The Welfare Fund of Plumbers Local Union #200

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Group Number: 0081636
Revised: January 1, 2009

SUMMARY PLAN DESCRIPTION FOR WELFARE FUND OF PLUMBERS LOCAL UNION #200
EFFECTIVE DATE: JANUARY 1, 2009

FUNDS MANAGER
Ann M. Jankay

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Frank Pellegrino

IDENTIFICATION NUMBER 11-3124836	TYPE OF PLAN ADMINISTRATION Self-Funded
PLAN SPONSOR NUMBER 501	PLAN YEAR January 1 to December 31
TYPE OF PLAN Health & Welfare	FISCAL YEAR July 1 – June 30

It is the intention of the Union to hereby establish a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986, and any amendments thereto.

IN WITNESS WHEREOF, the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200 has executed this Summary Plan Description as of the Plan Effective Date shown.

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Your Online Benefits Service from UMR

Your online benefits service provides you with convenient access to the information you need when you need it. You'll have 24/7 access to these great services:

- Claim status
- ID card ordering
- Health information
- Your Online Provider Directory
- Frequently used forms
- And so much more! See details on back.

Accessing Online Services

It's easy and fast to access your online benefits service at **www.umr.com**. Complete the instructions below.

New members

1. Go to **www.umr.com** and click **Login/Register**.
2. Enter your member ID (displayed on your benefits ID card). If you don't have an ID card, enter your Social Security number.
3. Click **Go to my online services**.
4. Follow the on-screen prompts; click **Sign-Up** to enter additional information and complete your registration.
5. Explore the site's features and view information about your benefits and claims.
6. Click **Logoff** near the top of the homepage when you're ready to leave the site.

(continued on back)

UMR

Registered members

1. Go to **www.umr.com** and click **Members**.
2. Enter your member ID (located on your benefits ID card). If you don't have an ID card, enter your Social Security number.
3. Click **Go to my online services.**
4. Follow the on-screen prompts; enter your current **Username** and **Password**.
5. Click the online benefits service site's features and services, as before.
6. Click **Logoff** near the top of the homepage when you're ready to leave the site.

Your online benefits service provides helpful, time-saving health and benefits information. Click the menu selections and site features to become familiar with the site and all that it has to offer.

Key features of your online benefits service

Provider lookup:
Find in-network providers by clicking Find A Provider under the All Members selection on My Menu.

Claims:
Access claims information for you and your covered dependents from the My Benefits selection on My Menu.

Eligibility:
View eligibility coverage information and effective dates for you and covered dependents at the eligibility service under My Benefits.

Get answers:
Use the Ask UMR A Question feature under My Benefits for email access to your Customer First Service Team.

Health information:
Help you and your family stay healthier and be wiser health care consumers by exploring links to reliable health and medical information. Click Health Info in the menu at the top of the homepage.

News:
Check the online benefits service's homepage for current benefits-related news and announcements from UMR and your employer.

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IMPORTANT MESSAGE

HOW TO REQUEST A CERTIFICATE OF CREDITABLE COVERAGE

You have a right under federal law to obtain proof of the time *you* were covered under this *plan*. That proof is called a certificate of creditable coverage. The *plan* will automatically provide *you* with a certificate when:

- ♦ *Your* coverage under the *plan* ends
- ♦ *You* reach the *lifetime maximum* of the *plan*
- ♦ COBRA continuation coverage under the *plan* ends

The plan will also provide you with a certificate, upon request:

- ♦ At any time during which *you* are covered under the *plan*
- ♦ At any time during the 24 months after *your* coverage under the *plan* ends

Requests for a certificate of creditable coverage should be made to the Fund Office. The request may be verbal or in writing. It should include: your name and social security number, the names of the individual's that need proof of coverage, and the address where the certificate should be sent.

The Fund Office may also be able to assist *you*, if necessary, in obtaining a certificate from any prior plan or issuer in which *you* were previously covered.

CHANGES IN ELIGIBILITY

You should report **ANY CHANGE IN ELIGIBILITY** to the Fund Office as soon as possible. Changes in eligibility include:

- ♦ Marriage or divorce
- ♦ Death of any *dependent*
- ♦ Birth or adoption of a child
- ♦ *Dependent* child reaching the limiting age
- ♦ IRS ineligible *dependent* child
- ♦ Total disability
- ♦ Retirement
- ♦ *Medicare* eligibility

For specific details on maintaining coverage under the plan, refer to SECTION 3 - ELIGIBILITY.

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SECTION 1 MEDICAL BENEFITS

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NOTE: UMR is the *plan's claims administrator*. UMR provides clerical and claim processing services to the *plan*. UMR is not financially responsible for the funding or payment of claims processed under the *plan*, nor is UMR a fiduciary to this *plan*.

SCHEDULE OF BENEFITS

NOTICE REQUIREMENTS

The Utilization Management company (UM) shown on your ID card will handle the notice requirements of *your plan*. *You* should call the UM as soon as possible to receive proper care coordination. However, *you* must call within the time frames shown below. The UM toll-free number is shown on the back of *your* ID card.

NOTICE REQUIRED	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Inpatient Hospital	The coinsurance is reduced to 70%. The penalty is taken after applying the deductible.	*You* must call UM prior to any non-*emergency* inpatient admission, including an admission for psychological disorders, chemical dependence or alcoholism. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require *you* to notify UM. If *you* do not notify UM, benefits will be payable after the non-compliance penalty. If admission is on an *emergency* basis, UM must be notified within 48 hours following *your* admission or as soon as possible.	1-43
Convalescent Nursing Home/Inpatient Rehabilitation Center	The coinsurance is reduced to 70%. The penalty is taken after applying the deductible.	*You* must call UM prior to any non-*emergency* admission. All inpatient admissions require *you* to notify UM. If *you* do not notify UM, benefits will be payable after the non-compliance penalty. If admission is on an *emergency* basis, UM must be notified by the first business day following *your* admission.	1-43
Home Health Care	The coinsurance is reduced to 70%. The penalty is taken after applying the deductible.	*You* must call UM prior to starting any Home Health Care services. All Home Health Care services require *you* to notify UM. If *you* do not notify UM, benefits will be payable after the non-compliance penalty.	1-43

NOTICE REQUIRED	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Inpatient and Outpatient Surgical Procedures	The coinsurance is reduced to 70%. The penalty is taken after applying the deductible.	*You* must call UM prior to any inpatient or outpatient surgical procedure. If *you* do not notify UM, benefits will be payable after the non-compliance penalty. If *your* surgery is on an *emergency* basis, UM must be notified within 48 hours following *your* surgery or as soon as possible.	1-43
MRI/CAT Scans	The coinsurance is reduced to 70%. The penalty is taken after applying the deductible.	*You* must call UM at least five days in advance of an MRI or CAT scan. If *you* do not notify UM, benefits will be payable after the non-compliance penalty. If *your* MRI or CAT scan is on an *emergency* basis, UM must be notified within 48 hours after or as soon as possible.	1-43
Medical Bill Review	None	If *you* discover a billing error, report it to the *plan*. As a reward, *you* will receive 50% of the error amount, but not more than $250.	1-44

Schedule of Benefits - continued

ACTIVE MEMBER PLAN

Active Member Plan ***Lifetime*** **Maximum:** $2,000,000 per *covered person*, including medical and prescription drug expenses.

ACTIVE MEMBER PLAN MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* *PPO* Individual Family Non-*PPO* Individual Family	 $0 $0 $0 $0	 $0 $0 $200 $600	The amount *you* must pay each year before the *plan* will begin paying any benefits. *PPO* and Non-*PPO* family maximums are calculated on a combined dollar basis for all *covered persons* in the family. No one *covered person* will incur more than the individual maximum shown.	1-42
Individual Coinsurance per *Calendar Year* *PPO* Non-*PPO*	 80% 70%	 20% 30%	After the deductible, the coinsurance applies to all *covered expenses* for the remainder of the *calendar year*.	1-42
Pre-Existing Conditions	0%	100%	For *members* and their eligible *dependents*, enrolled in the *plan* on or after 1/1/09, benefits for conditions existing prior to *your enrollment date* may be limited during *your* first 12 months of coverage. The Pre-Existing Condition Limitation does not apply to retirees and their eligible *dependents*.	1-55
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The deductible and coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.				

Schedule of Benefits – continued

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	*PPO*: $500 copay per day, then 100% up to a maximum of two copays per *confinement* Non-*PPO*: Deductible/70% coinsurance	Semi-private room and board, intensive care or coronary care and miscellaneous charges. If *you* receive services from a Non-*PPO* provider while confined in a *PPO* facility, *covered expenses* received from the Non-*PPO* provider will be payable at the *PPO* benefit level.	1-45
Qualified Practitioner Office Services Benefit Primary Care Physician Specialist	 *PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance *PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance	*PPO*: Benefits include office visits and other *covered expenses* performed in the office whether an office visit is billed with that service or not. This copay will apply to all *covered expenses* listed below, if performed in an office, unless the benefit specifically states that it does not apply. The copay applies per day per provider. Primary Care Physician includes family practice, general practice, internal medicine, nurse practitioner, physician assistant, pediatrician and OB/GYN. All other types of *qualified practitioners* will be considered a specialist.	1-45
Qualified Practitioner Benefits – Inpatient Hospital Visits Primary Care Physician Specialist	 *PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance *PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		1-45

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Qualified Practitioner Benefits – Outpatient Hospital Visits Primary Care Physician Specialist	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance *PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		1-45
Qualified Practitioner Benefits – Surgery	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance		1-45
Qualified Practitioner Benefits – Anesthesia	*PPO*: 100%, coinsurance waived Non-*PPO*: 80% coinsurance, deductible waived		1-45
Oral Surgery	*PPO*: 80% coinsurance Non-*PPO*: Deductible/70% coinsurance	Refer to list of covered oral surgeries in text. The Office Visit copay does not apply to this benefit.	1-45
Wellness Benefit Routine Exams and Immunizations for Covered Persons under Age 6	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance	Limited to 6 visits per *calendar year*. Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, and immunizations. Only one copay will apply per date of service.	1-46

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit Routine Exams for Covered Persons Age 6 and Older	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, immunizations and routine endoscopic surgeries (i.e. colonoscopy). For routine care that is subject to a copay, only one copay will apply per date of service for all routine care received on that same day. Please refer to the text for frequency limitations.	1-46
Routine Mammograms and Pap Smears	*PPO*: 100%, coinsurance waived Non-*PPO*: 80% coinsurance, deductible waived		
Routine Endoscopic Surgeries (i.e. colonoscopy)	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		
Routine X-Ray and Laboratory Tests (other than mammograms or pap smears)	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		
Immunizations for Covered Persons Age 6 and Older	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		
Outpatient Hospital Benefit (Facility Charge)	*PPO*: $250 copay per date of service, then 100% Non-*PPO*: Deductible/70% coinsurance	If *you* receive services from a Non-*PPO* provider in conjunction with treatment received from an outpatient *PPO hospital*, *covered expenses* received from the Non-*PPO* provider will be payable at the *PPO* benefit level.	1-46

Comment [t1]: Amendment #1

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Outpatient Hospital Surgery Benefit (Facility Charge)	*PPO*: $250 copay per date of service, then 100% Non-*PPO*: Deductible/70% coinsurance	If *you* receive services from a Non-*PPO* provider in conjunction with treatment received from an outpatient *PPO hospital*, *covered expenses* received from the Non-*PPO* provider will be payable at the *PPO* benefit level.	1-47
Ambulatory Surgical Center	*PPO*: $250 copay per date of service, then 100% Non-*PPO*: Deductible/70% coinsurance	If *you* receive services from a Non-*PPO* provider in conjunction with treatment received from an outpatient *PPO ambulatory surgical center*, *covered expenses* received from the Non-*PPO* provider will be payable at the *PPO* benefit level.	1-47
Emergency Room Benefit	$100 copay per visit, then 100%, deductible and coinsurance waived, for *PPO* and Non-*PPO*. For *covered expenses* received from Non-*PPO* providers, *customary, usual and reasonable* will be waived	The copay is waived if *you* are admitted to the *hospital* directly from the *emergency* room. This benefit includes *emergency* room physician charges and other services provided in the *emergency* room. NOTE: *Emergency* room treatment is limited to *emergencies*, as defined in this *plan*. *Your* first non-*emergency* visit to the *emergency* room will be allowed as a *covered expense* under the *plan*. After this visit, *you* will receive notification explaining that non-*emergency* treatment received in the *emergency* room will no longer be a *covered expense*.	1-46
Urgent Care Center Benefits	*PPO*: $50 copay per visit, then 100% Non-*PPO*: $50 copay per visit, then 100%	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all *covered expenses* performed during the visit.	1-47

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
X-ray (Radiology) Tests High End Radiology	*PPO*: $150 copay per date of service, then 100% (includes both the reading and taking of the x-ray) Non-*PPO*: Deductible/70% coinsurance	High end radiology includes: magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), computerized tomography scan (CT scans), positron emission tomography scan (PET scans), single photon emission computed and tomography scan (SPECT scans).	1-47
Other Than High End Radiology		Dental x-rays limited to covered oral surgery or *injury*. X-rays performed in a *qualified practitioner's* office are payable as shown above in the *Qualified Practitioner* Office Services benefit.	
Primary Care Physician	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		
Specialist	*PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		
Indepen-dent X-ray Facility	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Laboratory Tests (Office Visit Setting) Primary Care Physician Specialist Independent Laboratory Facility	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance *PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance *PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance	Lab tests performed in a *qualified practitioner's* office are payable as shown above in the *Qualified Practitioner* Office Services benefit. For *PPO* providers, if a different provider other than *your qualified practitioner* who performed the office visit submits a claim for lab tests, the copay will apply.	1-47
Laboratory Tests (Outpatient Hospital)	*PPO*: Actual allowed cost up to $250 copay per date of service, then 100% Non-*PPO*: Deductible/70% coinsurance	If using an Outpatient Hospital facility, this higher copay will be applied.	1-47
Ambulance Service Benefit	100%, deductible and coinsurance waived, for *PPO* and Non-*PPO*	Limited to $500 paid per trip, up to a maximum of two trips per *sickness* or *injury*. Limited to appropriate transport to the nearest facility equipped to treat the *sickness* or *injury*.	1-47

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pregnancy Benefit - Qualified Practitioner Charges	*PPO:* 100%, coinsurance waived Non-*PPO:* 70% coinsurance, deductible waived	Non-*PPO qualified practitioner* charges are limited to $3,500 paid per vaginal delivery of $4,000 paid per cesarean section delivery. Covered for *member*, spouse and *dependent* daughter. When pre and post-natal care is billed separate of the delivery charge, benefits for services performed in a *qualified practitioner's* office will be payable as shown above in the *Qualified Practitioner* Office Services benefit.	1-47
Pregnancy Benefit - Facility Charges	*PPO*: $500 copay per day, then 100% up to a maximum of two copays per *confinement* Non-*PPO*: Deductible/70% coinsurance	Covered for *member*, spouse and *dependent* daughter. If *you* receive services from a Non-*PPO* provider while confined in a *PPO* facility, *covered expenses* received from the Non-*PPO* provider will be payable at the *PPO* benefit level.	1-47
Newborn Benefits	Payable based on services received	The inpatient *hospital* copay is waived for a newborn's initial *hospital* stay. All newborn benefits, including care of premature newborns, are limited to $25,000 per *lifetime*. See "Section 3 – Eligibility" for important information on *Dependent* Coverage.	1-47
Convalescent Nursing Home Benefit	*PPO*: 80% coinsurance Non-*PPO*: Deductible/80% coinsurance	Limited to $5,000 paid per *lifetime*.	1-48

Comment [t2]: Amendment #1

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Home Health Care Benefit	Subject to a separate $100 deductible per *calendar year*, then 75% coinsurance for *PPO* and Non-*PPO*	40 visits per *calendar year*, when Home Health Care is in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-48
Hospice Care Benefit	100%, deductible and coinsurance waived, for *PPO* and Non-*PPO*	Limited to $6,000 paid per *lifetime*. *Hospice care* must be in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-49
Psychological Disorders	**Inpatient/ Transitional** *PPO:* 80% coinsurance Non-*PPO:* Deductible/70% coinsurance **Outpatient** 80% coinsurance, deductible waived, for *PPO* and Non-*PPO*	Inpatient/Transitional: Limited to 30 days per *confinement*, up to a maximum of two *confinements* per *lifetime*. Outpatient: Limited to 30 visits per *calendar year*. The Office Visit copay does not apply to this benefit.	1-50

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chemical Dependence and Alcoholism Benefit Note: Authorization for this benefit must be approved by the Fund.	**Inpatient/ Transitional** *PPO:* 100% Non-*PPO:* Deductible/70% coinsurance **Outpatient** 100%, deductible and coinsurance waived, up to a maximum of $50 paid per visit, for *PPO* and Non-*PPO*	Note: Treatment of chemical dependence and alcoholism is only a covered benefit for *members* (not *dependents*). All treatment of chemical dependence and alcoholism is limited to $15,000 paid per *lifetime*. Inpatient/Transitional: Limited to 28 days per *confinement*, up to a maximum benefit paid of $13,500 per *lifetime*. *You* must complete the entire 28-day stay. If *you* do not complete the entire 28-day stay, *your* treatment will not be covered by the *plan*. Outpatient: Limited to 30 visits, up to maximum benefit paid of $1,500 per *lifetime*. Outpatient benefits will **only** be available if *you* have first completed the 28-day inpatient stay. The Office Visit copay does not apply to this benefit. **Apprentice Program** **Inpatient** For covered *members* in the apprentice program, the inpatient benefit can be used in 14-day inpatient stays, up to a maximum of 28 days per *lifetime* or $13,500 paid per *lifetime*. *You* must complete the entire 14-day stay. If *you* do not complete the entire 14-day stay, *your* treatment will not be covered by the *plan*. Sub-acute detox is covered if recommended by *your qualified practitioner* and is applied toward the 28-day *lifetime* maximum. **Outpatient** Covered up to two courses of treatment, which consist of 12 visits each, for a maximum of 24 outpatient visits per *lifetime* or $1,500 paid per lifetime.	1-50

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Other Covered Expenses	*PPO*: 80% coinsurance Non-*PPO*: Deductible/70% coinsurance		1-51
Private Duty Nursing	*PPO*: 80% coinsurance Non-*PPO*: Deductible/80% coinsurance	Limited to $20,000 paid per *lifetime*.	1-51
Prosthetic Appliances	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance	Limited to $1,500 paid per *calendar year*. *You* must obtain pre-authorization from the *plan* prior to purchasing a prosthetic appliance. If *you* do not obtain pre-authorization, benefits will not be payable.	1-51
Special Medical Supplies	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance	Catheters, colostomy supplies, casts, splints, braces etc.	1-51
Durable Medical Equipment	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance	Rental is covered up to the purchase price of the equipment.	1-51
Implantable Mechanical Devices	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance	Pacemaker, artificial hip, etc.	1-51

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	**Manipulations and Other Treatment** 100%, deductible and coinsurance waived, up to a maximum of $35 paid per visit, for *PPO* and Non-*PPO* **Chiropractic X-Rays** *PPO*: 70% coinsurance Non-*PPO*: Deductible/70% coinsurance	Limited to 30 visits per *calendar year*. Routine or maintenance care is not covered. The Office Visit copay does not apply to this benefit.	1-51
Physical and Occupational Therapy	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance, up to a maximum benefit paid of $50 per visit	Limited to a combined maximum of 30 visits per *calendar year*.	1-51
Speech Therapy	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance, up to a maximum benefit paid of $50 per visit	Limited to a maximum of 50 visits per *calendar year*.	1-51
Respiratory Therapy	*PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance, up to a maximum benefit paid of $50 per visit		1-51

Comment [t3]: Amendment #2

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Radiation and Chemo Therapy	Payable based on services received		1-51
Acupuncture	100%, deductible and coinsurance waived, to a maximum benefit paid of $35 per visit, for *PPO* and Non-*PPO*	Limited to 30 visits per *calendar year*.	1-51
Pre-Admission Testing	*PPO*: 80% coinsurance Non-*PPO*: Deductible/70% coinsurance	Includes any related x-ray or laboratory tests.	1-51
Second Surgical Opinion	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance		1-51
Organ Transplants	Transplant Network: 80% coinsurance Non-Transplant Network: Not covered	Covered transplant expenses are subject to the following maximums: • $10,000 paid per transplant for procurement expenses • $10,000 paid per transplant for donor expenses (donor expenses only covered if not available to the donor from any other source) • $2,000 paid per transplant for ambulance expenses Please refer to list of covered transplants in text.	1-52

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Vision Care Benefit	100%, deductible and coinsurance waived, for *PPO* and Non-*PPO*	Limited to a maximum benefit paid of $100 per *calendar year*. Benefits include vision exams, glasses, contacts and prescription sunglasses. *You* must obtain a voucher from the Fund Office for benefits to be payable. If *you* do obtain a voucher, benefits will be reimbursed through the Fund Office.	1-53
Hearing Aid Benefit	100%, deductible and coinsurance waived, for *PPO* and Non-*PPO*	Limited to a maximum benefit paid of $500 per 36-month period. Benefits include hearing exams, hearing aids and hearing aid repair.	1-53
Sleep Apnea Benefit Initial Testing Primary Care Physician	 *PPO*: $25 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance	After the initial testing, only equipment used to treatment sleep apnea is a *covered expense*. Benefits are limited to $2,000 paid per *lifetime*.	1-53
Specialist	*PPO*: $40 copay per visit/100% Non-*PPO*: Deductible/70% coinsurance		
Equipment	*PPO*: 100%, coinsurance waived Non-*PPO*: Deductible/70% coinsurance		
Limitations and Exclusions	Not Payable	List of exclusions that apply to all *covered expenses*. A service that is normally covered may be excluded when provided with an excluded item.	1-54

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay	**Retail** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to the lesser of a 30-day or 100-unit dosage. If *you* purchase *your* prescription drug from a Non-Participating pharmacy, benefits will be payable subject to a 30% copay, after the medical *plan* deductible. **Mail Order** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to 90-day supply. **Maintenance Drugs** Maintenance drugs should be obtained through the mail order program. If *you* do not use the mail order program, on the 3rd retail refill, *your* drug will not be covered by the *plan*. **Specialty Pharmacy** Specialty pharmacy drugs must be purchased through the Specialty Pharmacy Program or they will not be a *covered expense* under the *plan*. Specialty pharmacy drugs are generally considered to: • cost more than $250 per prescription, • be administered by injection or infusion, • treat rare, unusual or complex diseases, • require additional clinical oversight and expertise for best management.	1-59

RETIREE UNDER 65 PLAN

Retiree Under 65 Plan *Calendar Year* Maximum: $50,000 per *covered person*, including base, major medical and prescription drug expenses.

PPO Option

A *PPO* option is available for *your* use. Bills from participating providers will be discounted by the *PPO* network prior to submission for payment. *You* are not responsible to pay any discounts taken by the *PPO* network. *PPO* claims are payable, subject to the deductible and coinsurance, after the discount is taken.

RETIREE UNDER 65 BASE BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year*	$0	$0	Base benefits are not subject to a deductible.	
Individual Coinsurance per *Calendar Year*	100%	0%	Applies to all *covered expenses* under the Base Benefits. Subject to any maximums as stated.	1-42
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The deductible and coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.				

RETIREE UNDER 65 MAJOR MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* Individual Family	 $0 $0	 $200 $600	The amount *you* must pay each year before the *plan* will begin paying any benefits. The family maximum is calculated on a combined dollar basis for all *covered persons* in the family. No one *covered person* will incur more than the individual maximum shown.	1-42
Individual Coinsurance per *Calendar Year*	80%	20%	After the deductible, the coinsurance applies to all *covered expenses* for the remainder of the *calendar year*.	1-42
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The deductible and coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.				

Retiree Under 65 Schedule of Benefits – continued

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	100%, up to $40 paid per day under the Base Benefit. Excess charges to Major Medical. Base benefit applies to the first 31 days per *confinement* After the first 31 days per *confinement*, deductible/80% under the Major Medical Benefit	Semi-private room and board, intensive care or coronary care and miscellaneous charges. Miscellaneous *hospital* charges (i.e. other *hospital* services and supplies, anesthesia and its administration) are paid at 100% under the Base Benefit, up to a maximum of $300 per *sickness* or *injury*. Excess charges are payable under the Major Medical Benefit.	1-45
Qualified Practitioner Office, Inpatient and Outpatient Hospital Visits	100%, up to $16 paid per visit under the Base Benefit. One visit allowed per day. Maximum of $300 paid per *calendar year* under the Base Benefit Excess charges payable at deductible/80% under the Major Medical Benefit	This benefit does not include x-ray and laboratory benefits. *Covered expenses* will be payable as stated in the X-ray and Laboratory Test benefit.	1-45
Qualified Practitioner Benefits – Surgery	Deductible/80% under the Major Medical Benefit		1-45
Qualified Practitioner Benefits – Anesthesia	Deductible/80% under the Major Medical Benefit		1-45
Oral Surgery	Deductible/80% under the Major Medical Benefit	Refer to list of covered oral surgeries in text.	1-45

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit Routine Exams and Immunizations for Covered Persons under Age 6	Deductible/80% under the Major Medical Benefit	Limited to 6 visits per *calendar year*. Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, and immunizations.	1-46
Wellness Benefit Routine Exams for Covered Persons Age 6 and Older Other Routine Services and Immunizations	Deductible/80% under the Major Medical Benefit 80%, deductible waived, under the Major Medical Benefit	Benefits include routine x-ray and laboratory tests, immunizations and routine endoscopic surgeries (i.e. colonoscopy). Please refer to the text for frequency limitations.	1-46
Outpatient Hospital Benefit (Facility Charge)	Deductible/80% under the Major Medical Benefit		1-46
Outpatient Hospital Surgery Benefit (Facility Charge)	Deductible/80% under the Major Medical Benefit		1-47
Ambulatory Surgical Center	Deductible/80% under the Major Medical Benefit		1-47
Emergency Room Benefit	Deductible/80% under the Major Medical Benefit	This benefit includes *emergency* room physician charges and other services provided in the *emergency* room. NOTE: *Emergency* room treatment is limited to *emergencies*, as defined in this *plan*. *Your* first non-*emergency* visit to the *emergency* room will be allowed as a *covered expense* under the *plan*. After this visit, *you* will receive notification explaining that non-*emergency* treatment received in the *emergency* room will no longer be a *covered expense*.	1-46
Urgent Care Center Benefits	Deductible/80% under the Major Medical Benefit	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all *covered expenses* performed during the visit.	1-47

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
X-ray and Laboratory Tests	100%, up to $50 paid per *calendar year* under the Base Benefit Excess charges payable at deductible/80% under the Major Medical Benefit	Dental x-rays limited to covered oral surgery or *injury*.	1-47
Ambulance Service Benefit	100% under the Base Benefit Charges do not excess to the Major Medical Benefit	Limited to $500 paid per trip, up to a maximum of two trips per *sickness* or *injury*. Limited to appropriate transport to the nearest facility equipped to treat the *sickness* or *injury*.	1-47
Pregnancy Benefit - Qualified Practitioner Charges	Deductible/80% under the Major Medical Benefit	Covered for *member*, spouse and *dependent* daughter.	1-47
Pregnancy Benefit - Facility Charges	Deductible/80% under the Major Medical Benefit	Covered for *member*, spouse and *dependent* daughter.	1-47
Newborn Benefits	Payable based on services received	See "Section 3 – Eligibility" for important information on *Dependent* Coverage.	1-47
Convalescent Nursing Home Benefit	Deductible/80% under the Major Medical Benefit	Limited to $2,500 paid per *lifetime*.	1-48
Home Health Care Benefit	Subject to a separate $100 deductible per *calendar year*, then 75%	40 visits per *calendar year*, when Home Health Care is in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-48

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Hospice Care Benefit	100% under the Base Benefit Charges do not excess to the Major Medical Benefit	Limited to $6,000 paid per *lifetime*. *Hospice care* must be in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-49
Psychological Disorders	Deductible/50% Charges do not excess to the Major Medical Benefit after the stated maximums have been reached	Inpatient/Transitional: Limited to 30 days per *calendar year*. Outpatient: Limited to 30 visits per *calendar year*. Both inpatient/transitional and outpatient treatment is limited to two *lifetime* events.	1-50
Chemical Dependence and Alcoholism Benefit	**Inpatient/ Transitional** 100% under the Base Benefit **Outpatient** 100% under the Base Benefit, up to a maximum of $50 paid per visit. Charges do not excess to the Major Medical Benefit after the stated maximums have been reached	Note: Treatment of chemical dependence and alcoholism is only a covered benefit for retirees (not *dependents*). All treatment of chemical dependence and alcoholism is limited to $15,000 paid per *lifetime*. Inpatient/Transitional: Limited to 28 days per *confinement*, up to a maximum benefit paid of $13,500 per *lifetime*. *You* must complete the entire 28-day stay. If *you* do not complete the entire 28-day stay, *your* treatment will not be covered by the *plan*. Outpatient: Limited to 30 visits, up to maximum benefit paid of $1,500 per *lifetime*. Outpatient benefits will **only** be available if *you* have first completed the 28-day inpatient stay.	1-50
Other Covered Expenses			1-51
Private Duty Nursing	Deductible/80% under the Major Medical Benefit	Limited to $10,000 paid per *lifetime*.	1-51
Blood	Deductible/80% under the Major Medical Benefit	Covered when not replaced by donation.	1-51

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prosthetic Appliances	Deductible/80% under the Major Medical Benefit	Limited to $1,500 paid per *calendar year*. *You* must obtain pre-authorization from the *plan* prior to purchasing a prosthetic appliance. If *you* do not obtain pre-authorization, benefits will not be payable.	1-51
Special Medical Supplies	Deductible/80% under the Major Medical Benefit	Catheters, colostomy supplies, casts, splints, braces etc.	1-51
Durable Medical Equipment	Deductible/80% under the Major Medical Benefit	Rental is covered up to the purchase price of the equipment.	1-51
Implantable Mechanical Devices	Deductible/80% under the Major Medical Benefit	Pacemaker, artificial hip etc.	1-51
Chiropractic Care	**Manipulations and Other Treatment** 100% under the Base Benefit, up to a maximum of $35 paid per visit. Charges do not excess to the Major Medical Benefit **Chiropractic X-Rays** Deductible/80% under the Major Medical Benefit	Limited to 30 visits per *calendar year*. Routine or maintenance care is not covered.	1-51
Physical and Occupational Therapy	100% under the Base Benefit, up to a maximum of $25 paid per visit. Charges do not excess to the Major Medical Benefit	Limited to a combined maximum of 30 visits per *calendar year*.	1-51

Comment [t4]: Amendment #2

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Speech Therapy	$25 copay per visit, then 100% under the Base Benefit. Charges do not excess to the Major Medical Benefit	Limited to a maximum of 50 visits per *calendar year*.	1-51
Respiratory Therapy	100% under the Base Benefit, up to a maximum of $25 paid per visit. Charges do not excess to the Major Medical Benefit		1-51
Radiation and Chemo Therapy	Deductible/80% under the Major Medical Benefit		1-51
Acupuncture	100% under the Base Benefit, up to a maximum of $35 per visit. Charges do not excess to the Major Medical Benefit	Limited to 30 visits per *calendar year*.	1-51
Pre-Admission Testing	100% under the Base Benefit, up to $300 paid per *sickness* or *injury*. Excess charges payable at deductible/80% under the Major Medical Benefit	Includes any related x-ray or laboratory tests.	1-51

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Second Surgical Opinion	100%, up to $50 paid per second opinion under the Base Benefit Excess charges payable at deductible/80% under the Major Medical Benefit		1-51
Organ Transplants	Transplant Network: Deductible/80% Non-Transplant Network: Not covered	Covered transplant expenses are subject to the following maximums: • $10,000 paid per transplant for procurement expenses • $10,000 paid per transplant for donor expenses (donor expenses only covered if not available to the donor from any other source) • $2,000 paid per transplant for ambulance expenses Please refer to list of covered transplants in text.	1-52
Vision Care Benefit	100% under the Base Benefit Charges do not excess to the Major Medical Benefit	Limited to a maximum benefit paid of $100 per *calendar year*. Benefits include vision exams, glasses, contacts and prescription sunglasses. *You* must obtain a voucher from the Fund Office for benefits to be payable. If *you* do obtain a voucher, benefits will be reimbursed through the Fund Office. This does not apply to *members* residing outside of the state of New York. *You* may receive treatment from a provider in *your* area and submit a claim to the *plan* for reimbursement.	1-53

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Hearing Aid Benefit	100% under the Base Benefit Charges do not excess to the Major Medical Benefit	Limited to a maximum benefit paid of $500 per 36-month period. Benefits include hearing exams, hearing aids and hearing aid repair.	1-53
Sleep Apnea Benefit Initial Testing and Equipment	 Deductible/80% under the Major Medical Benefit	After the initial testing, only equipment used to treatment sleep apnea is a *covered expense*. Benefits are limited to $2,000 paid per *lifetime*.	1-53
Limitations and Exclusions	Not Payable	List of exclusions that apply to all *covered expenses*. A service that is normally covered may be excluded when provided with an excluded item.	1-54

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay	**Retail** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to the lesser of a 30-day or 100-unit dosage. If *you* purchase *your* prescription drug from a Non-Participating pharmacy, benefits will be payable subject to a 30% copay, after the medical *plan* deductible. **Mail Order** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to 90-day supply. **Maintenance Drugs** Maintenance drugs should be obtained through the mail order program. If *you* do not use the mail order program, on the 3rd retail refill, *your* drug will not be covered by the *plan*. **Specialty Pharmacy** Specialty pharmacy drugs must be purchased through the Specialty Pharmacy Program or they will not be a *covered expense* under the *plan*. Specialty pharmacy drugs are generally considered to: • cost more than $250 per prescription, • be administered by injection or infusion, • treat rare, unusual or complex diseases, • require additional clinical oversight and expertise for best management.	1-59

RETIREE OVER 65 PLAN

Retiree Over 65 Plan *Calendar Year* Maximum: $50,000 per *covered person*, including base, major medical and prescription drug expenses.

PPO Option
A *PPO* option is available for *your* use. Bills from participating providers will be discounted by the *PPO* network prior to submission for payment. *You* are not responsible to pay any discounts taken by the *PPO* network. *PPO* claims are payable, subject to regular *plan* benefits, after the discount is taken.

RETIREE OVER 65 BASE BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year*	$0	$0	Base benefits are not subject to a deductible.	
Individual Coinsurance per *Calendar Year*	100%	0%	Applies to all *covered expenses* under the Base Benefits. Subject to any maximums as stated.	1-42

All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.

Medicare
Benefits payable under this *plan* are based on Medicare approved charges that are in excess of any Part A or B Medicare deductible.

RETIREE OVER 65 MAJOR MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year*	$0	$0	Major medical benefits payable under this *plan* are not subject to a deductible.	1-42
Individual Coinsurance per *Calendar Year*	80%	20%	Applies to all *covered expenses* under the Major Medical Benefits. Subject to any maximums as stated.	1-42

All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The coinsurance limits shown above apply to all *covered expenses* unless stated otherwise below.

Medicare
Benefits payable under this *plan* are based on Medicare approved charges that are in excess of any Part A or B Medicare deductible.

Retiree Over 65 Schedule of Benefits – continued

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Inpatient Hospital Benefit	Base Benefit for the first 60 days per *calendar year* After the first 60 days per *calendar year*, Major Medical Benefit	Semi-private room and board, intensive care or coronary care and miscellaneous charges.	1-45
Qualified Practitioner Office, Inpatient and Outpatient Hospital Visits	Major Medical Benefit		1-45
Qualified Practitioner Benefits – Surgery	Major Medical Benefit		1-45
Qualified Practitioner Benefits – Anesthesia	Major Medical Benefit		1-45
Oral Surgery	Major Medical Benefit	Refer to list of covered oral surgeries in text.	1-45
Wellness Benefit Routine Exams and Immunizations for Covered Persons under Age 6	Major Medical Benefit	Limited to 6 visits per *calendar year*. Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, and immunizations.	1-46
Wellness Benefit Routine Exams for Covered Persons Age 6 and Older Routine Pap Smear	Major Medical Benefits Major Medical Benefit	As with any other expense covered by the *plan*, covered wellness expenses for the Retiree Over 65 Plan **only** include those allowed by Medicare.	1-46
Outpatient Hospital Benefit (Facility Charge)	Major Medical Benefit		1-46
Outpatient Hospital Surgery Benefit (Facility Charge)	Major Medical Benefit		1-47

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Ambulatory Surgical Center	Major Medical Benefit		1-47
Emergency Room Benefit	Major Medical Benefit	This benefit includes *emergency* room physician charges and other services provided in the *emergency* room. NOTE: *Emergency* room treatment is limited to *emergencies*, as defined in this *plan*. *Your* first non-*emergency* visit to the *emergency* room will be allowed as a *covered expense* under the *plan*. After this visit, *you* will receive notification explaining that non-*emergency* treatment received in the *emergency* room will no longer be a *covered expense*.	1-46
Urgent Care Center Benefits	Major Medical Benefit	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all *covered expenses* performed during the visit.	1-47
X-ray and Laboratory Tests	Major Medical Benefit	Dental x-rays limited to covered oral surgery or *injury*.	1-47
Ambulance Service Benefit	Base Benefit Charges do not excess to the Major Medical Benefit	Limited to $500 paid per trip, up to a maximum of two trips per *sickness* or *injury*. Limited to appropriate transport to the nearest facility equipped to treat the *sickness* or *injury*.	1-47
Pregnancy Benefit - Qualified Practitioner Charges	Major Medical Benefit	Covered for *member*, spouse and *dependent* daughter.	1-47
Pregnancy Benefit - Facility Charges	Major Medical Benefit	Covered for *member*, spouse and *dependent* daughter.	1-47
Newborn Benefits	Payable based on services received	See "Section 3 – Eligibility" for important information on *Dependent* Coverage.	1-47

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Convalescent Nursing Home Benefit	Major Medical Benefit	Limited to $2,500 paid per *lifetime*.	1-48
Home Health Care Benefit	Subject to a separate $100 deductible per *calendar year*, then 75%	40 visits per *calendar year*, when Home Health Care is in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-48
Hospice Care Benefit	Base Benefit Charges do not excess to the Major Medical Benefit	Limited to $6,000 paid per *lifetime*. *Hospice care* must be in lieu of a covered *confinement* in a *hospital* or *convalescent nursing home*.	1-49
Psychological Disorders	50% Charges do not excess to the Major Medical Benefit after the stated maximums have been reached	Inpatient/Transitional: Limited to 30 days per *calendar year*. Outpatient: Limited to 30 visits per *calendar year*. Both inpatient/transitional and outpatient treatment is limited to two *lifetime* events.	1-50
Chemical Dependence and Alcoholism Benefit	Not covered		1-50
Other Covered Expenses			1-51
Private Duty Nursing	Major Medical Benefit	Limited to $10,000 paid per *lifetime*.	1-51
Blood	Major Medical Benefit	Covered when not replaced by donation.	1-51
Prosthetic Appliances	Major Medical Benefit	Limited to $1,500 paid per *calendar year*. *You* must obtain pre-authorization from the *plan* prior to purchasing a prosthetic appliance. If *you* do not obtain pre-authorization, benefits will not be payable.	1-51
Special Medical Supplies	Major Medical Benefit	Catheters, colostomy supplies, casts, splints, braces etc.	1-51

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Durable Medical Equipment	Major Medical Benefit	Rental is covered up to the purchase price of the equipment.	1-51
Implantable Mechanical Devices	Major Medical Benefit	Pacemaker, artificial hip etc.	1-51
Chiropractic Care	**Manipulations and Other Treatment** Base Benefit, up to a maximum of $35 paid per visit. Charges do not excess to the Major Medical Benefit **Chiropractic X-Rays** Major Medical Benefit	Limited to 30 visits per *calendar year*. Routine or maintenance care is not covered.	1-51
Physical and Occupational Therapy	Base Benefit, up to a maximum of $25 paid per visit. Charges do not excess to the Major Medical Benefit	Limited to a combined maximum of 30 visits per *calendar year*.	1-51
Speech Therapy	$25 copay per visit, then Base Benefit. Charges do not excess to the Major Medical Benefit	Limited to a maximum of 50 visits per *calendar year*.	1-51
Respiratory Therapy	Base Benefit, up to a maximum of $25 paid per visit. Charges do not excess to the Major Medical Benefit		1-51
Radiation and Chemo Therapy	Major Medical Benefit		1-51

Comment [t5]: Amendment #2

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Acupuncture	Base Benefit, up to a maximum of $35 per visit. Charges do not excess to the Major Medical Benefit	Limited to 30 visits per *calendar year*.	1-51
Pre-Admission Testing	Base Benefit, up to $300 paid per *sickness* or *injury*. Excess charges payable under the Major Medical Benefit	Includes any related x-ray or laboratory tests.	1-51
Second Surgical Opinion	Major Medical Benefit		1-51
Organ Transplants	Transplant Network: Major Medical Benefit Non-Transplant Network: Not covered	Covered transplant expenses are subject to the following maximums: • $10,000 paid per transplant for procurement expenses • $10,000 paid per transplant for donor expenses (donor expenses only covered if not available to the donor from any other source) • $2,000 paid per transplant for ambulance expenses Please refer to list of covered transplants in text.	1-52

RETIREE OVER 65 COVERED EXPENSES	**PAYABLE AT**	**BENEFIT SUMMARY**	**TEXT PAGE**
Vision Care Benefit	Base Benefit Charges do not excess to the Major Medical Benefit	Limited to a maximum benefit paid of $100 per *calendar year*. Benefits include vision exams, glasses, contacts and prescription sunglasses. *You* must obtain a voucher from the Fund Office for benefits to be payable. If *you* do obtain a voucher, benefits will be reimbursed through the Fund Office. This does not apply to *members* residing outside of the state of New York. *You* may receive treatment from a provider in *your* area and submit a claim to the *plan* for reimbursement.	1-53
Hearing Aid Benefit	Base Benefit Charges do not excess to the Major Medical Benefit	Limited to a maximum benefit paid of $500 per 36-month period. Benefits include hearing exams, hearing aids and hearing aid repair.	1-53
Sleep Apnea Benefit Initial Testing and Equipment	Major Medical Benefit	After the initial testing, only equipment used to treatment sleep apnea is a *covered expense*. Benefits are limited to $2,000 paid per *lifetime*.	1-53
Limitations and Exclusions	Not Payable	List of exclusions that apply to all *covered expenses*. A service that is normally covered may be excluded when provided with an excluded item.	1-54

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	100%, after copay	**Retail** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to the lesser of a 30-day or 100-unit dosage. If *you* purchase *your* prescription drug from a Non-Participating pharmacy, benefits will be payable subject to a 30% copay. **Mail Order** 10% copay per generic drug/refill; 20% copay per brand name drug/refill. Limited to 90-day supply. **Maintenance Drugs** Maintenance drugs should be obtained through the mail order program. If *you* do not use the mail order program, on the 3rd retail refill, *your* drug will not be covered by the *plan*. **Specialty Pharmacy** Specialty pharmacy drugs must be purchased through the Specialty Pharmacy Program or they will not be a *covered expense* under the *plan*. Specialty pharmacy drugs are generally considered to: • cost more than $250 per prescription, • be administered by injection or infusion, • treat rare, unusual or complex diseases, • require additional clinical oversight and expertise for best management.	1-59

Schedule of Benefits – continued

DENTAL BENEFITS

CALENDAR YEAR INDIVIDUAL MAXIMUM BENEFIT

Members and *dependent* spouses: $2,000
Dependent children: $1,000

DENTAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year*			The dental benefits do not have a deductible.	
Pre-Existing Conditions	0%	100%	For *members* and their eligible *dependents*, enrolled in the *plan* on or after 1/1/09, benefits for conditions existing prior to *your enrollment date* may be limited during *your* first 12 months of coverage. The Pre-Existing Condition Limitation does not apply to retirees and their eligible *dependents*.	**Error! Bookmark not defined.**
Covered dental expenses are only those listed in the Tables of Covered Dental Charges, beginning on page 1-60. Charges are payable up to the allowable amount listed on the Tables of Covered Dental Charges. **PPO Option** A *PPO* option is available for *your* use. Bills from participating providers will be discounted by the *PPO* prior to submission for payment. *You* are not responsible to pay any discounts taken by the *PPO*. *PPO* claims are payable, subject to regular *plan* benefits, after the discount is taken.				

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Preventive Services	100%	Oral exams, routine cleanings, bitewing and full mouth x-rays, fluoride treatments and sealants. Oral exams, cleaning and scaling of teeth and x-rays received as part of an oral exam, are limited to once per 6-month period.	1-60

COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Basic Services	80%	Emergency services, fillings, endodontics, periodontics, and oral surgery. Treatment of periodontal disease is limited to 4 treatments per 12-month period.	1-60
Major Restorative Services	50%	Inlays, onlays, crowns, bridges and dentures.	1-61
Limitations and Exclusions	Not Payable	This is a list of exclusions that apply to all covered expenses.	1-63

Schedule of Benefits – continued

DISABILITY BENEFITS FOR ACTIVE MEMBERS ONLY	BENEFIT SUMMARY
Disability Benefit	Benefits are provided according to the provisions of the New York State Disability Benefits Law. As of 1/1/09, the benefit is 50% of *your* **average weekly wage**. Benefits will not exceed a maximum of $170 per week.
Elimination Period	Benefits are payable from: Day 8 *injury* Day 8 *sickness*
Maximum Benefit Period	26 weeks per period of disability.
Average weekly wage means the *member's* basic wage, salary or earnings from the contributing employer. Commissions, bonuses, overtime and other special payments are **not** included.	

Schedule of Benefits – continued

DEATH OR DISMEMBERMENT BENEFITS (FOR MEMBERS ONLY)

Your death and dismemberment benefits provide valuable financial protection for *your* family members or other beneficiary, in case of *your* death, or for *you*, if *you* are severely hurt in an accident. These benefits include:

- Death benefit, or
- Dismemberment benefit

Plan Benefits

The amount of *your* death and dismemberment benefit is based on *your* period of continuous service from *your* date of employment, as shown in the following table. Retirees are only eligible for the death benefit. Benefits will be payable through the Fund Office.

IF YOUR PERIOD OF CONTINUOUS SERVICE FROM DATE OF EMPLOYMENT IS:	YOUR DEATH BENEFIT IS:	YOUR DISMEMBERMENT BENEFIT IS:	TEXT PAGE
Less Than 5 Years	$8,000	$8,000	1-67
5 Years But Less Than 10 Years	$13,000	$12,000	1-67
10 Years or More	$25,000	$20,000	1-67
Retirees 1. If *you* are a retiree who is not receiving medical benefits through the Fund, *you* will receive a $5,000 death benefit, if *you* are a member in good standing with the *union*, as evidence of proof of continuous service. 2. If *you* are a retiree who is receiving medical benefits through the Fund, *you* will receive a $10,000 death benefit, if *you* are a member in good standing with the *union* as evidence of proof of continuous service.			1-67

PPO NETWORK INFORMATION

PPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the *plan's* incentives to use *PPO* providers. These contracts establish a fair market value for health care services, which in most cases will reduce *your* costs.

The *Board of Trustees* has contracted one or more *PPO's* to provide services to this *plan* in the areas it has *members*. Each *PPO* network consists of physicians, *hospitals* and other medical care providers. The *PPO* that is applicable to *you* is shown on *your* ID card.

A directory of providers that are part of *your PPO* network will automatically be provided to *you* at no charge. The provider directory is a separate document from this *plan*. The directory contains the name, address and phone number of the providers that are part of the *PPO* network.

Any *plan* limits on access to specialist or emergency care, use of primary care physicians, or pre-authorization of benefits are shown on the Schedule of Benefits.

HOW TO FILE A MEDICAL CLAIM

You will receive a *plan* identification (ID) card. It will show *your* name, group number and the effective date of *your* coverage.

PPO provider bills should be sent to the *PPO* address on *your* ID card. Non-*PPO* provider bills can be sent directly to the *claims administrator*, UMR, on a standard government claim form. **UMR does not require special claim forms.** *You* can mail the bills directly to UMR if the provider does not forward them. Mail the bills to:

Attention: Claim Department
UMR
2700 Midwest Drive
Onalaska, WI 54650-8764

Be sure each bill shows the group number and participant number found on *your* ID card. The *member's* name and the patient's name should also be included on each bill.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items *you* purchased yourself should be sent to UMR at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, *member* name, patient name, name of prescribing *qualified practitioner* and date purchased.

PAYMENT OF CLAIMS

The *plan* will make direct payment to the service provider. If *you* have paid the bill, please indicate on the original bill "paid by *member*" and payment will be made to *you*. *You* will receive a written explanation of payment or reason for denial of any portion of a claim. The *plan* reserves the right to request any information required to determine benefits or process a claim. *You* or the service provider will be contacted if additional information is needed to process *your* claim.

CLAIM FILING LIMITS

You must provide the *plan* with written proof of *your* claim. *Your* claim will not be denied if it was not reasonably possible to give such proof. However, unless *you* were legally incapacitated during the period, any claim received by the *plan* more than 180 days after the date the claim was incurred will not be covered under the *plan*.

If the *plan* is terminated, written proof of any claims incurred prior to the termination must be given to the *plan* within 90 days of its termination. Any claim received by the *plan* more than 90 days after it is terminated will not be covered under the *plan*.

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Deductible

The deductible applies to each *covered person*, each *calendar year*. Only charges that are a *covered expense* will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

In certain cases, a *covered expense* may be used toward *your* deductible for this *calendar year* and as a credit to *your* deductible for the next *calendar year*. This will occur when the expense is incurred during the last three months of the *calendar year* and is used to satisfy all or part of the deductible for that year.

Maximum Family Deductible

The maximum deductible per family is shown on the Schedule of Benefits. No further deductibles will be taken during a *calendar year* once this maximum has been met.

Common Accident Deductible

When more than one *covered person* in a family is involved in the same *accident,* only one deductible per *calendar year* will be applied to all *covered expenses* resulting from that *accident*. The same will apply if two or more *covered persons* in a family get the same contagious disease within ten days of each other.

Coinsurance

The deductible must be satisfied each *calendar year*. Benefits are then payable at the percentage rate shown on the Schedule of Benefits for the remainder of the *calendar year*. Benefits are payable up to any *plan* maximums on a *customary, usual and reasonable* basis.

RETIREE OVER 65 PLAN

Medicare Deductible

The *Medicare* deductible is the amount of covered expenses each *covered person* must pay during the *calendar year* before *Medicare* will consider expenses for reimbursement.

This *plan* does not reimburse *you* for the *Medicare* deductible.

Services Covered By Medicare

Medicare Part A assists *you* with expenses for hospital services, services provided by a skilled nursing facility, home health care, services provided by a hospice facility and durable medical equipment.

Medicare Part B assists *you* with expenses for *qualified practitioner* home and office visits, home health care, physical therapy, speech pathology, outpatient hospital services, x-rays, lab tests, ambulance services and durable medical equipment.

When all of the provisions of this *plan* are satisfied, the *plan* will provide benefits as outlined on the Schedule of Benefits. Total benefits for any covered service payable under *Medicare* and this *plan* will not exceed the *Medicare* approved amount for that service.

NOTICE REQUIREMENTS

HOW THE PROGRAM WORKS

When *you* call UM, *you* will be asked the following questions:

1. Group name and number
2. Name of *member*
3. *Member's* Social Security #
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once notice is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new notice must be made if: you do not receive the treatment within 30 days of the scheduled date; *you* use a different facility or physician; or *you* are admitted for a different reason.

NOTICE REQUIREMENTS

You are required to notify UM prior to receiving certain types of health care. The services that require prior notice are listed on the Schedule of Benefits. **If *you* fail to provide notice as required, benefits may be reduced or denied.**

NOTIFICATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL *PLAN* PROVISIONS.

NON-COMPLIANCE PENALTY

If *you* fail to provide notice, *your* treatment will be reviewed when a claim is received. If it is determined to be a *covered expense*, benefits that are otherwise payable will be reduced as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken after subtracting the deductible.

If *your* treatment is not a *covered expense*, no benefits will be payable under the *plan*.

SECOND OPINION

UM may suggest the need for a second opinion. Benefits for the second opinion will be paid as stated on the Schedule of Benefits. *You* may go to a *qualified practitioner* of *your* choice.

NOTICE SECONDARY COVERAGE WAIVER

If this *plan* is secondary to another medical plan that also covers you, notice will not be required.

CASE MANAGEMENT

Case management services help *you* use *your* benefits wisely during periods of treatment due to a serious *sickness* or *injury*. This is done through early identification of the need for case management in UM. Followed by on-going work with *you* and *your* provider to plan health care alternatives to meet *your* needs. The case manager will try to conserve *your* benefits by making sure that *your* care is handled as efficiently as possible.

The case management staff at UM consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to *you* and *your* doctors, case management helps to control health care costs and use *your* benefits wisely.

MEDICAL BILL REVIEW

You should carefully review *your* bill for any service. If *you* find any errors such as:

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received;

you should report them to the provider of service and request a corrected itemized billing. *You* should then submit copies of the original bill, with the errors circled, and the corrected bill to the *claim administrator*. This serves as proof that the provider of service agreed to the corrections. **If *you* are correct, *you* will receive 50% of the errors in the bill, but not more than $250 per bill.**

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for these services furnished during *your hospital confinement* are payable as shown on the Schedule of Benefits:

1. Room and board charges for: average daily semi-private; ward; intensive care; isolation or coronary care. General nursing services for each day of *confinement*. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the *hospital*, unless necessary due to *your sickness* or *injury*.

2. Services and supplies provided for the treatment of *your sickness* or *injury*. Benefits include services of a radiologist, pathologist and anesthesiologist, when billed directly by the *hospital* or separately.

QUALIFIED PRACTITIONER BENEFITS

Charges for these services of a *qualified practitioner* are payable as shown on the Schedule of Benefits:

1. Home and office visits;

2. Inpatient and outpatient *hospital* visits;

3. Administration of anesthesia;

4. Surgical procedures, including post-operative care.

Benefits are not payable for incidental procedures done during a covered surgery (e.g. the removal of a healthy appendix during abdominal surgery).

Oral Surgery

Charges made for these oral surgeries are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. *Hospital* or *ambulatory surgical center* services are also covered.

1. Excision of partially or completely unerupted, impacted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;

3. Surgeries required to correct *accidental* injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;

4. Reduction of fractures and dislocations of the jaw;

5. External incision and drainage of cellulitis;

6. Incision of accessory sinuses, salivary glands or ducts;

7. Frenectomy (the cutting of the tissue in the midline of the tongue); and

8. Repair of or initial replacement of natural teeth damaged due to *injury*. To be a *covered expense* under the *plan*, the replacement expense must be incurred within six months of the *injury*. Damage resulting from biting or chewing will not be considered an *injury*.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. *Covered expenses* for the Active Member Plan and Retiree Under 65 Plan include:

1. Routine physical exams, limited to once per *calendar year*. For the retiree plans, routine exams are not a *covered expense*;

2. Routine x-ray and laboratory tests. Benefits include one routine mammogram and one routine pap smear per *calendar year* for any covered female person;

3. Routine immunizations. Immunizations for Lyme disease are not covered;

4. Well child care services, including school/sport exams. For covered *dependents* under 6 years of age, limited to 6 visits per *calendar year*. For covered *dependents* age 6 and older, limited to one well child exam per *calendar year*. For the retiree plans, routine exams for covered dependents age 6 and older are not a *covered expense*;

5. Routine endoscopic surgeries (e.g. colonoscopy).

Covered wellness expenses for the Retiree Over 65 Plan **only** include those allowed by Medicare.

In addition to the general Limitations and Exclusions of the *plan*, no benefits are payable under this Wellness Benefit for:

1. Medical examinations for *injury* or *sickness*;

2. Medical examinations caused by or related to a pregnancy;

3. Eye examinations for the purpose of prescribing corrective lenses;

4. Hearing tests; or

5. Any dental examinations.

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient *hospital* services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of *your sickness* or *injury*;

2. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by *your* attending *qualified practitioner*; and

3. *Emergency* room charges, but **only** if incurred due to:

    a. *emergency accident* treatment provided within 24 hours of the *accident*,
    b. a surgical procedure, or
    c. treatment of a *sickness* that is a medical emergency.

OUTPATIENT HOSPITAL SURGERY BENEFIT

Outpatient surgery is payable as shown on the Schedule of Benefits. It must be done in an *ambulatory surgical center* or outpatient *hospital*. All *covered expenses* with a direct relation to performing the surgery are included.

URGENT CARE CENTER BENEFIT

Charges for *covered expenses* provided by an *Urgent Care Center* are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by an *ambulatory surgical center* for use of the facility in performing a covered surgery are payable as shown on the Schedule of Benefits. *Hospital* miscellaneous services provided in the facility are also covered.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A *qualified practitioner* must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered *injury* or oral surgery.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service are payable as shown on the Schedule of Benefits. If *you* need care that is not available in a local *hospital*, transport to the nearest *hospital* that can provide the care is covered. If *you* require care that is not available by ground ambulance, air ambulance service to the nearest *hospital* that can provide the care is covered.

PREGNANCY BENEFIT

Charges for pregnancy are payable as shown on the Schedule of Benefits for any covered female person. *Complications of pregnancy* are payable as a *sickness* at the point the complication sets in.

In general, Federal law prohibits group health plans and health insurance issuers from limiting benefits for any *hospital* stay in connection with childbirth to less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. This law applies equally to the stay of the mother and the stay of the newborn. This law does not generally prohibit the attending provider of the mother or newborn from discharging them, after consulting the mother, at an earlier time than the 48 hours (or 96 hours as applicable). In any case, *plans* and issuers may not, under Federal law, require that a provider or *member* obtain authorization from the *plan* or the insurance issuer for prescribing a length of stay that is not in excess of 48 hours (or 96 hours).

NEWBORN BENEFITS

This benefit does **not** apply unless *you* enroll *your* newborn *dependent* within 30 days of the date of birth. See the "Eligibility" section of this booklet for more information.

Well-Newborn

Charges for these services for a well-newborn are payable as shown on the Schedule of Benefits: hospital nursery services; circumcision of a male child; routine examination of the newborn child before release from the *hospital*.

Sick-Newborn
Charges for these services for a sick-newborn are payable as shown on the Schedule of Benefits: treatment of *injury* or *sickness*; care and treatment for premature birth; treatment of medically diagnosed birth defects and abnormalities; and surgery to repair or restore normal body functioning. *Covered expenses* do **not** include plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to *injury*, infection or other disease of the involved part; or

2. Congenital disease or anomaly that resulted in a functional defect.

CONVALESCENT NURSING HOME BENEFIT

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

Limitations
Benefits are only payable for a *confinement* that:

1. Begins within 14 days of discharge from a *hospital* or prior *convalescent nursing home confinement* of at least three consecutive days;

2. Is necessary for care of the same *injury* or *sickness* which caused the prior *confinement*; and

3. Occurs while *you* are under the care of the *qualified practitioner* who ordered the *confinement*.

HOME HEALTH CARE BENEFIT

Charges for Home Health Care, as described below, are payable as shown on the Schedule of Benefits. Benefits will not exceed the *customary, usual and reasonable* fee for care in a *convalescent nursing home*.

Each visit to evaluate the need for home health care will be considered one home health care visit. Each visit to develop a plan of home health care will be considered one home health care visit. Each four hour period of home health aide service will be considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof.

Home Health Care will **not** be covered unless a *qualified practitioner* certifies that:

1. *Confinement* in a *hospital* or *convalescent nursing home* would be required without the home care;

2. Necessary care is not available from *your family members* or other persons residing with *you*, without causing undue hardship;

3. The home health care services will be provided or coordinated by a state-licensed or *Medicare*-certified *home health care agency* or certified rehabilitation agency.

If *you* were in a *hospital* prior to starting home health care, the home health care plan must also be approved by the primary provider of services during *your hospital* stay.

A home health care plan may consist of:

1. Part-time home nursing care by or under the supervision of a registered nurse (R.N.);

2. Part-time home health aide services provided under the supervision of a registered nurse (R.N.) or medical social worker. Services must consist solely of caring for the patient;

Home Health Care - continued

3. Physical, respiratory, occupational or speech therapy;

4. Medical supplies and drugs prescribed by a *qualified practitioner*. Lab tests by or on behalf of a *hospital*, when necessary under the home care plan;

5. Nutritional counseling provided under the supervision of a registered or State certified dietician, when such services are necessary as part of the home care plan; and

6. An evaluation of home health care needs. The development of a home health care plan. This service may be done by an R.N., physician assistant or medical social worker.

HOSPICE CARE BENEFIT

Charges for these *hospice care* services are payable as shown on the Schedule of Benefits. H*ospice care* must be in lieu of a covered *hospital* or *convalescent nursing home confinement*.

1. Room and board;

2. Part-time nursing care by or supervised by a registered nurse (R.N.);

3. Counseling by a licensed clinical social worker. Counseling by a pastoral counselor. Benefits are provided for the hospice patient and immediate family;

4. Medical social services provided to *you* or *your* immediate family. Services include:

   a. assessment of social, emotional and medical needs, and the home and family situation, and
   b. identification of the community resources available and assisting in obtaining those resources;

5. Dietary counseling;

6. Consultation and case management services;

7. Physical or occupational therapy;

8. Part-time home health aide service;

9. Chemo and radiation therapy for symptom control; and

10. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Limitations

Hospice care must be furnished in a *hospice facility* or by a *hospice care agency* in *your* home. A *qualified practitioner* must certify that *you* are terminally ill with a life expectancy of six months or less. For *hospice care* only, *your* immediate family is *your* parent, spouse and *dependent* children.

Hospice care benefits do **not** include: private or special nursing services; a *confinement* not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; or services by a licensed pastoral counselor to a member of his congregation.

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

Inpatient and Transitional Treatment Benefits

Charges for inpatient treatment are payable as shown on the Schedule of Benefits. Charges for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services for alcohol and chemical dependence provided by a residential treatment program; and services for alcoholism and other chemical dependence provided in a day treatment program. Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Charges for outpatient treatment are payable as shown on the Schedule of Benefits. Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations

Benefits do **not** include: 1. Treatment of nicotine habit or addiction; 2. Treatment of being overweight or obese; 3. Marriage counseling; or 4. Court ordered examinations or counseling.

OTHER COVERED EXPENSES

These other *covered expenses* are payable as shown on the Schedule of Benefits:

1. Private duty services of a registered nurse (R.N.) for inpatient or outpatient nursing care. Private duty services of a licensed practical nurse (L.P.N.) for inpatient or outpatient nursing care. Care must be ordered by *your* attending *qualified practitioner*.

2. Blood and blood plasma that is **not** replaced by donation. Blood and blood products including blood extracts or derivatives.

3. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices will only be covered when necessary due to a pathological change. Repair and maintenance expenses are not covered.

4. Special supplies when prescribed by *your* attending *qualified practitioner* and necessary for the continuing treatment of a *sickness* or *injury*:

   a. catheters,
   b. colostomy bags, belts and rings,
   c. flotation pads,
   d. custom molded orthotic devices,
   e. casts, splints, surgical dressings, trusses, braces and crutches,
   f. oxygen and other gases,
   g. initial contact lenses or eyeglasses following cataract surgery.

5. Rental of durable medical equipment or purchase of such equipment when approved by the *plan* (e.g. wheelchair, *hospital* bed, insulin infusion pump). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an *injury* or *sickness*. Repair expenses are not covered, unless the equipment has been purchased. Maintenance expenses are not covered. Convenience items, as determined by the *plan*, are not covered. Unless approved by the *plan* benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

6. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

7. Chiropractic care for the treatment of an *injury* or *sickness*. Routine or maintenance chiropractic care is not a *covered expense*.

8. Treatment by a licensed: physical therapist; speech therapist; respiratory therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an *injury* or *sickness*.

9. Radiation therapy and chemotherapy.

10. Acupuncture, when received from a licensed acupuncturist.

11. Pre-admission testing, if the tests are ordered by *your qualified practitioner* after a *medical condition* has been diagnosed and if an inpatient *hospital* admission has been arranged.

12. Second surgical opinions, including any related x-ray or laboratory tests. *You* may go to a *qualified practitioner* of *your* choice, however, the *qualified practitioner* may not be in practice with the practitioner who gave the initial opinion.

Other Covered Expenses - continued

13. Tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to *sickness* or *injury*.

14. These human organ or tissue transplants. The transplant must be provided from a human donor to a living human recipient:

    a. bone marrow transplants;
    b. heart transplants;
    c. heart lung transplants (combined procedures);
    d. kidney transplants;
    e. liver transplants;
    f. lung transplants;
    g. pancreas transplants;
    h. pancreas kidney transplants (combined procedures);
    i. small bowel transplants; and
    j. small bowel liver transplants (combined procedures).

    NOTE: THE *PLAN* SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS *YOU ARE AWARE OF* THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR *YOU*. ACCESS TO THE TRANSPLANT NETWORK IS SUBJECT TO THE *PLAN'S* ONGOING COORDINATION.

    The *plan* will provide *you* with a list of Transplant Network facilities. It will help to coordinate *your* referral and access to the facility of *your* choice. Only facilities that are participating in the Transplant Network at the time of *your* admission are Transplant Network facilities.

    When both the recipient and donor are covered by this *plan*, each is entitled to benefits.

    When only the recipient is covered by the *plan*, both the donor and the recipient are entitled to benefits. The donor's benefits are limited to those not available to the donor from any other source, subject to the applicable limitations of the *plan*. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the *plan*.

    When only the donor is covered by the *plan*, the donor is entitled to benefits. The benefits are limited to only those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. No benefits are provided to the non-covered transplant recipient.

    If any organ or tissue is sold rather than donated, no benefits are payable for the purchase or removal of such organ or tissue. Other costs related to the evaluation and procurement are covered for a recipient who is covered under this *plan*.

Other Covered Expenses – continued

15. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

    a. reconstruction of the breast that was removed,
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
    c. prostheses to replace the breast that was removed, and
    d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

    Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the *plan*. *Covered expenses* will be payable as any other *sickness* or *injury*.

16. Vision care benefits. *Covered expenses* include routine vision exams (including the refraction charge), glasses, contacts and prescription sunglasses. For *covered persons* enrolled in the Active Member Plan and Retiree Under 65 Plan, benefits will be payable through the Fund Office. For *covered persons* enrolled in the Retiree Over 65 Plan, benefit will be payable through this medical *plan*.

17. Hearing exams, hearing aids and hearing aid repair.

18. Sleep apnea. If *you* are diagnosed with sleep apnea, after the initial testing, *covered expenses* are limited to equipment only, subject to the maximum stated on the Schedule of Benefits. Follow-up visits are not a *covered expense*.

MEDICAL LIMITATIONS AND EXCLUSIONS

This *plan* does **not** provide benefits for:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy, herbal therapy, vitamin therapy, and hypnotherapy;

2. **Mechanotherapy** or other forms of passive motion therapy, unless specifically approved by the *plan*;

3. **Athletic training** or rehabilitation services; or

4. **Vertebral Axial Decompression (VAX-D)**.

DENTAL

1. **Dental care** or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated;

2. **Dental implantology** techniques, including prosthetic devices related to such techniques; or

3. **Surgical and non-surgical treatment of any jaw joint problem**, including but not limited to appliances and therapy. Jaw joint problems include: temporomandibular joint disorder (**TMJ**); craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and skull; conditions of the facial muscles used in expression or mastication; and symptoms thereof including headaches. Treatment will be a *covered expense* if due to organic joint disease or physical trauma such as a dental accident.

DRUGS

1. **Birth control drugs**, biologicals, implants, injections, patches and devices;

2. Charges for **prescription drugs**, except when not covered by the *plan's* Prescription Drug Card and not excluded under any other provision of this *plan*; or

3. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a** *qualified practitioner* **(OTC - over the counter)**. OTC items specifically stated in this plan as a *covered expense* will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a *qualified practitioner's* office, *hospital* or other facility it will be covered.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Any **drug which is not approved for marketing by United States Food and Drug Administration (FDA)** by issuance of a New Drug Application or other form of formal approval. This includes new drugs which have reached a Phase 3 clinical testing for the treatment of HIV;

Medical Limitations and Exclusions – continued

2. Any medical procedure that on the date performed is consistent with an **experimental or investigative** protocol. Such protocol will be determined by the rules of the United States Department of Health and Human Services and its Agencies, Bureaus, Institutes and Divisions;

3. Any **medical procedure or drug that is approved for use, but is not used for the specific indication that led to its approval** unless the *plan* determines the use to be appropriate based on generally accepted medical practice; or

4. Any **medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect** on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting. Decisions to cover, or exclude, a treatment will be based on the conclusions of prevailing medical research.

   If *you* have a life threatening condition (e.g. likely to cause death within one year), the *plan* may provide coverage for a treatment that would otherwise be excluded under this provision. The *plan* reserves sole discretion to make this determination. Such coverage will only be approved if a treatment is provided under a specific research protocol that meets standards equal to those of the National Institutes of Health and has shown promise in limited use.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to *injury*, infection or other disease of the involved part is a *covered expense* when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;

2. Any charges for, relating to or resulting from **sex change operations**;

3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;

4. Any treatment or services for **weight control or reduction**. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs;

5. Any treatment of **obesity or morbid obesity**, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy);

6. **Wigs** or artificial hairpieces;

7. Any treatment of **gynecomastia** (enlargement of the breast tissue in males); or

8. Any treatment of **hyperhidrosis** (excessive sweating).

PRE-EXISTING CONDITIONS

1. **For *members*, and their eligible *dependents*, enrolled in the *plan* on or after 1/1/09, pre-existing conditions**. A sickness or *injury* is pre-existing if *you* received treatment or drugs for it during the six-month period immediately prior to *your enrollment date*. Treatment includes initial diagnosis or medical advice of the condition. Unless *you* satisfy one of the exceptions listed below, *you* will not be covered for Pre-Existing conditions if *you* have a lapse in coverage from any *plan* of more than 63 days. Pre-existing conditions are covered after the end of a period of 12 months from *your enrollment date*.

   Pre-Existing Condition Exceptions

   The exclusion will not apply:
   a. to retirees and their eligible *dependents*;
   b. to any *covered expenses* due to pregnancy,
   c. to a newborn *dependent* child. Such child must be enrolled for coverage within 30 days of the date of birth. A child that is provided coverage under the Mother's plan of benefits will be considered to be enrolled as of the date of birth,
   d. to a *dependent* child that is adopted or placed for adoption prior to their 18th birthday. Such child must be enrolled for coverage within 30 days of the adoption or placement,
   e. to any condition that has not been diagnosed by a *qualified practitioner*, but has been indicated by genetic testing, and
   f. to any *covered expenses* that are determined pre-existing conditions, up to a maximum of $300,000, in the first 12 months from *your* enrollment date. After the first 12 month period expires *you* will be covered, up to *your lifetime* maximum of $2 million, less any *covered expenses* that were paid in the first 12 months.

   Pre-Existing Condition Credit
   Credit will be given under the pre-existing condition limitation, for all benefits, to the extent of *your* continuous coverage, without a lapse of more than 63 days. Coverage under any of the following plans is creditable: a. a group health plan; b. group, individual or other form of health insurance; c. Medicare (Part A, B or C); d. Medicaid; e. the Active Military Health Program or TRICARE; f. a medical program of the Indian Health Service or of a tribal organization; g. a State sponsored health benefits risk sharing pool; h. the Federal Employees Health Plan; i. a Peace Corp. Health Program; j. a public health plan that provides health coverage by insurance or other means including any plan established by the U.S. government, a State, a foreign country, or any political subdivision thereof; k. a State Children's Health Insurance Program (CHIPS).

   When *you* have coverage under a *plan*, *you* have the right to request written proof of that coverage at any time. When *your* coverage under a *plan* ends, *you* will be given written proof of coverage under that *plan*. It is *your* responsibility to provide this *plan* with this proof of coverage. If *your* prior plan did not provide *you* with proof of *your* coverage, this *plan* will assist *you* in providing proof of coverage by other means. Upon receiving proof of *your* prior coverage, *you* will be notified if there is any remaining pre-existing condition limit that may be applied.

PROVIDERS

1. Any service or supply:

   a. provided while *you* are **not under the regular care of a** *qualified practitioner*,
   b. **not authorized or prescribed by a** *qualified practitioner*,
   c. authorized or prescribed by a *qualified practitioner*, but **excluded under this** *plan***;** or

2. Services provided by a **person who ordinarily resides in** *your* **home** or who is a *family member*;

Medical Limitations and Exclusions – continued

3. **Telephone, computer or Internet consultations** between *you* and any provider. Completion of claim forms or forms necessary for *your* return to work or school. Any appointment *you* did not attend;

4. Charges for a **standby surgical team**, unless surgery is actually performed; or

5. **After hour charges in relation to a service performed during normal operating hours** for the provider.

REPRODUCTION

1. **Elective abortions** performed by any means including surgical and pharmaceutical methods;

2. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs;

3. Treatment, services or supplies for a **surrogate mother** or any pregnancy resulting from *your* service as a surrogate mother;

4. Treatment of a **sexual dysfunction**, including, but not limited to sexual counseling or therapy, implants and hormonal therapy;

5. **Genetic testing or counseling**, unless used to treat the *sickness* or *injury* of a *covered person* or used in the treatment of a high risk pregnancy; or

6. **Elective sterilization** procedures or the **reversal of voluntary sterilization** procedures.

ROUTINE AND GENERAL HEALTH

1. **Vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders, eyeglass repair. The initial purchase of eyeglasses or contact lenses after a cataract surgery is a *covered expense*;

2. **Health check-ups or routine exams and immunizations**; prophylactic surgery to prevent a *sickness* that has not occurred yet; or third party exams, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment, travel or the purchase of insurance; unless specifically stated as a *covered expense*;

3. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction; or

4. **Diabetic education** classes or programs.

SERVICES UNDER ANOTHER PLAN

1. Any *injury* or *sickness* arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which *you* would not be required to pay if *you* did not have this coverage;

3. Any charges that **would have been paid by** *your* **primary plan** had *you* complied with all of the pre-certification requirements of that plan;

4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include *Medicare* or Medicaid); or

5. Any service or supply provided in the care of any service related *injury* or *sickness* (past or present) **if** *you* **are in a** *hospital* **or facility owned or operated by the United States Government** or any of its agencies.

OTHER

1. Charges **in excess of the** *customary, usual and reasonable* **charge** for the service or supply;

2. Any service or supply that does **not** meet the ***plan's*** **guidelines for** ***clinical eligibility for coverage***;

3. *Custodial care*;

4. Any medical expense incurred **after the date** *your* **coverage under the** *plan* **terminates**, except as specifically described;

5. Charges incurred **outside the United States** if *you* traveled to such location to obtain the service, drug or supply;

6. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony**;

7. Any loss caused or contributed to by:

   a. **war or any act of war**, whether declared or not, or
   b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

8. **Educational testing or training or recreational therapy**;

9. Services or treatment for **behavioral problems, learning disabilities, developmental delays**, or other *medical conditions* that do not constitute a distinct medical diagnosis;

10. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;

11. The treatment of psychological disorders, chemical dependence or alcoholism except as stated;

12. ***Hospital*** **admission kits**;

13. Any treatment that is provided to **enhance the life style of a person without treating** a *sickness* or *injury*;

14. Any service or supply provided in connection with or **as a result of any service or supply that is not a** *covered expense*; or

15. Charges for treatment of any **intentionally self-inflicted** ***sickness*** **or** ***injury***, including suicide or attempted suicide except those resulting from domestic violence or medical (including both physical and mental) health conditions.

PRESCRIPTION DRUG CARD

A directory of participating pharmacies is available on the Drug Card's web site. *You* will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a separate document from this *plan*. The directory contains the name, address and phone number of the pharmacies that are part of the Drug Card.

Covered Drugs

Your Drug Card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." *Your* pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on *your* ID card. A complete list of covered and excluded drugs is available on the Drug Card's web site. If *you* are unable to access the Drug Card's web site, the *plan* will provide a copy upon request at no charge.

Please note that covered drugs do not include prescription drugs used to treat chemical dependence or alcoholism.

How To Use The Prescription Drug Card

Present the ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If *you* are without *your* ID Card or at a non-participating pharmacy, *you* may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from the Fund Office.

Mail Order Drug Service

If *you* are using an on going prescription drug, *you* must purchase that drug on a mail order basis. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an on going medical condition and are taken on a regular basis.

The copay for mail order prescriptions is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card service. Order forms are available at the Drug Card's web site or from the Fund Office. All prescriptions will be mailed directly to *your* home.

COVERED DENTAL CHARGES

PREVENTIVE SERVICES

CODE	DESCRIPTION	AMOUNT ALLOWED
0120	Periodic Oral Examination-Limited To Once/6 Months	22.00
0140	Limited Oral Evaluation-Problem Focused	19.00
0150	Comprehensive Oral Evaluation-Limited To Once/6 Months	25.00
0210	Complete Series X-rays	56.00
0220	Periapical-Single Film	10.00
0230	Additional Film	4.00
0250	Occlusal Film	19.00
0270	Bitewing-Single Film- Limited To Once/6 Months	10.00
0272	Bitewing-Two Films- Limited To Once/6 Months	14.00
0274	Bitewing-Four Films- Limited To Once/6 Months	21.00
0330	Panoramic Film	50.00
0340	Cephalometric Film	50.00
0460	Pulp Vitality Tests	28.00
0470	Diagnostic Models	37.00
1110	Prophylaxis-Adult-Limited To Once/6 Months	44.00
1120	Prophylaxis-Child-Limited to Once/6 Months	30.00
1203	Topical Acid Fluoride	31.00
1204	Adult Fluoride	32.00
1351	Sealants	30.00
1510	Space Maintainer Fixed-Unilateral	156.00
1515	Space Maintainer Fixed-Bilateral	220.00
1520	Space Maintainer Removable (also 1525)	188.00
2951	Pin Retention	25.00

BASIC

CODE	DESCRIPTION	AMOUNT ALLOWED
2140	Amalgam-One Surface	45.00
2150	Amalgam-Two Surfaces	60.00
2160	Amalgam-Three Surfaces	75.00
2161	Amalgam-Four Surfaces	85.00
2330	Composite One Surface	50.00
2331	Composite Two Surfaces	70.00
2332	Composite Three Surfaces	88.00
2335	Composite Four Surfaces	95.00
7140	Routine Extractions	66.00
7210	Surgical Extraction	110.00
7220	Impaction – Soft Tissue	155.00
7230	Impaction – Partial Bony	188.00
7240	Impaction – Full Bony	240.00
7241	Impaction – Full Bony (Complex)	275.00
7250	Surgical Removal – Roots	90.00
7260	Closure of Oroantral Fistula	395.00
7270	Tooth Reimplantation	120.00
7280	Surgical Exposure – Unerupted Tooth	225.00
7285	Biopsy – Hard Tissue	90.00
7286	Biopsy – Soft Tissue	75.00
7310	Alveoloplasty, w/ Extraction – Quad	62.00

Basic Services – continued

7320	Alveoloplasty, w/out Extraction – Quad	125.00
9110	Palliative Treatment	30.00
9220	General Anesthesia – 30 minutes	115.00
9221	General Anesthesia – additional 15 minutes	55.00
9310	Specialist Consultation	50.00
9951	Occlusal Adjustment – Limited	55.00
9952	Occlusal Adjustment – Complete	150.00
9973	Bleaching	150.00

MAJOR RESTORATIVE

2520	Gold Inlay Two Surfaces	300.00
2530	Gold Inlay Three Surfaces	360.00
2543	Only Three Surfaces	62.00
2610	Porcelain Inlay – One Surface	220.00
2650	Inlay composite – one surface	310.00
2652	Inlay composite – three or more	400.00
2710	Resin Crown	200.00
2720	Resin/High Noble Crown	525.00
2721	Resin/Noble Metal Crown (also 2722)	425.00
2740	Porcelain Crown	425.00
2750	Porcelain/High Noble Crown	595.00
2751	Porcelain/Noble Metal Crown (als0 2752)	525.00
2780	¾ Cast Crown	310.00
2790	Full Cast High Noble Crown	525.00
2791	Full Cast Noble Metal Crown (also 2792)	425.00
2910	Recement Inlay	36.00
2920	Recement Crown	38.00
2930	Stainless Steel Crown	110.00
2950	Build-Up with Pins-Core	100.00
2952	Cast Post	165.00
2954	Post	105.00
2962	Porcelain Laminate – Lab.	395.00
2970	Temporary crown	200.00
3110	Direct/Indirect Pulp Cap (also 3120)	25.00
3220	Pulpotomy	65.00
3310	Root Canal – Anterior	350.00
3320	Root Canal – Bicuspid	425.00
3330	Root Canal – Molar	500.00
3410	Apicoectomy – Anterior	210.00
3425	Apicoectomy – Molar	235.00
3426	Apicoectomy – Each Additional Root	125.00
3430	Retrograde Amalgam – Per Root	55.00
3450	Root Amputation – Per Root	150.00
3920	Hemisection	150.00
4210	Gingivectomy, Per Quad	180.00
4211	Gingivectomy, Per Tooth	42.50
4240	Gingival Flap Currettage, Per Quad	275.00
4260	Osseous Surgery, Per Quad	460.00
4263	Osseous Graft, Single	175.00
4270	Pedicle Soft Tissue Graft	130.00

Major Restorative Services – continued

4271	Free Gingival Graft	275.00
4341	Periodontal Scaling, Per Quad	90.00
4910	Periodontal Maintenance	72.50
5110	Full Upper/Lower Denture (also 5120)	650.00
5130	Immediate Upper/Lower Denture (also 5140)	675.00
5211	Partial Upper/Lower – Acrylic w/ Clasps (also 5212)	450.00
5213	Partial Upper – Cast Frame	695.00
5214	Partial Lower – Cast Frame	695.00
5410	Denture Adjustments (also 5411)	25.00
5610	Repair Broken Denture	65.00
5620	Repair Framework	100.00
5630	Repair/Replace Broken Clasp	90.00
5640	Replace Broken Tooth	55.00
5710	Rebase – Complete Denture	250.00
5730	Reline Full Denture – Chair (also 5731)	135.00
5740	Reline Partial Denture – Chair UP/LR (also 5741)	90.00/135.00
5750	Reline Full Denture – Lab UP/LR (also 5751)	150.00/200.00
5760	Reline Partial Denture – Lab UP/LR (also 5761)	145.00/180.00
5850	Tissue Conditioning (also 5851)	62.00
6210	Cast High Noble Pontic	525.00
6211	Cast Noble Metal Pontic (also 6212)	425.00
6240	Porcelain/High Noble Pontic	595.00
6241	Porcelain/Noble Metal Pontic (also 6242)	535.00
6250	Resin/High Noble Pontic	525.00
6251	Resin/Noble Metal Pontic (also 6252)	425.00
6545	Resin Bonded Retainers	225.00
6720	Resin/High Noble Abutment	525.00
6721	Resin/Noble Metal Abutment (also 6722)	425.00
6750	Porcelain/High Noble Abutment	595.00
6751	Porcelain/Noble Metal Abutment (also 6752)	525.00
6780	¾ Cast Abutment	310.00
6790	Cast High Noble Abutment	525.00
6791	Cast Noble Metal Abutment (also 6792)	425.00
6930	Recement Bridge	62.00
7111	Coronal Extraction – Primary	56.00

DENTAL LIMITATIONS AND EXCLUSIONS

The *plan* does not provide benefits for:

APPLIANCE AND SERVICE SPECIFIC

1. Replacement of **lost, missing, broken or stolen appliances** or duplicate appliances;

2. **Preventive control programs** including: oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations;

3. Surgical and non-surgical treatment of any jaw joint problem, including but not limited to appliances and therapy. Jaw joint problems include: **temporomandibular joint disorder (TMJ)**; craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and skull; conditions of the facial muscles used in expression or mastication; and symptoms thereof including headaches;

4. Appliances or restorations for: **increasing vertical dimension**; restoring occlusion; replacing tooth structure lost by attrition; correction of congenital or developmental malformations;

5. **Dental implantology** techniques, including prosthetic devices related to such techniques; or

6. Any **orthodontic** service, treatment or supply.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Dental services that do not have **uniform professional endorsement;** or

2. Any **procedure or drug that does not have scientific evidence that permits conclusions as to its effect** on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting.

PHYSICAL APPEARANCE

1. *Cosmetic dentistry*, including personalization or characterization of dentures and crown facings, abutments or pontics posterior to the second bicuspid; or labial veneer laminates; or

2. **Precision or semi-precision attachments**.

PRE-EXISTING CONDITIONS

1. **For *members*, and their eligible *dependents*, enrolled in the *plan* on or after 1/1/09, pre-existing conditions**. A sickness or *injury* is pre-existing if *you* received treatment or drugs for it during the six-month period immediately prior to *your enrollment date*. Treatment includes initial diagnosis or medical advice of the condition. Unless *you* satisfy one of the exceptions listed below, *you* will not be covered for Pre-Existing conditions if *you* have a lapse in coverage from any *plan* of more than 63 days. Pre-existing conditions are covered after the end of a period of 12 months from *your enrollment date*.

Pre-Existing Condition Exceptions
The exclusion will not apply:

a. to retirees and their eligible *dependents*;
b. to any *covered expenses* due to pregnancy,
c. to a newborn *dependent* child. Such child must be enrolled for coverage within 30 days of the date of birth. A child that is provided coverage under the Mother's plan of benefits will be considered to be enrolled as of the date of birth,
d. to a *dependent* child that is adopted or placed for adoption prior to their 18th birthday. Such child must be enrolled for coverage within 30 days of the adoption or placement,
e. to any condition that has not been diagnosed by a *qualified practitioner*, but has been indicated by genetic testing, and
f. to any *covered expenses* that are determined pre-existing conditions, up to a maximum of $300,000, in the first 12 months from *your* enrollment date. After the first 12 month period expires *you* will be covered, up to *your lifetime* maximum of $2 million, less any *covered expenses* that were paid in the first 12 months.

Pre-Existing Condition Credit

Credit will be given under the pre-existing condition limitation, for all benefits, to the extent of *your* continuous coverage, without a lapse of more than 63 days. Coverage under any of the following plans is creditable: a. a group health plan; b. group, individual or other form of health insurance; c. Medicare (Part A, B or C); d. Medicaid; e. the Active Military Health Program or TRICARE; f. a medical program of the Indian Health Service or of a tribal organization; g. a State sponsored health benefits risk sharing pool; h. the Federal Employees Health Plan; i. a Peace Corp. Health Program; j. a public health plan that provides health coverage by insurance or other means including any plan established by the U.S. government, a State, a foreign country, or any political subdivision thereof; k. a State Children's Health Insurance Program (CHIPS).

When *you* have coverage under a *plan*, *you* have the right to request written proof of that coverage at any time. When *your* coverage under a *plan* ends, *you* will be given written proof of coverage under that *plan*. It is *your* responsibility to provide this *plan* with this proof of coverage. If *your* prior plan did not provide *you* with proof of *your* coverage, this *plan* will assist *you* in providing proof of coverage by other means. Upon receiving proof of *your* prior coverage, *you* will be notified if there is any remaining pre-existing condition limit that may be applied.

PROVIDERS

1. Fees for **treatment by other than a** *dentist*. The following services when performed by a licensed dental hygienist will be covered: scaling or cleaning of teeth; and topical application of fluoride. These services must be done under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

2. Any service or supply:

   a. **not authorized or prescribed by a** *dentist*,
   b. authorized or prescribed by a *dentist*, but **excluded under this** ***plan*;**

4. **Telephone, computer or Internet consultations** between *you* and any provider. Completion of forms. Any appointment *you* did not attend; or

5. **After hour charges in relation to a service performed during normal operating hours** for the provider.

SERVICES UNDER ANOTHER PLAN

1. Any *injury* or *sickness* arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers' Compensation** or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which *you* would not be required to pay if *you* did not have this coverage;

3. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include *Medicare* or Medicaid);

4. Any service or supply provided in the care of any service related *injury* or *sickness* (past or present) **if** *you* **are in a** *hospital* **or facility owned or operated by the United States Government** or any of its agencies; or

5. Any charges covered under **the *plan's* medical benefits**. Such charges include but are not limited to hospital charges, services of an anesthesiologist and prescription drugs.

OTHER

1. Charges **in excess of the** *customary, usual and reasonable* **charge** for the service or supply;

2. That portion of any fee that is in excess of the fee for the *dentally necessary* treatment. That portion of any fee that is in excess of the services needed to restore the tooth or dental arch to contour and function;

3. Any expense incurred **after the date** *your* **coverage under the** *plan* **terminates**, except as specifically described;

4. Any dental expense due to commission or attempt to commit a **civil or criminal battery or felony**;

5. Any loss caused or contributed to by:

   a. **war or any act of war**, whether declared or not, or
   b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

6. Any dental expense unless specifically indicated; or

7. Any service or supply provided in connection with or **as a result of any service or supply that is not a** *covered expense*.

EXTENSION OF BENEFITS

When *your* coverage under this *plan* terminates all benefits end, except as stated below. Coverage for operative procedures that are in progress will be provided as follows, up to any stated *plan* maximum:

1. Services for root canals and crowns started before *your* termination date; and

2. Prosthetic devices, dentures and bridges ordered and fitted before *your* termination date.

The *plan* **must** remain in effect for Extension of Benefits to be payable.

You have up to 90 days after *your* termination date to submit claims for these Extended Benefits.

DEATH AND DISMEMBERMENT BENEFITS

When Your Coverage Amount Changes

Your death and dismemberment benefit amount will change on the date your period of continuous service changes sufficiently to change your coverage, provided you are not away from work due to disability on that day. If you are out of work due to disability, your coverage will change on the day you return to active full-time work. Any increase in benefits will apply only to losses sustained after the increase becomes effective.

Payment of Death Benefits

The full amount of your death benefit is paid to your named beneficiary in the event of your death. You can name anyone you wish as your beneficiary. You should be certain that the beneficiary designation you have on file with the Fund Office is up to date.

To change your beneficiary designation, all you need to do is obtain a new beneficiary designation form from the Welfare Fund Office, complete and return it.

Payment of Dismemberment Benefits

If you loose sight or a limb as the result of and within 90 days after an accident, you will receive half or all of your dismemberment coverage as follows:

IF YOU LOSE:	YOU RECEIVE:
Both hands, both feet or sight of both eyes	100% of your dismemberment benefit
Any combination of foot, hand or sight of one eye	100% of your dismemberment benefit
One hand or one foot or sight of one eye	50% of your dismemberment benefit

Loss of hand or foot means severance through or above the wrist or ankle joints. Loss of eye sight means entire and irrecoverable loss.

No more than 100% of your coverage will be paid for all losses resulting from one accident.

DISMEMBERMENT BENEFIT EXCLUSIONS

Dismemberment benefits are not paid for losses caused or contributed to by:

1. Disease or infections

2. Medical or surgical treatment;

3. Bodily or mental infirmity;

4. Suicide or any attempted threat;

5. War or international armed conflict.

Claiming Benefits

In the event of your death, your beneficiary must file a claim to receive benefits. In the event of your dismemberment, you or your beneficiary must file a claim to receive benefits. Claim forms are available from the Fund Office. The Fund has the right to investigate a claim, or request an autopsy, unless prohibited by law, before payment is made.

SECTION 2 DEFINITIONS

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DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the *plan*. Defined words appear in *italic* throughout the *plan*.

Accident
A happening by chance and without intention or design. A happening, which is unforeseen, unexpected and unusual at the time it occurs.

Ambulatory Surgical Center
A distinct facility whose business purpose is to provide surgical services on an outpatient basis. The facility must be duly licensed by the state in which it is located. It may not provide accommodations for patients to stay over night.

Amendment
A written document that changes the provisions of the *plan*. It must be duly authorized and signed by the *plan administrator*.

Board of Trustees
Trustees of the Welfare Fund of Plumbers Local Union #200, representing *union* members and employers.

Birthing Center
A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the *birthing center*; 2. Is directed by a *qualified practitioner* specializing in obstetrics and gynecology; 3. Has a *qualified practitioner* or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to *qualified practitioners* who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area *hospital* for *emergency* transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Calendar Year
A 12 month period of time that starts on January 1 and ends on December 31.

Claims Administrator
The person or firm employed by the *Board of Trustees* to provide clerical services to the *plan*. Clerical services include the processing of claims. If a *claims administrator* is not employed by the *plan administrator*, *claims administrator* will mean the *Board of Trustees*.

Clinical Eligibility for Coverage
Services required to diagnose or treat an *injury* or *sickness*. Services must be known to be safe, effective and appropriate by most *qualified practitioners* who are licensed to treat that *injury* or *sickness*. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the *injury* or *sickness*. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the *qualified practitioner*.

Definitions - continued

Complications of Pregnancy

1. *Medical condition*s that are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. A terminated ectopic pregnancy; or

4. A spontaneous termination of pregnancy that occurs during a gestation in which a viable birth is not possible.

Complications of pregnancy does not mean: false labor; occasional spotting; prescribed rest during the pregnancy; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct medical diagnosis.

Confinement

Being a resident patient in a *hospital* for at least 15 consecutive hours per day. Being a resident bed patient in a *convalescent nursing home* or other *qualified treatment facility* 24 hours a day. Successive *confinements* are considered one if:

1. Due to the same *injury* or *sickness*; and

2. Separated by fewer than 30 consecutive days when *you* are not confined.

Convalescent Nursing Home **(Skilled Nursing Facility or Extended Care Facility)**

A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;

2. A *qualified practitioner's* services available at all times;

3. A registered nurse (R.N.) or *qualified practitioner* in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;

4. A daily record for each patient; and

5. Continuous skilled nursing care during convalescence from *sickness* or *injury*.

A *convalescent nursing home* is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Cosmetic Dentistry

Those services provided solely to improve appearance. Correction of form and function are not needed and no pathological condition exists.

Covered Expense

Expense not excluded by the *plan* that is incurred by *you* or *your* covered *dependents* due to an *injury* or *sickness*. Expenses must be incurred while *you* are covered for that benefit under this *plan*.

Covered Person

The *member* or any *dependent*, when *you* are properly enrolled in the *plan*.

Definitions - continued

Custodial Care
Care to assist in the activities of daily living. Care that is not likely to improve *your sickness* or *injury*.

Customary, Usual and Reasonable
For Non-*PPO* Providers, the lesser of the fee most often charged by the provider or the maximum allowable fee as determined by the *plan*. The maximum allowable fee is set by comparing the service to a national database of fees. The database is adjusted to the locality where the service was performed.

1. If more than one surgery is performed during an operative session, the *covered expense* will be limited. The *customary, usual and reasonable* (CU&R) fee for the primary surgical procedure will be payable. 50% of the CU&R fee for the secondary procedure will be payable. 50% of the CU&R fee for the third and following procedures will be payable.

2. The CU&R fee for an assistant surgeon or physician's assistant is based on the CU&R fee for the primary surgeon as follows: 16% for an assistant surgeon; and 14% for a physician's assistant.

In the case of a *PPO* Provider, it will mean the negotiated *PPO* discount rate for the service or procedure.

Dentally Necessary
The extent of care needed to correct form and function or treat *sickness* or *injury*. Such care must be generally accepted, proven and established practice by most *dentists* with similar experience.

Dentist
An individual licensed to practice dentistry or perform oral surgery. Such individual must be operating within the scope of that license.

Dependent
1. A covered *member's* lawful spouse, as defined in the State where *you* reside, provided that:

   a. the spouse is not legally separated from the *member,* and
   b. the *member* is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;

2. A covered *member's* unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the *member's* legal guardianship by court order; or a child placed with the *member* for the purpose of adoption and for which the *member* has a legal obligation to provide full or partial support; whose age is less than the limiting age. Each child must be claimed on the covered *member's* most recently filed federal tax return. If the covered *member* is required by court order or divorce decree to provide coverage for a child who does not meet this requirement, this provision is waived for that child.

   For the Active Member Plan, the limiting age for each *dependent* child is:

   a. 19 years, or
   b. 25 years, if such child is in regular full-time attendance, as determined by the school, at a State recognized high school or an accredited college, university or other institution of higher education as defined by Federal law (20 USC 1088) and are principally dependent upon you for maintenance and support.

   Dependent children who drop below full-time student status due to *injury* or *sickness* will be covered through the end of the current term (semester, quarter, trimester). *Dependent* children will be covered for up

Definition of Dependent - continued

to four months following the close of a school term, provided they are enrolled as a full-time student for the next following school term.

For the Retiree Under 65 Plan and Retiree Over 65 Plan, the limiting age for each *dependent* child is 19.

If, from the date a *dependent* child reaches a limiting age, all of the following conditions exist at the same time:

1. The child is mentally retarded or physically handicapped;

2. The child is incapable of self-sustaining employment;

3. The child is *dependent* on the covered *member* for at least 50% support and maintenance; and

4. The child is unmarried,

that child will remain an eligible *dependent* of a covered *member* or may be enrolled as the *dependent* of a new *member*. If the child has not continuously satisfied all of the conditions above since reaching a limiting age, the child will not be eligible for coverage under the *plan*.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof may not be requested more often than annually after two years from the date the first proof was provided. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

In any event, no person may be covered as both a *member* and a *dependent* at the same time. If both parents are eligible for coverage under this *plan*, only one may enroll for *dependent* coverage.

Emergency
Any *injury* or *sickness* that would jeopardize or impair the health of the *covered person* if not treated immediately. An *emergency* may or may not be life threatening.

Enrollment Date
The first day of *your* eligibility period or if earlier, *your* effective date of coverage under this *plan*. If *you* are a *late applicant*, *your enrollment date* is the effective date of *your* coverage under this *plan*.

Expense Incurred
For medical expenses, the *customary, usual and reasonable* fee charged for services and supplies needed to treat the *injury* or *sickness*. The date a supply or service is provided is the *expense incurred* date.

For dental expenses, the *customary, usual and reasonable* fee charged for services and supplies. The *expense incurred* date is: the date the service is completed; or the date that the teeth are prepared for fixed bridges, crowns, inlays, or onlays; or the date the final impression is made for dentures or partials.

Family Member
Your lawful spouse. *Your* child. *Your* parent. *Your* grandparent. *Your* brother or sister. Any person related in the same way to *your* covered *dependent*.

Home Health Care Agency
An agency or organization that specializes in providing medical care in the home. Such a provider must meet all of the following conditions:

1. Its primary purpose is to provide skilled nursing and other medical services. Is duly licensed in the location where services are provided;

Definition of Home Health Care Agency – continued

2. Has policies set by a professional group. This professional group must have at least one registered nurse (R.N.) to govern the services provided. It must provide for full-time supervision of such services by a *qualified practitioner* or registered nurse;

3. Maintains a complete medical record on each patient;

4. Has a full-time administrator; and

5. Is approved by *Medicare*.

Hospice Care Agency
An agency whose primary purpose is providing hospice services. It must be licensed and operated according to the laws of the state in which it is located. It must meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven day a week service; is supervised by a

qualified practitioner; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.

A *hospice care agency* will establish policies for the provision of *hospice care*. It will assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program. It will permit area medical personnel to use its services for their patients. It will use volunteers trained in care of and services for non-medical needs.

Hospice Care
Palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients. It offers an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. *Hospice care* must be provided under a written plan of *hospice care*. The plan must be established and reviewed by the *qualified practitioner* attending the person and the *hospice care agency*.

Hospice Facility
A licensed facility or part thereof that principally provides *hospice care*. It has 24 hour a day nursing services provided under the direction of a registered nurse (R.N.). It has a full-time administrator. It keeps medical records of each patient. It has an ongoing quality assurance program, and has a *qualified practitioner* on call at all times.

Hospital
A facility that:

1. Maintains full-time facilities for bed care of resident patients;

2. Has a *qualified practitioner* and surgeon in regular attendance;

3. Provides continuous 24 hour a day nursing services;

4. Primarily provides diagnostic and treatment facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and

6. Has surgical facilities on its premises or has a contractual agreement for surgical services with a facility having a valid license to provide such surgical services.

Definition of Hospital - continued

Hospital does **not** include an institution, which is principally a rest home, nursing home, convalescent home or a home for the aged. *Hospital* does **not** include a place principally for alcoholics, drug addicts or persons with psychological disorders.

Injury
Physical damage to *your* body caused by an external force. Damage must be due directly and independently of all other causes to an *accident*. Muscle tiredness or soreness is a *sickness* under the *plan*. Overexertion in an athletic or physical activity is a *sickness* under the *plan*.

Late Applicant
A *member* who enrolls for coverage more than 30 days after they are eligible to be covered. A *dependent* who is enrolled for coverage more than 30 days after they are eligible to be covered.

Lifetime
When used in reference to benefit maximums and limitations, the time *you* are covered under this *plan*. In no circumstances does *lifetime* mean *your* life span.

Medical Condition
A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

Member
You when *you* are: a *member* in good standing with the *union*; or are employed by the *union*. For purposes of this *plan*, *member* does not include independent contractors, leased employees, or any employee who is part-time, temporary or seasonal.

Named Fiduciary
The *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200, which has the authority to control and manage the operation of the *plan*.

Outpatient
A period of time during which *you* are not confined as a resident bed patient in a: *hospital*; *convalescent nursing home*; or other *qualified treatment facility*.

PPO
Preferred Provider Organization. If a provider has contracted with the *PPO* Network, they are a *PPO* Provider. *PPO* providers furnish services at a discounted rate to the *plan*. If a provider has not contracted with the *PPO* Network, they are a Non-*PPO* provider.

Plan
This *plan* of benefits as established by the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200. The term *plan* includes any schedules, attachments and *amendments* to the *plan*. Prior, current and successive *plans* will be considered one *plan* and not separate and distinct *plans*. This Summary Plan Description provides a description of the *plan*.

Plan Administrator
A representative appointed by the *Board of Trustees*, who is responsible for the day to day functions and engagement of the *plan*. The *plan administrator* may employ other persons or firms to process claims and perform other services.

Definitions - continued

Post-Service Claim
Any claim that is not a pre-service claim.

Predetermination
A review by the *plan* of a *dentist's* planned treatment and expected charges. The review will include diagnostic charges performed prior to the actual services.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the *plan* for the medical care.

Qualified Practitioner
A licensed practitioner providing services within the scope of that license. A *qualified practitioner's* services are not covered if the practitioner resides in *your* home or is a *family member*.

Qualified Treatment Facility
A facility that is duly licensed and operating within the scope of its license.

Sickness
A disease or disturbance in function or structure of *your* body. It must cause physical signs and/or symptoms and if left untreated, will result in a deterioration of the health state of the structure or systems of *your* body.

Union
Plumbers Local Union #200.

Urgent Care
Any care that in the opinion of *your qualified practitioner* is an urgent care situation. Any care that the use of non-urgent care time frames would put *your* life, health or ability to regain maximum function at risk.

Urgent Care Center (Walk-In Clinic)
A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. *Urgent Care Center* does not include a *hospital* or emergency room.

You and Your
You as the covered *member*. Any of *your dependents*, unless otherwise indicated.

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SECTION 3   ELIGIBILITY

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Member Coverage section applies to *members* hired on or after the effective date of this *plan*. The Dependent Coverage section applies to *dependents* that are added on or after the effective date of this *plan*.

Members who were covered under any plan that this *plan* replaces will be covered on the effective date of this *plan*. Coverage will include *dependents* of such a *member*. *You* must have met the eligibility requirements of the *plan*.

MEMBER COVERAGE

Member Eligibility

You are eligible for coverage under the *plan* if *you* are an:

1. Employee whose employment is covered by a collective bargaining agreement between an employer contributor and the *union*; or

2. Administrative or clerical employee of the *union*; or

3. Administrative or clerical employee of the Fringe Benefit Funds of Plumbers Local Union #200.

Coverage begins on the following:

1. For initial medical and dental coverage, when *you* complete 60 days (420 hours) of covered employment during 12 consecutive months, *you* are covered for the next nine months (a qualified period of coverage).

2. For continuous coverage, *you* have nine months from when *you* last qualified to meet the requirements (which is 60 days/420 hours of covered employment) to maintain *your* coverage for nine months (a qualified period of coverage).

   However, if *you* do not meet the requirements (60 days/420 hours) within the nine month time frame, *you* have an additional three months to do so.

   Your benefits will not be in effect during this three months grace period until *your* requirement has been met.

   In the event *you* do not qualify in the twelve month period, *you* will then lose all credit that *you* had gained in the original nine month time frame, but *you* will not lose any credit that *you* gained during the three month grace period.

Coverage will begin on the date *you* meet the eligibility requirements.

Member Effective Date

You must enroll on forms accepted by the *plan administrator*. Each *member's* effective date is determined as follows:

1. *Your* completed forms are received by the *plan administrator* within 30 days of the date *you* are eligible. This is a timely enrollment. Y*our* coverage will be effective on *your* eligibility date.

2. *Your* completed forms are received by the *plan administrator* **more than** 30 days after the date *you* are eligible. This is **late enrollment**. *You* will not be eligible for coverage except as specifically stated in the Special Enrollment Rights section.

Member Effective Date – continued

Coverage will begin at 12:01 AM, Standard Time, on *your* effective date. *You* must actually begin work for the *union* or Fund Office before coverage will be effective under the *plan*.

DEPENDENT COVERAGE

Dependent Eligibility

A *dependent* is eligible to be covered on the later of:

1. The date the *member* is covered;
2. The date of the *member's* marriage for a *dependent* acquired on that date;
3. The child's date of birth;
4. The date a court order places a child in the *member's* home. The child must be under the *member's* legal guardianship;
5. The date a child is legally adopted; or
6. The date a valid court order is issued which, by federal law or *plan* provision, requires the *plan* to provide coverage.

Dependents may only be covered if the *member* is covered. Check with the Fund Office on how to enroll for *dependent* coverage. Late enrollment may result in a denial of coverage.

When both parents are *members* only one may enroll for *dependent* coverage.

Dependent Effective Date

Each *dependent* must be enrolled on forms accepted by the *plan administrator*. Each *dependent's* effective date of coverage is determined as follows:

1. The completed forms are received by the *plan administrator* within 30 days of the *dependent's* eligibility date. This is a timely enrollment. That *dependent* is covered on their eligibility date.
2. The completed forms are received by the *plan administrator* **more than** 30 days after the *dependent's* eligibility date. This is a **late enrollment**. That *dependent* will not be eligible for coverage except as specifically stated in the Special Enrollment Rights section.

Coverage will begin at 12:01 AM, Standard Time, on the *dependent's* effective date.

A *dependent* child that becomes a *member* must apply for coverage as a *member* to remain covered by the *plan*. The child will not be eligible as *your dependent*.

RETIREE ELIGIBILITY

You are eligible for health, dental and death benefits on the day *you* are awarded retirement benefits, if *you* meet the following requirements:

1. If *you* are between the ages of 60 and 65, *you* are allowed one year break in service in the last ten years worked immediately prior to retirement, excluding the years 1989, 1990 and 1991.

2. If *you* are between the ages of 55 and 60, *you* are allowed one year break in service in the last 20 years worked immediately prior to retirement, excluding the years 1989, 1990 and 1991.

A *member* must also be covered under Plumbers Local Union #200 Welfare Plan or by COBRA at the time of retirement to be eligible.

To qualify for continuous service, a member must have earned at least one hour of credit during the plan year from a contributing employer signed under the Collective Bargaining Agreement of Plumbers Local Union #200. (Continuous service requirements for plan year 1989 through 1991 will not apply).

A member must be seeking employment through Plumbers Local Union #200 and not working in any other industry or occupation.

The *plan* excludes anyone under age 55 unless *you* are permanently disabled with at least 30 years of continuous services. Please refer to page 3-6 for additional information.

The *plan* also excludes officers, stockholders, directors, partners and principal owners directly or indirectly involved in the plumbing industry.

Coverage will begin on the date *you* meet the eligibility requirements. Coverage will end on the date of the retiree's death. Coverage for a *dependent* spouse will be continued until the end of the month of the retiree's death.

Dependents

Retiree coverage will be eligible for *your dependent* spouse, as long as *you* were married at least one year prior to *your* retirement. *Your dependent* children are also eligible for coverage, if they meet the eligibility requirements as stated in the definition of *dependent*.

You must elect retiree coverage for *your dependents* at the time of retirement. If *you* do not elect retiree coverage for *your dependents* at the time of *your* retirement, *your dependents* will not be eligible for retiree coverage, except as specifically stated otherwise in the Special Enrollment Rights section on page 3-4.

RETIREE PARTICIPATION IN ACTIVE MEMBER PLAN: ONE-TIME ELECTIVE OPTION

All retirees and their eligible *dependents* covered under the Welfare Plan are granted a 30-day period to elect to participate in the medical benefits of the active members on a contributory basis.

1. If a retiree elects the Active Member Plan, both the retiree and *dependents* must participate, otherwise, coverage will not be available.

2. Once *you* reach age 65 and choose to remain on the Active Member Welfare plan, Medicare will become the primary carrier and this *plan* becomes the secondary carrier.

3. If *you* are age 65 or older, *you* must be enrolled in Parts A and B of Medicare to receive benefits.

Retiree One-Time Elective Option – continued

In order to participate in the medical benefits of the Active Member plan, the eligible retiree must contribute on a monthly basis. The monthly contribution is based upon the number of *dependents* to be covered. This rate is available from the fund Office.

This "one-time", elective option must be elected within 30 days of *your* eligibility for retiree benefits. The *plan administrator* reserves the right to change the rates in the future if it is actuarially appropriate to do so. Any change in rates will apply to the entire group participating in the option.

Contributions must be made to the Fund Office. If a retiree fails to make the required contributions, coverage will lapse as of the first of the month following the date of the last contribution.

The retiree has the right to reinstate coverage in the Active Member plan by making payment within 30 days of the date of lapse. If the retiree fails to reinstate coverage in the Active Member plan during this period, *you* will not be ever allowed to reenter the Active Member plan.

The retiree will have 30 days to reinstate contributions. In the event the retiree does not reinstate contributions during the 30-day reinstatement period, then the coverage will automatically convert to the coverage under the Retiree Plan for retirees over age 65, effective the first of the month following the date of lapse.

The rate of contribution will be based upon the specific experience of the retiree participants. The *plan administrator* reserves the right to change the rate in the future if it is actuarially appropriate to do so, and to alter the *plan* of benefits or to discontinue the *plan* of benefits in the future.

A retiree who elects to participate in the Active Member plan will still have the dental benefits as outlined on the dental schedule of benefits (1-36) and death benefits (1-39).

In the event federal Medicare regulations are changed so that private plans providing retiree medical benefits are considered primary and not secondary to Medicare benefits, the *Board of Trustees* reserve the right to change, amend or terminate retiree benefits.

SPECIAL ENROLLMENT RIGHTS

If *you* have a special enrollment event, the *plan* will provide a new enrollment date for *you* to enter the *plan* as shown below. At that time, *you* will be able to enroll in the *plan* without being subject to the *late applicant* provisions of the *plan*. If the *plan* has more than one benefit option, *you* will be able to select from all options for which *you* are eligible.

Loss of Other Coverage

If *you* declined coverage under this *plan* in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to *your* exhaustion of the maximum COBRA period;

2. Due to *your* loss of eligibility, for any reason;

3. Due to *your* reaching the lifetime maximum for all benefits; or

4. Employer contributions towards the cost of the other coverage;

Then a special enrollment event has occurred. At that time, a *member* or *dependent* may be enrolled in this *plan* as follows:

Special Enrollment Rights – continued

1. When the *member* has a loss of coverage, the *member* and any *dependent* may enroll. The *dependent* does not have to have had a loss of coverage at that time to be enrolled;

2. When a *dependent* has a loss of coverage, that *dependent,* the *member* and any other eligible *dependents* may enroll. The *member* and other *dependents* do not have to have had a loss of coverage at that time to enroll.

You must enroll in this *plan* within 30 days of the date of a loss of other coverage to be a timely entrant to the *plan*. *You* **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this *plan* will not be effective until such proof is provided. Coverage under this *plan* will be effective on the day coverage under the other group plan ends. If *you* apply more than 30 days after the date the other coverage ends, *you* will be *late applicants* under this *plan*.

Marriage

If *you*, as the *member,* are now getting married, a special enrollment event will occur on the date of *your* marriage. At that time, *you* may enroll in this *plan*. Any eligible *dependents* acquired on the date of *your* marriage may also be enrolled at this time as well as any other eligible *dependents* that were not previously covered under the *plan*.

You must enroll in this *plan* within 30 days of the date of *marriage* to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the day of *your* marriage. If *you* apply more than 30 days after the date of *your* marriage, it will be considered late enrollment under this *plan*.

Birth, Adoption or Placement for Adoption

If *you* experience the birth of a *dependent* child, or the adoption or placement for adoption of a *dependent* child, a special enrollment event will occur on that date. At that time, *you* may enroll in this *plan*. *Your dependent* spouse and the newborn or adopted child may also be enrolled at this time as well as any other eligible *dependents* that were not previously covered under the *plan*.

You must enroll in this *plan* within 30 days of the date of birth, adoption or placement to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the date of such an event. If *you* apply more than 30 days after the date of such an event, it will be considered late enrollment under this *plan*.

MEDICAID/STATE CHILD HEALTH PLAN

If *you* and/or *your dependents* were covered under a Medicaid plan or State child health plan and *your* coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this *plan* within 60 days after the date of termination of such coverage. Coverage under this *plan* will be effective on the date the other coverage ends.

If *you* apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, *you* will be considered a *late applicant* under this *plan*.

Employment Assistance

Current *employees* and their eligible *dependents* may be eligible for a special enrollment event if the *employee* and/or *dependents* are determined eligible, under a state's Medicaid plan or State child health plan, for premium assistance with respect to coverage under this *plan*. *You* must request coverage under this *plan* within 60 days after the date the *employee* and/or *dependent* is determined to be eligible for such assistance. If *you* apply for coverage more than 60 days after this date, *you* will be considered a *late applicant* under the *plan*.

SPOUSAL TRANSFER PROVISION

If both spouses are *members* and each has taken single coverage under this *plan*, this *plan* permits *your* spouse to take coverage as *your dependent* at any time.

In addition, if both spouses are *members* and eligible for coverage under this *plan* and *your* spouse previously waived coverage as a *member* in favor of coverage as *your dependent*, this *plan* permits *your* spouse to take coverage as a *member* under the *plan* and to enroll *you* and any other eligible *dependents* as *dependents* of *your* spouse when:

1. *You* and *your* spouse decide to transfer coverage under the *plan* from one spouse to the other;

2. *Your* spouse decides to take coverage as a *member* for any reason; or

3. *You* terminate *your* coverage under the *plan* for any reason.

Your spouse must elect coverage under this *plan* within 30 days of the date *your* coverage ends to be a timely enrollment. *Your* spouse's coverage under this *plan* will be effective on the day *your* coverage ends. If *your* spouse applies more than 30 days after the date *your* coverage ends, *you* will be *late applicants* under the *plan*.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all *members* and *dependents*. Any change in coverage will be effective on the date of change for all *members* and *dependents*.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

This provision applies to active *members* only. For the purposes of this *plan*, permanently disabled means *you* are under age 55 and are receiving Social Security disability benefits.

If *you* are permanently disabled and have at least 30 years of continuous service, medical and dental plan benefits will continue for 12 months from the date *your* eligibility for active benefits terminates. Then, *you* will be covered for medical and dental benefits under the retiree portion of the *plan*. *Your* eligible *dependents* will also be covered under the retiree section of the *plan*.

If *you* are permanently disabled and have less than 30 years of continuous service, medical and dental plan benefits will continue for 12 months from the date *your* eligibility for active benefits terminates. *You* and *your dependents* will **not** be eligible for retiree medical or dental benefits. After 12 months, *you* will be eligible to apply for COBRA continuation coverage (see page 3-13). *Your* eligible *dependent's* coverage will end as of the date *your* active medical and dental *plan* benefits end. However, at that time *your* eligible *dependents* may apply for COBRA continuation coverage (see page 3-13).

If *you* become permanently disabled and are eligible for a pension benefit and are receiving a Social Security Disability Award, *you* and *your dependents* will be eligible for retiree medical and dental benefits if *you* meet the retiree eligibility requirements as stated on page 3-3.

Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The *plan* must remain in effect for this provision to apply.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the *plan* terminates;
2. For any benefit, the date the benefit is removed from the *plan*;
3. The end of the period for which any required *member* contribution was due and not paid;
4. The date *you* enter the full-time military, naval or air service of any country;
5. For all *members*, the date a qualified period of coverage ends, unless *you* meet the requirements for a new qualified period of coverage;
6. For all *members*, the date of *your* retirement, unless *you* are eligible for and elect Retiree Coverage;
7. For *your dependents*, the date *your* coverage terminates;
8. For a *dependent*, the date the *dependent* enters the full-time military, naval or air service of any country;
9. For a *dependent*, the date that *dependent* no longer meets this *plan's* definition of *dependent*;
10. The date *you* request termination of coverage to be effective for yourself and/or *your dependents*; or
11. The date *you* die.

Important Notice for Active Members and Spouses Age 65 and Over

The *plan* cannot terminate *your* coverage due to age or *Medicare* status. An active *member* that is eligible for *Medicare* due to age (age 65 or over) has the choice to:

1. Maintain coverage under this *plan*, in which case *Medicare* benefits would be secondary to this *plan*; or
2. End coverage under this *plan*, in which case *Medicare* would be the only coverage available to *you*.

An active *member's* spouse who is eligible for *Medicare* due to age (age 65 or over) has the same choice.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to employers with 50 or more employees. It requires that coverage under this *plan* be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the employee as it would have been had FMLA leave not been taken.

If this *plan* is established while *you* are on FMLA, *your* coverage will be effective on the same date it would have been had *you* not taken leave. If the *plan* is amended while *you* are on FMLA leave, the changes will be effective for *you* on the same date as they would have been had *you* not taken leave.

EMPLOYEE ELIGIBILITY

An employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The employee has been employed with the employer for a total of at least 12 months;

2. The employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and

3. The employee is employed at a worksite that employs at least 50 employees.

TYPES OF LEAVE

Coverage under this *plan* can be continued during a period of FMLA leave. The employee must continue to pay the employee portion of the *plan* contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the employer*,* for:

1. The birth of the employee's child;

2. The placement of a child with the employee for adoption. The placement of a child with the employee for foster care;

3. The employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;

4. The employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or

5. Any qualifying necessity that results from the employee’s spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the employer, to care for a member of the armed forces that is the employee’s spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.

FMLA - continued

Maximum Leave Period
The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the employee and the employee's spouse are both employed by the employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;

2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or

3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period
If the employee decides not to return to work, coverage under the *plan* may end at that time.

If the *plan* contribution is not paid within 30 days of its due date, coverage under the *plan* may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions
The employer has the right to recover the portion of *plan* contributions it paid to maintain coverage under the *plan* during an unpaid FMLA leave. If the employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the employee's return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the *plan* will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived. The pre-existing condition limit will be credited as if *you* had been continually covered under the *plan*.

DEFINITIONS

For this provision only, the following terms are defined as shown below:

Serious Health Condition is any *sickness*, *injury*, impairment or physical or mental condition that involves:

1. Inpatient care in a *hospital*, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;

FMLA - continued

2. Continuing treatment by a *qualified practitioner*, including any period of incapacity:

   a. for more than three consecutive calendar days, if a *qualified practitioner* is consulted two or more times during the period or a *qualified practitioner* is consulted at least once and a continuing treatment program is provided;
   b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
   c. due to a chronic condition (i.e. a condition which requires periodic treatments by a *qualified practitioner* and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
   d. which is permanent or long term due to a condition which requires the supervision of a *qualified practitioner*, but for which treatment is ineffective;
   e. to receive multiple treatments from a *qualified practitioner* for restorative surgery due to *accident* or *sickness* or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

   Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

Spouse is *your* lawful husband or wife.

Son or Daughter is *your* natural blood related child, adopted child, step-child, foster child, a child placed in *your* legal custody or a child for which *you* are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or

2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

Parent is *your* natural blood related parent or someone who has acted as *your* parent in place of *your* natural blood related parent.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this *plan* be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the *plan* to similar active employees. This means that when coverage is changed for similar active employees it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the employee contribution required for active employees;

2. For leaves of 31 days or more, up to 102% of the full contribution.

This Act only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the Act.

Coverage provided due to this Act will reduce any coverage required by COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date *you* fail to return to employment with the employer after completion of *your* leave. Employees must return to employment within:

   a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
   b. 14 days of completing military service, for leaves of 31 to 180 days,
   c. 90 days of completing military service, for leaves of more than 180 days; or

2. 24 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon *your* return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the leave or not. To be eligible for reinstatement *you* must be honorably discharged from the military service and return to work within:

1. The first, full business day after *your* military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

2. 14 days after *your* military service ends, for leaves of 31 to 180 days;

3. 90 days after *your* military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if *your* military service: causes a *sickness* or *injury*; or worsens a *sickness* or *injury*. Your failure to return within the times stated must be due to such a *sickness* or *injury*. In that case, *you* may take up to a period of two years to return to work. If for reasons beyond *your* control *you* cannot return to work within two years, *you* must return as soon as is reasonably possible.

USERRA - continued

On reinstatement, all provisions and limits of the *plan* will apply to the extent that they would have had *you* not taken leave. The eligibility period will be waived. The pre-existing condition limit will be credited as if *you* had been continually covered under the *plan*.

This does not waive the *plan's* limits on *sickness* or *injury*: caused by *your* military service; or worsened by *your* military service. The Secretary of Veterans Affairs will determine if *your* military service caused or worsened a *sickness* or *injury*.

NOTE: For complete information regarding *your* rights under the Uniformed Services Employment and Reemployment Rights Act, contact the Fund Office.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to employers that have 20 or more employees. The law requires employers to offer covered individuals continuation coverage (COBRA) under the *plan* if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The *plan* cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active *members* under the *plan*. This means that when coverage is changed for similar active *members* it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Member Rights to COBRA

A *member* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *member's* hours of work; or

2. The termination of the *member's* employment. This will not apply if termination is due to gross misconduct on the *member's* part.

Spouse Rights to COBRA

The spouse of a *member* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *member's* hours of work;

2. The termination of the *member's* employment. This will not apply if termination is due to gross misconduct on the *member's* part;

3. The death of the *member*;

4. The end of the spouse's marriage to the *member*. The marriage must end due to dissolution, annulment, divorce, or legal separation; or

5. The *member* becoming entitled to *Medicare*.

Dependent Child Rights to COBRA

The *dependent* child of a *member* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *member's* hours of work;

2. The termination of the *member's* employment. This will not apply if termination is due to gross misconduct on the *member's* part;

3. The death of the *member*;

4. The end of the *member's* marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The *member* becoming entitled to *Medicare*; or

6. The child ceasing to be considered a *dependent* child as defined in this *plan*.

Electing COBRA

Each person covered by this *plan* has an independent right to elect COBRA for himself or herself. A covered *member* or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case only, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the *member's dependent* child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the *member* during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, *you* have a right to elect COBRA. *You* also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the *union* files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, *you* must inform the *plan administrator* within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. *You* must also inform the *plan administrator* within 60 days of a child no longer meeting the *plan's* definition of *dependent*. The employer must notify the *plan administrator* of: the *member's* death; termination of employment; reduction in hours of work; or *Medicare* entitlement. The employer must also notify the *plan administrator* of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the *plan administrator* will notify *you* that *you* have the right to elect COBRA. If the employer and plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law *you* must elect COBRA within 60 days from the later of: the date *you* would lose coverage or cost would increase due to the qualifying event; or the date notice of *your* right to COBRA and the election form are sent.

The *plan administrator* must provide *you* with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If *you* elect COBRA within the 60 day period, COBRA will be effective on the date that *you* would lose coverage. If *you* do not elect COBRA within this 60 day period, COBRA will not be available. *Your* coverage under the *plan* will terminate.

If *you* elect COBRA, it is *your* duty to pay all of the monthly payments directly to the *plan administrator*. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The *plan* may add a 2% administration charge to that cost. The *plan* may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

COBRA – continued

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the *plan administrator*.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the *plan* maintain COBRA for up to:

1. 18 months, if due to the *member's* termination of employment. Termination must be for reasons other than gross misconduct on the *member's* part;

2. 18 months, if due to the *member's* reduction in work hours;

3. 36 months, if due to the death of the *member*;

4. 36 months, if due to the end of the *member's* marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. 36 months, if due to the *member* becoming entitled to *Medicare*. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the *member's Medicare* entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to *your* ceasing to be a *dependent* child as defined in the *plan*; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the *union* files Chapter 11 bankruptcy. Upon the retiree's death, any covered *dependent* may elect COBRA for an additional 36 months from that date.

If *you* or a *dependent* are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if *you* or a *dependent* become disabled during the first 60 days of COBRA. *You* must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. *You* must provide notice to the *plan administrator* within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, *you* will not be eligible for the extended period. If it is determined that *you* are no longer disabled, *you* must notify the *plan administrator* within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the *member's* death; the *member's* divorce; a child no longer meeting the definition of *dependent*. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active member or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the *plan*, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The *plan administrator*/employer no longer provides a group benefit plan to any of its *members*;

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to *you*. *You* will have 30 days from the date of notice to make the additional payment;

3. *You* obtain another group plan after the date *you* elect COBRA. This will not apply if that group plan has a pre-existing condition exclusion or limit that applies to *you*. If such limit or exclusion has been met by a credit from *your* previous coverage, this provision will apply. If *your* new plan does have a pre-existing condition exclusion or limit that applies to *you*, then COBRA will end on the earlier of: the date that exclusion or limit no longer applies to *you*; or the end of the maximum coverage period;

4. *You* become entitled to *Medicare* after the date *you* elect COBRA;

5. There has been a final determination that *you* are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Additional Election Period due to The Trade Act of 2002

If *you* did not elect COBRA during the election period described above, another 60 day period may be presented for *you* to elect COBRA. If *your* loss of coverage was due to a Trade Adjustment Assistance (TAA) event and *you* are determined to be TAA eligible during the six month period following *your* loss of coverage, *you* will have an additional period in which to elect COBRA. This election period will begin the first of the month in which *you* become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following *your* loss of coverage due to a TAA event.

If *you* elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which *you* became TAA eligible. COBRA will not be provided for the period of time between *your* loss of coverage and the first of the month in which *you* became TAA eligible. However, that time will not be counted as a lapse in coverage for purposes of determining if the *plan's* pre-existing condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date *you* lost coverage under the *plan*, not the date COBRA is effective. If *you* do not elect COBRA within this period, COBRA will not be available again.

If *you* elect COBRA, it is *your* duty to pay all of the monthly payments directly to the *plan administrator*. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 65% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If *you* have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact.

ARRA made several amendments to the Trade Act of 2002, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered *employees* who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

COBRA – continued

Procedures for Providing Notice to the Plan

In order to maintain *your* rights under COBRA, *you* are required to provide the *plan* with notice of certain events, as described above. The *plan* will consider *your* obligation to provide notice satisfied if *you* provide written notice to the *plan administrator* that includes:

1. The member's name and social security number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where you can be contacted.

Notice should be addressed to the Welfare Fund of Plumbers Local Union #200, Attn: COBRA Administration. Notice should be mailed to the *plan administrator's* address shown in this *plan*. *Your* notice will not satisfy *your* obligation if it is not provided within the time frame stated above for that notice.

Other Information

The *plan administrator* will answer any questions *you* may have on COBRA. *You* can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to *your* questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect *your* rights under COBRA, *you* should notify the *plan administrator* of any changes that affect *your* coverage. Such changes include a change for *you* or a family member in marital status; address; or other insurance coverage. When providing any notice to the *plan*, a copy should be maintained for *your* own records.

AMERICAN RECOVERY AND REINVESTMENT ACT

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. If a *covered person* experienced a loss of coverage due to involuntary termination by the *employer* during the period that begins with September 1, 2008 and ends with December 31, 2009, the *covered person* may be eligible for the temporary premium reduction for up to nine months.

ELIGIBLE INDIVIDUALS

Covered persons and their *dependents* who experienced a loss of coverage under the *plan* due to an involuntary termination of employment between September 1, 2008 and December 31, 2009 and as a result, fit the definition of Qualified Beneficiary under COBRA are eligible. These individuals may also be referred to as Assistance Eligible Individuals (AEIs).

Some AEIs will have declined COBRA prior to passage of the law or elected COBRA but then dropped coverage prior to passage of the law. These AEIs will have a second opportunity to elect COBRA coverage and take advantage of the premium subsidy (reduced premium).

Assistance Eligible Individuals must not be eligible for coverage under any other group health plan (other than certain limited plans). This includes eligibility for coverage under a spouse's employer's plan or Medicare. Failure to notify the *plan* of eligibility under any other group health plan can result in significant penalties.

The subsidy will be phased out starting with taxpayers whose modified adjusted gross income exceeds $125,000 ($250,000 in the case of a joint return). This means a percentage of the subsidy will be recaptured in the federal income taxes imposed on individuals making more that $125,000 ($240,000 for joint returns). Higher income individuals ($145,000/single and $290,000/joint) can make an election to waive the subsidy in the manner and form set forth by the Secretary of the Treasury.

AMOUNT AND LENGTH OF SUBSIDY
Assistance Eligible Individuals will be responsible for only 35% of the amount of their COBRA premium. That means a Qualified Beneficiary whose normal full COBRA premium would be $500 per month would be responsible for paying only $175 per month for the qualifying time period.

The subsidy period ends at the earliest following date:

1. Nine months after the date the individual becomes eligible for the subsidy;

2. The date the Qualified Beneficiary becomes eligible for coverage under any other group health plan (other than certain limited plans) or becomes eligible for Medicare. This also includes eligibility for coverage under a spouse's employer's plan. The Qualified Beneficiary must notify the administrator in writing of such eligibility as set forth by the Department of Labor. Failure of the Qualified Beneficiary to notify the administrator may result in a penalty of 110% of the premium reduction provided after termination.

3. The date the Qualified Beneficiary's maximum period of continuation coverage required under the applicable COBRA continuation coverage provision is met. Note that for those Qualified Beneficiaries receiving a second opportunity to elect coverage, the maximum COBRA continuation coverage period runs from the original Qualifying Event.

ELECTING THE SUBSIDY
If *you* have a qualifying event between September 1, 2008 and December 31, 2009, the COBRA Administrator will send *you* a formal notification of *your* COBRA rights under the American Recovery and Reinvestment Act. The notification will include the necessary forms and instructions on how to elect to receive the subsidy as applicable.

If it is determined that *you* are not an AEI, and *you* disagree with this determination, *you* may appeal this determination with the Department of Labor (DOL) in the manner and form specified by them. Please see http://www.dol.gov/ebsa/subsidydenialreview.html.

ELECTING DIFFERENT COVERAGE
If *your plan* offers a lower cost option, Assistance Eligible Individuals have the option to elect enrollment in the less expensive coverage than what the individual was enrolled in at the time the Qualifying Event occurred, if such coverage is generally available to current employees. If the *employer* offers this option, the notification that *you* will receive in the next few weeks will include information on the plans that are available and explain the procedure for enrolling in different coverage. If an AEI chooses to enroll in different coverage, such coverage shall be treated as COBRA continuation coverage.

In order for the Qualified Beneficiary to be eligible to elect different coverage than what they were enrolled in at the time of the Qualifying Event, all of the following must apply:

1. The premium for different coverage cannot be more than the premium for the coverage the individual was enrolled in when the qualifying event occurred;

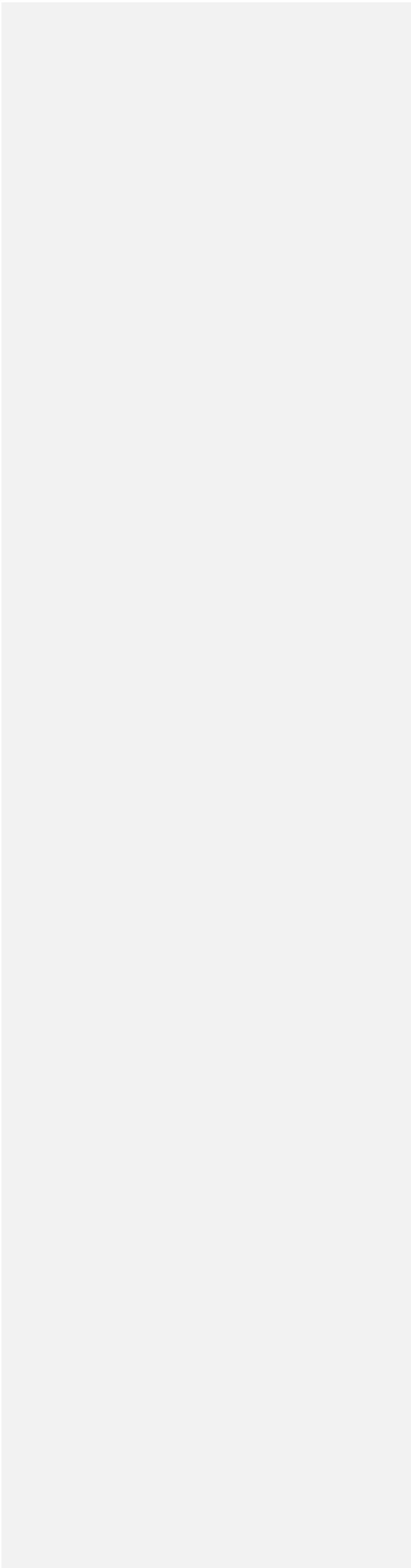
2. The different coverage must also be offered to active employees at the time the election is made;

COBRA - continued

3. The different coverage cannot be coverage that provides only:

   a. dental, vision, counseling or referral services (or a combination of such services),
   b. a flexible spending account,
   c. coverage for services or treatments furnished in an on-site medical facility maintained by the *employer* and that consists primarily of first-aid services, prevention and wellness care, or similar care (or combination of such care).

This election must be made in writing and not more than 90 days after the date of *your* formal COBRA notification. If *you* have any questions about *your* rights to COBRA continuation coverage, *you* should contact *your* COBRA administrator.



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SECTION 4 GENERAL PLAN INFORMATION

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PLAN DESCRIPTION INFORMATION

The *Board of Trustees* sets the benefits under the *plan*. The *Board of Trustees* sets the rights and privileges of plan participants to those benefits. The *plan* pays benefits directly from a trust fund established by the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200.

Each *member* in the *plan* will receive a Summary Plan Description (SPD). This booklet is the SPD and Plan Document for the *plan*. It contains information on: eligibility; termination; benefits provided; and other general *plan* provisions.

The purpose of this SPD is to set forth the provisions of this *plan*. The *plan* provides for the payment or reimbursement of eligible medical and dental expenses.

PLAN NAME	Welfare Fund of Plumbers Local Union #200
TYPE OF PLAN	A self funded welfare plan that provides medical and dental benefits to covered *members* and *dependents*. This *plan* is not financed or administered by an insurance company. The *plan's* benefits are not guaranteed by a contract of insurance.
PLAN EFFECTIVE DATE	January 1, 2009 Revision
GROUP NUMBER	0081636
PLAN YEAR FOR GOVERNMENT REPORTING	January 1 to December 31
PLAN ADMINISTRATOR/ PLAN SPONSOR	Welfare Fund of Plumbers Local Union #200 2121 5th Avenue Ronkonkoma, NY 11779 (631) 739-0021
PLAN NUMBER	#501
EMPLOYER IDENTIFICATION NUMBER	11-3124836
CLAIMS ADMINISTRATOR	UMR 333 West Vine Street Suite 500 Lexington, KY 40507 (866) 497-5711 (Toll-free)
AGENT FOR SERVICE OF LEGAL PROCESS	Welfare Fund of Plumbers Local Union #200 2121 5th Avenue Ronkonkoma, NY 11779 (631) 739-0021

STATEMENT OF ERISA RIGHTS

PARTICIPANT RIGHTS

As a *member* covered by this welfare *plan*, *you* have certain rights through the Employee Retirement Income Security Act of 1974 (ERISA). *You* also have certain protections through ERISA. ERISA provides that all covered *members* will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, all documents governing the *plan*. *You* may examine them at the *plan administrator's* office. *You* may also examine them at other specified locations, such as worksites and Union halls, if any. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series) filed by the *plan* with U.S. Department of Labor, if filing is required by law. These filings are available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of documents governing the *plan*. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series), if the report is required by law, and an updated summary plan description. Written request must be made to the *plan administrator*. The *plan administrator* may make a reasonable charge for the copies.

Receive a summary of the *plan's* annual financial report, if one is required by law. If a summary annual report is required, the *plan administrator* is required by law to furnish each covered *member* with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of any pre-existing condition exclusion under this group health *plan*, if *you* have creditable coverage from another plan. *You* should be given a certificate of creditable coverage, free of charge, by the group health plan or health insurance issuer *you* lose coverage under. The certificate of creditable coverage should be given to *you* when *you* lose coverage, become entitled to elect COBRA continuation coverage, and when COBRA continuation coverage ends. If *you* request it, a certificate of creditable coverage should also be given to *you* at any time during the 24 months after *you* lose coverage. Without proof of creditable coverage, *you* may be subject to a pre-existing condition exclusion of up to 12 months (18 months for late enrollees) after *your enrollment date* in your coverage.

Prudent Actions by Plan Fiduciaries

ERISA also imposes duties on the people who are responsible for the *plan*. The people who operate the *plan* are called "fiduciaries" of the *plan*. They have a duty to operate the *plan* prudently and in the interest of *you* and other *covered persons*. No one may fire or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA. This includes *your Union*, if any or any other person.

ERISA Rights – continued

Enforce Your Rights

If *your* claim for a welfare benefit is denied or ignored, in whole or in part, *you* have a right to know why this was done with certain time frames. *You* have a right to obtain copies of documents relating to the decision without charge and within certain time frames. *You* also have the right to appeal any denial, within certain time frames.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, if materials, such as plan documents or the latest annual report, that *you* asked the *plan* for are not received within 30 days, *you* may request the alternate dispute resolution process provided by the *plan* or file suit in Federal court. In such a case, the *plan administrator* may be ordered to provide *you* with the materials. The *plan administrator* may also be ordered to pay *you* up to $110 a day until the materials are received. If the materials were not sent due to reasons beyond the *plan's* control, penalties will not be imposed.

If *you* have a claim or part of a claim for benefits that is denied or ignored, *you* may request the alternate dispute resolution process provided by the *plan*, if any, or file suit in state or Federal court. In addition, if *you* do not agree with the *plan's* decision or lack of decision on the qualified status of a medical child support order, *you* may file suit in Federal court. If the *plan's* fiduciaries misuse the *plan's* money, or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court will decide who should pay filing costs and legal fees. If *you* are successful, the person *you* have sued may be ordered to pay these costs and fees. If *you* lose, for example, *your* claim is found frivolous; *you* may be ordered to pay these costs and fees.

Assistance with Your Questions

If *you* have any questions about *your plan*, *you* should contact the *plan administrator*. If *you* have any questions about this statement, *you* should contact the nearest office of the Member Benefits Security Administration (EBSA). If *you* have any questions about *your* rights under ERISA, *you* should contact the nearest office of the EBSA. If *you* need assistance in obtaining documents from the *plan administrator*, *you* should contact the nearest office of the EBSA. *You* can contact the EBSA at the U.S. Department of Labor number listed in *your* telephone directory. *You* can also contact them at the Division of Technical Assistance and Inquiries; Member Benefits Security Administration, U.S. Department of Labor; 200 Constitution Avenue N.W.; Washington, D.C. 20210. Certain publications about *your* rights and responsibilities under ERISA can be obtained by calling the publications hotline of the EBSA.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This *plan's* benefits are coordinated with benefits provided by other plans that cover *you*. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this *plan*. This provision will apply whether or not *you* file a claim under any other plan that covers *you*.

Effect on Benefits

In certain cases, this *plan's* benefits will be reduced when *you* are covered by other plans that provide benefits for the same service. Benefits under this *plan* and any other plans, as defined below, will be coordinated. The total benefit will not exceed 100% of the total *covered expenses* incurred under this *plan*.

Definitions

A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;

2. *Hospital* or medical service organizations on a group basis and other group pre-payment plans;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage sponsored or provided by or through an educational institution;

5. Any governmental program or a program mandated by state statute;

6. Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the *covered person's* membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total *covered expense*. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the *customary, usual and reasonable* value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.

Coordination of Benefits – continued

2. The plan that covers the person as a *member* or employee will be primary.

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:

   a. the plan of a parent who has primary physical placement will be primary,
   b. the plan of a step-parent that has primary physical placement will pay benefits next,
   c. the plan of a parent who does not have primary physical placement will pay benefits next, and
   d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

   Unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active member or the dependent of an active member.

7. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active member or the dependent of an active member.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this *plan* does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

In all cases, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare

In all cases, coordination with *Medicare* will conform to Federal Statutes and Regulations. Each person that is eligible for *Medicare* will be assumed to have full *Medicare* coverage. Full *Medicare* coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full *Medicare* coverage will be assumed whether or not it has been taken. *Your* benefits under this *plan* are subject to the allowable limiting charges set by *Medicare*. Benefits will be coordinated to the extent they would have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this *plan*, *you* agree to all of the following conditions. The payment of any claims by the *plan* is an advancement of *plan* assets. The *plan* has first priority to receive repayment of those *plan* assets out of any amount *you* recover. The *plan's* recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before *you* receive payment from that party. The *plan's* recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The *plan's* recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not you are made whole.

The *plan* will not pay attorney fees without the express written consent of the *plan administrator*. The *plan* will not pay any costs associated with any claim or lawsuit without the express written consent of the *plan administrator*.

If *you* are deceased, the rights and provisions of this section will apply equally to *your* estate. If *you* are legally incapacitated the rights and provisions of this section will apply equally to *your* legal guardian.

In consideration of the coverage provided by this *plan*, when *you* file a claim *you* agree to all of the following conditions. *You* will sign any documents that the *plan* considers necessary to enforce its recovery rights. *You* will do whatever is necessary to enable the *plan* to exercise its recovery rights. *You* will follow the provisions of this section and do nothing at any time to prejudice those rights. *You* will assign to the *plan* any rights *you* have for expenses the *plan* paid on *your* behalf. *You* will hold any settlement funds in trust, either in a separate bank account in *your* name or in *your* attorney's trust account, until all *plan* assets are fully repaid or the *plan* agrees to disbursement of the funds in writing, if *you* receive payment from any liable or responsible party and the *plan* alleges that some or all of those funds are due and owed to the *plan*. *You* will serve as a trustee over those funds to the extent of the benefits the *plan* has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the *plan*. It also includes any medical, dental or loss of time expense that may be payable by the *plan* in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; *you* or *your* covered *dependent's* own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the *plan* in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of *your* benefits under this *plan*.

Right of Subrogation

If, after payments have been made under this *plan*, *you* have a right to recover damages from a responsible or liable party, the *plan* shall be subrogated to that right to recover. The *plan's* right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the *plan*.

Recovery Rights - continued

Right of Reimbursement

If benefits are paid under this *plan* and *you* recover from a responsible or liable party by settlement, judgment or otherwise, the *plan* has a right to recover from *you*. Recovery will be in an amount equal to the amount of *plan* assets paid on *your* behalf. The *plan's* right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of *plan* assets that are paid or payable for any health care expenses under the *plan*.

Excess Coverage Provision

Benefits are not payable for an *injury* or *sickness* if there is any responsible or liable party providing coverage for health care expenses *you* incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the *plan* may make payments on *your* behalf for *covered expenses* for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the *plan* and will be considered an advancement of *plan* assets to *you*.

This *plan* does not provide benefits or may reduce benefits for any present or future *covered expenses* that *you* have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the *plan*.

Workers' Compensation

This *plan* excludes coverage for any *injury or* sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the *plan* and *you* receive Workers' Compensation for the same incident, the *plan* has the right to recover. That right is described in this section. The *plan* reserves its right to exercise its recovery rights against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the *injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by *you* or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *plan*.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The *plan's* benefits may be amended by the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200 at any time. The *plan* may be terminated by the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200 at any time. Any changes to the *plan* will be communicated immediately by the *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200 to the persons covered under the *plan*.

If the *plan* is terminated, the rights of the *covered persons* to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. *Plan* assets will be allocated to the exclusive benefit of the *covered persons*. No benefits provided by this *plan* are guaranteed or a vested benefit. Any taxes and expenses of the *plan* may be paid from the *plan* assets.

ASSIGNMENT

Any assignment will only be applied if the provider will refund any payments made in error. The *plan* does not attest to the legal validity or effect of any assignment.

CONFORMITY WITH APPLICABLE LAWS

If any part of this *plan* conflicts with any law that applies to the *plan*, it is hereby amended to comply with that law.

CONTRIBUTIONS TO THE PLAN

The *plan* is funded by contributions from the contributing employers and the covered *members*.

Any funds contributed by the *members* (if any) are applied to the expenses of the *plan* as soon as is reasonably possible. Any excess funds are used to pay claims. The *plan administrator* sets the amount of the *member* contribution. The *plan administrator* reserves the right to modify such contributions. All *member* contributions are on a non-discriminatory basis.

DISCRETIONARY AUTHORITY

Benefits under this *plan* will be paid only if the *plan administrator* decides in its discretion that the *covered person* is entitled to the benefits. The *plan administrator* will have full discretion to interpret *plan* terms; make decisions regarding eligibility; and resolve factual questions. This discretion will apply with respect to all claim payments and benefits under the *plan*.

FAILURE TO ENFORCE PLAN PROVISIONS

The *plan's* failure to enforce any part of the *plan* will not affect the right, thereafter, to enforce that provision. Such failure will not affect the right to enforce any other provision of the *plan*.

FREE CHOICE OF PROVIDER

The *covered person* has a free choice of any legally licensed provider. The *plan* will not interfere with the provider/patient relationship.

INTERPRETATION

This *plan* does not constitute a contract between the employer, *union* or *Board of Trustees* and any *covered person*. It will not be considered as an incentive or condition of employment. The *plan* will not modify the provisions of any collective bargaining agreement that may be made by any employer with the bargaining representatives of any *members*. A copy of any such agreement is available from the *plan administrator* upon written request.

LEGAL ACTIONS

You may request the alternate dispute resolution process, if available, provided by the *plan* or bring an action at law or equity against the *plan*. Such action may not be sought until 60 days after the date *you* provide written proof of loss to the *plan*. If an alternative method of dispute resolution has been agreed to, action at law or equity may not be sought until the end of that process. Any such action cannot be sought more than three years after such proof of loss is submitted.

PAYMENT OF CLAIMS

All benefits (except for prescription drugs) will be paid directly to the provider of services, unless *you* direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of *you* or *your* covered *dependent*, upon death, will be paid at the *plan's* option to any one or more of the following: y*our* spouse; y*our dependent* children, including legally adopted children; y*our* parents; y*our* brothers and sisters; or y*our* estate.

Any payment made in good faith will fully discharge the *plan* of its obligations to the extent of such payment.

PHYSICAL EXAMINATION

The *plan* has the right to have *you* examined as often as reasonably necessary while a claim is pending. Such examination will be at the *plan's* expense.

PRIVACY

The *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200, who is the sponsor of this *plan,* will receive protected health information. The information may be identified to the individual in some cases. The *Board of Trustees* is limited in how it may use this information. Its uses and disclosures must be necessary to carry out *plan* functions. The *plan* functions must relate to payment or health care operations, as defined in 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy. It may also use or disclose the information as required by law.

Prior to receiving any protected health information the *Board of Trustees* must certify to the *plan* that it agrees to:

1. Not use or disclose the information, except as stated above;

2. Require that any agent or subcontractor of the *Board of Trustees* agree to the same limits that apply to the *Board of Trustees* prior to giving the information to them;

3. Not use or disclose the information for employment related decisions or actions;

4. Not use or disclose the information in connection with other benefit plans the *Board of Trustees* may sponsor;

5. Report to the *plan* any use or disclosure that does not comply with this General Provision;

General Provision for Privacy – continued

6. Make the information available for review by the person that it relates to;

7. Make the information available for amendment and include any amendments with it;

8. Provide the necessary information to give an accounting of disclosures;

9. Make its internal practices, books and records in relation to the information open for review by the Secretary of Health and Human Services;

10. Return or destroy all information when it is no longer needed. If that is not possible, limit any further use or disclosure to the reason it was not possible to return or destroy it;

11. Maintain adequate separation between the *plan* and itself. Access to the information will be limited to members of the Human Resources and Finance Departments that work with the *plan*. These individuals will receive the minimum necessary information to carry out the *plan* functions they perform; and

12. Provide an effective process to address non-compliance by the *Board of Trustees* or its agents or subcontractors.

PRONOUNS

All personal pronouns used in the *plan* include either gender. This will be true unless its use clearly indicates otherwise.

PROTECTION AGAINST CREDITORS

Benefit payments under the *plan* are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the *plan* finds that such an attempt has been made, it, at its sole discretion, may terminate *your* interest in the payments. The *plan* will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the *covered person*. Such payment will fully discharge the *plan* to the extent of the payment.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If a child is the subject of a Qualified Medical Child Support Order (QMCSO), the child must be considered an alternate recipient under the *plan*. Upon the *plan's* decision that an order is a QMCSO, coverage must be provided to the child. Coverage may not be subject to *plan* requirements such as: custody; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of *dependents* are also waived for that child. If a *member* does not enroll the child in the *plan*, the *plan* must recognize the child's right to be enrolled as an alternate recipient. The custodial parent or legal guardian of the child may also exercise this right.

An alternate recipient will be as a *member* under the *plan* for the purpose of reporting and disclosure under ERISA. The custodial parent or legal guardian may have this right on behalf of the alternate recipient. They must receive all information needed to be enrolled in and receive benefits under the *plan*. They must be provided with a copy of the *plan's* Summary Plan Description (SPD). Any payments made by the *plan* must be made to the alternate recipient or the provider of service. Payment may also be made to the custodial parent or legal guardian.

General Provision for QMCSO – continued

A QMCSO is any judgment, decree or order relating to the benefits of this *plan* for the child of a *member*. It may be issued pursuant to State domestic relations law, including community property law. It may be issued to enforce a law relating to medical child support under the Social Security Act. The order may be from a court of competent jurisdiction. It may also be through administrative process under State law. The order must include the following items to be considered a QMCSO:

1. The name and last known mailing address of the *member*;

2. The name and address of each alternate recipient;

3. A description of the type of coverage to be provided or the manner in which coverage will be determined for each alternate recipient; and

4. The period of time for which coverage is to be provided to each alternate recipient.

The *plan* will provide *you* with a written notice of its decision regarding the status of an order as a QMCSO. A properly completed National Medical Support Notice will be treated as a QMCSO under this *plan*.

A QMCSO will not require the *plan* to offer any benefits or coverage not already offered by the *plan*.

RIGHT TO NECESSARY INFORMATION

The *plan* may require certain information in order to apply the provisions of this *plan*. To get this information the *plan* may release or obtain information from any party it needs to. The exchange of such information will not require *your* consent. Any party may include an insurance company, organization or person. Information will only be exchanged to the extent needed to implement the provisions of the *plan*. *You* agree to furnish any information needed to apply the *plan* provisions.

RIGHT TO RECOVER

The *plan* reserves the right to recover payments made under the *plan*. Recovery is limited to the amount that exceeds the amount the *plan* is obligated to pay. This right of recovery applies against:

1. Any person(s) to, for or with respect to whom such payments were made; and

2. Any insurance company or organization. If under the terms of this *plan*, it owes benefits for the same expense under any other plan.

The *plan* alone shall determine against whom this right of recovery will be exercised.

If benefits have been paid by any other plan that should have been paid by this *plan*, the *plan* reserves the right to directly reimburse such plan. Reimbursement will be to the extent needed to satisfy the obligations of this *plan*. Any such payment made in good faith will fully discharge the *plan* of its obligation to the extent of such payment.

SECURITY

The *Board of Trustees* of the Welfare Fund of Plumbers Local Union #200, who is the sponsor of this *plan,* will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the *employer* certifies to the *plan* that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the *employer* agrees to the same requirements that apply to the *employer* under this provision;

3. Report to the *plan* any security incident that the *employer* becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the *plan* and itself.

STATEMENTS

In the absence of fraud, all statements made by a *covered person* will be deemed representations and not warranties. A statement will not be used to contest coverage under the *plan* unless a signed copy of it has been provided to the *covered person*. If the *covered person* is deceased, the copy will be provided to their beneficiary.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the *plan* will notify *you* of its decision on *your* claim and issue payment, if any is due, as follows:

Urgent Care

Within 72 hours or as soon as possible if, *your* condition requires a shorter time frame. If more information is needed to make a decision on the claim, the *plan* will notify *you* of the specific information needed within 24 hours. *You* will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the *plan* will give its decision on the claim. If *you* fail to provide the information requested by the *plan*, the *plan* will provide *you* with its decision on the claim within 48 hours of the end of the period that *you* were given to provide the information.

If *you* fail to follow the *plan* procedure for a *pre-service claim*, the *plan* will notify *you* within 24 hours of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for *you* to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a *plan amendment*. This will not apply if the benefit is being stopped due to the termination of the *plan*.

Requests to extend a pre-authorized treatment that involves *urgent care* must be responded to within 24 hours or as soon as possible if, *your* condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-*urgent care* claim. The *plan* may extend this period by 15 days if; *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

If *you* fail to follow the *plan* procedure for a non-*urgent care pre-service claim*, the *plan* will notify *you* within five days of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims

Within 30 days of receipt of the claim. The *plan* may extend this period by 15 days if; *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

WORKERS' COMPENSATION NOT AFFECTED

This *plan* is not issued in lieu of Workers' Compensation coverage. It does not affect any requirement for coverage by any Workers' Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.

CLAIM APPEAL PROCEDURE

You may appeal the denial of a claim or utilization review decision by following these procedures:

1. File a written request, with the *claims administrator*, for a full and fair review of the claim by the *plan*;

2. Request to review documents pertinent to the administration of the *plan*; and

3. Submit written comments and supporting documents and issues outlining the basis of *your* appeal.

A request for a review must be filed with the *plan* within 180 days after receipt of the claim denial. If *your* request for review is not received within 180 days, *your* right to appeal the claim denial is forfeited.

If *your* request for review is received within 180 days, a full and fair review of the claim will be held by the *plan*. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical necessity, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed.

After the review, the *plan's* decision will be made to *you* in writing. It will include specific reasons for the decision as well as specific references to the *plan* provisions on which the decision is based. *You* will be notified of the *plan's* decision as follows:

1. For *urgent care* claims, within 72 hours or as soon as possible if *your* condition requires a shorter time frame;

2. For *pre-service claims*, within 30 days or as soon as possible if *your* condition requires a shorter time frame; or

3. For *post-service claims*, within 60 days.

An expedited appeal process is available for *urgent care* cases.

AMENDMENT #1 TO: **Welfare Fund of Plumbers Local Union #200**
Employer Identification Number: 11-3124836
Plan Number: 501
Group Number: 0081636

BENEFITS PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

On page 1-6, the Active Member Plan Wellness Benefit is amended to read as follows:

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Wellness Benefit Routine Exams for Covered Persons Age 6 and Older	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance	Benefits include routine physical exams, well child exams, routine x-ray and laboratory tests, immunizations and routine endoscopic surgeries (i.e. colonoscopy). For routine care that is subject to a copay, only one copay will apply per date of service for all routine care received on that same day. Please refer to the text for frequency limitations.	
Routine Mammograms, Pap Smears and Related Pelvic Exam	*PPO*: 100%, coinsurance waived Non-*PPO*: 80% coinsurance, deductible waived		
Routine Endoscopic Surgeries (i.e. colonoscopy)	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		
Routine X-Ray and Laboratory Tests (other than mammograms or pap smears)	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		
Immunizations for Covered Persons Age 6 and Older	*PPO*: $25 copay per visit, then 100% Non-*PPO*: Deductible/70% coinsurance		

On page 1-10, the Active Member Plan Newborn benefit is amended to read as follows:

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Newborn Benefits	Payable based on services received	The inpatient *hospital* copay is waived for a newborn's initial *hospital* stay. All newborn *hospital* benefits, including care of premature newborns, are limited to $25,000 per *lifetime*. The benefit maximum only applies to the newborn's initial *hospital* stay. If the newborn is discharged after the initial *hospital* stay and readmitted at a later date, the maximum does not apply. See "Section 3 – Eligibility" for important information on *Dependent* Coverage.	

IN WITNESS WHEREOF, the undersigned has caused this Amendment to be duly adopted and effective as of January 1, 2009.

Welfare Fund of Plumbers Local Union #200

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(Authorized Representative)

____
(Date)

SIGNED

AMENDMENT #2

Welfare Fund of Plumbers Local Union #200
Employer Identification Number: 11-3124836
Plan Number: 501
Group Number: 0081636

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

On page 1-14, the Active Member Plan Chiropractic Care benefit is amended to read as follows:

ACTIVE MEMBER PLAN COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	**Manipulations and Other Treatment** 100%, deductible and coinsurance waived, up to a maximum of $35 paid per visit, for *PPO* and Non-*PPO* **Chiropractic X-Rays** *PPO*: 70% coinsurance Non-*PPO*: Deductible/70% coinsurance	Limited to 30 visits per *calendar year*. Routine or maintenance care is covered. The Office Visit copay does not apply to this benefit.	

On page 1-23, the Retiree Under 65 Plan Chiropractic Care benefit is amended to read as follows:

RETIREE UNDER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	**Manipulations and Other Treatment** 100% under the Base Benefit, up to a maximum of $35 paid per visit. Charges do not excess to the Major Medical Benefit **Chiropractic X-Rays** Deductible/80% under the Major Medical Benefit	Limited to 30 visits per *calendar year*. Routine or maintenance care is covered.	

On page 1-32, the Retiree Over 65 Plan Chiropractic Care benefit is amended to read as follows:

RETIREE OVER 65 COVERED EXPENSES	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Chiropractic Care	**Manipulations and Other Treatment** Base Benefit, up to a maximum of $35 paid per visit. Charges do not excess to the Major Medical Benefit **Chiropractic X-Rays** Major Medical Benefit	Limited to 30 visits per *calendar year*. Routine or maintenance care is covered.	

On page 1-51, item 7 of the Other Covered Expenses section is amended to read as follows:

7. Chiropractic care for the treatment of an *injury* or *sickness*. Routine or maintenance chiropractic care is a *covered expense*.

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of January 1, 2009.

Welfare Fund of Plumbers Local Union #200

____
(Authorized Representative)

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(Date)