property of the Participant.* Amounts recovered by the Participant in excess of conditional benefit payments made by the Fund are the separate property of the Participant. In addition, amounts received from a source other than the Fund are the separate property of the Participant if the amounts are received from a policy of insurance for which the Participant or a member of the Participant's family has paid premiums.

(b) Acknowledgement Form Required

If a Participant incurs an illness or injury for which a third party may be responsible or liable, then, in order to receive one or more conditional benefit payments from the Fund to cover claims arising from such illness or injury, the Participant and the Participant's attorney (if any) must sign a Subrogation and Reimbursement Agreement | Acknowledgement of Plan Provisions Form (Acknowledgement Form) before any conditional benefit payments are made. If the Participant or the Participant's attorney (if any) refuse to sign the Acknowledgement Form, the Fund may withhold conditional benefit payments and may recoup by offset, lawsuit, or other appropriate means any amount already paid. The Fund's right to reimbursement as described in this Section is governed by the terms of the Plan whether or not the Participant or the Participant's attorney (if any) has signed the Acknowledgement Form.

(c) Notification | No Settlements or Disbursements Without the Fund's Consent | Cooperation

- (1) *Obligation to Notify the Fund Office.* A Participant is obligated to notify the Fund of any illness or injury for which a third party may be responsible or liable. By accepting conditional benefit payments from the Fund, the Participant agrees to notify the Fund Office promptly of efforts made to recover from a third party, including (but not limited to) filing a lawsuit to recover amounts in connection with the illness or injury. Furthermore, in the event the Participant, or someone acting on the Participant's behalf, receives payment from any source for claims related to the illness or injury, the Participant must notify the Fund Office immediately.
- (2) *No Settlements or Disbursements.* By accepting conditional benefit payments from the Fund, the Participant agrees that neither the Participant nor anyone acting on the Participant's behalf will settle any claim related to the illness or injury without the written consent of the Fund. The Participant further agrees that the amount of any recovery arising from the illness or injury will remain in the possession of the Participant, or someone acting on behalf of the Participant, and be placed and held in a specifically identifiable segregated account. Finally, the Participant agrees that neither the Participant nor anyone acting on the Participant's behalf will distribute the amount of any recovery arising from the illness or injury without a release from the Fund of the Fund's right to reimbursement as described in this Section.

- (3) *Cooperation.* By accepting conditional benefit payments from the Fund, the Participant agrees to cooperate fully with the Fund in connection with any claim brought by the Fund to assert its right to reimbursement. The Participant further agrees to refrain from doing anything to impair, prejudice, or discharge the Fund's right to reimbursement. The Participant further agrees to execute and deliver any and all documents required by the Fund and do whatever else is necessary to fully protect the Fund's right to reimbursement. Finally, the Participant must provide the Fund with any information the Fund requires so that the Fund may successfully assert its right to reimbursement.

(d) Remedies

If a Participant fails to comply with this Chapter (e.g., fails to reimburse the Fund in accordance with this Chapter or otherwise fails to meet the Participant's obligations under this Chapter), the Fund may take one or more of the following actions:

- (1) *Legal Action.* The Fund may bring suit to collect the full amount of the conditional benefit payments made to or on behalf of the Participant. The Fund may bring such a suit against the Participant, anyone acting on the Participant's behalf, insurers, any recipient(s) of Fund assets improperly distributed without the consent of the Fund, and any other person, organization, or entity. If it becomes necessary for the Fund to bring suit against the Participant for failure to comply with this Section: (A) the Participant will be liable to the Fund for all of its expenses, including attorneys' fees, related to cost of collecting unreimbursed amounts; (B) the Trustees, in their sole discretion, may require the Participant to pay interest at the rate determined by the Trustees from the date the conditional benefit payments were made through the date the Fund is reimbursed in full; and (C) the Participant waives any applicable statute of limitations defense available regarding the enforcement of the Participant's obligation to reimburse the Fund.
- (2) *Offset.* The Fund may recover the full amount of the conditional benefit payments made to or on behalf of the Participant by treating such benefits as an advance and deducting such amounts from benefits which become due to the Participant and/or to the Participant's immediate family members until the conditional benefit payments are recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage the Fund or anyone else may have given to such providers.
- (3) *Any Other Action.* In addition to the remedies set forth herein, the Fund may take any other action it deems appropriate to ensure that the Fund is fully reimbursed, recover plan assets, and protect the Fund.

(e) Example

Let's assume that a Participant was injured in an automobile accident, and the other driver may have been at fault. If the Fund made a conditional benefit payment on the Participant's behalf in the amount of \$5,000 due to the injuries resulting from the accident, and the Participant recovered any money from the other driver or the other driver's insurance company (by lawsuit, settlement, or otherwise), the Fund would be entitled to receive up to \$5,000 of that money as reimbursement for the claims paid on the Participant's behalf.

14.03 SUBROGATION

If a Participant incurs an illness or injury for which a third party may be responsible or liable, and the Fund makes one or more conditional benefit payments to or on behalf of the Participant, the Fund is not required

to participate in any claims the Participant may have against the third party. However, the Fund may require the Participant to assign his or her claims and any other right of recovery to the Fund so that the Fund may enforce its right to reimbursement. Moreover, by accepting conditional benefit payments from the Fund, the Participant authorizes the Fund to elect to pursue any claims arising from the illness or injury in the name of the Participant and/or the Fund's name, and to sue, compromise, or settle such claims without the approval of the Participant to the extent of benefits paid and/or to be paid.

If the Fund invokes its subrogation rights as described in this Section, the Participant must cooperate fully with the Fund in connection with any claim brought by the Fund to recover its assigned or subrogated interest. If the Participant does not cooperate, or if the Participant or anyone acting in his or her interest takes any action which harms the Fund's subrogated interest, the Plan is entitled to cease payment of conditional benefit payments connected to the third-party caused illness or injury and to collect any conditional benefit payments already-made pursuant to this Chapter.

CHAPTER 15—CLAIMS & APPEALS PROCEDURES

15.01 IN GENERAL

The provisions of this Chapter shall apply to: (a) any claim for (or right to) a benefit under the Plan; and (b) any claim against the Plan or Fund, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

A “claim” is a request from a claimant or a claimant’s authorized representative for payment of benefits from the Fund made in accordance with the Fund’s procedures. A claim is considered filed as soon as a written claim form is received at the correct address by mail or personal delivery. Claims can also be filed electronically directly from the provider of service. Telephone calls and e-mails are not acceptable. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by a bill from the provider and such other proof as may be required by the Fund.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. A request for a determination of whether an individual is eligible for benefits under the Plan is not considered a claim; however, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a claim. Also, a request for an optional pre-service evaluation whether a particular benefit will be paid is not a claim.

You have the right to appoint an authorized representative to act on your behalf for the purpose of filing a claim and seeking a review of a denied claim. If the Fund Office is uncertain whether or not you have appointed a representative, it may request that you put such designation in writing and may decline to communicate with a third party claiming to be your representative until such written designation is received.

In determining eligibility for any benefit, the Plan has the right to have the person for whom the benefits are claimed examined by a professionally qualified practitioner designated and paid for by the Fund. Such examination may be repeated as often as may be reasonably required while the claim is pending. The Fund also has the right to conduct an autopsy, if not forbidden by law or court order, to be performed in case of death.

You and your Eligible Dependents, if any, must have a completed enrollment card on file at the Fund Office. Neither you nor your Eligible Dependent will be eligible for any benefits until the completed enrollment form is on file.

Decisions regarding whether to grant or deny all or part of a claim will be made by the Fund. For purposes of this Chapter, the term Fund includes a designated agent or applicable service provider of the Fund. Both in determining initial claims and in deciding appeals, the Fund will make all determinations in accordance with the applicable Plan documents, policies, and rules, and will apply such provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

The Fund intends to follow all applicable legal requirements when adjudicating benefit claims. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to Fund staff or an individual providing services to the Plan, such as a claims adjudicator or medical expert, will not be based upon the likelihood that the individual will support the denial of benefits.

Throughout the procedures set forth below, there are time limits within which a claimant must file a claim or appeal and within which the Fund must issue a decision on the claim or appeal. The Fund may agree to extend the time limits within which the claimant must file, and the claimant may agree to extend any time limit within which the Fund must issue a decision. The agreement to extend a time limit must be knowing, explicit, and confirmed in writing before the time period in question expires.

15.02 TIME LIMITS | WHERE TO FILE

Claims must be filed as soon as reasonably possible after the expense is incurred. We recommend that you send any claim for benefits under the Plan within 90 days of the date of service. **Any claims submitted more than 15 months after the date of service will not be considered.** Claims for benefits available under the Plan must be filed with the correct address as follows:

(a) Medical Claims

Most medical claims will be filed electronically by your provider. However, if you need to file a claim manually, the procedure for doing so is outlined in this subsection.

Claim forms are available from the Fund Office. Read the claim form carefully. Make sure you answer all questions on the form and include any required information. The center portion of the claim form has an "Authorization to Pay Benefits to Provider." You should sign this only if you have NOT paid the bill and wish the Fund to pay the provider of services directly. Your Physician or any other provider of service must complete the "Attending Physician's Statement" on the bottom portion of the claim form.

The claim form should then be mailed, along with the ITEMIZED bills to:

Automatic Sprinkler Local 281, U.A. Welfare Fund
11900 South Laramie Avenue
Alsip, IL 60803

All bills must indicate: (1) the patient's full name; (2) the nature of the Sickness or injury; (3) the date(s) of service; (4) the type(s) of services(s) rendered; and (5) the charge(s) for each service.

(b) Prescription Drug Claims

If you fill your prescription at a participating pharmacy (In-Network), you do not have to complete a written claim form. Rather, you must present your prescription drug card to the participating pharmacy and pay the appropriate Copayment or Coinsurance amounts. (Copayment and Coinsurance amounts may not be submitted to the Fund for reimbursement.)

Any medication deemed to be a maintenance drug should be ordered from the Mail Order Service. The In-Network Mail Order Service prescription benefit provides up to a 90-day supply for each Copayment. Order forms can be obtained from the Fund Office, and should be submitted to the following address:

OptumRX
1600 McConnor Parkway
Schaumburg, IL 60173-6801

If OptumRx denies any claim for prescription drugs in whole or in part, you have the right to seek review by the Trustees in accordance with this Chapter.

(c) Dental Claims

Dental claims should be submitted to:

Blue Care Dental
Phone: (800) 367-6401
<https://www.bcbsil.com/member/advantages-of-membership/blue-care-dental-connection>

If Blue Care denies any claim for dental claims in whole or in part, you have the right to seek review by the Trustees in accordance with this Chapter.

(d) Vision Claims

Vision claims should be submitted to:

EyeMed
P.O. Box 8504
Mason, OH 45040-7111

If EyeMed denies any claim for vision claims in whole or in part, you have the right to seek review by the Trustees in accordance with this Chapter.

(e) Death / AD&D Benefit Claims

If the unfortunate event you need to file a death benefit claim or an AD&D benefit claim, please contact the Fund's Office. The Fund Office will assist you with the paperwork necessary to file a claim with the Fund's fully-insured death and AD&D benefit carrier.

(f) MAPD Plan Claims

If you are a Medicare-eligible Participant covered under the MAPD Plan, claims should be submitted to the MAPD Plan for processing. If the MAPD Plan denies any claim in whole or in part, you have the right to seek review of that decision in accordance with the terms of the MAPD Plan. Please contact the Fund Office if you have any questions.

15.03 APPLICABLE DEFINITIONS

In order to understand how your claim or appeal will be processed, it is important you understand how the Fund categorizes claims. A definition or explanation of each category the Fund will use is set forth below.

(a) Pre-Service Claim

A Pre-Service Claim is any claim for a benefit for which pre-approval of the benefit is **required** by the Fund before medical care is obtained. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Pre-Service Claims.

(b) Urgent Care Claim

An Urgent Care Claim is a **Pre-Service Claim** that: (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) a Physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described in this Chapter. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Fund, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Fund will treat your claim as an Urgent Care Claim.

(c) Post-Service Claim

This is any claim for a benefit that is not a Pre-Service Claim. In the case of a Post-Service Claim, you request reimbursement after medical care has already been rendered. Most claims you submit will be Post-Service Claims.

(d) Concurrent Care Claim

This is any claim to extend an ongoing course of treatment beyond the period of time or number of treatments that the Fund has already approved. A Concurrent Care Claim can be either an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

(e) Incomplete Claim

A claim will be deemed incomplete if you do not provide enough information for the Fund to determine whether and to what extent your claim is covered by the Plan. This includes, but is not limited to, your failure to communicate to a person who ordinarily handles benefit matters for the Fund, your name, your specific medical conditions or symptom, and the specific treatment or service for which you request approval.

(f) Disability Claims / Weekly Accident and Sickness Claims

Disability Claims / Weekly Accident and Sickness claims, which include claims relating to ongoing eligibility while disabled, will generally be handled like Post-Service Claims for medical benefits; however, there are special time periods that apply to processing such claims.

(g) Rescission

A rescission of coverage is a retroactive cancellation or termination of your coverage. The Fund may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact. A prospective termination of coverage is not a rescission. Termination of coverage for failure to pay a required premium is not a rescission. Additionally, termination of coverage retroactive to the date of divorce (or other event making a dependent ineligible for coverage) is not a rescission if COBRA is not elected and/or the full COBRA premium is not paid by you or your dependent(s). A rescission is a benefit claims decision that you have the right to appeal. If your coverage is rescinded for a reason other than fraud, intentional misrepresentation of material fact, your coverage under the Plan will continue during the appeal period. Coverage will not continue during any applicable appeal period if your coverage is terminated due to failure to pay a premium.

15.04 TIMEFRAMES FOR MAKING INITIAL CLAIM DECISIONS

(a) Pre-Service Claims

For properly submitted Pre-Service Claims, the claimant will be notified in writing of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from the claimant on an Incomplete Claim, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal period for making a decision on the claim will be suspended from the date of the extension notice until either the passage of 45 days or the date the claimant responds to the request, whichever is earlier.

(b) Urgent Care Claims

Urgent Care Claims must be submitted in the same manner as Pre-Service Claims. For properly filed Urgent Care Claims, the claimant will be notified of a decision in writing or by telephone as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. If the claimant is notified by telephone, the determination will also be confirmed in writing not later than 3 days after the telephone notification.

If an Urgent Care Claim is an Incomplete Claim, the claimant will be notified as soon as possible, but not later than 24 hours after receipt of the Incomplete Claim, of the specific information necessary to complete the claim. The claimant must provide the specified information within 48 hours from receipt of the notification to supply the requested information. If the information is not provided within that time, the claim will be denied.

During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the passage of 48 hours from receipt of the request to supply additional information or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.

(c) Concurrent Care Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves a termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request to extend approved urgent care treatment must be submitted in the same manner as Urgent Care Claims. The claimant will be notified of a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If the claim is not made at least 24 hours prior to the expiration of the approved treatment, the request must be treated as an Urgent Care Claim and decided according to the Urgent Care Claim time frames. A request to extend approved treatment that does not involve urgent care will be decided according to the Pre-Service or Post Service Claim time frames, whichever applies.

(d) Post-Service Claims

For properly filed Post-Service Claims, the claimant will be notified of decisions on Post-Service Claims within 30 days from the receipt of the claim by the Fund. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the claimant submits an Incomplete Claim, the notice will also describe the information it needs to make a decision. The claimant will have 45 days after receiving this notice to provide the specified information. If the information is not provided within that time, the period for making the benefit determination will be tolled or frozen from the date on which the Fund sends the notification of the extension until the date the claimant responds to the request for additional information or the claimant's time to respond expires. If the claimant provides additional information in response to such a request, the Fund will make a decision within 15 days of when the additional information was received by the Fund.

(e) Disability Claims / Weekly Accident and Sickness Claims

The Fund will decide Disability / Weekly Accident and Sickness claims within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund if the Fund notifies you of the extensions prior to the expiration of the initial 45-day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a

benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

If an extension is required because the claimant submits an Incomplete Claim, the notice will also describe the information it needs to make a decision. The claimant will have 45 days after receiving this notice to provide the specified information. If the information is not provided within that time, the period for making the benefit determination will be tolled or frozen from the date on which the Fund sends the notification of the extension until the date the claimant responds to the request for additional information or the claimant's time to respond expires. If the claimant provides additional information in response to such a request, the Fund will make a decision within 15 days of when the additional information was received by the Fund.

(f) Death / AD&D Benefit Claims

If a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the Fund will provide a written notice of the denial within 90 days after it receives the claim. Should special circumstances require additional time to decide the claim, the Fund will provide a written notice of the extension within 90 days after receipt of the claim explaining the special circumstances and the date by which the Fund expects to render the benefit determination. This extended due date cannot exceed 180 days from the date on which the claim originally was filed.

In the case of a claim for an AD&D benefit claim, written notice of the event on which the claim is based must be provided to the insurance carrier no later than 30 days after the loss for which the claim is made. Late notice will be accepted only if it is shown to have been furnished as soon as reasonably possible. Written proof in support of the claim must be provided to the life insurance carrier no later than 90 days after the date of loss for which the claim is made. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible.

15.05 CONTENT OF INITIAL DENIAL NOTICES

(a) Medical Care Claims

If a medical care claim is denied, in whole or in part, the claimant will be provided written notice of the denial. However, for Urgent Care Claims and Concurrent Claims to extend approved urgent care treatment, the claimant may be notified of denial by telephone, provided that written notice is provided no later than 3 days after telephone notification.

The notice of denial will provide, where applicable:

- (1) Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
- (2) The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) or rescission;
- (3) A description of any standard used to deny your claim;
- (4) References to the specific Plan provisions on which the benefit determination or rescission was based;

- (5) If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
- (6) If the denial is based on Medical Necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
- (7) A description of any additional material or information which might help your claim (including an explanation of why that information may be helpful);
- (8) A description of any internal or external appeals available, how to initiate them and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- (9) A statement that you or your representative may submit information in support of your claim in writing upon filing a request for review of denial of benefits or a rescission;
- (10) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- (11) Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal request.

(b) Disability / Weekly Accident and Sickness Benefit Claims

If a Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

- (1) The specific reason(s) for the adverse determination;
- (2) References to any pertinent Plan provisions, internal rules, guidelines, protocols or other criteria relied on in making the adverse determination;
- (3) A description of any additional materials or information which might help your claim (including an explanation of why that information may be helpful);
- (4) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- (5) A description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.
- (6) If the determination is based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request.

(c) Death / AD&D Benefit Claims

If a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will include:

- (1) The specific reason(s) for the adverse determination;
- (2) References to the specific Plan provisions on which the determination was based;
- (3) A description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information might be necessary);
- (4) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- (5) A statement describing the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

15.06 YOUR RIGHT TO APPEAL

(a) Time Period in Which to Appeal

If a claim is denied, in whole or in part, or if a claimant disagrees with the decision made on a claim, or if your coverage is rescinded, the claimant or his authorized representative may ask for the benefit denial to be reviewed. To be reviewed, a claimant's written appeal must be filed in a timely manner:

- (1) Generally, claimants have 180 days from the day they received notice of the initial decision to appeal. However, in the case of a Concurrent Care Claim that involves the termination or reduction of previously approved care, the appeal must be completed before the care is terminated or reduced.
- (2) In the case of a death benefit claim or an AD&D benefit claim, the claimant has 60 days from the day he received notice of the initial decision to appeal.
- (3) In the case of an Urgent Care Claim, a claimant may request, orally or in writing, immediate review of an adverse determination. Communications between the claimant (or claimant's authorized representative) and the Fund Office may be made by telephone, facsimile, or other similar means.

(b) Content of Your Appeal

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for the appeal. You should also submit any documents that support your claim. This does not mean that you are required to cite all the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Plan policy, determination or action. The review of your claim will take into account all comments and documents that support your position, even if the Fund did not have this information when making its initial determination. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

(c) Where to File Your Appeal

Your appeal should be filed at the following address:

Board of Trustees
Automatic Sprinkler Local 281, U.A. Welfare Fund
c/o Tim Morrin, Fund Administrator

11900 South Laramie Avenue
Alsip, IL 60803
P: (708) 597-1832

(d) Review Process

The Trustees, or a designated Committee of the Trustees, will conduct a full review your appeal. Neither the Trustees nor any member of a Committee designated by the Trustees will have been involved in the initial benefit determination. The review will take into account all comments, documents, records and other information submitted relating to your claim (regardless of whether this information was submitted or considered in the initial benefit determination). The decision on appeal will not give deference to the initial denial.

If the Fund generates new evidence or a new rationale for denial to be reviewed by the Trustees when considering your appeal, the Fund will provide such new evidence or rationale for denial to you as soon as possible in advance of the date a determination on your appeal is to be made. Upon receipt of such new evidence or rationale for denial, you have the right to respond and submit additional evidence or arguments for the Trustees' consideration. However, if the Fund receives such new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

If the initial denial was based, in whole or in part, on a medical judgment, the Trustees shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not consulted, and is not the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim.

(e) Failure to File a Timely Appeal

Failure to file a timely appeal will result in a complete waiver of your right to appeal, and the Fund's determination regarding the claim will be final.

15.07 TIMING OF NOTIFICATION OF DECISION ON APPEAL

(a) Pre-Service Claims

A notice of a decision on review will be sent within 30 days of receipt of the appeal.

(b) Urgent Care Claims

A notice of a decision on review will be sent within 72 hours of receipt of the appeal by the Fund.

(c) Concurrent Care Claims

A notice of a decision on review for a Concurrent Care Claim that involves termination or reduction of previously approved care will be sent before the care is terminated or reduced. Notice of a decision on review on a Concurrent Care Claim that involves an extension of care will be sent based on the time frames for Urgent Care, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

(d) Post-Service Claims and All Other Claims

The Trustees or a designated Committee of the Trustees will review your appeal within 60 days following receipt of your appeal. If special circumstances require a further extension of time for review

by the Trustees, a benefit determination will be made not later than 120 days following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. Once a decision on review of the claim has been reached, the claimant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

(e) New Evidence or Rationale for Denial

In cases where the Fund must provide you with any new evidence or rationale for denial considered, relied upon, or generated by the Fund in connection with your claim, and the Fund receives such new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

15.08 CONTENT OF NOTICE OF DECISION ON APPEAL

(a) Medical Benefit Appeals

If an appeal concerning a health care claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

- (1) Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
- (2) The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or rescission;
- (3) A description of any standard used to deny your claim;
- (4) References to the specific Plan provisions on which the benefit determination or rescission was based;
- (5) If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
- (6) If the denial is based on Medical Necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
- (7) The identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- (8) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- (9) A description of the external review process, including information on how to initiate an external review and applicable time limits, and the right to bring a civil legal action under ERISA;
- (10) A statement describing any voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA; and

- (11) Disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Fund will not consider a request for such diagnosis and treatment information, in itself, to be an appeal request.

(b) Disability / Weekly Accident and Sickness Benefit Appeals

If an appeal concerning a Disability / Weekly Accident and Sickness claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

- (1) The specific reason(s) for the adverse determination;
- (2) References to the specific Plan provisions on which the determination was based;
- (3) A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit Claim upon request;
- (4) If the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request;
- (5) A statement describing your right to bring a civil legal action under ERISA.

(c) Death / AD&D Benefit Appeals

If an appeal concerning a death benefit claim or an AD&D benefit claim is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

- (1) The specific reason(s) for the adverse determination;
- (2) References to the specific Plan provisions on which the determination was based;
- (3) A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit Claim upon request;
- (4) A statement describing your right to bring a civil legal action under ERISA.

15.09 EXTERNAL REVIEW OF MEDICAL BENEFIT APPEALS

If you receive an adverse benefit determination on your appeal concerning a health care claim that involves medical judgment or on a rescission of your coverage, you have the right to request an external review. A determination involves medical judgment if, for example, it is based on the Plan's requirements for Medical Necessity, appropriate health care setting, level of care, or a determination that a treatment is experimental.

The request should be sent to the address identified in this Chapter for submitting an appeal to the Trustees. Your request for an external review must be made no later than four months after the date you receive the adverse decision on your appeal. If there is no corresponding date four months after the date of receipt of such notice, the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days following receipt, the Fund Office will make a preliminary review to determine whether: (1) you are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided; (2) the adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review); (3) you have exhausted the Plan's internal appeal process unless you are not required to exhaust the final internal appeals process; and (4) you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund Office will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (1) the four-month filing period, or (2) the 48-hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization, and the IRO will contact you. The Fund Office will contract with at least three IROs for assignments under the Fund and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

Once you are contacted by the IRO, you will have ten business days to submit additional information directly to the IRO if you choose to do so. The IRO is not required to, but may accept and consider additional information submitted after ten business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan. Within five business days after the assignment of the IRO, the Fund Office will provide to the IRO the documents and information considered in making the adverse benefit determination or final internal appeal including information that you previously submitted to the Fund Office. Failure by the Fund Office to timely provide the documents and information will not delay the conduct of the external review. If the Fund Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify you and the Fund.

Upon receipt of any information that you submit, the IRO must forward the information to the Fund within one business day. The Fund may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Fund will not delay the external review. If the Fund decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Fund will provide written notice of its decision to you and the IRO within one business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Fund.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision: (1) your medical records; (2) the attending health care professional's recommendation; (3) reports from appropriate health care professionals and other documents submitted by you, your treating provider, the Fund or issuer; (4) the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law; (5) appropriate practice guidelines, which must include applicable evidence based standards and may include any other

practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (6) any applicable clinical review criteria developed and used by the Fund, unless the criteria are inconsistent with the Plan's terms or with applicable law; and (7) the opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its final external review decision. The written decision of the IRO will contain:

- (a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable) and the reason for the previous denial);
- (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards considered in reaching its decision;
- (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (e) A statement that the determination is binding except to the extent that other remedies may be available under the state or federal law to either the group health plan or to you;
- (f) A statement that judicial review may be available to you; and
- (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Fund, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Fund from making payment on the claim or otherwise providing benefits at any time. The Fund must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

15.10 EXPEDITED EXTERNAL REVIEW OF MEDICAL BENEFIT APPEALS

When external review is otherwise available pursuant to this Chapter, the Fund will allow you to make a request for an expedited external review at the time you receive:

- (a) An adverse benefit determination on appeal involving a medical condition for which the timeframe to complete a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or
- (b) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination appeal concerns an admission, availability of care, continued stay, or health care item

or service for which you received emergency care services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Fund will immediately send a notice of its eligibility determination that meets the requirements for a standard external review eligibility determination notice.

Upon determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO in accordance with the requirements for assigning an IRO for a standard external review. The Fund will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The IRO's decision is binding on you and the Fund, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Fund from making payment on the claim or otherwise providing benefits at any time. The Fund must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Fund intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process.

The IRO will provide written notice to you and the Fund of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible, but not more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to you and the Fund.

If the IRO reverses the Fund's adverse benefit determination or final internal adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

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

15.11 OPTIONAL PRE-SERVICE EVALUATION OF MEDICAL SERVICES

The Plan permits you to request an optional pre-service evaluation of whether a particular health care or medical service will be covered and provides these special procedures for such requests. The purpose of such evaluation is to inform you regarding the likelihood as to whether the contemplated service meets the Plan's Medical Necessity standard and other Plan requirements for payment. Although an advance determination is not required for you to obtain medical care, it may be advisable to obtain information regarding whether coverage for a contemplated procedure may be denied because it is experimental or might otherwise not be covered by the Plan.

Requests made pursuant to this Section may be made by calling the Fund Office, by writing to the Fund Office, or by emailing the request to tmorrin@SF281.org.

The Fund Office will tell you the results of its evaluation within 30 days after receiving your inquiry. If the initial 30-day period of time needs to be extended due to a failure to provide the Fund Office with the information it needs to make an evaluation, you will be notified of the specific information needed, and you or your medical care provider will have at least 45 days to provide the requested information.

It is important to remember that an unfavorable evaluation by the Fund Office is not a denial of benefits. It is an optional service provided by the Plan to enable you to obtain an evaluation of whether particular medical services are likely to be covered by the Plan. If the evaluation is negative, you are still free to obtain the services and submit a claim, which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance evaluation.

15.12 POLICIES, DETERMINATIONS OR ACTIONS

If you disagree with a policy, determination, or action of the Fund, you may ask the Trustees to review the policy, determination, or action with which you disagree by submitting a written appeal to the Trustees. You must state the reason for your appeal and submit any supporting documentation. Your written appeal must be submitted within 60 days after you learn of the policy, determination or action with which you disagree, which is not a benefits denial. The Trustees will have sole authority and discretion to interpret and apply Plan policy, determinations, and actions.

The Fund Office will generally notify you of its decision on appeal within 60 days after the appeal is received, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision will be in writing and will include: (a) specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based; (b) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and (c) a statement describing your right to bring a civil legal action under ERISA.

15.13 DECISIONS OF THE TRUSTEES ARE FINAL AND BINDING

(a) Trustee Discretion and Authority

The Trustees have exclusive discretionary authority to interpret the Plan and to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, benefits, eligibility and interpretation of the Plan and other policies and rules. The Trustees have exclusive discretionary authority to determine if a benefit is covered or subject to reimbursement under the Plan.

(b) Decisions are Final and Binding | Option to Reconsider if New Information is Presented

The Trustees' decision on review or appeal is final and binding on all parties, including anyone claiming a benefit on your behalf. Except in cases where the Trustees determine that reconsideration of your claim or appeal is appropriate, there is no further level of appeal under this Plan. The Trustees may determine that reconsideration of your claim or appeal is appropriate based on new information that was not available at the time of the initial appeal. The Trustees have exclusive discretionary authority to determine if reconsideration is warranted.

(c) Limited Judicial Review | 1-Year Limitations Period | Required Exhaustion of Claim Procedures

You may not commence a judicial proceeding against any person, including the Plan, a fiduciary of the Plan, the Administrative Manager, the Trustees, the Fund Office, or any other person, with respect to a claim for benefits, Plan policy changes, or other determinations or actions, without first exhausting the claims procedures set forth in this Chapter.

If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Fund Office's decision on appeal, but only if the action is commenced within a period of one year from the date of the Fund Office's decision on appeal. Any such action must be brought exclusively in the federal courts located within the County of Cook, State of Illinois, where the Plan is administered.

If you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether their decision was arbitrary and capricious. Additionally, evidence may not be used in court unless it was first submitted to the Trustees prior to the decision on appeal.

If the Fund fails to adhere to all the claims procedure set forth within this Chapter, then to the extent mandated by law, the claimant may initiate an external review or bring an action in an appropriate court without exhausting the claims procedure set forth in this Chapter, but only if the action is commenced within the one-year limitations period. However, you cannot initiate an external review or bring an action in an appropriate court without first exhausting the claims procedures of this Chapter if the violation by the Fund is: (1) de minimis; (2) not likely to cause you prejudice or harm; (3) attributable to good cause or matters beyond the Fund's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance by the Plan.

Within ten days of the Fund's receipt of your written request, you are entitled to an explanation of the Fund's basis for asserting that it meets the above exception. The explanation will include the specific description of its bases, if any, for asserting that the violation should not cause the claims procedure to be deemed exhausted. If an external review or a court rejects your request for immediate review on the basis that the Fund meets the requirement for the exception, then the Fund will provide you with notice of the opportunity to resubmit and pursue internal appeal of the claim within a reasonable time after the external review or court rejects the claim for immediate review (but not to exceed ten days). Time periods for refiling the claim will begin to run upon your receipt of such notice.

CHAPTER 16—IMPORTANT MISCELLANEOUS PROVISIONS

16.01 EXCLUSIVE DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES

(a) Plan Interpretation & Modification

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to interpret the Plan and to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees' exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan's provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment. Decisions made by the Board of Trustees are final and binding on all parties. Judicial review of any decision made by the Board of Trustees will be limited to determine only whether the decision was arbitrary and capricious.

Interpretations regarding eligibility for benefits, claims, status of Participants or Employers, or any other matter relating to the Plan should only be obtained through the full Board of Trustees or the Administrative Manager. The Trustees are not bound by, responsible for, or obligated by opinions, information or representations from any other source.

(b) Plan Termination

The Fund may be terminated by a document in writing adopted by the Trustees. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to meet the payments due or which may become due under the Plan of benefits. The Fund may also be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan of benefits, including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of Participants or to cover the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing Employer, the Association or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, the Association, Employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Fund.

16.02 NO VESTING

Benefits made available through the Plan are not guaranteed to Participants. In other words, benefits made available under this Plan are not vested with respect to any individual. Benefits are provided only from the assets of the Fund collected and available to support them, and to the extent the benefits of the Plan are supported by an insurance policy.

As described in the previous paragraphs, the Trustees have the authority to increase, decrease or modify benefits of the Plan as they may find it necessary for the sound and efficient administration of the Fund. All benefits of the Plan are conditional and subject to the Trustees' authority under the Plan and Trust Agreement to change them.

16.03 EXCLUSIVE RIGHT TO BENEFITS

No individual shall have a right to benefits provided under the Plan except as specified in the Plan. No party may rely on any representations about the meaning of any provision of the Plan or the benefits provided under the Plan that are inconsistent with the terms of the Plan.

16.04 NO ASSIGNMENT OR ATTACHMENT OF BENEFITS

No Participant is permitted to assign any benefits, rights or claims for benefits to any third party including, but not limited to, a provider or facility, without the express written consent of the Administrative Manager. "Benefits, rights or claims for benefits" includes, but is not limited to, a claim for payment of a benefit under the terms of the Plan or other Plan document or communication, a claim for benefits under Section 502(a) of ERISA, a claim under ERISA for breach of fiduciary duty, or a claim for penalties assessable under law or regulation.

A Participant may direct that benefits payable from this Plan to him or her instead be paid to the provider or facility that provided the related medical care. However, the Plan is not obligated to accept such direction, and no payment made pursuant to such direction, nor any communication about benefits or payment between representatives of the Plan and a provider or facility, shall be considered an assignment of the benefit, a contract to pay benefits or a recognition by the Plan of a duty or obligation to pay a provider or facility, except to the extent the Plan actually chooses to do so.

All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings.

16.05 NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund, the Board of Trustees, and their designees are not engaged in the practice of medicine. They do not have control over the health care services provided or delivered to a participant by any provider. They similarly do not have control over the diagnosis, treatment, care, or lack thereof with respect to any Accident or Sickness. Using the services of a provider is a voluntary act, regardless of whether the Fund designates such provider, or participates in the Blue Cross Blue Shield network. Nothing in the Plan is intended to be a recommendation or instruction to use a particular provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Providers are not employees of the Fund.

The Fund is not responsible for any act or omission of any provider in connection with any service or treatment. The Fund makes no representation regarding the quality of the service or treatment rendered by any provider. Neither the Fund, the Board of Trustees, nor any of their designees will have any liability whatsoever for any loss caused to any participant by any provider by reason of negligence, failure to provide care or treatment, or otherwise. A provider is solely responsible for the services and treatments he or she renders.

16.06 WORKERS' COMPENSATION

The benefits provided by the Plan are not in lieu of any coverage mandated under a Workers' Compensation law or similar statute. This Plan does not provide benefits under circumstances where benefits are payable under a Workers' Compensation law or similar statute.

16.07 OVERPAYMENTS AND REIMBURSEMENTS

If there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have directed those benefits to your Hospital, Physician or other provider. This is true even if the Fund has pre-certified coverage. Additionally, if another group insurance or employee benefit plan pays benefits that are subsequently payable under this Plan, this Plan may reimburse the other benefit plan for the benefit that plan paid. Likewise, if you or a third party makes COBRA premiums or other self-payments to the Fund that later become unnecessary because you gained eligibility under the Plan for that month, the Fund may reimburse the party who remitted the COBRA premium or made the self-payment. See Chapter 14 for additional information regarding the recovery of overpayments, whether erroneous or fraudulent in nature, and the recovery of conditional benefit payments.

16.08 ALLOCATING / DELEGATING TRUSTEE AUTHORITY; ACTIONS IN ACCORDANCE WITH TRUST

To the extent permitted under ERISA, the Trustees may take action in accordance with the terms of the Trust Agreement to allocate and delegate their responsibilities, including fiduciary responsibilities, to others where it is deemed appropriate for the effective operation and administration of the Plan. The Trustees may also take action in accordance with the terms of the Trust Agreement to retain one or more persons to render advice regarding their responsibilities or to designate one or more persons to take such action on their behalf. Finally, in accordance with the terms of the Trust Agreement, the Trustees may appoint one or more investment managers to invest, reinvest and otherwise manage assets of the Fund, including the power to acquire or dispose of such assets. The Trustees may take any other action in accordance with the Trust Agreement as they deem necessary.

16.09 PRESERVATION OF PLAN PROVISIONS

This document supersedes and replaces any previous literature furnished regarding the Plan's benefits and is intended to serve as both the Summary Plan Description and the Plan Document under ERISA. Should any provision of the Plan be held to be unlawful, or unlawful as to any person or instance, such holding will not, to the extent possible, adversely affect the other provisions contained in the Plan or the application of said provisions to any other person or instance.

16.10 FORUM SELECTION CLAUSE

Any legal action under Title I of ERISA brought against the Plan, the Fund, the Board of Trustees, the Administrative Manager, and/or any employee or agent thereof must be brought exclusively in the federal courts located within the County of Cook, State of Illinois, where the Plan is administered, in which case the parties consent and submit to the personal jurisdiction of the federal courts located within the County of Cook, State of Illinois. Any other legal action brought against the Plan, the Fund, the Board of Trustees, the Administrative Manager, and/or any employee or agent thereof must be brought exclusively in the state or federal courts located within the County of Cook, State of Illinois, where the Plan is administered, in which case the parties consent and submit to the personal jurisdiction of the state or federal courts located within the County of Cook, State of Illinois.

16.11 GOVERNING LAW

The terms of the Plan are governed by and construed in accordance with federal law to the extent federal law applies. To the extent federal law does not apply, the terms of the Plan will be governed by and construed in accordance with the laws of the State of Illinois. The Trustees have the exclusive discretionary authority to interpret the Plan and render all decisions with respect to the Plan.

CHAPTER 17—GENERAL INFORMATION AND YOUR ERISA RIGHTS

17.01 NAME OF THE PLAN

The name of the Plan is the Automatic Sprinkler Local 281, U.A. Welfare Plan.

17.02 PLAN ADMINISTRATION

The Fund is a collectively bargained trust fund administered by a joint Board of Trustees. The Board of Trustees is the Administrator of the Plan as defined by ERISA. The Trustees have delegated responsibility for day-to-day Plan administration to an Administrative Manager:

Tim Morrin
11900 South Laramie Avenue
Alsip, IL 60803

The names and business addresses of the Trustees are:

UNION TRUSTEES

Dennis Fleming
Automatic Sprinkler Local 281, U.A. Welfare Fund
11900 South Laramie Avenue
Alsip, IL 60803

John Zubricks
Automatic Sprinkler Local 281, U.A. Welfare Fund
11900 South Laramie Avenue
Alsip, IL 60803

EMPLOYER TRUSTEES

Cornelius J. Cahill
National Fire Sprinkler Association
P.O. Box 1000
Patterson, NY 12563

Frederic Barall
National Fire Sprinkler Association
P.O. Box 1000
Patterson, NY 12563

17.03 NAME OF PLAN SPONSOR

The Plan Sponsor of the Plan is the Board of Trustees of the Automatic Sprinkler Local 281, U.A. Welfare Fund.

17.04 AGENT FOR SERVICE OF LEGAL PROCESS

The designated agent of the Fund for service of legal process is Tim Morrin. In addition, service of legal process may be made upon the Board of Trustees at the Fund Office.

17.05 PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER (EIN)

Plan Number: 501

EIN: 36-2242666

17.06 TYPE OF PLAN

The Plan is an employee welfare benefit plan providing medical, prescription drug, dental, vision, death, accident and dismemberment, disability, and other related benefits. The Plan is a self-insured multiemployer plan governed by ERISA and the Laborer Management Relations Act of 1947 (The Taft-Hartley Act).

17.07 PLAN YEAR

January 1 through December 31.

17.08 SOURCE OF FINANCING

The Plan is funded by contributions made by individual Employers under the provisions of Collective Bargaining Agreements, by self-payments by Employees and Retired Employees in accordance with the

provisions of this Plan, and any income earned from investment of such contributions and payments. All monies are used exclusively to provide benefits to Participants, and to pay all expenses incurred with respect to the operation of the Plan. The Trustees periodically review the funding status of the Plan.

Participants may receive from the Fund Office, upon written request, information as to whether or not a particular Employer is a contributing Employer and any applicable Collective Bargaining Agreement.

17.09 SERVICE PROVIDERS

The Plan has arrangements with various organizations such as preferred provider networks that affect the payment of benefits. To the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. The following is a list of those organizations and the services they provide to the Plan.

(a) Preferred Provider Organization – Medical Benefits

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112
Phone: (800) 571-1043
<http://www.bcbsil.com>

(b) Preferred Provider Organization – Dental Benefits

Blue Care Dental
Phone: (800) 367-6401
<https://www.bcbsil.com/member/advantages-of-membership/blue-care-dental-connection>

(c) Prescription Drug Program

OptumRx
1600 McConnor Parkway
Schaumburg, IL 60173-6801
www.myoptumrx.com

(d) Accidental Death & Dismemberment Insurance, Life Insurance

Dearborn National
1020 31st Street
Downers Grove, IL 60515

(e) Case Management

Hines & Associates
115 E. Highland Avenue
Elgin, IL 60120
Phone: (800) 944-9401

(f) Durable Medical Equipment (DME)

Walgreens/Dependicare
1815 Gardner Road
Broadview, IL 60155
Phone: (800) 244-7404

(g) Vision Services

EyeMed
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0513
www.eyemedvisioncare.com

(h) Hearing Provider

EPIC Hearing Healthcare
17870 Castleton Street, Suite 320
City of Industry, CA 91748
Phone: (866) 956-5400

(i) Member Assistance Program (MAP)

Employee Resource Systems, Inc.
29 E. Madison, Suite 1600
Chicago, IL 60602
Phone: (800) 292-2780

All other benefits are administered under the direction of the Trustees. Except as otherwise indicated in the Plan, no payments provided for in this Plan are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund.

17.10 COMPLIANCE WITH PRIVACY STANDARDS

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected Health Information ("PHI") will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law.

You may authorize the disclosure of your PHI to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided Participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of PHI or your rights with regard to this information, you may request a copy of the Notice from the Fund Office.

The Plan is will also comply with HIPAA's Security Standards. In doing so, the Plan will

- (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains, or transmits.
- (b) Use PHI only for Plan administration activities and not for any employment-related actions or for any purpose unrelated to Plan administration.
- (c) Take appropriate action related to any security incident of which it becomes aware.

- (d) Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.

17.11 YOUR RIGHTS UNDER ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits

Examine, without charge, at the 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 Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and the 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 Administrator is required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Coverage

Continue health care coverage for yourself, Spouse, or other Eligible Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. This document includes the rules governing your COBRA rights.

(c) Prudent Action by Plan Fiduciaries

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

(d) Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation for the reason for the denial. You have the right to have the Fund 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 Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Administrator.

(e) Assistance with Your Questions

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1730 K Street, N.W., Washington, D.C. 20006, (866) 444-EBSA (3272) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

17.12 NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT | WOMEN'S HEALTH & CANCER RIGHTS ACT

(a) Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Also, under federal law, plans may not set the level of benefits or out-of-pocket expenses so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket expenses, you may be required to obtain pre-certification.

(b) Women's Health and Cancer Rights Act of 1998

Pursuant to the Women's Health and Cancer Rights Act of 1998, surgical expenses shall include reconstructive surgery and post-surgical scar correction following a mastectomy. Reconstructive surgery following a mastectomy includes reconstruction of the breast in which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses. Coverage is also provided for physical complications at all states of mastectomy, including lymphedemas.