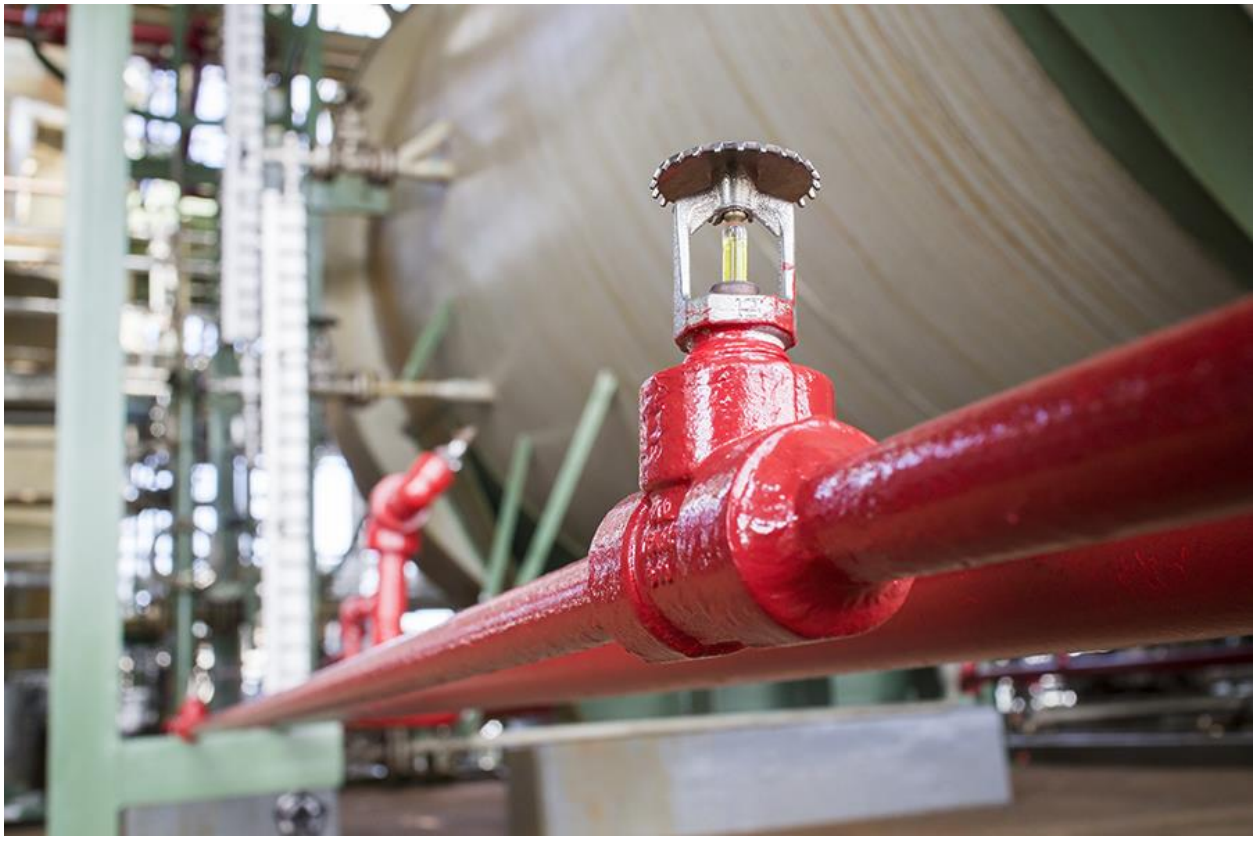
HEALTH AND WELFARE BENEFITS



THE STEAMFITTERS' INDUSTRY WELFARE FUND
SPRINKLER DIVISION

JULY 2023
Printed in U.S.A.

THE STEAMFITTERS' INDUSTRY WELFARE FUND
SPRINKLER FITTER DIVISION

General Office

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725
Telephone: (212) 465-8888
FundOffice@steamny.com

www.steamfitters.com

Fund Administration

William J. Turnbull, Executive Administrator
James J. Ippolito, Assistant Administrator
James C. White, Assistant Administrator

TRUSTEES OF THE WELFARE FUND

Employee Trustees

Michael Mulvaney
Daniel Mulligan
James R. Sheeran, Jr.

Enterprise Association
Steamfitters' Local Union 638
27-08 40th Avenue, 4th Floor
Long Island City, NY 11101-3725

Employer Trustees

Anthony Saporito
Edward English
Shane McMorrow

Mechanical Contractors Association of New York, Inc.
535 Eighth Avenue, 17th Floor
New York, NY 10018-1716

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THE STEAMFITTERS' INDUSTRY WELFARE FUND
Sprinkler Fitter Division

Effective July 1, 2023

SUMMARY PLAN DESCRIPTION

The purpose of this booklet is to provide you with the provisions and benefits of The Steamfitters' Industry Welfare Fund. The benefits summarized in this booklet are effective as of July 1, 2023. The provisions of the Plan Document governing the Fund and the various contracts with benefit providers or insured certificates, or insurance contracts govern the payment of all benefits, and the Plan Document and full contracts with benefit providers or insured certificates or insurance contracts should be consulted if you have any questions regarding your benefits. Copies of the Plan Document and all contracts with benefit providers or insured certificates or insurance contracts pertaining to the Plan are available for your inspection and copying at the Fund Office. If there is any difference between this booklet and the Plan Document or contracts with benefit providers, insured certificates or insurance contracts, the provisions of the Plan Document, contracts and certificates will govern.

To All Participants in the Steamfitters' Industry Welfare Fund Sprinkler Division:

The Steamfitters' Industry Welfare Fund has been designed specifically to protect the health and welfare of you and your families. The effective communication of your health and welfare benefits is a vital element in the overall success of the Plan to you and to the entire group. This booklet will describe those benefits for you.

The Trustees of The Steamfitters' Industry Welfare Fund are proud of the current Plan. The participants we represent can be assured of our continuing effort to further improve the Plan while keeping it on a sound financial basis.

If you have any questions that are not answered by the material contained in this booklet, we encourage you to contact the Fund Office or any of the Trustees.

The Trustees of the Steamfitters' Industry Welfare Fund

Employee Trustees

Michael Mulvaney
Enterprise Association
Steamfitters' Local Union 638
27-08 40th Avenue, 4th Floor
Long Island City, NY 11101-3725

Daniel Mulligan
Enterprise Association
Steamfitters' Local Union 638
27-08 40th Avenue, 4th Floor
Long Island City, NY 11101-3725

James R. Sheeran, Jr.
Enterprise Association
Steamfitters' Local Union 638
27-08 40th Avenue, 4th Floor
Long Island City, NY 11101-3725

Employer Trustees

Anthony Saporito
Mechanical Contractors
Association of New York, Inc.
535 Eighth Avenue, 17th Floor
New York, NY 10018-1716

Edward English
Mechanical Contractors
Association of New York, Inc.
535 Eighth Avenue, 17th Floor
New York, NY 10018-1716

Shane McMorrow
Mechanical Contractors
Association of New York, Inc.
535 Eighth Avenue, 17th Floor
New York, NY 10018-1716

GENERAL INFORMATION ABOUT THE PLAN

Identifying the Plan:

The full, official name of the Plan is "The Steamfitters' Industry Welfare Fund" but many participants simply refer to it as the "Welfare Fund," "Health Plan," or the "Plan." The Plan is administered by a joint Board of Trustees composed of Employee and Employer Trustees.

Name, Address, Telephone Number, and Email Address of the Board of Trustees, the Plan Administrator and the Plan Sponsor:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, New York 11101-3725
Phone: (212) 465-8888
Email: FundOffice@steamny.com

The Trustees as of the printing of this booklet are Edward English, Shane McMorrow, Daniel Mulligan, Michael Mulvaney, Anthony Saporito and James R. Sheeran, Jr.

Type of Plan:

This Plan is multiemployer group health plan that includes hospital expense benefits, medical expense benefits, prescription drug benefits, dental benefits, vision care and hearing aid benefits, life insurance and accidental death and dismemberment benefits, and a health reimbursement account fund.

Employer Identification Number of the Plan: 13-1545680

Plan Number: 502

Plan Year Ends: December 31

Type of Administration: Self-Administered

Agent for Service of Legal Process:

William J. Turnbull, Executive Administrator
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, New York 11101-3725
Phone: (212) 465-8888

Service of legal process may also be made on any of the Trustees.

Collective Bargaining Agreement:

The Fund is maintained pursuant to collective bargaining agreements between the Enterprise Association of Steam, Hot Water, Hydraulic, Sprinkler, Pneumatic Tube, Ice Machine and General Pipe Fitters of New York and Vicinity, Local Union 638 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada "Union" and the Mechanical Contractors Association of New York, Inc., "MCA" and other employers. Copies of these agreements may be obtained upon written request to the Fund Executive Administrator and may be examined at the Fund Office or Union Office. The Fund will provide information as to whether an employer is a contributing employer and, if it is, its address, once a written request for this information is made to the Executive Administrator. Upon written request to the Executive Administrator, a complete list of sponsoring employers and employee organizations will be provided.

Source of Financing:

The Fund is financed by contributions received from employers who employ steamfitter participants covered by a collective bargaining agreement. The amount of this contribution is determined by the agreement.

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and eligible beneficiaries and for defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies with vendors.

Plan assets are invested under the direction of the Trustees of the Welfare Fund.

Plan Text:

This booklet provides you with the provisions and benefits of the Welfare Plan for the Sprinkler Fitter Division. This SPD is not a substitute for the Plan Document that governs the Welfare Plan, insurance policies that the Fund has with benefit providers or insured certificates or insurance contracts. In the event of any actual or perceived conflict between the Plan Document, contracts with benefit providers or insured certificates or insurance contracts and this booklet, the terms and conditions of the Plan Document, contracts with benefit providers or insured certificates or insurance contracts will control.

Trustee Discretion:

In carrying out their respective responsibilities under the Plan, the Trustees or any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Liability for the Practice of Medicine:

The Plan, the Trustees, or any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack of care, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees nor any sub-committee or designee(s) appointed by the Trustees, the Executive Administrator or other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated will have any liability whosoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Plan Amendments and Termination of the Plan:

No amendment or termination will deprive a Participant, Beneficiary or Qualifying Dependent of any benefit which has already become payable under the Plan, but it could deprive them of future benefits. The Fund reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively (as opposed to prospectively) except in certain instances, such as you or your covered dependent(s) commits fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Executive Administrator or his designee(s)). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly provide false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage including COBRA.

Welfare benefits do not vest, and the Trustees reserve the right to amend or terminate the Plan, or any part of it, at any time for any reason without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- The Board of Trustees may amend the terms of the Plan by adopting a written amendment to the Plan Document, effective as of the date specified in the document amending the Plan Document.

- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverage(s) may be added by the Board of Trustees.

Allocation and Disposition of Assets Upon Termination:

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by the Welfare Plan.

- To alter or postpone the method of payment of any benefit.

- To amend or rescind any provision of the Plan Document.

In addition, the Plan may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

For Information or Assistance:

If you require any information or assistance, please contact the Fund Office at (212) 465-8888 or by email at FundOffice@steamny.com.

Information on the Steamfitters' Industry Welfare Fund, and all your employee benefit programs, can be found on the Fund Office website **www.steamfitters.com.** You may view your personal benefit information at any time by accessing your member login account on the website.

By accessing your member account, you may also: track employer contributions, view work history, review benefit payments, view Cash Fund balances, check eligibility status, view all Fund Office correspondence and documents, update dependent and beneficiary information, upload important documents (marriage and birth certificates, social security

cards, etc.), instantly update your address and contact information, file and submit disbursement forms digitally, message the Fund Office and more.

PLAN INFORMATION OVERVIEW	
General Plan Information and Eligibility ♦ Eligibility ♦ Information about USERRA, FMLA, QMCSOs and your Rights under the Plan ♦ Request documents or other Plan related information ♦ General questions about Plan coverage **COBRA Information** **HIPAA Privacy Information**	***Program Administered By:*** **Steamfitters' Industry Welfare Fund**
Life Insurance and Accidental Death and Dismemberment Benefits	***Benefits Provided By:*** **MetLife** ***Submit Application To:*** **Steamfitters' Industry Welfare Fund**
Medical and Hospital Benefits	***Benefits Provided By:*** **Empire BlueCross BlueShield EPO**
Prescription Drug Program	***Benefits Provided By:*** **Express Scripts, Inc.**
Dental Benefits	***Benefits Provided By:*** **MetLife**
Vision Care & Hearing Aid Benefit	***Benefits Provided By:*** **Steamfitters' Industry Welfare Fund**
Health Reimbursement Account	***Benefits Provided By:*** **Steamfitters' Industry Welfare Fund**

ACTIVE ELIGIBILITY

Who is Eligible for Coverage?

Individuals are eligible to participate in the Steamfitters' Industry Welfare Fund. They are:

1. Any Sprinkler Fitter [in any category] whose employment is covered by a collective bargaining agreement between Enterprise Association Local Union 638 and an employer obligated to contribute to the Steamfitters' Industry Welfare Fund;

When Does My Coverage Become Effective?

You are covered on the first day of the second calendar quarter following any period of four or less consecutive calendar quarters in which you work in covered employment for 1,000 hours for an employer or employers obligated to contribute to the Welfare Fund.

Example:

- You start work in covered employment in January.
- Between January 1 and June 30, you are paid for 1,000 hours in covered employment.
- You allow for the waiting period of one calendar quarter – from July 1 to September 30.
- Your coverage becomes effective on October 1.

NOTE: You do not have to meet the requirement of 1,000 paid hours in a particular calendar quarter in order to qualify for coverage. If you work in covered employment for a total of 1,000 hours in any four, or less, **consecutive** calendar quarters, you will qualify for coverage.

Coverage Eligibility Example: You start work in covered employment in January.

January 1 to March 31	You are paid for	370 Hours
April 1 to June 30	You are paid for	0 Hours
July 1 to September 30	You are paid for	450 Hours
October 1 to December 31	You are paid for	180 Hours
	Total Paid Hours	**1,000 Hours**

You allow for the waiting period of one calendar quarter from January 1 to March 31. *Your coverage becomes effective on April 1.*

How Often Is My Coverage Reviewed?

Eligibility for coverage in the Welfare Fund is reviewed quarterly.

How Do I Maintain Coverage?

Once your ***initial*** coverage begins, it lasts for at least one year from the time your coverage begins. Thereafter, your hours are reviewed at the end of each calendar quarter. You will continue to be covered as long as you work in covered employment for 1,000 hours during every four consecutive calendar quarters.

When Will a Participant's Coverage Terminate?

If you do not work in covered employment for the required 1,000 hours within four consecutive calendar quarters, your coverage will terminate at the end of the next calendar quarter.

For Example:

You were covered through all of 2021. You worked the following hours in 2022:

January 1 to March 31, 2022	You are paid for	370 Hours
April 1 to June 30, 2022	You are paid for	180 Hours
July 1 to September 30, 2022	You are paid for	370 Hours
October 1 to December 31, 2022	You are paid for	0 Hours
	Total Paid Hours	**920 Hours**

A total of 1,000 paid hours of work in covered employment, within four consecutive calendar quarters, ***has not*** been achieved; therefore, the last day of coverage is *March 31, 2023.*

EXCEPTION TO THE 1,000-HOUR ELIGIBILITY RULE:

There is a "one-time exception" to the 1,000-hour eligibility rule, as follows:

One-Time "Career Extension": At the first quarterly eligibility review in which the number of your aggregate hours earned during the review falls below 1,000 but equals or exceeds 800 hours, you will be granted automatically a one-quarter extension of your eligibility. **This extension shall not be granted more than once in your career**.

Can My Benefits be Suspended or Terminated?

A) If you are found guilty of committing any of the following acts, except as stated in Section B, you and your dependents will be suspended from all coverage for a period of three (3) years for the first offense and permanently for any subsequent offense, as determined by the Trustees:

- Performing work covered by Local 638's Collective Bargaining Agreement for a non-signatory employer;
- Receiving a cash payment in lieu of contributions that your employer is required to make to the Fund;
- Knowingly conspiring, aiding or assisting an employer to avoid payment of contributions;
- Defrauding the Fund of any payment to which the Fund is entitled;
- Knowingly conspiring, aiding or assisting a doctor or any other person in defrauding the Fund;
- Fraudulently obtaining coverage or benefits from the Fund that you or your dependent(s) are not entitled to.

B) If you are found guilty of submitting a claim based upon a misrepresentation or fraud for a particular benefit, you and your dependents will be suspended from all coverage for that benefit for a period of one (1) year for the first offense and two (2) years for any subsequent offense, as determined by the Trustees. The participant's dependents will not lose coverage under this Section.

The Trustees or a group designated by the Trustees will use their discretion in determining when benefits shall be suspended or terminated based on the above.

When a participant or beneficiary is suspended or terminated from coverage, the Fund will not make payments on the participant's behalf, notwithstanding the fact that contributions are required to be paid for such participant during the suspension period. However, coverage will continue during the suspension period for any disability benefits to which a participant may be entitled to under New York State Law.

What Happens If I Lose Coverage?

A federal law, commonly referred to as COBRA, requires that group health plans offer participants and their families whose coverage would otherwise end, the opportunity for a temporary extension of health coverage called "Continuation Coverage" at their own expense. The Federal laws allow a plan to charge a 2% surcharge for continuation coverage. The Welfare Fund will charge those electing COBRA coverage 102 percent of the Fund's cost of coverage.

If your loss of coverage is due to insufficient hours, you and your qualifying dependents may continue coverage for up to 18 months. Participants considering COBRA coverage must request the extended coverage in writing within 60 days from the date the participant is notified of the right to continue coverage.

If a spouse and dependents lose coverage due to the death of an active or retired participant, COBRA continuation coverage is available for up to 36 months.

Divorced or legally separated spouses and dependent children who are no longer covered when they reach the age specified in the Plan may extend coverage for up to 36 months. If you become either divorced, legally separated or your children no longer qualify as dependents, you must notify the Fund Office in writing within 60 days to protect their COBRA rights.

For more details about COBRA, please see the section entitled “Continuation of Coverage - COBRA” that appears later in this booklet. Complete details concerning the COBRA coverage are available from the Fund Office. The government website for general information is dol.gov/cobra.

It is mandatory that you report a divorce to the Fund Office immediately upon entry of a divorce decree or judgment. You will be instructed to submit a full copy of your divorce decree or judgment. If your divorce decree or judgment is not yet available from the court or municipal clerk, you will be required to complete a pre-printed affidavit. The Fund Office cannot accept your verbal notification; you must submit your divorce decree or judgment or complete an affidavit for the divorce to be recognized by the Fund Office.

> ***Please note:*** You will be financially liable for the costs the Welfare Fund should incur due to your non-timely notification or failure to notify the Fund of your divorce.

How Can I Become Covered Again?

Once your coverage terminates, in order to become covered again, you must satisfy the requirements set forth in the answer to the question, *“When Does My Coverage Become Effective?”* on page 10.

What Happens When an Active Participant is on Jury Duty?

A participant shall receive seven (7) hours per day credit towards the 1,000 hours requirement when serving on jury duty provided that no Employer has contributed to the Fund on the participant’s behalf for those hours. Documentation of the jury duty service must be in a form acceptable to the Trustees.

What Happens When an Active Participant Receives Benefits Under the New York State Paid Family Leave Law?

For each day a participant is enrolled in New York State Paid Family Leave (NYSPFL) and provides the Fund with official documentation, you will be granted seven (7) hours of credit towards eligibility.

For more information on the NYSPFL please visit ny.gov/paidfamilyleave or call the Paid Family Leave Helpline at (844) 337-6303.

What Happens If I Need FMLA Leave?

Under the Family and Medical Leave Act ("FMLA"), you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child or children, or to care for your seriously ill spouse, parent, or children.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

If you qualify, during your FMLA leave your health coverage will be maintained under the Fund. You may be eligible for FMLA leave if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1,250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the Employer within 75 miles.

Please contact your Employer and the Fund Office if you are planning to take FMLA leave. Appropriate documentation for FMLA must be provided to your Employer and the Fund Office prior to benefit commencement and/or continuation.

What Happens If I Enter the Uniformed Services?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") applies to a person who perform duty, voluntarily or involuntarily, in the Uniformed Services as well as the reserve components of the Uniformed Services. If you

are drafted, activated from reserve status or enlist into the Uniformed Services of the United States (which includes the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service Commissioned Corps, the Army National Guard, and the Air National Guard or any other category designated by the President in time or war or national emergency), your coverage as an active participant will terminate in accordance with regular eligibility rules (see "When Will a Participant's Coverage Terminate").

Your qualified dependents will maintain coverage in the Welfare Fund throughout your service as long as you were covered the day before your service commenced. Although this dependent coverage is not required under USERRA, the Trustees have extended coverage as an additional benefit.

As a participant, if you worked one (1) hour within 90 days immediately prior to entry into service as a covered participant on the date of your entry, the following is applicable:

- If you are on active military duty for 30 days or less, you will continue to receive medical coverage under this Plan.
- If you are on active duty for more than 30 days, USERRA permits you to continue medical, prescription and dental coverage for you and your dependents at your own expense for up to 24 months provided you enroll for coverage. This continuation of coverage operates in the same way as COBRA. (Please refer to the COBRA section of this booklet for details.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services (TRICARE). This Plan will coordinate coverage with TRICARE (see the "Coordination of Benefits" section of this booklet).
- You should carefully review the benefits, costs, provider networks, and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing the Plan's benefits under USERRA or COBRA is the best choice.
- When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating Employer for the quarter in which you return to active employment. If you were on active duty for more than 30 days, you must provide proof of military service, such as Form DD-214, upon your return to work with a participating Employer. Additionally, if you meet these requirements, comply with the time limits set forth herein, and your military service was for ninety (90) or more days, you will be eligible for an additional two (2) calendar quarters of coverage.

The time limits for returning to work are as follows:

- **<u>Less than 31 days of Service:</u>** one (1) day after discharge (allowing for 8 hours of travel).

- **31 to 180 days:** 14 days from the date of discharge, if the period of military service was 31 days or more, but less than 181 days (provided that you either returned to work or applied for employment with a participating employer).

- **181 days or more:** 90 days from the date of discharge, if the period of military service is more than 180 days (provided that you either returned to work or applied for employment with a participating employer).

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Please contact the Fund Office for more details.

Please note: You must provide oral or written advance notice to the Welfare Fund that you are leaving your job for service in the Uniformed Services (unless such notice was precluded by military necessity or otherwise impossible or unreasonable.)

DEPENDENT ELIGIBILITY

Are All of My Family Members Eligible for the Plan's Coverage?

Your **legal spouse** is eligible for coverage through the Welfare Fund. Your spouse will lose coverage on the day after a divorce or legal separation document is legally entered in a municipal institution.

Your children will be considered qualifying dependents and eligible for coverage through the Welfare Fund in accordance with the following:

A) the child has not reached beyond the end of the month of his/her 26th birthday.

B) unmarried children who have reached beyond the end of the month of his/her 26th birthday remain covered if they are incapable of self-support because of mental illness, developmental disability, mental retardation (as defined in the New York State mental hygiene law) or physical handicap provided the incapacitating condition started before the end of the month of his/her 26th birthday.

Please note: If your child is employed where employer-sponsored group coverage of a non-contributory nature is available, the Welfare Fund will provide secondary coverage only.

The term "children" includes:

- your biological or legally adopted children,
- children in your custody while awaiting final legal adoption,
- your stepchildren and
- any other children related to you by blood or marriage who live with you in a regular parent-child relationship and who are primarily dependent upon you for financial support who are eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively or and who will be claimed as a dependent on the your tax return for each plan year for which coverage is provided (an Affidavit of Dependency must be completed).

Excluded:

1) Parents and grandparents, even though they may reside in your household and be dependent upon you for support and maintenance, are **not** covered under the Plan.
2) No dependents of participants covered under the Helper classification are covered.

What Proof Do I Have to Provide for Dependent Status?

Specific documentation to substantiate dependent status will be required by the Plan. For each dependent, a copy of that dependent's social security card, along with the dependent specific items listed below, are **required** by the Plan to substantiate dependent status:

- **Spouse:** a copy of the certified marriage certificate.
- **Child:** a copy of the certified birth certificate showing biological child of employee.
- **Stepchild:** a copy of the birth certificate (showing your spouse as the biological parent of the child) plus the marriage certificate between you and the child's biological parent.
- **Adopted Child or Child Placed for Adoption:** a court order paper signed by the judge showing that the participant has adopted or intends to adopt the child, and a copy of the certified birth certificate.
- **Disabled Dependent Child:** a current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document), that disability existed before the attainment of the Plan's age limit, and that the child is incapable of self-sustaining employment as a result of that disability. In addition, the child must be chiefly dependent on you and/or your Spouse for support and maintenance. To continue coverage beyond age 26, an "Affidavit of Dependency for Mentally or Physically Handicapped Children", which includes proof of incapacitation from the dependent's physician or physicians, must be submitted to the Welfare Fund. Proof of incapacitation must be submitted to the Welfare Fund as often as requested. An independent examination must be permitted if the Trustees so requests. In addition, proof of dependent status from the Internal Revenue Service income tax filings must be made available to the Trustees as often as so requested. The affidavit must be filed with the Trustees prior to the date such a child attains age 26 in order to qualify for continuance of coverage.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by judge or National Medical Support Notice.

It is essential that any changes in family status (marriage, birth, death, adoption, divorce etc.) be reported in writing to the Fund Office. Failure to do so may delay or prevent payment of your claims.

What Happens to My Family's Health Coverage If I Die?

If you die while covered by the Fund, the health coverage for your spouse and qualifying non-spouse dependents will continue for a period of two months following the month of your death.

Health coverage for surviving spouses and qualified non-spouse dependents is provided in accordance with the Plan's applicable coordination of benefit regulations. Health coverage includes only hospital, medical, prescription drug, dental, vision care, and hearing aid benefits.

Do I need to Enroll in Benefits for Myself or My Dependents for Health Coverage?

You are automatically enrolled in benefits when you meet the eligibility requirements. However, for your dependents to be eligible you must enroll them for benefits**. You may enroll your dependents for coverage by submitting a completed written Health Insurance Enrollment Form to the Fund Office before coverage is effective.** The Health Insurance Enrollment Form may be obtained from the Fund Office. You may also enroll your dependents online by logging into your account on **www.steamfitters.com**.

Special Enrollment for a Newly Acquired Spouse and/or Dependent Child for Health Coverage

If you are enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child(ren) provided you notify the Welfare Fund by completing an Health Insurance Enrollment Form. The Health Insurance Enrollment Form may be obtained from the Fund Office. You may also enroll such dependents online by logging into your account on **www.steamfitters.com**. Coverage for your dependent will begin the first day of the month in which the Health Insurance Enrollment Form is received (or, in the case of a newborn Dependent Child, retroactive to the date of birth).

Proof of adoption or placement for adoption must be provided to the Welfare Fund. If you adopt a child, your adopted Dependent Child will be covered from the date that the child is "Placed for Adoption" with you. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. Adopted newborns are covered from the moment of birth, provided that the child is placed for adoption with you no later than 31 days after the child is born and you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Special Enrollment for Loss of Coverage

- Special Enrollment for Individuals who lose coverage under Medicaid or a State Children's Health Insurance Program (CHIP): Effective April 1, 2009, if you did not enroll your dependent(s) in the Welfare Fund when first eligible, you may enroll your dependents if they have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage.

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at (212) 465-8888 or FundOffice@steamny.com.

CONTINUATION OF COVERAGE (COBRA)

If you lose coverage, you may be able to continue your coverage under the Plan. The Welfare Fund will charge those electing COBRA Continuation Coverage 102% of the Fund's cost of coverage. Please read this section carefully and contact the Fund Office if you have any questions or if you think you may be eligible.

This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person's COBRA rights.

Background Information

In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group plans offer employees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect to temporarily continue their group health care coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long?

Each Qualified Beneficiary has an **independent right** to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered participants may elect COBRA on behalf of their spouses and children. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Participant or the Spouse or Dependent Child of a participant who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

   - A child of a covered participant who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Participant's or retiree's period of coverage, is a Qualified Beneficiary.

2. "**Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and,** as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a Qualifying Event but,

as a result, **does not lose their health care coverage** under this Plan, (*e.g.* Participant continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Events and Maximum Periods of Continuation Coverage

Qualifying Event* Causing Welfare Fund Benefits to End	**Maximum Period of COBRA Continuation Coverage**		
	Participant	**Spouse**	**Dependent Child(ren)**
Participant is terminated (for reasons other than gross misconduct)	18 months	18 months	18 months
Participant experiences a reduction in hours worked (making Participant ineligible for the same coverage)	18 months	18 months	18 months
Participant Dies (while under COBRA Continuation Coverage)	N/A	36 months	36 months
Participant becomes Divorced or Legally Separated	N/A	36 months	36 months
Participant becomes Entitled to Medicare	N/A	36 months	36 months
Dependent Child loses Dependent Status	N/A	N/A	36 months

**To be considered a "Qualifying Event", the event must cause a loss of coverage under the Plan.*

When Must a Spouse or Dependent Child Notify the Plan of a Qualifying Event for Continuation of Coverage Purposes?

In order for a Spouse or Dependent Child to be entitled to COBRA Continuation Coverage, the Participant, Spouse, or Dependent Child must notify the Plan within 60 days of the date of the following:

- The death of the Participant;
- The divorce or legal separation from the Participant; or (Note: for purposes of preventing ineligible benefit usage the Fund Office must be notified immediately. Please refer to the Active Eligibility section of this booklet "What Happens If I Lose Coverage?" page 12); or

- The event under which a Dependent Child loses Dependent status.

Notification must be made in writing to the Fund Office. You need to include the qualifying event, name of the Participant, name of Dependent, and the date of the qualifying event. You also need to provide the supporting documentation (for example, a copy of the Divorce Decree or Judgment or Death Certificate).

If the Plan does not receive written notice of any such event within that 60-day period, the Spouse and/or Dependent Child(ren) will not be eligible for COBRA Continuation Coverage. You must send this notice to the Fund Office.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA Continuation Coverage, the individual will be sent an explanation indicating why COBRA Continuation Coverage is not available. This notice of the unavailability of COBRA Continuation Coverage will be sent according to the same timeframe as a COBRA election notice.

How Will I be Informed if I or My Dependent(s) are Entitled to Continuation of Coverage?

The Plan will send you and your Dependents an Election Notice when a Qualifying Event occurs. The Election Notice will explain your right to continue health care coverage under the Plan. You and/or your Dependent(s) will then have 60 days to apply for COBRA Continuation Coverage. If you and/or they do not apply within that time, health care coverage will end as of the last day of the calendar quarter in which the Qualifying Event occurs.

What Coverage Will Be Provided if Continuation of Coverage is Elected?

If you and/or your Dependent(s) choose COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical and/or dental plan that is provided for similarly situated employees and their family members.

Addition of Newly Acquired Dependents

If during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse or Dependent Child may be enrolled in coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active employees. Enrollment must occur no later than 31 days after the marriage, birth or placement for adoption.

A child born or placed for adoption with you while you are on COBRA Continuation Coverage (but not a spouse that you marry while you are on COBRA Continuation

Coverage) will have all the same COBRA rights as your Spouse or Dependent Child(ren) who were covered by the Plan before the event that resulted in your loss of coverage. If you marry while on COBRA Continuation Coverage, your new spouse may be enrolled in coverage, but they will not be a Qualified Beneficiary. This means that if you die, divorce, or become eligible for Medicare during COBRA Continuation Coverage, your new spouse will not be permitted to elect COBRA for his/herself.

Otherwise, the same rules about Dependent status and qualifying changes in family status that apply to active Participants will apply to Dependent(s). Adding a spouse or a Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. If during the period of COBRA Continuation Coverage, the Plan's benefits change for active participants, the same changes will apply to you and/or your Dependent(s).

Is an Extension of COBRA Continuation Coverage Period Due to Multiple Qualifying Events a Possibility?

If your COBRA Continuation Coverage is for a maximum period of 18 months, and during that period, another Qualifying Event takes place that would otherwise entitle a Spouse or Dependent Child to a 36-month period of COBRA Continuation Coverage, the 18-month period will be extended for that Spouse or Dependent Child. The total period of COBRA Continuation Coverage for any Spouse or Dependent Child will never exceed 36 months from the date of the first Qualifying Event. For example, if you terminated employment and elected COBRA Continuation Coverage for 18 months for you and your covered Spouse and/or Dependent Child(ren), and you died during that 18-month period, the COBRA Continuation Coverage for your Spouse and/or Dependent Child(ren) could be extended for the balance of 36 months from the date your employment terminated.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date you became entitled to Medicare, your Spouse and/or Dependent Child(ren) would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date you become entitled to Medicare, your Spouse and/or Dependent Child(ren) would be entitled to COBRA Continuation Coverage for a 36-month period beginning on the date you became entitled to Medicare, although your period of COBRA Continuation Coverage would be limited to 18 months from your termination.

What is the Maximum Period of COBRA Continuation Coverage?

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may

be extended for up to 11 months if one of the Qualifying Beneficiaries becomes disabled). The maximum period of COBRA Continuation Coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this section.

Entitlement to Social Security Disability Income Benefits

If you, your Spouse of any of your covered Dependent Child(ren) are entitled to COBRA Continuation Coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security benefits, and for any other Qualifying Beneficiaries, for up to 11 additional months if all the following conditions are satisfied:

- The disability occurred on or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage; and
- The disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
- The Plan is notified by you or the disabled Qualifying Beneficiary that the determination was received:
  - No later than 60 days after it was received; and
  - Before the end of the 18-month COBRA Continuation Coverage period.
- This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the original Qualifying Event or the date the disabled individual becomes entitled to Medicare.

What is the Payment Amount for COBRA Continuation Coverage?

You, your covered Spouse and/or your covered Dependent Child(ren) will have to pay 102% of the full cost of the coverage during the COBRA Continuation Coverage period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA Continuation Coverage.

The amount you, your covered Spouse and/or your covered Dependent Child(ren) must pay for COBRA Continuation Coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date you elect COBRA Continuation Coverage. Payments are due on the first day of the month for which coverage is being continued. However, there is a grace period of 30 days to pay any subsequent payment. If payment of the amount due is not received by the end of the applicable grace period, COBRA Continuation Coverage will terminate, if:

- You, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage; and

- The amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect; and
- A Health Care Provider requests confirmation of coverage.

COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid and that COBRA Continuation Coverage will terminate, effective as of the due date of any unpaid amount if the payment of the amount due is not received by the end of the grace period.

Is Early Termination of COBRA Continuation Coverage Possible?

COBRA Continuation Coverage may be cut short (terminated early) if:

- The Plan no longer provides group health coverage to any of its similarly situated employees;
- You do not pay the applicable premium for your COBRA Continuation Coverage on time;
- The Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA Continuation Coverage;
- The employer that employed you before the Qualifying Event stops contributing to the Plan and either establishes another group health plan or contributes to another multiemployer health plan; or
- The Qualified Beneficiary becomes covered under another group health plan.

If any Qualified Beneficiary becomes entitled to Medicare, the COBRA Continuation Coverage of that person will end, but the COBRA Continuation Coverage of any covered Spouse or Dependent Child of that covered person will not be affected.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary of early termination of COBRA Continuation Coverage. This written notice will explain the reason for early termination of COBRA Continuation Coverage, the date coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Welfare Fund determines that COBRA Continuation Coverage will terminate early.

Other Information about COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone who has

elected COBRA Continuation Coverage. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA, as of the effective date of those changes.

What are the Special Enrollment Rights?

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or, under certain circumstances, 60 days) after your group health coverage ends because of the Qualifying Events listed in this section. The special enrollment right is also available to you at the end of the maximum period of COBRA Continuation Coverage.

Is a Participant or Dependent Entitled to Convert to an Individual Health Plan after COBRA Ends?

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan. You may have other options available to you. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. For more information about the Marketplace, visit: www.HealthCare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation of Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA Continuation Coverage instead, you may have to pay a Part B lifetime late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA Continuation Coverage and then enroll in Medicare Part A or B before the COBRA Continuation Coverage ends, the Plan may terminate your Continuation Coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA Continuation Coverage

may not be discontinued based on Medicare eligibility, even if you enroll in the other part of Medicare after the date of the election of COBRA Continuation Coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA Continuation Coverage will pay second. Certain COBRA Continuation Coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

HOSPITAL AND MEDICAL BENEFITS

These benefits are administered through insurance contracts with Empire BlueCross BlueShield.

Active Participants and Dependents

Hospital and Medical Benefits are provided under an EPO Plan (an Exclusive Provider Organization). EPOs will only cover medical expenses if the provider you utilize is part of the network of providers covered by the plan. Partial reimbursement may be allowed for emergency cases outside the network.

A full and complete description of the hospital and medical benefits available are contained in the blue-colored pages of this booklet. You should pay particular attention to information about exclusions and limitations, Medical Management, and precertification requirements.

PRESCRIPTION DRUG BENEFITS

Who Administers the Benefits?

Prescription drug benefits are available to all non-Medicare participants and their qualifying dependents who meet the Welfare Fund eligibility requirements. Your prescription drug benefits are administered by **Express Scripts, Inc.** which covers almost all drugs prescribed by a licensed medical doctor, osteopath, dentist or podiatrist for their generally accepted medical use.

This benefit includes both a Retail Program and a Home Delivery/Mail Service Program. This benefit program was instituted to increase benefits, alleviate the claim filing burden and reduce costs when you or your eligible dependents require prescription drugs. At the time your coverage becomes effective you may receive an identification drug card and home delivery/mail service order forms.

What are the General Types of Prescription Drugs?

There are three types of Prescription Drugs:

- Generic
- Brand
- Specialty**

All Prescriptions have a Co-Payment associated with them except for those prescriptions that are considered “preventative” under the Patient Protection and Affordable Care Act. (PPACA).

**The Trustees of the Steamfitters Welfare Fund, in an effort to alleviate the costs of certain specialty drugs, approved the participation in the Express Scripts SaveonSP program. This program identifies certain high cost specialty drugs that are eligible for copayment assistance through the drug manufacturer. Should you be taking any prescription that is considered “qualifying”, you will be contacted by SaveonSP to participate. Should you choose to participate, you will have no out of pocket costs for the drug.

How Does the Prescription Drug Benefit Program Work?

The Prescription Drug Benefit works through the following three components: The Retail Program, the Home Delivery/Mail Service Program and a Direct Reimbursement Program. These components are further explained in this section.

Both retail and mail order prescriptions must be filled with generic drugs if a generic equivalent is available. If you have a prescription filled with a brand name drug when a generic is available ***for any reason*** you will pay the brand name co-payment plus

the difference between the cost to the Welfare Fund for the generic and the brand. ***Using a brand name drug when a generic is available may cost you a great deal of out-of-pocket expense.***

❖ RETAIL PROGRAM

Whenever you need to fill a prescription at a local pharmacy all you will have to do is present your Express Scripts identification card to a network pharmacy and make a small co-payment. The co-payments for each prescription will be $10.00 for generic drugs, $30.00 for brand name drugs and $43.00 for controlled substances. You can receive up to a 21-day supply of your medication and ***one*** refill only for the same number of days. Beyond that, you ***must*** use the Home Delivery/Mail Service Program.

A 30-day fill will be permitted for controlled substances only. Although there is no limit in terms of refills for controlled substances, the law requires a prescription for each reorder.

Under the Retail Program, the Walgreen Co. retail pharmacies (Walgreen's, Duane Reade, et al.) are not covered as they are not in the retail pharmacy network we contracted with Express Scripts, Inc. Visit express-scripts.com to find a participating retail pharmacy.

❖ HOME DELIVERY/MAIL SERVICE PROGRAM

If you or any of your dependents need medication on an on-going basis (maintenance drugs), you ***must*** fill those prescriptions through the Home Delivery/Mail Service Program, commonly called *Express Scripts, Inc. By Mail*. Prescriptions filled through the Home Delivery/Mail Service Program are subject to individual participant and dependent co-payment of $40. The drugs are delivered to your home, postage paid. Your physician can prescribe up to a 90-day supply with refills of the medication you need.

You will then submit your prescription and claim form to the home delivery/mail service pharmacy for dispensing. If you require a refill, just notify the home delivery/mail service pharmacy by mail, by phone (800) 445-9707, or online at express-scripts.com.

No claim forms are required for prescriptions obtained through the Retail or Home Delivery/Mail Service Program.

❖ DIRECT REIMBURSEMENT PROGRAM

Should there arise an occasion that you are unable to use the Retail Program or Home Delivery/Mail Service Program, a *direct reimbursement claim* process has been established between the Welfare Fund and Express Scripts, Inc. ***This program may reimburse you significantly less than the amount you paid for the prescription.*** Participants are permitted to use the Direct Reimbursement Claim procedure only once during their lifetime coverage for a reason deemed valid by the Fund. Under no circumstances will you be reimbursed for a prescription purchased at a Walgreen Company pharmacy.

Contact the Fund Office at (212) 465-8888, option 4 to obtain a Direct Reimbursement Claim form. The claim form must be filled out by the patient as well as the pharmacist and returned to the Fund Office. Along with the complete claim form, you must submit a letter to the Fund Office explaining why you were unable to use the Retail Program or the Home Delivery/Mail Service Program. Upon approval by the Fund, your claim will be submitted to Express Scripts, Inc. for processing.

❖ THE EXPRESS SCRIPTS MOBILE APP

The Express Scripts mobile app helps you stay on track with taking your medications as prescribed and help with prescription refills and renewals, safety alerts, reminder, and potential savings. The app also offers a feature to use your phone to display a virtual card that you can show at the pharmacy. The app is called “Express Scripts” and is compatible with all mobile devices. Download it for free today from the App Store or on Google Play. After downloading the app, log in with your express-scripts.com user ID and password to open. Iif you haven’t yet registered on express-scripts.com, please go to the site to get your Express Scripts user ID and password.

What Prescription Drugs Are Covered in This Program?

Both retail and mail order prescriptions must be filled with a generic drug if a generic equivalent drug is available. Prescription drugs available under both the Retail Program and the Home Delivery/Mail Service Programs include:

- Federal Legend Drugs that are included in the National Preferred Formulary*
- State Restricted Drugs
- Compounded Medications
- Insulin and insulin syringes only
- Narcotic painkillers (considered controlled substances)
- Certain OTC items pursuant to the ACA

Each state establishes its own legal list of controlled substances. Typically, under state laws, a controlled substance cannot have more than a 30-day fill.

The National Preferred Formulary is a list of the most commonly prescribed drugs that are covered under the prescription plan. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

Are There Any Exclusions in This Program?

The following are the excluded items to the prescription plan:

- Non-Federal Legend Drugs including certain "over the counter" items, regardless of whether they are prescribed.
- All gene therapy drugs.
- Charges for the administration or injection of any drug.
- Needles and syringes, support garments, and other non-medical substances (such items may be covered under your medical benefits coverage).
- Prescriptions which you are entitled to receive without charge under any Workers' Compensation Laws or any municipal, state or federal program.
- Medication taken by, or administered to, a person while an inpatient in a licensed hospital, hospice, rest home, sanitarium, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceutical products.
- Drugs labeled "Caution - limited by federal use to investigational use" or experimental drugs.
- Blood, blood plasma or biological sera.
- Vitamins; except those, which by law, require a prescription.
- Any prescription filled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

What Programs Have Been Instituted to Ensure Proper Drug Use?

The Welfare Fund is committed to providing quality prescription drug benefits. With this goal in mind, we use a set of Utilization Management Programs (UM), administered by Express Scripts, Inc. to determine how your prescription drug plan will cover certain medications. The goal of these programs is to alleviate inappropriate and potentially harmful use of prescription drugs while simultaneously assuring the proper utilization of

benefit dollars. Member health, safety, and satisfaction remain the primary objectives of the prescription drug coverage. In addition to the UM programs, the Welfare Fund is also enrolled in “SafeguardRX”; a value-based set of programs to prevent and guard the Fund against unnecessary and prohibitive drug price increases.

The UM programs are Coverage Review, Step Therapy, Preferred Step Therapy, Quantity Duration and Retrospective Drug Utilization Review Health and Safety Program along with a Fraud, Waste & Abuse Program. These programs are defined below:

Coverage Review (Prior Authorization Required)

For some medications, you must obtain prior approval through a review process in order to obtain coverage. When you use Express Scripts By Mail, Express Scripts will call your doctor to start the coverage review. If you submit a prescription to a participating retail pharmacy for a medication that requires coverage review, you, your doctor, or your pharmacist can initiate the review by calling (800) 753-2851.

If coverage is not approved, either at a retail or mail-order basis, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request the appeal will be included in the letter that you receive.

Step Therapy

Step Therapy looks at a patient’s prescription history and determines whether he or she is eligible for a given medication without a coverage review. If there is not enough information in the history, a coverage review may be necessary.

Preferred Step Therapy

The Preferred Step Therapy program manages our prescription-drug waste within specific therapy classes by guiding patients to frontline medications before “stepping up” to more costly backup medications.

Within specific therapy classes, several clinically effective medications are often available to treat the same condition. This program takes advantage of these opportunities by utilizing clinically effective, lower-cost medications. Evidence-based clinical protocols for each step therapy module ensure patients receive cost-effective drug therapy that is clinically appropriate for their condition.

Quantity Duration

Your prescription drug plan provides coverage for a quantity of medication and duration of treatment sufficient to meet the needs of most patients. If a greater quantity or longer course of treatment is needed, a coverage review process is required.

Quantity Duration – No Review

Your plan will cover 6 pills of the certain medications within a 21-day period. Prescriptions that exceed that amount will not be covered by the plan. Your retail pharmacist or your

mail-order pharmacy may reduce the quantity of medication dispensed to an amount covered by your plan. If you choose to obtain additional quantities, you will be responsible for the full cost of the medication at your retail pharmacy.

Retrospective Drug Utilization Review Health and Safety Program

Express Scripts may provide information to your doctor about potential prescribing or medication utilization issues. These include situations in which similar and overlapping medications appear to have been prescribed for the same condition, or when medications may interact with each other in a way that could be harmful to your health.

The information we provide to your doctor is intended to help ensure that you get the safest and most effective therapy possible, especially when more than one doctor is involved in your care. A change in your prescription(s) can sometimes result from these communications between Express Scripts and your doctor.

Fraud, Waste & Abuse

The Fraud, Waste & Abuse Program is designed as a preventative, cost saving measure to identify and eliminate instances of “doctor or pharmacy shopping” as well as detecting duplicate therapies, stockpiling, fraud, overprescribing as well as other costly and detrimental practices.

Pharmacy Vaccination Program

The Steamfitters Welfare Fund encourages all its members to take advantage of the Pharmacy Vaccination program. To assist you and your families to stay healthy, you can now receive vaccines directly at your local participating retail pharmacy through the Welfare Funds prescription drug benefit through Express Scripts. Some of the vaccines include Flu, Childhood Vaccines, HPV, Meningitis, Pneumonia, Shingles, Tetanus, Travel Vaccines and others.

Before you visit the pharmacy, it is your responsibility to ensure that the pharmacy is part of the Express Scripts pharmacy network. You can look up a specific pharmacy on the Express Scripts website, express-scripts.com. Call the pharmacy to verify their vaccination schedule, availability and any restrictions. Remember that the Walgreen Co. retail pharmacies (Walgreen’s, Duane Reade, et al.) are not in the retail pharmacy network we contracted with Express Scripts, Inc

It is your responsibility to ensure the vaccine is administered by the pharmacist and **NOT** an onsite clinic.

DENTAL EXPENSE BENEFITS

METLIFE PREFERRED DENTIST PROGRAM (PDP PLUS)

The following benefits are provided to all eligible Welfare Fund participants and their qualifying dependents subject to the provisions of the program. The Dental Plan is administered by MetLife.

SCHEDULE OF BENEFITS

DENTAL EXPENSE BENEFITS

DEDUCTIBLE AMOUNT
For Services of Network Providers……None

For Services of Non-Network Providers
Type A, B, C and/or D Expenses Combined
Individual ……$250
Family ……$500

COVERED PERCENTAGE
For Services of Network Providers
Type A Expenses……100%
Type B Expenses……100%
Type C Expenses……100%
Type D Expenses…… 75%

For Services of Non-Network Providers
Type A Expenses…… 80%
Type B Expenses…… 80%
Type C Expenses…… 60%
Type D Expenses…… 50%

[When a Non-Network Provider is used, the covered expenses schedule is based on the MetLife PDP network schedule of benefits.]

MAXIMUM
For Orthodontic Treatment
Aggregate Maximum Benefit
Lifetime per covered Dependent Child……$4,000

For Other Covered Dental Expenses
Maximum Benefit
Per Calendar year per Covered Individual……$4,000

PLEASE NOTE:

- Expenses for orthodontia, including any procedures necessary for such treatment, will be considered covered dental expenses only for a Dependent Child until the end of the month of his or her 26th birthday.
- Covered dental expenses for orthodontia are not included in the Maximum Benefit per calendar year.
- The maximums for both orthodontic treatment and all other covered dental expenses apply to all expenses incurred whether treatment is provided by a Network Provider, a Non-Network Provider or a combination thereof.
- If a dental bill is expected to be $300 or more, see section F, Predetermination of Benefits.

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

Covered Dental Expense means the charges based on the Preferred Dentist Program Schedule of Maximum Payments for the types of dental services shown in section C. These services must be:

1. performed or prescribed by a dentist who is:
    - a Network Provider; or
    - a Non-Network Provider; and
2. necessary in terms of generally accepted dental standards.

There may be more than one way to treat a dental problem. If, in MetLife's view, an adequate method or material which costs less could have been used, the dental expense benefits will be based on the method or material which costs less. The balance of the cost will not be a covered dental expense. See section E for examples that show how this works.

Covered Percentage means the percentage shown in the Schedule of Benefits.

Dentist means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a doctor will be considered for dental expense benefits as if it were performed or prescribed by a dentist.

Deductible Amount means the amount shown in the Schedule of Benefits for non-network. The deductible amount during any one calendar year will not apply to covered non-network dental expenses after:

1. you incur covered dental expenses for covered persons in your family; and
2. those expenses, when applied to the deductible amount, equal the family deductible amount.

Network Provider means a dentist who has been selected by MetLife for inclusion in the Preferred Dentist Program. These Network Providers agree to accept the Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Non-Network Provider means a dentist who is not a Network Provider.

Preferred Dentist Program means MetLife's program to offer a covered person the opportunity to receive dental care from dentists who are designated by MetLife as Network Providers. When dental care is given by Network Providers, the covered person will generally incur less out-of-pocket cost for the services rendered.

Preferred Dentist Program Directory means the list which consists of selected dentists who:

- are located in the covered person's area; and
- have been selected by MetLife to be Network Providers and part of the Preferred Dentist Program. These Network Providers agree to accept our Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Preferred Dentist Program Schedule of Maximum Payments means MetLife's fee agreement with a Network Provider in which such Network Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

B. COVERAGE

1. When Benefits May Be Payable

MetLife will pay dental expense benefits if you incur covered dental expenses:

- for a covered person during any calendar year; and
- while the person is covered for the dental expense benefits; and
- to the extent that the covered dental expenses for Non-Network Providers are more than the deductible amount

An expense is “incurred” on the date the dental service complete.

2. How Benefits Are Determined

Benefits will be equal to the covered percentage of those covered dental expenses (in the case of Non-Network Provider services, and which are more than the deductible amount). However:

- The sum of all benefits for all covered dental expenses incurred for a covered person during any calendar year will not be more than the Maximum Benefit per calendar year; and

- The sum of all benefits for all covered dental expenses incurred for a covered person for orthodontic treatment during the covered person's lifetime will not be more than the applicable Aggregate Maximum Benefit.

In order to determine the amounts of covered dental expenses, MetLife may ask for x-rays and other diagnostic and evaluative materials. If they are not submitted, MetLife will determine covered dental expenses based on the information which is available. This may reduce the amount of benefits which otherwise would have been payable.

3. How the Preferred Dentist Program Works

You will generally incur less out-of-pocket cost if you use a Network Provider. Services by Non-Network Providers will be covered, but your coverage will be less and you will be required to pay a deductible.

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

a. Oral exams but not more than twice in any calendar year and no less than 180 days apart.

b. X-rays:
   - full mouth x-rays but not more than once every 36 months.
   - bitewing x-rays but not more than twice in any calendar year (every 183 days).

c. Preventative Treatment
   - cleaning and scaling of teeth (oral prophylaxis) but not more than twice in any calendar year; and
   - topical fluoride treatment for a Dependent Child who has not reached the end of the month of his or her 26th birthday, but not more than twice in any calendar year.

d. Space maintainers for a Dependent Child until the end of the month of his or her 26th birthday.

e. Two applications of sealant material for each molar tooth of a Dependent Child under age 16 not more than twice in a lifetime.

f. Emergency palliative treatment.

2. Type B Expenses

a. Fillings - amalgam, silicate, acrylic, synthetic porcelain or composite fillings.

b. Extractions

c. Root canal treatment

d. Treatment of periodontal disease and other diseases of the gums and tissues of the mouth.

e. Oral surgery

f. Injections of antibiotic drugs

g. Administration of general anesthesia, when medically necessary in connection with oral surgery, extractions, or other covered dental services.

h. Relining and rebasing of existing removable dentures, but not more than once in any 36-month period.

i. Repair or re-cementing of crowns; inlays or onlays; dentures; or bridgework.

3. Type C Expenses

a. Those services needed to replace one or more natural teeth which are lost while dental expense benefits for the covered person are in effect for:

- Installation of fixed bridgework done for the first time.
- Installation for the first time of a partial removable denture or a full removable denture.

b. Replacing an existing removable denture or fixed bridgework if it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed or it is needed because the existing denture or bridgework can no longer be used and the existing denture or fixed bridgework was installed at least 60 months prior to its replacement.

c. Replacing an existing immediate temporary full denture by a new permanent full denture when the existing denture cannot be made permanent, and the permanent denture is installed within 12 months after the existing denture was installed.

d. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

e. Inlays, onlays, and crown restorations, but not more than one such restoration to the same tooth surface within 60 months of the prior restoration.

f. Implantology.

4. Type D Expenses

Orthodontia, including appliance therapy for Dependent Children until the end of the month of his or her 26th birthday. The Aggregate Maximum Benefit for orthodontia during a Dependent Child's lifetime is shown in the Schedule of Benefits.

D. EXCLUSIONS: SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a covered person before the dental expense benefits start for that person.
2. Services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist, and which are for:
    - cleaning and scaling of teeth; or
    - fluoride treatments.
3. Cosmetic surgery or supplies. However, surgery or supply will be covered IF:
    - it otherwise is a covered dental expense; and
    - it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
    - it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent Child which has resulted in a functional defect.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Repair or replacement of an orthodontic appliance.
6. Services or supplies which are covered by any Workers' Compensation Laws or occupational disease laws.
7. Services or supplies which are covered by any employers' liability laws.
8. Services or supplies which any employer is required by law to furnish in whole or in part.
9. Services or supplies received through a medical department or similar facility which is maintained by the covered person's employer.
10. Services or supplies received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person.
11. Services or supplies for which a covered person is not required to pay.
12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.
13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect.

14. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
15. Any duplicate appliance or prosthetic device.
16. Use of materials to prevent decay other than fluorides and sealant material for the molar teeth of a Dependent Child under age 16.
17. Instruction for oral care such as hygiene or diet.
18. Periodontal splinting.
19. Services or supplies to the extent that benefits are otherwise provided under this plan or under any other plan which the employer (or an affiliate) contributes to or sponsors.
20. Myofunctional therapy or correction of harmful habits.
21. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started for the covered person (adults only).
22. Charges for broken appointments.
23. Charges by the dentist for completing dental forms.
24. Sterilization supplies.
25. Services or supplies furnished by a family member.
26. Treatment of temporomandibular joint disorders.

Coverage for Dental Expenses will be based on the materials and method of treatment which cost the least, and which meet generally accepted dental standards.

E. EXAMPLES OF ALTERNATE BENEFITS

1. **Fillings: Inlays, Onlays and Crowns**

   If a tooth can be repaired by a less costly method than an inlay, onlay or crown, dental expense benefits will be based on the adequate method of repair which costs the least.

2. **Crowns, Pontics, and Abutments**

   Veneer materials may be used for front teeth or bicuspids. However, dental expense benefits will be based on the adequate veneer materials which cost the least.

3. **Bridgework and Dentures**

   Dental expense benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental expense benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your dental expense benefits will be, see section F.

F. PREDETERMINATION OF BENEFITS

If a dental bill is expected to be $300 or more, before the dentist starts the treatment, you and your dentist should submit a pre-treatment estimate outlining the treatment plan and related charges. This way, you will know what services MetLife will cover and at what payment level. Services that usually require a pretreatment estimate include crown, bridges, inlays, onlays and periodontics. To do this, send a claim form to MetLife in which the dentist states:

1. the work to be done; and
2. what the cost will be.

MetLife will then tell you what the dental expense benefits schedule is. The predetermination does not review eligibility for services which have time limitations, for example, dentures cannot be replaced within 5 years of installation. If you do not use this method to find out what dental expense benefits MetLife will pay, the decision will be final and binding regarding what are covered dental expenses and what dental expense benefits will be paid.

This method should not be used for:

- emergency treatment; or
- routine oral exams; or
- x-rays, cleaning and scaling, and fluoride treatments: or
- dental services which cost less than $300.

G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available under a government plan, as defined below, they will not be considered for dental expense benefits under this benefit program. This provision will apply whether or not you are enrolled for all government benefits for which you are eligible. This provision will not apply to a government plan if it requires that dental expense benefits under this benefit program be paid first.

A government plan is any plan, program or coverage, other than Medicare:

- which is established under the laws or the regulations of any government; or
- in which any government participates other than as an employer.

H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for covered dental expenses incurred by a covered person after the dental expense benefits for that person end. This will apply even if we have pre-determined benefits for dental services. However, benefits for covered dental expenses incurred for a covered person for the following services will be paid after dental expense benefits end:

1. For a prosthetic device if:
    - the dentist prepared the abutment teeth and made impressions while dental expense benefits for the covered person were in effect; and
    - the device is installed within 60 days after the date the dental expense benefits end; or
2. For a crown if:
    - the dentist prepared the tooth for the crown while the dental expense benefits for the covered person were in effect; and
    - the crown is installed within 60 days after the date the dental expense benefits end; or
3. For root canal therapy if:
    - the dentist opened the tooth while the dental expense benefits for the covered person were in effect; and
    - the treatment is finished within 60 days after the date the dental expense benefits end.

I. PAYMENT OF BENEFITS

MetLife will send payment directly to your Network Provider. When a Non-Network Provider is used, dental expense benefits will be paid to you and you are responsible for paying the provider. MetLife will pay benefits when it receives satisfactory written proof of your claim. Proof must be submitted not later than 90 days after the end of the calendar year in which the covered dental expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

WHEN BENEFITS END

- All your benefits will end on the date your coverage in the Welfare Fund ends. Your coverage ends when you fail to maintain eligibility. Please refer to the **ACTIVE ELIGIBILITY** section for details.
- If this benefit program ends in whole or in part, your benefits which are affected will end.
- All benefits on account of a qualifying dependent will end on the last day of the calendar year in which that qualifying dependent ceases to qualify for dependent coverage under the Welfare Fund.

The end of any type of benefits on account of a covered person will not affect a claim which is incurred before those benefits ended.

The dental expense benefits for a covered person may be continued in accordance with the federal law called COBRA. Please refer to the answer to the question ***"What Happens If I Lose Coverage**?"* under the **ACTIVE ELIGIBILITY** section of this booklet for details.

Dental care benefits are considered “excepted benefits” and are not subject to the Patient Protection and Affordable Care Act provisions such as the essential health benefits mandate. You can reject coverage for dental care benefits if you choose to. Please contact the Fund Office for information regarding rejecting this coverage.

VISION CARE BENEFITS

What vision care benefits does the plan offer?

Vision care benefits are available for you and your qualifying dependents. This benefit will reimburse you for the cost of eye examinations, frames, and/or lenses, including contact lenses and prescription sunglasses. Non-prescription sunglasses are excluded from this program.

Vision care benefits are available in the maximum amount of $300 per covered individual each calendar year. You must be covered under the Welfare Fund on the date of service or the purchase date. In addition, the date of service or the purchase date will determine whether you have reached the maximum benefit for the year. Claims must be filed within a twelve-month period following the date services were provided. Failure to file proof of claims within the required time period shall result in a forfeiture of benefits.

Any unpaid balance of your or your qualifying dependents' vision care purchase may be submitted to the Health Reimbursement Account Fund provided you have a sufficient account balance in that Fund. Please call the Fund Office at (212) 465-8888, option 8 if you have any questions regarding this matter.

Vision care benefits are considered "excepted benefits" and are not subject to the Patient Protection and Affordable Care Act provisions such as the essential health benefits mandate. You can reject coverage for vision care benefits if you choose to. Please contact the Fund Office for information regarding rejecting this coverage.

HEARING AID BENEFITS

This benefit is available solely as a reimbursement towards the cost of purchasing a hearing aid. It is available to you and your qualifying dependents. Hearing aid benefits cannot exceed $2,000 per covered individual during any calendar year. The purchase date of the hearing aid is the applicable date for reimbursement, not the date you file the form. You must be covered in the Welfare Fund on the purchase date. This benefit cannot be used for the cost of repairs or for batteries.

All applications for the hearing aid benefits must be accompanied by an itemized bill and a letter of medical necessity written by a healthcare professional. This healthcare professional must be a Doctor of Medicine (MD), Doctor of Audiology (AuD), or have a certificate of Clinical Competence (American Speech-Language-Hearing Association Certification) (CCC-A)). The letter must be specifically addressed to the Trustees of the Welfare Fund and must state the patient's name, the date they were evaluated and the diagnosis.

Any unpaid balance for you or your qualifying dependents hearing aid purchase must be submitted to the Health Reimbursement Account provided you have a sufficient balance. Please call the Fund Office at (212) 465-8888, option 8 if you have any questions regarding this matter.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a provision in group health and group dental contracts, where applicable, that prevent duplicate payments for the same covered medical or dental expenses. The COB provision applies only when a participant or eligible dependent is covered under more than one group health or dental program. When that is the case, the Welfare Fund will coordinate benefit payments with the other group plan. One group will pay its full benefit as the primary plan and the other group will pay secondary benefits (if necessary) to cover some or all the remaining expenses. This COB provision prevents duplicate payments and overpayments. In no case should the benefits received from the two group plans in total be greater than the medical or dental allowed charges.

The rules to determine the order of payment under Welfare Fund coverage in those cases where there is coverage under more than one group plan are as follows:

A) If the other group plan does not have a COB provision similar to the Welfare Fund's, then that group will be primary.

B) If both groups have a COB provision, the group covering the person as a participant is primary.

C) If a Dependent Child is covered under both parents' group plan and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. For purposes of determining the earlier birthday only the month and day are considered; the year of birth has no significance. If both parents have the same birthday, the plan which covered the parent longer will be primary. However, if the other group plan does not use the "birthday rule," but instead uses a rule based on the gender of the parent and as a result the two plans do not agree on which is primary, then the father's group plan shall be primary.

D) If a Dependent Child is covered under both parents' group plan, the parents are separated or divorced, and there is no court decree which establishes financial responsibility for the child's coverage, the plan of the parent who has custody (the custodial parent) shall be primary. However, if the custodial parent has remarried and the child is also covered as a dependent under the stepparent’s plan, the custodial parent's plan will pay first, the stepparent’s plan second and the non-custodial parent's plan third.

E) If a court decree specifies which parent is to be responsible for the child's coverage and that parent's plan has actual knowledge of the decree, then that parent's plan will be primary.

F) If a person is covered under one group as an active participant or as the dependent of an active participant and is also covered under another group as a retired participant or as the dependent of a retired participant, the group which covers that person as an active participant or as the dependent of an active participant is primary. If the other group plan does not have this rule, and as a result the two plans do not agree on which is primary, then this rule will be ignored.

G) If none of the above rules determine which group plan is primary, the group plan covering the person for the longer period is primary.

Coordination of Benefits with Medicare

If you or your spouse are age 65 or older, you may be eligible for benefits under Medicare. You do not have to be retired to receive these benefits. Medicare includes hospital insurance benefits ("Part A"), as well as supplementary medical insurance ("Part B").

If you remain eligible for coverage under the Plan due to your current Employment status with an Employer, regardless of your age, you will receive the same benefits from the Plan as a Participant under age 65. Likewise, if a claim is incurred by an eligible Dependent covered by Medicare while you maintain eligibility because you are currently employed by an Employer, the Plan is primary and Medicare is secondary. Medicare will provide secondary coverage for some care if the Plan does not pay the full cost.

Coordination of Benefits with Medicaid

For purposes of coordinating benefits with Medicaid, the Plan will assume primary payer status for any Participant or alternate recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Participant or alternate recipient will be made in accordance with any assignment of rights made by or on behalf of such Participant or alternate recipient as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If the Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or alternate recipient for payment of such benefits. The provisions of Section 1908 of the Social Security Act apply to the extent such provisions are in accordance with state Medicaid law.

Coordination of Benefits with TRICARE

If an eligible Dependent is covered by both this Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and the Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Who Provides Our Term Life Insurance Benefits?

MetLife provides group term life insurance benefits for any active covered participant who is eligible for coverage under the Welfare Fund. If you are an active covered participant and you die from any cause, your designated beneficiary will be paid $50,000. Proof of death must be provided within 90 days of loss.

When the Fund Office forwards your claim to MetLife, MetLife will review the claim, and if they approve it, they will pay the Beneficiary the Life Insurance in effect on the date of death. Further details may be found in “Your Benefit Plan” provided to you by MetLife.

Please call the Fund Office at (212) 465-8888, option 4 for further details and to obtain the required claim forms. If notice of claim or proof is not given within the time limits, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible.

Are there Life Insurance Payment Options?

Your beneficiary may receive life insurance proceeds from MetLife in one of two ways:

- A single lump-sum check or
- Proceeds can be deposited into a MetLife sponsored and guaranteed “checking” account called a Total Control Account whereby your beneficiary can access proceeds at his or her discretion.

Does Our Life Insurance Include an Accelerated Benefit Option?

Yes, if you should become terminally ill while covered under the Welfare Fund for Life Insurance, you or your legal representative may request that MetLife pay an Accelerated Benefit Option (herein called ABO). A terminal illness diagnosis due to injury or sickness requires that the life expectancy must be no longer than 12 months. *The Accelerated Benefit Option request must be made while ABO Eligible Life Insurance is in effect.*

Upon MetLife approval of any ABO, they will pay you up to $40,000 (80% of the life benefit of $50,000). MetLife will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once. Definitions for covered losses and illnesses are listed in “Your Benefit Plan” provided by MetLife. If a claim is submitted for insurance benefits other than life insurance benefits, MetLife has the right to ask the insured to be examined by a physician(s) of MetLife’s choice as often as reasonably necessary to process the claim. MetLife will pay the cost of such exam. Please call the Fund Office at (212) 465-8888, option 4 with any questions or for further details.

What are the Requirements for Payment of an Accelerated Benefit?

Subject to the conditions and requirements of the Accelerated Benefit Option MetLife will pay an accelerated benefit to you or your legal representative if:

- the amount of your ABO Eligible Life Insurance benefit to be accelerated cannot exceed $40,000 and
- proof that you are terminally ill is properly filed and received.

Please note MetLife will only pay an accelerated benefit once.

LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID.

Disclosure: *The Life Insurance Accelerated Benefit Option offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from your income and not subject to federal taxation.* ***You are advised to consult with a qualified tax advisor about circumstances under which you could receive an accelerated benefit excludable from income under federal law.***

Receipt of an accelerated benefit may affect your, your spouse's or your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplemental Social Security Income (SSI), and drug assistance programs. ***You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect your, your spouse's or your family's eligibility for public assistance.***

When Is A Participant Eligible for Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance?

Please refer to the **Active Eligibility** section of this booklet *"When Does My Coverage Become Effective?"* and *"How Do I Maintain Coverage?"* (pages 10 and 11).

What Date Does My Life Insurance Take Effect and Accidental Death and Dismemberment Insurance?

Your life insurance takes effect on the date you become eligible for all health and welfare coverage as an active participant.

When Does My Life Insurance and Accidental Death and Dismemberment End?

Your insurance will end on the earliest of the date the group policy ends or the date you lose coverage in the Welfare Fund.

Can I Continue Life Insurance or Accidental Death and Dismemberment Coverage If I Fail to Remain Covered Under the Group Plan?

If your Welfare Fund coverage terminates, you may apply, without medical examination or other evidence of insurability, for an individual life insurance policy through MetLife. You will have the option to convert when:

- Your Life Insurance ends because you cease to be eligible for any reason, including retirement; or
- The Group Policy ends.

Life Insurance or Accidental Death and Dismemberment Coverage Conversion Application Period:

The application period is based on the date your group coverage terminates and the date of the termination notice. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if you are given written notice of the option to convert dated more than 15 days from the date of termination, your application period is extended for an additional 45 days. If the 45-day extension applies to you, it will not exceed more than 135 days from the date group insurance was terminated.

The option to convert the Life Insurance as well as the maximum amount of the new policy is subject to conditions listed in lengthy detail in “Your Benefit Plan” from MetLife.

If you die during the conversion policy application period *during* the first 31 days of the Application Period, and a new policy did not take effect during this period, MetLife will review the claim and if MetLife approves it, will pay the Beneficiary the amount of Life Insurance under this Group Policy to which the participant was entitled to convert.

If you die after the first 31 days of the conversion policy application period, the claim will be reviewed. If the claim is approved, MetLife will pay the beneficiary from a new individual policy. The amount MetLife will pay is the amount of Life Insurance that you were entitled to convert under the Group Policy.

MetLife will not pay insurance under both a new policy applied for during the conversion policy Application Period and the Group Policy.

What Is Accidental Death and Dismemberment Insurance?

Accidental Death and Dismemberment Insurance will pay you (or, in the event of your accidental death, your designated beneficiary) a benefit if you sustain an accidental injury that is the direct and sole cause of a covered loss described in the schedule of benefits listed hereafter. Proof of the accidental injury and covered loss must be sent to the Welfare Fund. When the proof is received, the claim will be reviewed. If it is approved by MetLife, the insurance claim will be paid if in effect on the date of the injury.

The covered loss must have occurred within 12 months of the date of the accidental injury, must have been a direct result of the accidental injury, independent of other causes, and the covered loss must not have been caused or contributed to by non-accidental events, such as suicide, attempted suicide, intentional self-inflicted injury, physical or mental infirmity or the diagnosis or treatment of such illness or infirmity or by infection (other than infection occurring in an external, accidental wound). Nor may the covered loss be caused or contributed to by voluntary actions such as:

- the voluntary intake or use by any means of any drug, medication or sedative, unless it is:
  - taken or used as prescribed by a physician, or
  - an "over the counter" drug, medication or sedative taken as directed;
- the voluntary intake or use by any means of alcohol in combination with any drug, medication, or sedative; or
- the voluntary intake or use by any means of poison, gas or fumes.

MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Presumption of Death

The participant will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which he or she were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a common carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

Exclusions

Under the Accidental Death and Dismemberment Insurance, MetLife will not pay benefits under this section for any loss caused or contributed to by service in the armed forces or units auxiliary thereto; aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; war, whether declared or undeclared; or act of war, participation in a felony, riot or insurrection.

MetLife will not pay benefits under this section for any loss if you are intoxicated at the time of the incident and are the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Benefit Payment Schedule

The following schedule shows the benefits that are available under the AD&D Insurance Policy. You will only be insured for the benefits for which you become and remain eligible, which you elect, if subject to election, and which are in effect. The full amount for purposes of the following Schedule of Covered Losses for AD&D Insurance as indicated here is $50,000.

Accidental dismemberment benefits are payable to the participant, but life insurance and accidental death benefits will be paid to the participant's designated beneficiary.

Benefit	***Payable for***
$20,000	loss of life.
$25,000	loss of a hand permanently severed at or above the wrist or below the elbow.
$25,000	loss of foot permanently severed at or above the ankle but below the knee.
$37,500	loss of an arm permanently severed at or above the elbow.
$37,500	loss of a leg permanently severed at or above the knee.
$25,000	loss of sight in one eye.
$12,500	loss of the thumb and index finger of the same hand.
$50,000	loss of any combination of hand, foot, or sight of one eye, as defined above.
$25,000	loss of speech or loss of hearing.
$50,000	loss of speech and loss of hearing.
$12,500	paralysis of one arm or leg.
$25,000	paralysis of the arm and leg on either side of the body.
$25,000	paralysis of both legs.
$50,000	paralysis of both arms and both legs.
$50,000	brain damage. *[See MetLife Insurance's "Your Benefit Plan" for detail.]*
$500/mo.	beginning on 7th day and for the duration of a coma - maximum of 60 months. *[See MetLife Insurance's "Your Benefit Plan" for details.]*

Additional Accidental Death Benefits

The following amounts may be payable in addition to the accidental death benefit in the above Schedule of Benefits under the specified circumstances.

A) **Seat Belt Use:**

An additional $10,000 benefit is payable if the participant's death was caused by an automobile accident in which the participant was wearing a seatbelt that was properly fastened. If the participant was driving at the time of the automobile accident, this Seat Belt Use benefit is payable only if the participant was properly licensed to operate the automobile at the time of the accident. A police officer investigating the accident must certify that the seat belt was properly fastened. A copy of such certification must be submitted to the Welfare Fund with the claim for benefits.

The Seat Belt Use benefit is an additional benefit equal to $10,000. (A detailed definition of a passenger and seat belt may be found in the document Your Benefit Plan.)

B) **Air Bag Use:**

An additional $5,000 benefit is payable if the participant's death was caused by an automobile accident in which the automobile was equipped with airbags. This Air Bag Use benefit is payable only if the participant was wearing a seat belt that was properly fastened at the time of the accident and, if the participant was driving at the automobile accident, only if the participant was properly licensed to operate the automobile at the time of the accident. A police officer investigating the accident must certify that the seat belt was properly fastened and that the passenger car in which the deceased was traveling was equipped with air bags. A copy of such certification must be submitted to the Welfare Fund with the claim for benefits.

The Air Bag Use benefit is an additional benefit equal to $5,000. (A detailed definition of a passenger, seat belt and air bag may be found in the document Your Benefit Plan.)

C) **Child Care:**

If the covered loss of life of the participant occurs as a direct result of an accident, this additional benefit will be paid if, on the date of the participant's death or within 12 months after the date of the participant's death, the participant's child was enrolled in a Child Care Center. Proof of enrollment in a Child Care Center is required.

For each child who qualifies for this benefit, MetLife will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed: an annual maximum of $5,000 and an overall maximum of $6,000. Child Care Center charges will not be paid for after the date a child attains age 12. Benefits will be paid quarterly upon submission of proof of payment to the Child Care Center. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date the participant dies and there is no child who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

D) Child Education:

If the covered loss of life of the participant occurs as a direct result of an accident, this additional benefit will be paid if, on the date of the participant's death, the participant's child was (1) enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or (2) at the 12th grade level and, within one year after the date of the participant's death, enrolled as a full-time student in an accredited college, university or vocational school. Proof of enrollment in an accredited college, university or vocational school will be required.

For each child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period up to 4 consecutive academic years, not to exceed: an academic year maximum of $10,000 and an overall maximum of 20% of the Full Amount shown in the Schedule of Benefits. Benefits will be paid semi-annually upon submission of proof of payment of tuition charges. Payment will be made to the person who pays such tuition charges on behalf of the child.

If this benefit is in effect on the date the participant dies and there is no child who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

E) Spouse Education:

If the covered loss of life of the participant occurs as the direct result of an accident, MetLife will pay this additional Spouse Education benefit if, on the date of the participant's death, his or her Spouse (1) was enrolled as a full-time student in an accredited college, university, or vocational school; or (2) within 12 months after the date of the participant's death, the participant's Spouse enrolled as a full-time student in an accredited school.

MetLife will pay an amount equal to the tuition charges incurred for a period up to 1 academic year, not to exceed: an academic year maximum of $1,500 and an overall maximum of 3% of the Full Amount shown in the Schedule of Benefits.

Benefits will be paid semi-annually upon submission of proof of payment of tuition charges. Payment will be made to the Spouse.

If this benefit is in effect on the date the participant dies and there is no Spouse who could qualify for it, MetLife will pay $1,000 to the participant's designated beneficiary in one sum.

F) Hospital Confinement:

If the covered loss of life of the participant occurs as the direct result of an accident, MetLife will pay this additional Hospital Confinement benefit if the participant was confined in a hospital as a result of the accident.

MetLife will pay an amount for each full month of hospital confinement equal to the lesser of 1% of the full amount shown in the Schedule of Benefits or $2,500.

Benefit payments will be made monthly. Payment will be made to the participant's beneficiary.

Please note: This Additional Benefit provides insurance only for ACCIDENTS. It does not provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

G) Common Carrier:

If the covered loss of life of the participant occurs as the direct result of an accident while traveling in a Common Carrier, MetLife will pay this additional benefit amount equal to $50,000. For loss of life the participant's benefits will be paid to his or her beneficiary. A detailed definition of a Common Carrier can be found in the document "Your Benefit Plan."

H) Repatriation of Remains Benefit:

This Plan pays a Repatriation of Remains Benefit for the actual expenses incurred to prepare a person's body for transportation to a mortuary if, as a direct result of an accident for which a benefit is payable under this section, he or she suffers loss of life while outside a 100 mile radius from his or her principal place of residence. The maximum benefit payable is $5,000. Benefits will be paid when proof is provided that the charges described above have been paid. Payment will be made to the person who paid such charges

When and How Do I File A Claim for the Accelerated Benefit Option and the Accidental Death and Dismemberment Benefit(s)?

The request for payment of an Accelerated Benefit Option must be made while ABO Eligible Life Insurance is in effect. For any claim other than ABO and Life both the notice of claim and the required proof should be sent to the Fund Office within 90 days of the date of a loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonable.

It is essential that you keep your beneficiary information current. Contact the Fund Office if you wish to change or update your beneficiary information.

Failure to do so can delay or prevent payment of your group life and accidental death insurance benefits or result in payment which is not what you wished.

THE HEALTH REIMBURSEMENT ACCOUNT

The Health Reimbursement Account benefit has been designed specifically to provide you and your families with the ability to pay Medical Care Expenses which are not covered by insurance, not covered by the Steamfitters' Industry Welfare Fund or otherwise not covered under another arrangement, as well as to enable you to save for future medical expenses, on a tax-favored basis. In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. Only these expenses considered medically or dentally necessary are eligible for reimbursement. The Helper classification does not participate in the Health Reimbursement Account. This account is not subject to reciprocity.

Participant Accounts:

An account is established for each participant under the Plan and is credited with contributions received in accordance with the collective bargaining agreement. If the Plan's investment income exceeds its expenses, each account will be credited with an allocable share of the Plan's investment income. Benefit disbursements will be deducted from your account. In addition, amounts previously contributed to the Security Benefit Fund may be transferred as contributions to your HRA account.

Contributions to your account become available to you after they have been posted to your account. Benefits paid to you from your account are deducted from your balance on the date paid. The amount of benefits available to you is limited to the balance in your account.

The maximum balance in your account cannot exceed $5,000. Any balance in excess of this amount will be transferred on a quarterly basis to your Supplemental Retirement Fund (401(a) Plan) account.

Who is Eligible for Health Reimbursement Benefits?

You, the participant of the Steamfitters' Industry Welfare Fund, as well as your qualified dependent(s) enrolled in the Welfare Fund, are eligible for benefits from the Health Reimbursement Account at any time, provided you have a properly documented claim for benefits, that you submit the claim timely, and that you have a balance in your account upon the Fund Office's receipt of your application. Other dependents are not eligible.

If you are no longer eligible to receive additional contributions to your HRA, you are still eligible to receive reimbursement from the HRA until your account balance is exhausted.

After a participant's death, substantiated Medical Care Expenses for the deceased participant may be submitted for reimbursement. Eligible dependents may continue to submit their own claims for Medical Care Expenses until the deceased participant's account is exhausted. There is no time limit in which the account must be exhausted. If,

or when, there are no eligible dependents in the Welfare Fund the balance in the account will be forfeited to the Plan.

How Long is a Claim Eligible for Reimbursement?

Generally, your Health Reimbursement Account will accept properly documented claims for benefits for dates of service up to one year from the date the reimbursable expense was incurred. (Please note: A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care or service.)

What is the Minimum Dollar Amount for which a Claim Will Be Processed?

In order to limit the costs of the administration of the Plan, it is requested that you accumulate a minimum of $100 in receipts in order for the Fund Office to process your reimbursement request.

The $100 minimum is not applicable **ONLY IF:**

- You are enrolled in EFT (Electronic Funds Transfer); **or**
- Your unreimbursed medical expense is at least 11 months old (from date the date incurred) but no greater than 1 year old.

What Happens if I Don't Have a Sufficient Balance to Cover my Claim?

If, at any time your application is received and your claim is for an amount greater than the balance in your HRA account, you may transfer the difference between the application amount and your HRA account balance from your Security Benefit Fund. The transfer amount cannot exceed your Security Benefit Fund account balance and is not subject to tax.

What Must I Submit with my Claim for Benefits?

You may apply for reimbursement by submitting the required application to the Fund Office. To contact the Fund Office for a form, please call (212) 465-8888, option 8 or you may find the form on the website at **www.steamfitters.com**. The form will require you to provide:

- The name of the person (you or your qualified dependent(s)) on whose behalf the expenses which qualify for reimbursement were incurred; and
- The nature of the expenses that were incurred; and

- The amount of the requested reimbursement; and
- A statement that the expenses have not been reimbursed and are not reimbursable through any other source.

The application for reimbursement must be accompanied by bills, invoices, medical Explanation of Benefits, dental expense statements, Medicare Part B premium proofs, or other satisfactory third-party statements showing that the reimbursable expenses have been incurred and the amounts of such expenses. You must also furnish any additional information which the Plan may require.

How Long Will It Generally Take for the Processing of a Claim?

In general, within 30 days of receipt of a claim by the Fund Office, the Fund Office will reimburse the claim if the claim is approved or notify you that the claim is denied. This 30-day period may be extended for an additional 15 days for matters beyond the Fund Office's control, including a case in which the reimbursement claim is incomplete. The Fund Office will provide written notice of any extension, including the reason for the extension. If the problem is an incomplete reimbursement claim, you will be allowed 45 days in which to complete the claim.

Which Expenses are Reimbursable?

The following expenses, not already covered by insurance, are reimbursable:

- Medical
- Hospital
- Dental
- Vision care
- Hearing aid
- Medicare Part B & D premiums
- COBRA premiums
- Qualified Long-Term Care services
- Assisted living medical costs
- Other healthcare insurance *(Co-payment, coinsurance, deductibles)*
- Only those over-the counter (OTC) medicinal products which are FSA eligible.

The definitions for these expenses are as follows:

Medical Care Expenses: These expenses are covered when they are incurred. A medical care expense is incurred at the time the medical care or service giving rise to the expense is furnished and ***not*** when you are billed for it. A "Medical Care Expense" as defined in Internal Revenue Code Section 213 is the "amount paid for the diagnosis, cure, mitigation, treatment, or prevention of disease for the purpose of affecting any structure or function of the body." Medical care expenses **do not** include costs incurred for cosmetic surgery and similar procedures not necessary to ameliorate (improve) a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" for this purpose means a procedure directed to "improving the patient's appearance" that does not "meaningfully promote the proper function of the body or prevent or treat illness or disease."

"Medical care" includes treatments by persons who are not licensed to practice medicine or nursing in the conventional sense, such as chiropractors and psychologists. In order to qualify as medical care, the practitioner's services must be addressed to a physical or mental disability, not to the participant's general wellbeing. For the purpose of the Plan, "Medical care" includes transportation only by ambulances and similar vehicles.

Hospital Medical Care Expenses: While in the hospital, the amount actually paid for medically necessary hospital services. Please contact the Fund Office for further details.

Dental Expenses: The amount actually paid for dental services, excluding cosmetic dentistry.

Vision Care: Eye examinations, frames, and/or lenses including contact lenses. (Non-prescription sunglasses are not eligible for reimbursement).

Hearing Aid: A small electronic apparatus that amplifies sound and is worn in or behind the ear to compensate for impaired hearing.

Medicare Part B & D Premiums: Part B - The amount paid for Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Medicare Part A.

Part D – the Medicare Part D Prescription Drug Plan is a Medicare sponsored insurance plan, sold and administered through private insurance companies, to cover prescription drug costs for people on Medicare.

COBRA Premiums: The amount paid for a health insurance plan which allows an individual that loses health insurance coverage to continue to be covered under the health plan, for a certain time period and under certain conditions.

Qualified Long-Term Care Expenses: Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services required by a "chronically ill individual" that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Medical care does not include long-term care expenses paid to relatives or businesses owned in whole or in part by you or your relatives unless the expenses are for services performed by a relative who is a licensed health care professional.

Assisted Living Medical Costs: The medical care portion of a retirement home or assisted living facility monthly life-care fee is also considered a medical expense. The percentage method is used to determine the medical care portion. For further details and an explanation as to how to determine this expense, please contact the Fund Office.

Other Healthcare Insurance:

- **Co-payment:** The portion of a claim or medical expense that a participant must pay out of his or her own pocket to a provider or a facility for each service.

- **Coinsurance**: A provision in a participant's coverage that limits the amount of coverage by the plan to a certain percentage. Additional costs are paid by the participant, which is referred to as coinsurance.

- **Deductibles:** The dollar amount a participant must pay each year before his or her medical and/or dental plan begins to pay benefits for certain covered expenses.

- **Over-the-Counter Products Prescribed by an Appropriate Health Care Provider:** Only those over the counter (OTC) medicines and drugs which are accompanied by a prescription.

Which Expenses are Not Reimbursable?

Medical care expenses which are eligible for payment or reimbursement by any other accident or health plan are not reimbursable from the HRA. If the other plan does not fully cover your medical expenses, for example, because of co-payment or deductible limitations, this Plan can reimburse the remaining portion of the expense so long as the claim satisfies the definition of expenses covered by the Plan.

Coverage under a Group Health Plan

Beginning January 1, 2014, and applicable only to contributions made to the HRA Plan on your behalf, and eligible claims incurred by you or your dependents as of January 1, 2014 or later, in order to be eligible for benefits from the HRA Plan, you must be enrolled in a group health plan, either through the Fund, another employer or one sponsored by

your spouse's employer. You are not eligible for reimbursement from the HRA Plan unless you are enrolled in a group health plan that provides at least Minimum Value as described below (including the Steamfitters' Industry Welfare Fund). You will be required to provide the Fund with proof of enrollment in a group health plan if you are not enrolled in the Welfare Fund.

Proof of Coverage

Proof of other group health plan coverage that provides Minimum Value is required, in a manner to be determined by the Trustees. If proof is not provided, benefits will be restricted, as described below.

Minimum Value

A group health plan provides Minimum Value if the coverage has an actuarial value of at least 60 percent under the actuarial value of a standard plan as determined by the IRS. Proof of Minimum Value may be found on the group health plan's Summary of Benefits and Coverage (SBC). You will be required to provide a copy of the SBC at the time you submit a claim for benefits.

Benefits are Not Payable for Individual Insurance

In no event are premiums for individual health insurance a reimbursable Medical Care Expense, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

Opt-Out

Upon termination of coverage under your group health plan, i.e., either the Fund or one sponsored by another employer or your spouse's employer, you must opt-out of and waive future reimbursements from the HRA at least once per year, in a time and manner determined by the Trustees. This opt-out is applicable only to those contributions made to the HRA Plan on your behalf prior to the date you elect to opt-out of the Plan. This does not preclude any future contributions being made to the HRA Plan on your behalf based on future employment.

HRA Rules and Regulations

Investment Earnings

After the close of each Plan Year, if the net investment income of the Fund exceeds expenses, at the direction of the Trustees, the net amount may be proportionally allocated to each participant's account balance.

Assignment of Benefits

You may not assign or use as collateral any part of your account balance or any benefits you are entitled to from the Fund.

Coordination of Benefits

In no event shall the combined reimbursement payable to a Participant with respect to any Medical Care Expense, from this Plan and all other sources, exceed one hundred percent of such Medical Care Expense.

Fraudulent Claims

If you file a claim for benefits which the Trustees determine is based upon misrepresentation or fraudulent conduct on your part, the Trustees shall deny the claim and will suspend all payments to or withdrawals by you from the Fund for a period of one year for the first offense and two years for any subsequent offense.

Indemnification of Plan Sponsor

If any Participant receives one or more payments or reimbursement under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

STEAMFITTING INDUSTRY ASSISTANCE PROGRAM

The Steamfitting Industry Assistance Program (SIAP or the Assistance Program) was one of the first Assistance Programs in the Building and Construction Trades Industry and has been helping participants and their families since 1986. Through the Program, resources are available to assist both active and retired members as well as their families with alcohol, drug, prescription drug, pain medications and other mental health issues.

Addiction is not intentional, but, left untreated, it can destroy families and take lives. The Program refers participants and their families to Inpatient and Outpatient Treatment. Once inpatient treatment has been completed, participants may attend SIAP's internally developed aftercare program.

To contact the Steamfitting Industry Assistance Program, the direct phone number is (212) 563-0378. You can be assured that anyone who calls the Assistance Program will receive completely confidential assistance.

CLAIM FILING PROCEDURES

HOSPITAL

Empire EPO

Should you or any of your dependents require emergency care or admission to a participating hospital, you should present your Empire BlueCross BlueShield identification card at the time of service. The hospital will bill Empire for benefits payment. No claim forms are required for hospital coverage. The pages at the end of this booklet, for more information about your hospital coverage.

MEDICAL BENEFITS

Empire EPO

There are no claim forms to file for medical benefits for services rendered by participating EPO providers. You simply identify yourself as a member of the EPO by showing your identification card to the provider and make any required co-payment. The providers are responsible for filing all claims for benefits directly with Empire BlueCross BlueShield. See the EPO Guide, the blue pages at the end of this booklet, for more information about your hospital coverage.

DENTAL BENEFITS

MetLife Preferred Dentist Program

No claim forms are required if you see a Preferred Dentist. The Preferred Dentist will submit your claim for you, and MetLife will pay the dentist directly.

You are responsible for paying for services from Non-Network Dentists and requesting reimbursement from MetLife. All necessary forms for dental work can be obtained by calling MetLife at (800) 942-0854. Claim forms can be downloaded from the MetLife website, metlife.com/dental**.** Access specific information about dental claims at metlife.com/mybenefits.

If you require treatment in excess of $300, you and your dentist should submit a pre-treatment estimate outlining the treatment plan and related charges. This way, you will know what services MetLife will cover and at what payment level. Services that usually require a pre-treatment estimate include crowns, bridges, inlays, onlays and periodontics.

Initial Determination for Claims Other Than Urgent Care Claims

After you submit a claim for Dental Insurance benefits to MetLife, MetLife will review your claim and notify you in writing of its decision to approve or deny your claim.

Such notification will be provided to you within a 30-day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

The denial will also include a statement of your right to make an appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

It will also describe your right to bring civil action to enforce your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

PRESCRIPTION DRUG PROGRAM

Express Scripts, Inc.

No claim forms are required for prescriptions obtained through the Mail Service or Retail Program. If you are required to purchase a prescription at a non-participating pharmacy because of circumstances beyond your control, contact the Fund Office at (212) 465-8888, option 4 to obtain a Direct Reimbursement Claim form. You may be reimbursed significantly less than your purchase price of the prescription. After you and your pharmacist have completed the claim form, return it to the Fund Office for processing.

VISION CARE & HEARING AID BENEFITS

There is a special claim form for these benefits. Should you or any of your qualifying dependents require an application, please contact the Fund Office at (212) 465-8888, option 8 or please visit the website, **www.steamfitters.com**. After you have completed the application and followed its specific instructions, submit it to the Fund Office for processing. An itemized receipt for the services rendered or products purchased must accompany the application.

In general, claims for Vision Care Benefits and Hearing Aid Benefits are paid or denied within 30 days of receipt of a claim by the Fund Office. This 30-day period may be extended for an additional 15 days for matters beyond the Fund Office's control, including a case in which the claim is incomplete. The Fund Office will provide written notice of any extension, including the reason for the extension. If the problem is an incomplete claim, you will be allowed 45 days in which to complete the claim.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The claimant(s) must contact the Fund Office at (212) 465-8888, option 4 to commence the process to file a claim for Life Insurance or Accidental Death and Dismemberment Insurance. Except in case of application for the Advanced Benefit Option, claims must be submitted within 90 days of the date of loss (or otherwise as soon as possible).

After the Fund Office forwards your claim to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

APPEAL OF DENIED CLAIMS

The following explains how to appeal denied claims in the Welfare Fund:

Hospital and Medical Benefits

The appeals and grievances procedures for hospital and medical claims for services provided by Empire BlueCross BlueShield – EPO are set forth in the Empire EPO Guide at the end of this booklet. If you exhaust Empire's internal appeals procedures and receive an adverse determination with Empire, you may appeal to the Welfare Fund's Board of Trustees.

Prescription Drugs

You should first appeal your denial of Prescription Drug claims with Express Scripts. If you exhaust Express Script's internal appeals procedures and receive an adverse determination, you may appeal to the Welfare Fund's Board of Trustees.

There are two types of appeals: clinical coverage and administrative coverage reviews.

How to request an initial coverage review of your prescription drug claim:

The preferred method to request an initial clinical coverage review, based on clinical conditions of coverage i.e. medications that require a preauthorization, is for the prescriber or dispensing Pharmacist to call the Express Scripts Coverage Review Department at (800) 753-2851. Alternatively, the prescriber may submit a completed coverage review form to fax number (877) 329-3760. Forms may be obtained online at express-scripts.com/services/physicians/. Requests may also be mailed to: Express Scripts, Attn: Prior Authorization Dept., PO Box 66571, St. Louis, MO 63166-6571. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, based on the Plan's benefit design, the member or his or her representative must submit the request in writing to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at (800) 753-2851.

How a prescription drug initial coverage review is processed:

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support his or her request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

How to request a level 1 prescription drug appeal or urgent prescription drug appeal after an initial coverage review has been denied:

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax: (877) 852-4070

Administrative review requests: Express Scripts, Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587. Fax: (877) 328-9660

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone (800) 935-6103 or fax (877) 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 prescription drug appeal or urgent prescription drug appeal is processed:

Express Scripts completes appeals per business policies that are compliant with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Specialist, panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 prescription drug appeal after a level 1 appeal has been denied:

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination

- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical review requests: Express Scripts, Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax: (877) 852-4070

Administrative review requests: Express Scripts, Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587 Fax: (877) 328-9660

An urgent level 2 appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by Phone: (800) 935-6103 or Fax: (877) 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 prescription drug appeal is processed:

Express Scripts completes appeals per business policies that are compliant with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Specialist, and panel of clinicians or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service* Standard Post-Service*	15 days (Retail) 5 days (home delivery) 30 days	Patient: automated call *(letter if call not successful)* Prescriber: Fax *(letter if fax not successful)*	Patient: letter Prescriber: Fax *(letter if fax not successful)*
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax *(letter if fax not successful)*	Patient: live call and letter Prescriber: Fax *(letter if fax not successful)*

When and how to request an external review of your prescription drug claim:

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to: MCMC, LLC, Attn: Express Scripts Appeal Program, 300 Crown Colony Drive, Suite 203, Quincy, MA 02169. Phone: (617) 375-7700 ext. 28253 Fax: (617) 375-7683 and the request must be received within four (4) months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

How an external review of a prescription drug claim is processed:

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claim's administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Dental Benefits

You should first appeal your denial of Dental Benefit claims with MetLife. If you exhaust MetLife's internal appeals procedures and receive an adverse determination, you may appeal to the Welfare Fund's Board of Trustees.

Appealing the Initial Determination of Dental Claims - First Level of Review

If MetLife denies your claim, you may take two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination

- An explanation why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim such as diagnostic materials, x-rays, or narrative.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will consider all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a dental judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

A denial of your first request for appeal will also include a statement of your right to make a second appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

Each denial of an appeal will also describe your right to bring civil action to enforce your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

Finally, each denial of an appeal will describe your right to request an additional, external review under New York state law.

Second Level of Review of a Dental Claim

If the appeal is not resolved to your satisfaction, you can appeal the action to second level of review for reconsideration. Decisions on your appeal in the second level of review will be made no later than 30 days after receipt of the request for reconsideration.

After MetLife receives your written request for a second level of review, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial or the initial appeal, and MetLife's review will look at the claim anew. The review on the second appeal will consider all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination or on the initial appeal. The person who will review your second appeal will not be the same person as the person who made the initial decision or the person who made the decision on the initial appeal to deny your claim. In addition, the person who is reviewing the second appeal will not be a subordinate of the person who made the initial decision or the person who made the decision on the initial appeal to deny your claim. If the initial denial or the denial on the initial appeal is based in whole or in part on a dental judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination or on the initial appeal and will not be a subordinate of any person who was consulted on the initial determination or the initial appeal.

If your second level of review also denies your claim, your written notice of denial will contain the same items of information that were contained in your initial appeal notice.

Please note, by undertaking a second level review you may foreclose your right to an external appeal as an external appeal must be filed within 45 days of the Final Adverse Determination of the first level review.

External Procedures for Dental Claim Review Outside of MetLife

New York state law gives you the right to an external appeal when payment of benefits for dental services have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational. This applies both to Urgent Care Claims and non-Urgent Care Claims.

If you have received a Final Adverse Determination after our first level of review, you can request an external appeal by completing an application form and sending it to the New York State Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Final Adverse Determination means a written notification from us that your claim for dental benefits has been denied through our appeal process.

You may obtain an application form or any additional information by calling us at (800) 275-4638 or by calling the New York Insurance Department at (800) 400-8882. You may also obtain an application or further information by visiting the New York Insurance Department's web site at www.ins.state.ny.us.

Eligibility for an External Appeal of a Dental Claim

To be eligible for an external appeal, payment of benefits for dental services must have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational and:

- You must have received a Final Adverse Determination as a result of our internal utilization review appeal process; or
- You and MetLife must have agreed to waive that appeal process.

If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

You may only appeal a service or procedure that is a Covered Service under this certificate. The external appeal process may not be used to expand your dental coverage.

Submission of Information for External Review of a Dental Claim

If your case is determined to be eligible for external review, you will be notified by the New York Insurance Department of the certified external appeal agent assigned to review your case.

MetLife will send your dental and treatment records to the external appeal agent.

When the external appeal agent reviews your case, the agent may request additional information from you or your Dentist. This information should be sent immediately to the external appeal agent. You and your Dentist can submit information even when the external appeal agent has not requested specific information. You must submit this information to the Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Once the external appeal agent makes a determination or your 45-day time period ends, you will not be able to submit additional information.

The external appeal application contains a release of medical records provision that you must sign to authorize the release of medical and treatment records, including HIV, mental health and alcohol and drug abuse records to the certified external appeal agent assigned to review your appeal.

Eligibility for an Expedited External Appeal of a Dental Claim

If your attending Dentist attests that a delay in providing the treatment or service poses an imminent or serious threat to your health, you may request an expedited appeal. When requesting an expedited appeal, make sure you give the Attending Physician Attestation form to your Dentist to complete. Your appeal will not be forwarded to the external appeal agent until your Dentist sends this attestation to the Insurance Department.

Time Periods for External Appeals of Dental Claims

For standard appeals, the external appeal agent must make a determination within 30 days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five additional business days to make a determination. For expedited appeals, the external appeal agent must make a determination within three days of receiving your request for an external review from the state.

The Cost to You for an External Appeal of a Dental Claims

We may charge you a fee of up to $50.00 for an external appeal. If we determine that the fee will pose a hardship, you will not be required to pay a fee.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to you.

Notification of a Decision on External Review of a Dental Claim

When the external appeal agent has made the decision:

- for standard appeals, you and MetLife will be notified in writing within two business days; or
- for expedited appeals, you and MetLife will be notified immediately by telephone or fax. Written notification will follow.

The decision of the external appeal agent is binding on you and MetLife.

Final Appeal of Medical, Prescription Drug, and Dental Benefits to Board of Trustees

After you have exhausted your internal appeals with the following:

- Empire BlueCross BlueShield for Hospital and Medical Benefits
- Express Scripts for Prescription Drug Benefits
- MetLife for Dental Benefits

You may appeal the company's decision to the Board of Trustees. Appeals should be made in writing and sent, within 180 days of the receipt of the denial of the final internal appeal, and sent to:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You or your authorized representative may examine Plan records relating to your claim, without charge.

Your appeal must be made in writing and sent to the Fund Office within 180 days of the notification that your claim has been denied on review. You may submit written comments, documents, and other information relating to your claim, regardless as to whether such information was submitted or considered in the initial claim determination. You will be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim. You have the right to have another person represent you in your appeal.

The Trustees will respond to your appeal within 60 days, unless special circumstances make it necessary for them to take an additional 60 days to review your request. You will be notified of the need for an additional 60 days, and a description of the reason additional time is needed, before the end of the initial 60-day period.

The Board's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Board's review will not provide deference to the denial by Empire, Express Scripts, or MetLife (as applicable). If the denial is based in part on a medical judgment, the Board will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim or consideration of your claim on appeal. Any medical or vocational experts consulted will be identified even if the Board does not rely on their advice in making the determination on appeal.

Notice of Board of Trustee's Decision:

You will be provided with written notice of the Board's decision on your appeal (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol, was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation for the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If you feel that legal action concerning your claim is necessary, legal process may be served upon the Administrator, or upon one or more of the Trustees at the address shown in the front of this booklet. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. Any lawsuit filed against the Plan must be filed no more than one year after a final decision on review is reached.

Vision Care Benefit, Hearing Aid Benefit and the Health Reimbursement Account

If your claim for Vision Care Benefits, Hearing Aid Benefits, or HRA reimbursement is denied, you will be provided with a written notice of denial of your claim (whether denied in whole or in part).

This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A description of any additional information necessary to perfect the claim, and an explanation of why the material or information is necessary,

- A description of the appeal procedures and applicable time limits,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity or because the treatment was experimental, or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim or a statement that is available upon request at no charge.

If you disagree with the denial of your claim, you may contact the Executive Administrator and request review within 180 days of your receipt of the denial of your claim. You may submit written comments, documents, and other information relating to your claim. You will be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim. You have the right to have another person represent you in your request for review or appeal.

The Executive Administrator's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Executive Administrator's review will not provide deference to the initial denial. If the denial is based in part on a medical judgment, the Executive Administrator will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim. Any medical or vocational experts consulted will be identified even if the Executive Administrator does not rely on their advice in making the determination on appeal. The Executive Administrator will notify you of the determination on review within 30 days after receipt of your request for review of the denial of your claim.

If the Executive Administrator denies your claim on appeal, you may appeal to the Board of Trustees. Your request for a review of the Executive Administrator's adverse determination on your appeal of your denied claim should be made in writing and sent to:

Board of Trustees
The Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

Your appeal must be made in writing and sent to the Fund Office within 180 days of the notification from the Executive Administrator that your appeal has been denied. You may submit written comments, documents, and other information relating to your claim. You will be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to your claim. You have the right to have another person represent you in your request for review or appeal.

The Board's review will take into account all comments, documents, and other information that you have submitted, whether or not such information was submitted or considered in the initial benefit determination. The Board's review will not provide deference to the denial by the Executive Administrator. If the denial is based in part on a medical judgment, the Board will consult with a health care professional with appropriate training and experience who is independent of any health care professional consulted in the original consideration of your claim or in the Executive Administrator's consideration of your claim. Any medical or vocational experts consulted will be identified even if the Board does not rely on their advice in making the determination on appeal.

Your appeal will be presented at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review provided the appeal has been received at least 30 days before such meeting. However, if your request for review is not received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision no later than five (5) days after the decision has been reached.

If special circumstances require an extension of time for processing the claim, written notice of such extension, and a description of the special circumstances, must be given to you prior to the end of the review period. If such an extension is required, you will receive notice of a decision on the claim no later than five (5) days following the third regularly scheduled Board meeting following the initial submission of the claim. If notification of decision is not given within a period described herein, the claim will be considered denied.

You must seek review of a denied claim before seeking relief in court. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has lapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them following your request for review. Any lawsuit filed against the Plan must be filed no more than one year after a final decision on review is reached.

Notice of Decision:

You will be provided with written notice of a denial of your claim on review (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol, was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation for the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Life Insurance and Accidental Death and Dismemberment Benefits

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered

by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

MISCELLANEOUS PROVISIONS

Assignability

Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, and any attempt to alienate any amount, whether presently or hereafter payable shall be void, provided that benefits payable at any time may be used to make direct payments to health care providers upon written authorization of the participant. The Fund shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable through the Welfare Fund, or any part thereof.

Filing of Information

Each eligible participant, qualifying dependent or other interested person shall file with the Welfare Fund such pertinent information as requested, including proof or continued proof of eligibility or dependency, and in such a manner and form as the Fund may specify or provide. Failure to file the requested information will result in the suspension of entitlement to any benefits hereunder until such time as said information is filed by the covered person or on behalf of the covered person.

Misstatements

In the event of any misstatement of fact(s) affecting coverage and/or benefits under the Welfare Fund, the true facts will be used to determine the proper coverage and the participant or qualifying dependent will be liable to repay the Fund for any excess coverage or benefits provided on the basis of the misstatement. The Trustees have sole and absolute discretion to determine eligibility for benefits and the type and amount of benefits to which a participant or beneficiary is entitled.

Overpayments

If a covered person has been paid benefits by the Welfare Fund that either should not have been paid or are in excess of the benefits that should have been paid, the Fund may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such covered person or other present or future amounts payable to such person. The Fund, in its sole discretion, may also recover such amount by any other legal means. Each covered person hereby authorizes the deduction of such excess payment for such benefits or other present or future compensation payments.

No-Fault Benefits

If a person covered by this Plan has a claim, which involves a motor vehicle accident covered by the “no-fault” insurance law of any state, health care expenses must be

reimbursed first by the no-fault insurance carrier. Only when the claimant has exhausted his or her health care benefits under the no-fault coverage will he or she be entitled to receive health care benefits under this Plan. If there are expenses for services that are covered under this Plan and which are not completely reimbursed by the no-fault carrier, such expenses may be reimbursed under this Plan, subject to the Plan's applicable maximums and other provisions.

Payment To Other Than Participant

If it is determined that any person to whom benefits are payable is unable to care for personal affairs; is a minor; or has died, then any payment due the participant or his/her estate may be paid to the duly appointed legal representative, spouse, child, other relative or an institution maintaining or having custody of such person otherwise entitled to payment. The Trustees have sole and absolute discretion to determine to whom the payment will be made. Any such payment shall be a complete discharge of the liabilities of the Fund Office. The Fund may, at its discretion, hold any such payments until a legal representative is appointed.

Right Of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Welfare Fund may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any potential or current covered person who benefits from the Fund's coverage.

In so acting, the Welfare Fund shall be free from any liability that may arise with regard to such action. Any covered person claiming benefits shall furnish to the Welfare Fund information which may be necessary to implement this provision.

Notice Of Exclusion

As to those participants who elect to exclude themselves from a Worker Compensation and Employer Liability insurance policy, pursuant to a New York exclusion of Executive Officer, by executing a Worker's Compensation policy endorsement, take note: said individuals will not be covered under this Plan in the event that the injuries suffered by said excluded individual are work-related and/or occurred on the job. Said work-related and/or occupational injuries which, except for the election to exclude, would be covered under the employer's Worker Compensation and Employer Liability insurance policy have been specifically excepted by the policies of insurance the Fund has with its benefit providers or insured certificates or insurance contracts.

Newborns' and Mothers' Protections

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the

mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

SUBROGATION

The Welfare Fund has the right of subrogation. These provisions apply when the Welfare Fund pays benefits as a result of injuries or illnesses you sustained, and you have a right to a Recovery or have received a Recovery from any source. “You” refers to the participant and/or the participant’s beneficiary. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. The Plan shall be fully subrogated to any and all rights of recovery and causes of action which you may have against any liable third party or insurer. The right reimbursement comes first, even if you are not paid for all of your claims for damages or if the payment you receive is for damages other than medical expenses. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

SUBROGATION

The Welfare Fund has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Welfare Fund has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries. The Fund’s right of subrogation and reimbursement will not be effected, reduced or eliminated by the make whole doctrine, comparative fault, the common fund doctrine, or any other doctrine purporting to defeat the Fund’s right by allocating the proceeds exclusively, or in part, to non-medical expense damages.
- You and your legal representative must do whatever is necessary to enable the Welfare Fund to exercise the Welfare Fund's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Welfare Fund to exercise its subrogation rights, the Welfare Fund shall be entitled to deduct the amount the Welfare Fund paid from any future benefits under the Welfare Fund.
- The Welfare Fund has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid by the Welfare Fund.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Welfare Fund's subrogation claim and any claim held by you, the Welfare Fund's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The Welfare Fund is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Welfare Fund's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Welfare Fund.
- The Welfare Fund, once benefits are paid, is granted a lien on the proceeds of any payment, settlement, judgment or order received by or due to you. You consent to this lien and agree to cooperate with the Welfare Fund to affect the Fund's subrogation rights.
- You cannot assign any rights or causes of action that you might have against a third-party tortfeasor to recover medical expenses without the express.

REIMBURSEMENT

This Plan is granted a specific and first right of reimbursement out of any Recovery, whether by settlement, judgment, order or otherwise that you or your beneficiary receive from a third-party or insurer. If you obtain a Recovery and the Welfare Fund has not been reimbursed for the benefits the Welfare Fund paid on your behalf, the Welfare Fund shall have a right to be reimbursed from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Welfare Fund from any Recovery to the extent of benefits the Welfare Fund paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Welfare Fund shall have a right of full recovery, in first priority, against any Recovery. Further, the Welfare Fund's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Welfare Fund the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney's fees, other expenses or costs) to be paid to the Welfare Fund immediately upon your receipt of the Recovery. You must reimburse the Welfare Fund, in first priority and without any set-off or reduction for attorney's fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Welfare Fund.
- If you fail to repay the Welfare Fund, the Welfare Fund shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Welfare Fund has paid or the amount of your Recovery whichever is less, from any future benefit under the Welfare Fund if:
  - The amount the Welfare Fund paid on your behalf is not repaid or otherwise recovered by the Welfare Fund; or

- You fail to cooperate with the Welfare Fund in its exercise of its subrogation or reimbursement rights.

- In the event that you fail to disclose the amount of your settlement to the Welfare Fund, the Welfare Fund shall be entitled to deduct the amount of the Welfare Fund's lien from any future benefit under the Welfare Fund.
- The Welfare Fund shall also be entitled to recover any of the unsatisfied portion of the amount the Welfare Fund has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Welfare Fund has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Welfare Fund will not have any obligation to pay the Provider or reimburse you.
- The Welfare Fund is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

YOUR DUTIES

- You must notify the Welfare Fund promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Welfare Fund in the investigation, settlement and protection of the Welfare Fund's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Welfare Fund to exercise its subrogation or reimbursement rights, the Welfare Fund shall be entitled to deduct the amount the Welfare Fund paid from any future benefits under the Welfare Fund.
- You must not do anything to prejudice the Welfare Fund's rights.
- You must send the Welfare Fund copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Welfare Fund if you retain an attorney or if a lawsuit is filed on your behalf.

As with all other terms and conditions of this Plan, the Welfare Fund Trustees have sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Welfare Fund in its entirety and reserve the right to make changes as they deem necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to all of the aforesaid provisions. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery, because of injuries sustained by the covered person, that Recovery shall be subject to all of the aforesaid provisions.

The Welfare Fund is entitled to recover its attorney's fees and costs incurred in enforcing any of the aforesaid provisions.

The subrogation process is being handled by Meridian Resource Company, LLC, in conjunction with their relationship with Empire BlueCross BlueShield. Should a potential subrogation case be identified, Meridian will send a letter and questionnaire to you to start the recovery process. If there is a lawsuit involved, the subrogation process will monitor the lawsuit to be sure that the Welfare Fund is fully repaid for any health care costs (including, but not limited to hospital, medical, prescription, drug, dental costs, etc.) it may have expended.

YOUR RIGHTS UNDER ERISA

As a participant in The Steamfitters' Industry Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Fund Office and at the Union Office, all documents governing the Plan, including insurance or group health contracts, collective bargaining agreements and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report and Plan Document/Summary Plan Description, upon written request to the Fund Office. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- Continue health care coverage for yourself, Spouse or Dependent Children 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 Plan Document/Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ceases.
- You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report materials from the Welfare Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Executive Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If it should happen that the Plan "fiduciaries" misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquires, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you. You may also find answers to your questions at the EBSA website at: dol.gov/ebsa

QUALIFIED MEDICAL SUPPORT ORDER (QMCSO)

According to federal law, a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Plan and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires someone who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to heath care coverage for any of the employee's Dependent Children, the Fund Administrator or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the participant is covered by the Plan, the Fund Administrator or its designee will notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).

A QMCSO may not require that a plan provide any Plan benefits that are not otherwise provided under the Plan. However, if the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

If the employee is not covered by the Plan at the time the QMCSO is received and the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) specified by the QMCSO. Coverage of the employee and the Dependent will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan, including the exclusion of pre-existing conditions, insofar as is permitted by applicable law.

Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates, for any reason including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA continuation coverage if it applies.

If you have questions about, or wish to obtain a copy of, the procedures governing how the Fund determines if a medical child support order is a QMCSO (at no charge), contact the Fund Office at (212) 465-8888, option 4.

HIPAA PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

Introduction

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, requires that health plans like the Fund protect the confidentiality of your private health information.

Section 1: Purpose

The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Fund's duties with respect to your PHI,
4. Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Plan May Disclose Your PHI

The Plan Sponsor has amended its Plan Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent in the following cases:

- **At your request.** If you request it, the Fund is required to give you access to certain PHI in order to inspect it and copy it.
- **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

- **For treatment, payment or health care operations.** The Fund and its business associated will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:
    1. Treatment
    2. Payment, or
    3. Health care operations

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example: The Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example: The Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as “business associates.” We will also disclose enrollment information to contributing employers.

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example: The Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Fund Sponsor, the Board of Trustees of the Steamfitters' Industry Welfare Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before (each of these includes defined exceptions under which the Fund use or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.
- **Psychotherapy notes** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. When required by law.

2. ***Public health purposes.*** When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. ***Court proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:

    a. the requesting party must give the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice, and

    b. the notice provided sufficient information about the proceeding to permit you to raise an objection, and

    c. No objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes***. For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:

a. identifying or locating a suspect, fugitive, material witness or missing person, and

b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances

8. ***Determining cause of death.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties.

9. ***Funeral purposes***. When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Fund uses and disclosures not described in Section 2 of this Notice will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization.

Section 3: Your Individual Privacy Rights

Breach Notification

If a breach of your unsecured PHI occurs, the Fund will notify you.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You also may request a summary of your PHI.

Designated Record Set: Includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund must provide the requested information within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. You may be charged a reasonable, cost-based fee for creating or copying the PHI or preparing a summary of your PHI. Requests for access to PHI should be made to the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You should make your request to amend PHI to the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six years before the date of your request. However, such accounting need not include PHI disclosures made:

To carry out treatment, payment or health care operations,

- To you about your own PHI, or
- Before the privacy rule compliance date.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order of appointment of the person as the conservator or guardian of the individual,
- An Appointment of Personal Representative form that is completed and signed by you, or
- The status of the personal representative as the parent of a minor child.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Fund may not (and does not) use your genetic information that is PHI for underwriting purposes. This notice is effective beginning on September 23, 2013 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

If material changes are made to this Notice, it will be posted to the Fund's website and thereafter included in the Fund's next general mailing.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.
- This notice does not apply to information that has been de-identified. De-identified information is information that:
- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Disclosures to the Fund Sponsor (Board of Trustees)

The "Fund Sponsor" of the Fund is The Steamfitters' Industry Welfare Fund Board of Trustees. As described in the amended Plan document, the Fund may share PHI with the Fund Sponsor (Board of Trustees) for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Fund. The Fund shares the minimum information necessary to accomplish these purposes.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or

type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following officer:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

You may also file a complaint with the Secretary of the U.S. Department of Health & Human Services. Filing instructions are available at: hhs.gov/ocr/privacy/hipaa/complaints/index.html.

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer at the Fund Office:

Privacy Officer
Steamfitters' Industry Welfare Fund
27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

IMPORTANT ADDITIONAL INFORMATION

The Welfare Fund is operated and controlled by a Joint Board of Trustees. The Trustees are responsible for interpreting the benefit programs, executing all contracts, amending or cancelling its provisions or benefits when they consider amendment or cancellation appropriate, and establishing whatever rules regarding the Fund's operation as they may deem necessary or appropriate. The Trustees intend to continue the Welfare Fund indefinitely but reserve the right to terminate any or all of its coverages and/or benefits at any time for any reason.

The Trustees have appointed an Executive Administrator to be responsible for the day-to-day operation of the Welfare Fund. It is the Executive Administrator who arranges for the maintenance of records, processing of claims for benefits and assists you in understanding your benefits. If you have any problems, the Fund Office will be glad to assist you.

Please understand that this is your Welfare Fund. You are encouraged to contact the Trustees or the Fund Office with any questions or comments you may have regarding benefits for you, your dependents and/or your beneficiaries.