

**Northeastern New York District
Council Pipefitters
Welfare Fund**

**Summary Plan Description
Effective January 1, 2024**



January 1, 2024

Dear Participant:

This booklet is a description of the Northeastern New York District Council Pipefitters Welfare Plan as it is in effect on January 1, 2024. There have been some changes to the Plan since the last booklet was written. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

You will find that the benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them. These and other matters are discussed in ten sections of the booklet as follows:

Section I.	Eligibility Requirements & Plan Participation
Section II.	Insurance Benefit
Section III.	Pooled Benefits
Section IV.	Health Expense Benefit
Section V.	Claim Procedure
Section VI.	COBRA
Section VII.	Qualified Medical Child Support Order
Section VIII.	Your Rights Under ERISA
Section IX.	Protected Health Information
Section X.	Technical Details

The Plan is governed by a Board of Trustees. Our role, as Trustees of the Welfare Fund, includes the responsibility for collecting contributions (which are required by an agreement between an employer and the Plumbers and Pipefitters Local 773 or between an employer and the Trustees).

The Board of Trustees has the sole power to amend, modify or discontinue the Plan and the ultimate responsibility for the management of Welfare Fund assets. The Board of Trustees is assisted in these and other tasks by professional advisors whom we hire from time to time. These include an actuary, an accountant, an attorney, and one or more investment managers.

The Plan Administrator, Christopher Baxter, maintains the daily operation of the Plan. Mr. Baxter and his staff at the Fund Office are available to answer any questions or as a resource to obtain additional information about the Plan.

If, after going through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Fund Office. If your questions are not answered to your satisfaction by the staff, you may direct them to the Plan Administrator, or to the Trustees, in writing. In some instances, you will be asked to submit your questions in writing.

Sincerely,

Board of Trustees
Northeastern New York District Council Pipefitters Welfare Fund

Directory

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Important Notices

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THE PLAN WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. No benefits or rules described in this Summary Plan Description are guaranteed (vested) for any Participant, retiree, spouse, or dependent. All benefits and rules may be changed, reduced, or eliminated at any time by the Board of Trustees, at their discretion, provided it is not in violation of a collective bargaining agreement already in effect. This booklet describes the Plan as it exists on January 1, 2024. You will receive updated information if and when the provisions described in this booklet are changed. If any of the changes constitute a material change in the benefits under this Plan, you will be notified through a Summary of Material Modifications.

Limit on Authority of Non-Trustees

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Fund Office employee, attorney or consultant is authorized to speak for or to commit the Board of Trustees of this Fund on any matter without express written authority from the Trustees.

Trustees' Authority and Discretion

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, the manner by which contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

Communications

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Plan Administrator or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

Your Responsibility For Selection of Providers

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, the manner by which contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

No Guarantee of Income Tax Consequences

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant, dependent or beneficiary under this Plan will be excludable from the Participant's, dependent's, or beneficiary's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant, dependent or beneficiary. It shall be the obligation of each Participant, dependent or beneficiary to determine whether each payment under the Plan is excludable from the Participant's, dependent's, or beneficiary's gross income for federal and state income tax purposes, and to notify the Fund Office if the Participant, dependent or beneficiary has reason to believe that any such payment is not so excludable.

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Important Aspects

- ♦ Familiarize yourself with the entire booklet.
- ♦ Application must be made for all benefits.
- ♦ Make the Fund Office aware of all your dependents (see page 5), and your current address.
- ♦ Keep your life insurance and beneficiary designations up to date.
- ♦ All claim forms must be submitted in a timely manner and completely filled in; incomplete or late forms will be denied or returned.

Plan Modification or Termination

The Trustees reserve the right to amend, modify or discontinue 1) the types and amounts of benefits under the Plan, and 2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated. Benefits provided by the Plan:

- ◆ are not guaranteed;
- ◆ are not intended or considered to be deferred income;
- ◆ are not vested at any time;
- ◆ are subject to the rules, regulations and interpretations adopted by the Trustees; and
- ◆ may be amended, modified or discontinued and the Trustees' right to amend, modify or discontinue benefits is not contingent on financial necessity.

The nature and amount of Plan benefits are always subject to and governed by the actual terms of the Plan as it exists at the time the claim occurs.

For All Participants. This summary plan description includes information concerning the benefits provided by the Trustees to Participants. It also outlines the circumstances that can result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of benefits that a Participant might otherwise reasonably expect welfare plans to provide.

The Trustees have established the benefits and eligibility rules applicable to Participants, pensioners and dependents as part of an overall benefit plan for Participants. The right to amend, modify or discontinue the eligibility rules and plan of benefits for Participants is reserved by the Trustees in accordance with the Agreement and Declaration of Trust establishing the Welfare Fund. The continuance of benefits for Participants and the eligibility rules relating to qualification are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

No Participant, dependent or beneficiary has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of Participants at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for dependents or beneficiaries and there shall not be any vested right by any Participant, dependent or beneficiary nor contractual rights after the disposition of Plan assets in connection with the termination of the Plan. The provisions for a Participant, dependent or beneficiary's coverage may be reviewed periodically by the Trustees.

I. Eligibility Requirements & Plan Participation

This section describes the provisions of the Plan, such as general eligibility requirements and the requirements for continuing your eligibility. In addition to these general eligibility requirements, you may also need to satisfy specific eligibility requirements for each individual benefit.

A. GENERAL DESCRIPTION OF THE PLAN

The Northeastern New York District Council Pipefitters Welfare Plan is a Health Reimbursement Account (HRA) plan operating under IRS code Section 501(c)(9). For each hour you work in Covered Employment, employer contributions will be made to the HRA plan. Covered Employment is work for an employer who is obligated to make contributions to the Fund pursuant to a Collective Bargaining Agreement or other written agreement with the Trustees.

A portion of such contributions will be credited to an HRA for you. The Trustees will determine the portion of the contributions which will be credited to your HRA. This determination may change from time to time depending upon the financial requirements of the Plan as a whole.

Once you have contributions in your HRA, you will be eligible to participate in the Plan. However, you must complete enrollment forms before you are eligible for the health insurance coverage under the Plan.

Your account will grow with all the contributions that are made to the Plan for your future hours worked. Your account will be decreased by any benefit distribution. No more will be paid out to you (or your eligible dependents or beneficiaries) under this Plan than has come into your HRA by way of contributions made on your work and special allocations.

Administration charges may be levied against each Participant's account, on an equitable basis, if, for instance, the investment yield on the Welfare Fund reserves is not sufficient to offset the costs of administration of the Plan. The Welfare Fund's reserves and administration charges levied against each Participant's account constitute the Plan's general account.

Once your account is reduced to zero or to an amount which is less than your monthly Insurance Benefit premium, you will stop being a Participant in this Plan unless you elect to self-pay to continue your coverage under the Plan (as described on page 9).

In the following sections you will see what is required to become eligible for the benefits that exist in the Plan for you once you are a Participant. There is also a description of each benefit.

B. ACTIVE PARTICIPANTS

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirements in your current period of Plan participation.

1. General Eligibility Requirements

To become eligible for benefits under the Plan, you must work at least 600 hours in Covered Employment during a period of not more than 12 consecutive months, or you must work at least 200 hours in Covered Employment during a period of not more than 2 consecutive months. Also, you must be available for Covered Employment at the time your coverage is to start.

If you are not available for Covered Employment at the beginning of the month (i.e., the date your coverage is scheduled to start), your months of Covered Employment and contributions will be forfeited. To be eligible for coverage again, you must satisfy the general eligibility requirements again. An exception is made if it is a disability that makes you unavailable for Covered Employment.

2. Continuing Eligibility Requirements

Once you are a Participant, you will continue as a Participant until your account is reduced to zero or to an amount which is less than your monthly Insurance Benefit premium. If you are self-paying to the Plan to continue coverage for your Insurance Benefit (as described on page 9), you are still a Participant.

If you have once satisfied the general eligibility requirements and become unavailable for Covered Employment, in order to qualify for coverage when you return to the Plan you must have a positive balance in your HRA and have worked at least 200 hours over a two-calendar month period immediately preceding your return to Covered Employment. If you do not have the required hours, then you must self-pay through COBRA to continue coverage under the Plan.

If contributions are made to the Plan for you before you satisfy the general eligibility requirements and such contributions cannot be used to satisfy the general eligibility requirements, such contributions will be forfeited and used for Plan administrative costs.

In addition to having satisfied the general eligibility requirements, you may have to satisfy special eligibility requirements depending upon which of the benefits you want to use.

3. Limitation on Benefits

Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

You are not permitted to withdraw money from your account for the Health Expense Benefit (see Section IV.) if such withdrawal would bring your account balance to less than \$6,000 or if your account balance is already less than \$6,000. However, this limitation does not apply to withdrawals made for the Insurance Benefit premiums and reimbursements for post-tax insurance premiums.

Other limitations, if any, will be listed where the individual benefit is described in this booklet.

C. DEPENDENTS

Your eligible dependents include your lawful spouse and your children, up to age 26, whether married or unmarried and regardless of student status, employment status or financial dependence on the Participant, who is the Participant's natural child or step-child; or is legally adopted; or is a proposed adopted child during the waiting period prior to the finalization of the child's adoption, or a child that the Plan is required to cover under a Qualified Medical Child Support Order (QMCSO).

If your child turns age 26 while he or she is covered as an eligible dependent and is, at that time, incapable of self-sustaining employment due to a physical handicap or intellectual disability, he or she will continue to be covered under the Plan as an eligible dependent so long as he or she is receiving a social security disability benefit and you continue as a Participant.

D. PENSIONERS

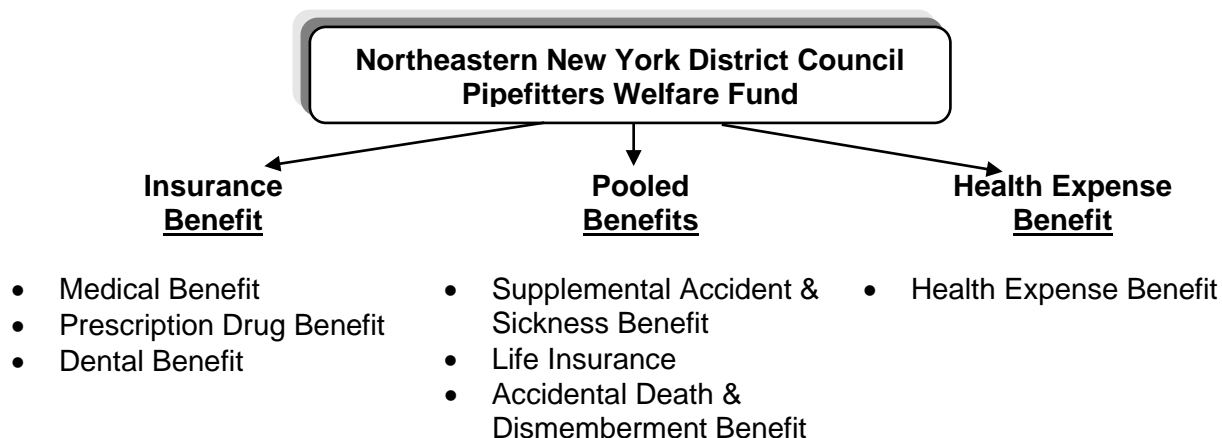
If you are a pensioner under the U.A. Local 773 Pension Plan and a Participant in this Plan eligible for the Insurance Benefit on the date your pension commences, you will continue to be covered under this Plan for as long as your account lasts, and after your account is exhausted, for as long as you make timely self-payments (as described on page 9).

E. INACTIVE ACCOUNTS

If, during a period of five consecutive years, no Employer contributions are received by the Fund for a Participant and no benefit distributions are made on his or her behalf hereunder, any balance he or she may have hereunder shall be forfeited and used for defraying administration costs of the Fund.

F. BENEFITS

Benefits provided by the Plan can be classified as one of three categories of benefits: Insurance Benefits, Pooled Benefits, and Health Expense Benefits. Each of these categories can then be further subdivided, as outlined below:



The Insurance Benefit is intended to cover most traditional medical expenses such as hospital charges, physician's fees, and prescription drug charges.

The Pooled Benefits include payments for loss of life and loss of income.

The Health Expense Benefits are designed to cover medical expenses not covered by the Insurance Benefit.

Please read the following sections for details regarding each Benefit.

II. Insurance Benefit

The following table is a brief outline of the benefits provided by the Insurance Benefit.

Type of Benefit	Persons Covered	Benefit
Medical	<ul style="list-style-type: none"> • Active Participants, • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Self-insured and administered by CPDHP
Prescription Drug Benefit	<ul style="list-style-type: none"> • Active Participants, • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Self-insured and administered by Express Scripts
Dental	<ul style="list-style-type: none"> • Active Participants, • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Self-insured and administered by Delta Dental
Employee Assistance Program	<ul style="list-style-type: none"> • Active Participants • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Self-insured and administered by AptiHealth

Each month, premiums will be deducted from your account (if you are eligible for the Insurance Benefit) to pay for your Medical Benefit (health care insurance), Prescription Drug Benefit and Dental Benefit.

A. ELIGIBILITY REQUIREMENTS FOR THE INSURANCE BENEFIT

1. Enrollment

You must enroll for health care insurance coverage under the Plan. You will have 60 days from the date of your eligibility to enroll or opt-out of health care insurance coverage under the Plan. If you fail or refuse to comply with enrollment requirements, you will be enrolled in the least expensive plan for which you are eligible based on the Fund's knowledge of your marital status. If the Fund automatically enrolls you in single coverage, the Fund's health care insurance will not become available to your eligible dependents until the next open enrollment period.

Special Enrollment Rights

If you decline 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 90 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.

2. Continuing Eligibility for the Insurance Benefit

As long as you remain available for employment that requires contributions to this Plan, each month the charges for certain health care coverages will be subtracted from your account as long as your account balance has a balance to cover the total monthly charges (unless you are approved for an “opt-out” from coverage, as described below). If your account runs out, you will be permitted to self-pay your health care insurance charges under certain conditions (as described on page 9).

3. Opt-Out Election for the Insurance Benefit

If your spouse and dependent children are already covered under your spouse’s employer’s health care plan or some other employer group health care plan, you may elect that you be covered for “single” health care insurance only. If you, yourself, are also covered under your spouse’s employer’s health care plan, or some other employer group health care plan, you may elect that you also not be covered under the Insurance Benefit. However, in order to forego or opt-out of coverage for your dependents or yourself, you (and your spouse, if applicable) must complete and sign the Election and Hold Harmless Agreement and an information sheet at the time of the election. The forms are available at the Fund Office. Health Care Insurance premiums will continue to be paid from your account until the Trustees approve the election. Upon approval, the account of those non-retired Participants who have elected to opt-out of Insurance Benefit coverage will be debited a reduced amount per month as established by the Trustees. The opt-out shall become effective the first day of the month following the month in which the Trustees approve your election.

If you are approved for an opt-out election and your other health care coverage stops (except for COBRA), the Plan’s health care insurance must be started and premiums deducted from your account, effective no later than the first day of the month after 90 days from the date the other coverage stops (except for COBRA).

4. Termination and Reinstatement of Eligibility for the Insurance Benefit

If you become unavailable for Covered Employment for a reason other than your total disability or becoming a pensioner under the U.A. Local 773 Pension Plan, your entitlement to the Insurance Benefit will stop at the end of the month in which you become unavailable for Covered Employment and you will not be eligible again for the Insurance Benefit until you satisfy, again, the general eligibility requirements, or if you have a balance in your account.

5. Qualified Military Service

If you leave Covered Employment for full-time Qualified Military Service, as defined by federal law, you and your eligible dependents are permitted to elect to continue your Insurance Benefit under the Plan’s self-payment provisions, subject to certain limitations under federal law. This coverage, subject to the rules of the Plan, must last for up to *twenty-four (24)* months beginning on the date of your entry into Qualified Military Service.

However, the coverage will terminate before the end of the *twenty-four*-month period if you are discharged earlier and you fail to make a timely application for reemployment in Covered Employment upon discharge. You will not forfeit any period of coverage for which you had previously qualified under the General Eligibility Requirements.

If you elect such continuation coverage, you will not be required to pay any premium for the first month of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to self-pay a monthly premium to the Plan, which will be based on the self-payment premium amount.

6. Continued Coverage by Self-Payment

If you are an active Participant who was covered under the Insurance Benefit during the month immediately preceding a month during which your account balance is insufficient to cover your monthly premium, you are allowed to self-pay the difference to continue your Insurance coverage. In order to continue coverage, you must make the appropriate payment before the 15th of the month for which the premium is due, and you must remain available for Covered Employment (unless you are disabled).

The self-payment period must be continuous; you may not start and stop such self-payment. An interruption in self-payment will prohibit you from being eligible to make self-payment again until you once again become eligible for the Insurance Benefit and such future self-payment is to continue your coverage under the Insurance Benefit.

If you are a Local 773 Pension Plan pensioner with an account balance that is insufficient to cover your monthly premium, you are also allowed to self-pay the difference to continue your insurance coverage. There is no limit on how long a pensioner may self-pay.

The spouse of a deceased active or retired Participant will also be permitted to self-pay for his or her coverage and the coverage for all of the deceased Participant's eligible dependents who were covered at the time of the Participant's death. Spouses of deceased active Participants may continue to self-pay for as long as they are eligible for COBRA continuation coverage. Spouses of retired Participants may continue to self-pay as long as they are eligible for COBRA continuation coverage or until they become eligible for Medicare, whichever is earlier.

The spouse of a retired Participant who was covered by the Insurance Benefit on the Participant's Medicare entitlement date may also elect to self-pay on his/her behalf even if the Participant elects not to participate in this Plan on his/her Medicare entitlement date. This self-pay period will be deducted from the COBRA continuation coverage period (see Section VI); it is not in addition to such coverage period. The self-pay option for the Participant's spouse and eligible dependents will cease if the spouse remarries or if the spouse and/or eligible dependents otherwise fail to satisfy the Plan's eligibility requirements (unless COBRA applies).

7. Domestic Partner

If you are covered under your domestic partner's employer sponsored health care plan, you may elect that you not be covered under the Insurance Benefit of this welfare plan. However, in order to forego or opt-out of coverage for your dependents or yourself, you (and your domestic partner, if applicable) must complete and sign the Election and Hold Harmless

Agreement and an information sheet at the time of the election. The forms are available at the Fund Office.

B. MEDICAL BENEFIT

The Medical Benefit (health care insurance) is a self-insured benefit. You may choose from two different plans. The products currently offered are administered by CDPHP. Please refer to the CDPHP summary plan descriptions for the details of the medical coverage options.

The charge to be made for your health care insurance will depend upon who in your family unit is to be covered and which health care plan you select.

1. Newborns' and Mothers' Health Protection Act 1996 (NMHPA)

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 normal 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).

2. The Women's Health and Cancer Rights Act of 1998

Under a federal law called the Women's Health and Cancer Rights Act of 1998, the Fund is required to provide you with an annual notice of your rights under this Act. Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan's benefit for breast reconstruction and related services will be the same as the benefits that apply to other covered services. You should refer to the medical plan booklet provided by your health insurance carrier or contact the Plan Administrator for a description of the benefits and any limitations that may apply.

C. PRESCRIPTION DRUG BENEFIT

Eligible active and retired Participants who are not eligible for Medicare, and their eligible dependents, will be covered for Prescription Drug Benefits upon proper application. The Prescription Drug Benefit is currently self-insured and administered by Express Scripts.

Please refer to the Express Scripts Prescription Drug summary plan description for detailed information.

D. DENTAL BENEFIT

Eligible active Participants and retired Participants who are not eligible for Medicare, and their eligible dependents, will be covered for Dental Benefits upon proper application. The Dental

Welfare Plan

Benefit is currently administered by Delta Dental. Please refer to the Employee Benefit Booklet provided by Delta Dental for details.

III. Pooled Benefits

A. **POOLED BENEFITS FOR ACTIVE PARTICIPANTS**

If you are eligible for the Insurance Benefit and not a retired Participant, you are eligible for the Pooled Benefits unless you are eligible for the Insurance Benefit through COBRA. COBRA Participants are not eligible for Pooled Benefits.

1. **Supplemental Accident and Sickness Benefit**

If you are an active Participant at the time you qualify for any State Disability or Workers Compensation, you may qualify for this benefit.

After a one-week waiting period, you will receive payments of \$30 per day (up to five days per week) for as long as you continue to receive either State Disability or Workers Compensation benefits.

This benefit is paid for a maximum of 26 weeks per period of disability. Successive periods of disability separated by less than two weeks of continuous Covered Employment will be considered one continuous period of disability unless they are due to different, unrelated causes.

Claims for this benefit must be submitted to the Fund Office within 60 days from the onset of disability.

2. **Life Insurance Benefit**

The Life Insurance Benefit provides a \$75,000 benefit if you die while still an active Participant in this Plan.

Anthem Life currently insures the Life Insurance Benefit for active Participants.

The description of this benefit is intended for informational purposes. The actual contractual language is outlined in the certificate of coverage and is on file at the Local 773 Fund Office for your review.

3. **Accidental Death and Dismemberment Benefit**

Active Participants are eligible for the Accidental Death and Dismemberment Benefit. Dependents and pensioners are not eligible for the Benefit.

If you suffer the loss of life, sight, hand, or foot as a result of an accident, and such loss occurs within 90 days of the accident, you will be paid in accordance with the following schedule:

Loss	Benefit
Life	\$75,000
One member*	\$37,500
Two members*	\$75,000

* A member means a hand, a foot, or loss of sight in one eye.

The Accidental Death and Dismemberment Benefit is currently insured by Anthem Life. Please refer to the certificate of insurance provided by Anthem Life for a complete description of this benefit.

B. POOLED BENEFITS FOR RETIRED PARTICIPANTS

If you are receiving a monthly benefit from the U.A. Local 773 Pension Fund and you were a Participant in this Plan and eligible for the Insurance Benefit on the date such benefit commenced, your beneficiary is eligible for a lump sum death benefit of \$10,000. This benefit is fully insured by Anthem.

IV. Health Expense Benefit

The Health Expense Benefit is designed to help you pay for medical costs not covered by this or any other health care or insurance plan. The Health Expense Benefit is available to eligible Participants under the Plan, assuming you are eligible (please review Section I. for eligibility requirements).

A. HEALTH EXPENSE BENEFIT

If you incur "Qualified Medical Expenses" for yourself, your spouse, or your dependent child, and such medical expenses are not covered under the Insurance Benefit, you may apply for a distribution of a portion of your account to pay for those Qualified Medical Expenses. However, you are not allowed to reduce the balance in your account below \$6,000 by using this Benefit.

You will be allowed to "opt out" of your HRA Benefits. If you opt out of your HRA Benefits you will forfeit any monies in your account as of the date you "opt out". You will be allowed to "opt out" of your HRA on the first day of any month. You are not required to waive or "opt out" of plan coverage for yourself or your dependents. It is your choice to decide on the medical coverage arrangements that are best for you and your family.

"Qualified Medical Expenses" are expenses that:

- ◆ have been submitted to and rejected by your Insurance Benefit provider,
- ◆ for which you have filed an appeal with that provider that has been denied in whole or in part,
- ◆ are deductible as medical expenses for I.R.S. purposes, and
- ◆ which the Trustees determine to be reasonable and appropriate for reimbursement.

Qualified Medical Expenses do not include premiums for life, accidental death and dismemberment, disability income, or other non-medical benefits.

Claims under this Benefit must be submitted in the calendar year during which the expenses are incurred, or before July 1 of the following calendar year. An expense is considered to be incurred on the date the service or the date treatment is received or a purchase is made, rather than on the date the bill is received. Also, your claims must total at least \$500 before they can be submitted to the Fund Office for reimbursement. You may add several bills together in order to reach \$500. In any event, regardless of the size of your covered bills, in the month of June you may submit such bills to the Plan.

Claims are reviewed by the Fund Office. Participants whose claims are denied by the Fund Office and who disagree with the denial may appeal to the Board of Trustees. For more information regarding Claims Procedures, please refer to Section V.G. of this booklet.

1. Eligible Expenses

The following products and supplies are considered Qualified Medical Expenses and may be reimbursable from individual accounts. In order to receive reimbursement, you must submit an original receipt (a copy is not acceptable). The receipt must include the medication name (if applicable), the purchase price, and the date of purchase. Certain product types are eligible for reimbursement only with a physician's letter (see pages 14-16).

The following product types are eligible for reimbursement **without a physician's letter**:

- Antibiotic Creams/Ointments
- Athletic Braces & Supports
- Birthing Tub and Birthing Supplies for at home birth
- Breast Pumps & Accessories
- Blood Glucose Monitors & Test Strips
- Blood Pressure Monitors
- Children's Stomach & Digestive Aids
- Contraceptive Devices: Condoms, Contraceptive Creams, Pregnancy Tests, and Ovulation Predictor Kits.
- Contact Lens Solution
- Diabetes Care Accessories
- Diaper Rash Cream
- Ear Drops & Wax Removers
- Eye Glass & Lens Accessories
- Feminine Hygiene Products
- First Aid Kits, Treatments, and Supplies
- Glucosamine Supplements
- Glucose Tablets
- Hearing Aid Batteries
- Heating Pads & Wraps
- Hot & Cold Packs
- Infant Formula
- Medical Monitoring & Testing Devices
- Motion Sickness Aids
- Orthopedic & Surgical Supports
- Reading Glasses & Magnifiers
- Shoe Insoles & Inserts
- Shower Chair
- Smoking Cessation Products: Nicotine Gum and Patches
- Sunscreen
- Thermometers

The following product types are eligible for reimbursement **only if you have a physician's letter acceptable to the Fund Office stating that the product is medically necessary**. The physician's letter must cite the specific medical condition being treated and indicate that the over-the-counter drug, medication, or treatment will treat or alleviate the condition. A form is available at the Fund Office that can be used to show medical necessity.

- Antiparasitic & Lice Treatments
- Cold & Flu: Chest Rubs, Cough and Sore Throat Lozenges, Decongestants, Nasal Sprays, Vapor Rubs and Pedialyte
- Canker and Cold Sore Treatments
- Corn & Callus Removers
- External Pain Relievers
- Foot Care Products
- Gym/Health Club Memberships
- Hemorrhoidal Treatments
- Laxatives
- Sleep Aids
- Stomach & Digestive Aids
- Teething Gel (Baby)
- Vitamins and Minerals
- Wart Removers

The following product types are eligible for reimbursement **only after you have first submitted a request for coverage from your medical insurance company, your medical insurance company has denied your request, and you have appealed that denial. The two denial letters must be submitted with your letter of medical necessity and original receipt of purchase**.

- Capital Expenses paid for special equipment to be installed in Participants' home for medically necessary equipment including, but not limited to, wheelchair ramps, handicap accessible toilet/shower/sink, etc.

Welfare Plan

- Exercise Equipment (reimbursable only one time and up to \$1,500)
- Handicap Vehicle Adjustments
- Hearing Impaired Telephonic Device
- Hot Tub
- Massage Chair
- Service Animals, including all costs to maintain the health of the animal so it may perform its duties
- Special Mattress
- Transcutaneous Electrical Nerve Stimulation (TENS) Units
- Tanning Bed
- Walking Aids and Accessories
- Weight Loss Plans and Aids (Scales, Pedometers, etc.)
- Wheelchairs
- Special Needs Daycare Services

2. Ineligible Expenses

The following product types are not eligible for reimbursement:

- Bath Products, Cleansers, and Soap
- Cosmetic Procedures and Products
- Creams, Lip Balm, Lipstick, Lotions, and Moisturizers
- Dental – OTC Miscellaneous
- Deodorants/Anti-Perspirants
- Hair Care Products
- Hair Removal Products
- Personal Training and Exercise Classes
- Powders
- Sales Tax
- Shaving and Grooming Products
- Shipping Costs
- Stimulants (to stay awake)
- Sunless Tanning, and After Sun Products

V. Claim Procedure

A. CLAIM PROCEDURE FOR MEDICAL, PRESCRIPTION DRUG, AND DENTAL BENEFITS

Please read your separate medical, prescription drug, and dental summary plan description booklets for the claim procedures for the medical, prescription drug and dental benefits provided under the Plan.

B. CLAIM PROCEDURE FOR ELIGIBILITY AND OTHER BENEFITS

Application for eligibility for all other benefits must be made in writing on forms that may be obtained from the Fund Office.

Time deadlines for filing, if any, are indicated under the particular benefit description of this booklet.

C. CLAIM DENIAL – MEDICAL, PRESCRIPTION DRUG, AND DENTAL BENEFITS

Please read your separate medical, prescription drug, and dental summary plan description booklets regarding denial medical, prescription drug, and dental coverage.

D. CLAIM DENIAL - ELIGIBILITY AND OTHER BENEFITS

In the event a claim is denied, in whole or in part, the Trustees will furnish to a claimant whose claim has been denied, a written notice stating:

1. the specific reason or reasons for the denial;
2. the specific reference or references to the Plan provisions on which the denial is based; and
3. a statement of Plan's appeal procedure.

E. TRUSTEES' INTERPRETATIONS AND DETERMINATIONS

In order to carry out their responsibility for interpreting the Plan and making determinations under it, the Trustees have exclusive authority and discretion to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to interpret all of the provisions and terms of the Plan, this Summary Plan Description, the Agreement and Declaration of Trust and any other documents involving or relating to the Plan. All such determinations and interpretations made by the Trustees or their designee shall be final and binding upon any individual claiming benefits under the Plan; shall be given deference in all courts of law to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found by the court to be arbitrary and capricious or made in bad faith or to be an abuse of discretion. All such determinations shall be based on criteria contained in the Plan, Summary Plan Description, the Agreement and Declaration of Trust and any other documents involving or relating to the Plan.

F. CLAIM DENIAL APPEAL PROCEDURE FOR MEDICAL, PRESCRIPTION DRUG AND DENTAL BENEFITS

Please read your separate medical, prescription drug, and dental summary plan description booklet regarding appeals of claim denials for medical, prescription drug, and dental coverages under the Plan. After exhausting the appeal procedures outlined in the applicable third-party summary plan descriptions, you may submit a final appeal to the Trustees.

G. CLAIM DENIAL APPEAL PROCEDURE FOR ELIGIBILITY, HEALTH EXPENSE BENEFIT, AND OTHER COVERAGES

If your claim for benefits or eligibility is denied, in whole or in part, you will be notified by the Fund Office, in writing:

1. regarding the specific reason for the denial;
2. the particular Plan provision upon which the denial is based; and
3. an explanation of the Plan's claim denial appeal procedure.

If additional information or documentation is required to perfect a claim, you will be so notified, and an explanation will be given as to why such additional material is necessary.

You, or your duly authorized representative, may appeal the denial of a claim (including claims denied under the third-party appeal procedures) by submitting a written application to the Fund Office made not later than 180 days after receipt of the denial and submission of such additional information and comments, in writing, as supports your appeal. If you do not receive a decision on a claim within 180 days of filing the claim (or 180 days in special circumstances) you may request a review of that claim.

You, or your duly authorized representative, may review the pertinent documents upon which the denial is based.

The Trustees will make a determination on any question involved with the disputed claim. If an appeal is within the domain of the Trustees, the Trustees will render a decision at their next regularly scheduled meeting. However, if the appeal is received less than 30 days before the next meeting, the decision on that appeal may be made at the second meeting following the receipt of the request. If special circumstances require an extension of time for processing, a decision may be made at the third meeting following the date the appeal is made. In any event, if you request a review of a denied claim, you will be notified of the approximate date that you can expect to receive a decision. The decision of the Trustees will be in writing and sent within 5 days of the date the appeal is heard.

H. FUND OFFICE CLAIM PAYMENT POLICIES

It is the policy of the Welfare Fund to issue payments for all claims that are administered by the Fund Office within a period of 30 days from the date of receipt of the claim by the Fund Office.

For all claims, you will need to complete the following steps:

1. Obtain the appropriate claim form(s) from the Fund Office.

2. Complete your portion of the form(s). Be sure that the Participant's signature and the Participant's social security number are in the proper spaces.
3. Upon completion of the claim form(s), attach all itemized bills and return to the Fund Office.

I. INCOMPETENCE

In the event it is determined that a claimant is unable to care for his or her affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless the claim has been made therefore by a duly appointed guardian, committee, or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

J. COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to promptly and in good faith comply with such requests will be sufficient grounds for delaying payments of benefits. The Trustees will be the sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods, and procedures as they consider advisable.

K. CLAIM REPRESENTATIONS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any benefit payments made in error.

L. TERMINATION OF BENEFITS UPON MISUSE

If your or your dependent(s) willfully misuse any benefits or misrepresent your own or a dependent's eligibility, you (and any dependents eligible for coverage under the plan) could lose coverage for Fund benefits, and you will have to repay the Fund for the full amount of any benefits improperly received. The Plan Administrator is responsible for investigating the misuse of any benefits. If the Plan Administrator believes benefits have been misused or improperly received you will be notified of the reason(s). Those reasons include, but are not limited to, the following:

1. Applying for benefits during any period of time for which you are not eligible,
2. Attempting to claim benefits for persons who do not qualify under the eligibility rules,
3. Submitting claims for benefits for covered health and welfare expenses not actually incurred,
4. Overusing prescription drugs in a manner which is not medically justified, or
5. Failing to cooperate with the Fund's investigations.

Based upon your response to this notice and an investigation of the facts, the Plan Administrator may recommend that the Board of Trustees suspend or terminate your coverage. Further, if there is a serious ongoing abuse of benefits, the Plan Administrator may suspend, in whole or in part,

your eligibility for benefits pending a determination by the Board of Trustees. Your failure to respond to the Plan Administrator's notice or failure to cooperate with the investigation could lead to a suspension and termination of your benefit coverage. Based on the investigation, the recommendation of the Plan Administrator, and any response from you, the Board of Trustees will determine whether a termination of coverage is appropriate. You will be notified of the Trustees' decision. In addition to possible suspension of benefits and termination of coverage under this Fund, anyone who is determined to have intentionally misused benefits may be:

1. Liable to the Fund for double the costs of the benefits wrongfully received, plus double all other expenses, including reasonable attorneys' fees, incurred by the Fund as a result of the misuse or the recovery of benefits.
2. Subject to appropriate civil action or possible criminal prosecution.

If a Participant's (or dependent's) claims are paid in error, or a claim has been paid based upon false or incomplete information, the Board of Trustees has the authority to request the return of the overpayment or the amount paid as a result of the false or incomplete information previously submitted to the Plan Administrator. The Board of Trustees may, in the exercise of its discretion, terminate, suspend, deny or discontinue coverage or benefits, in whole or in part, or may seek to recover any benefit payment to the extent that the Plan Administrator recommends based upon submission of false or incomplete information, or to the extent any overpayment has been made.

M. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all Participants, pensioners and their eligible spouses and dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Participants, pensioners, eligible spouses and dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills. The rules in this section govern how this Plan pays benefits in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses until your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

1. Rights of Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made to you or on your behalf under these circumstances. The Plan must be reimbursed from any

settlement, judgment or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form. In no event shall the failure of the Trustees to require execution of the lien forms diminish or be considered a waiver of the Plan's rights of subrogation and reimbursement. It is your responsibility to inform your attorney of the Plan's rights of subrogation and reimbursement.

2. Assignment of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If the Plan recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, including reasonable attorneys' fees, then the excess will be paid to you.

3. Failure to Disclose and/or Cooperate

If you fail to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you fail to inform your attorney of the Plan's subrogation and reimbursement rights; if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Plan for the reimbursement owed to this Plan by the third party. This Plan may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you.

VI. COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

A. COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're a Participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of a Participant, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Participant dies;
- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment ends for any reason other than his or her gross misconduct;
- The parent-Participant becomes entitled to Medicare benefits;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

The Trustees have determined that because Participants frequently work for more than one employer making contributions to the Plan, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

B. BENEFITS PROVIDED UNDER COBRA

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the COBRA qualifying event. However, no life insurance (death benefits), disability benefits, accidental death and dismemberment benefits, or other non-health benefits will be included in COBRA continuation coverage.

C. NOTIFICATION TO THE FUND OFFICE

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Participant;
- The Participant's becoming entitled to Medicare benefits.

The Trustees have determined that because Participants frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notification, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates or if contributions are not received on a Participant's behalf for twelve (12) consecutive months.

For all other qualifying events (divorce or legal separation of the Participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

D. COBRA ELECTION

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

E. COBRA EXTENSIONS**1. Disability**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

2. Second qualifying event

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the Participant dies, becomes entitled to Medicare benefits, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

F. OPTIONS BESIDES COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

G. HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Federal Marketplace for your state at www.HealthCare.gov.

Coverage through the federal Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the federal Marketplace.

Certain states have their own marketplaces, while other states use the federal Marketplace. If you live in New York State, you may purchase insurance through the NY Marketplace. New York residents should contact the NY Marketplace at <https://nystateofhealth.ny.gov/> or 1-855-355-5777 for more information. If you live in another state, you can access the Marketplace for your state through the federal Marketplace web site, www.HealthCare.gov.

H. MARKETPLACE ENROLLMENT

You always have 60 days from the time you lose your employment-based coverage to enroll in Marketplace coverage. That is because losing your employment-based health coverage is a “special enrollment” event. After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov (or <https://nystateofhealth.ny.gov/> for the New York Marketplace).

If you elect COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also terminate your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances after your 60-day COBRA enrollment period expires.

I. COBRA RIGHTS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

To protect your family’s rights, let the Plan administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

VII. Qualified Medical Child Support Order

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate recipients." Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

Upon receipt of a medical child support order, the Plan Administrator will promptly notify the Participant and each child of receipt of the order. The Participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a Participant under the Plan and will receive copies of summary plan descriptions, summary annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

VIII. Your Rights Under ERISA

As a Participant of the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan office all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Receive a certificate of coverage to provide documentation of your coverage under our Plan. While the certificate should be automatically provided when your coverage terminates, you have the right to request one. Certificates apply to both Participants and dependents. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had under a group health plan or other health insurance coverage because this can reduce or eliminate the length of time that any pre-existing condition clause in a new plan otherwise might apply to you. Each group health plan covered under this Plan is required by law to provide you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificates the names of your dependents who were also covered. Each applicable group health plan will provide automatic certificates for your dependents when it has reason to know that they are no longer covered. In addition, each applicable group health plan will provide a certificate for you (or your dependents) upon request if you make the request within 24 months after your coverage terminates.

Continuing Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 Benefits Security Administration, U.S. Department of Labor at:

Boston Regional Office
JFK Federal Building
Room 575
Boston, MA 02203
(617) 565-9600

Or

The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration,
U.S. Department of Labor at:

200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IX. Protected Health Information

This Section describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. Protected health information (or “PHI”) is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your protected health information.

A. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Plan shall disclose protected health information to the Plan Sponsor only to the extent necessary for the Plan Sponsor (which is the Board of Trustees) to perform the following Plan administrative functions:

1. Review benefit claims in regards to a claim denial, complaint or an appeal; and
2. To proceed under the Appeal Process under the Plan which is described in Section V.

B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PLAN SPONSOR

The Plan Sponsor shall use and/or disclose protected health information only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:

1. Address changes;
2. Eligibility for benefits;
3. Student status;
4. Provider lookup;
5. Billing;
6. New enrollment;
7. Reinstatements;
8. Order I.D. cards;
9. Add dependent;
10. Terminations of eligibility;
11. Benefit claims;
12. Monitor personal account balances for the purpose of paying health premiums; and
13. Contact service providers for the purpose of verifying service dates co-pays.

C. PLAN SPONSOR CERTIFICATION

The Plan agrees that it will only disclose protected health information to the Plan Sponsor, subject to the following:

1. Prohibition on Unauthorized Use or Disclosure of Protected Health Information

The Plan Sponsor will not use or disclose any protected health information received from the Plan, except as permitted in these provisions or required by law. When used in this Section, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

2. Subcontractors and Agents

The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide protected health information to agree to written contractual provisions that impose at least the same obligations to protect protected health information as are imposed on the Plan Sponsor.

3. Permitted Purposes

The Plan Sponsor will not use or disclose protected health information for employment-related actions and decisions or in connection with any other of Plan Sponsor’s benefits or employee benefit plans.

4. Reporting

The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of protected health information not authorized by the plan documents.

5. Access to Protected Health Information

The Plan Sponsor will make protected health information available to the Plan to permit Participants to inspect and copy their protected health information contained in the designated record set. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits.

6. Correction of Protected Health Information

The Plan Sponsor will make a Participant’s protected health information available to the Plan to permit Participants to amend or correct protected health information contained in the designated record set that is inaccurate or incomplete and the Plan Sponsor will incorporate amendments provided by the Plan.

7. Accounting of Protected Health Information

The Plan Sponsor will make a Participant’s protected health information available to permit the Plan to provide an accounting of disclosures.

8. Disclosure to Government Agencies

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services or its designee for the purpose of determining the Plan’s compliance with HIPAA.

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Fund will be required to operate. For example, where such laws have been enacted, the Fund will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance use/chemical dependency, genetic testing, reproductive rights, etc.

9. Return or Destruction of Health Information

When the protected health information is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all protected health information that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the protected health information. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. Minimum Necessary Requests

The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of protected health information to carry out the functions for which the information is requested.

D. ADEQUATE SEPARATION

The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that protected health information will be used only for plan administration. The following employees or persons under the control of the Plan Sponsor have access to Participants’ protected health information for the purposes set forth above:

Christopher Baxter, Plan Administrator
Kethem K. Novick, Assistant Plan Administrator

E. ADEQUATE SEPARATION CERTIFICATION

The Plan requires the Plan Sponsor to certify that the employees identified above are the only employees that will access and use Participants’ protected health information. The Plan Sponsor must further certify that the above employees will only access and use protected health information for the purposes set forth above.

F. REPORTS OF NON-COMPLIANCE

Anyone who suspects an improper use or disclosure of protected health information may report the occurrence to the Plan's Privacy Official at Local 773 Benefits Funds Office at (518) 792-0586. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

X. Technical Details

(As required by the Employee Retirement Income Security Act of 1974)

1. **PLAN NAME:** Northeastern New York District Council Pipefitters Welfare Plan.
2. **EDITION DATE:** This Summary Plan Description is produced as of January 1, 2024.
3. **PLAN SPONSOR:** Board of Trustees of the Northeastern New York District Council Pipefitters Welfare Fund.
4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 14-1418020.
5. **PLAN NUMBER:** 501 (assigned by federal government).
6. **TYPE OF PLAN:** Welfare Plan.
7. **PLAN YEAR ENDS:** May 31.
8. **PLAN ADMINISTRATOR:** Christopher Baxter, PO Box 312, Glens Falls, NY 12801, Telephone #: (518) 792-0586.
9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Christopher Baxter, PO Box 312, Glens Falls, NY 12801, Telephone #: (518) 792-0586.

In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Plan Trustee.

10. **TYPE OF PLAN ADMINISTRATION:** Direct employees of the Board of Trustees.
11. **TYPE OF FUNDING:** Some benefits are insured; some are self-insured.
12. **SOURCES OF CONTRIBUTIONS TO PLAN:** Employers required to contribute to the Northeastern New York District Council Pipefitters Welfare Fund, certain benefit funds with whom this Fund has reciprocal agreements, and, in certain circumstances, Participants.
13. **COLLECTIVE BARGAINING AGREEMENTS:** This Plan is maintained in accordance with a collective bargaining agreement. A copy of this agreement may be obtained by you upon written request to the Plan Administrator and is available for examination by you at the Fund Office.
14. **PARTICIPATING EMPLOYERS:** You may receive from the Plan Administrator, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.
15. **PLAN BENEFITS PROVIDED BY:** The Northeastern New York District Council Pipefitters Welfare Fund provides medical benefits through CDPHP, pharmacy benefits through Express Scripts, dental benefits through Delta Dental, and Life Insurance benefits and Accidental Death and Dismemberment benefits through Anthem.

- 16. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN:** See Sections I, II, III & IV of this booklet.

- 17. HOW TO FILE A CLAIM:** See Section V. of this booklet.

- 18. REVIEW OF CLAIM DENIAL:** If you submit a benefit application to the Plan or an Insurance Company, and it is denied, in whole or part, you will be so notified.

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees (or the Insurance Company, if appropriate) within 60 days of the denial, at the Fund Office asking that a review of the denial be made.

After the review, you will be notified of the results of the review.

More specific information regarding this procedure may be obtained from the Plan Administrator.

- 19. NO INSURANCE UNDER THE PGBC:** Since this Plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

- 20. TRUSTEES:** The Plan Sponsor is the Board of Trustees of the Northeastern New York District Council Pipefitters Welfare Fund. The following are the individual Trustees that make up the Board as of January 1, 2024:

Terry Bulman
Bulman Plumbing & Heating, Inc.
74 Stone Schoolhouse Road
Hudson Falls, NY 12839

William Austin
27 Iris Avenue
South Glens Falls, NY 12803

Joseph Collier
Collett Mechanical
138 Sicker Road
Latham, NY 12110

Adam A. Round
5 Oakwood Dr.
Queensbury, NY 12804

Andrew LaPlante
L.H. LaPlante Co., Inc.
P.O. Box 496
Plattsburgh, NY 12901

Michael Jarvis
P.O. Box 312
Glens Falls, NY 12801

Daniel R. Monroe Jr.
Monroe Mechanical, Inc.
24 Pearl Street
Hudson Falls, NY 12839

Michael S. Salerno
1606 Mahaffy Road
Fort Edward, NY 12828