Connecticut Pipe Trades Health Fund

Summary Plan Description

Effective November 1, 2016

Connecticut Pipe Trades Health Fund

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INTRODUCTION

This Plan is self-funded and is governed by a federal law known as the Employee Retirement Income Security Act of 1974 (ERISA). This means that your health care Claims are paid directly from Fund resources rather than by an outside insurance company with the exception of Life Insurance and Accidental Death and Dismemberment (AD&D) benefits, which are insured. Contributions are made by your Employer to a Trust in accordance with the terms of a collective bargaining agreement with Local Union No. 777 or a UA national agreement. Because the Plan is self-funded, it is not subject to state insurance law. However, it is subject to federal laws. Union Labor Life Insurance Company currently insures the Life Insurance and Accidental Death and Dismemberment benefits.

Being self-funded also means that you have a responsibility to be an informed, conscientious health care consumer. Your individual efforts to conserve Fund resources have a direct effect on the cost of health care benefits provided to you and your family and future benefit improvements. To help conserve the Fund's assets and provide you with more efficient treatment, the Trustees contract with HealthLink to review all hospital inpatient admissions, inpatient surgeries, and inpatient mental/behavioral health and substance use disorder treatment, along with managing catastrophic claims. In addition, we encourage you to contact the Connecticut Pipe Trades' Employee Assistance Program for all mental and behavioral health and substance use disorder services to assist you in receiving the most appropriate treatment.

The Fund Office handles the day-to-day administrative operations, including determining eligibility and processing Claims. If you need an ID card or have a question about a Claim or the benefits of the Plan, the Fund Office will be happy to assist you.

The Fund has an agreement with Anthem Blue Cross and Blue Shield (Anthem) to allow you access to medical care through a Preferred Provider Organization (PPO), which is also called a "network." The major advantage to you in using Anthem's National Accounts Division network of Physicians and Hospitals is that the Fund receives negotiated discounted fees and rates with the Physicians and Hospitals in the network, which are passed on to you. Your use of the network providers will also lower your out-of-pocket expenses, as the network plan of benefits generally requires that you pay a copayment at the time of service with the balance of charges generally paid in full. In addition, if you use a network provider, you are not required to submit Claim forms to the Fund as the Anthem provider is required to submit Claims electronically.

The Plan, Trustees or any of their designees are **not** engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services delivered to you by any Physician, dentist or other provider. Neither the Plan, Trustees nor any of their designees will have liability whatsoever for any loss or Injury caused to you by any Physician, dentist or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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CONTACT INFORMATION

Board of Trustees

Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Phone: (860) 571-9191
Toll Free: (800) 848-2129
Fax: (860) 571-9221
Website: connecticutpipetrades.com

The Fund Office:

- Receives Employer/Participant contributions
- Keeps eligibility records
- Coordinates processing and/or payment of Claims
- Provides information about the Plan

The rules and regulations described in this booklet apply to Claims incurred on and after October 1, 2016. Your Claims prior to this date will be processed and reimbursed based on the rules and regulations of the plan of benefits in force when the Claim was incurred.

To Locate a Medical Provider

Contact Anthem Blue Cross and Blue Shield of Connecticut at **www.anthem.com**

Participant Assistance Program

Professional assistance in addressing personal and family problems
Lower Hudson Valley EAP
(800) 327-2799
(914) 245-6300
www.lowerhudsonvalleyeap.com

Utilization Review Program (Pre-Certification)

Must be contacted prior to any non-emergency hospitalization or inpatient surgery
HealthLink
1-(877) 284-0102

Vision Program

Davis Vision
(800) 999-5431
www.davisvision.com
You will need to register if using the website for the first time by establishing a user name and password. Your unique ID number is your Health Fund ID.

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SCHEDULE OF BENEFITS

Active Participants	Plan Pays
Life Insurance	
Active Participants	$40,000
Accidental Death/Dismemberment Benefits	
Principal Sum	$40,000
Weekly Disability Income Benefits (non-work-related)*	
Maximum Weekly Payment	$550
Maximum Period of Benefit	26 Weeks

*Benefits commence on the first day due to Injury and on the eighth day due to Illness. Benefits are not payable if you are retired and collecting a pension.

Medical Benefits–In-Network (Active Participants and Eligible Dependents)

Deductible	None
Out-of-Pocket Maximum (Medical Only)	$1,500 per person per calendar year

A separate Out-of-Pocket Maximum of $1,500 applies to the Prescription Drug Benefit.

All in-network copayments for services recognized by the Plan as a Covered Expense will accumulate toward your calendar year out-of-pocket maximum, except copayments for dental, vision, hearing, and prescription drugs. Once your in-network copayments reach this threshold, the balance of your in-network expenses for the remainder of the calendar year will be paid in full without being subject to a copayment.

All Covered Charges are paid in full when provided by a participating Hospital, Physician, or provider, subject to the following copayments:

In-Network Benefit	You Pay
Primary Care Physician/Specialist Office Visit	$20 copayment
If charges exceed $2,000	$200 copayment
Preventive Care/Screening/Immunization	$0 copayment
Hospital Admission	$500 copayment
Regardless of length of Hospital stay; Physician/surgeon fees included.	

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In-Network Benefit	You Pay
Outpatient Surgery and Major Imaging/Laboratory and Diagnostic Procedures	$20 copayment
If charges exceed $2,000	$200 copayment
Physician/surgeon fees included.	
Emergency Room	$150 copayment
When services are for a diagnosis considered to be an emergency (copayment waived if admitted to the Hospital)	
When services are not for a diagnosis considered to be an emergency	$300 copayment
Emergency Medical Transportation/Ambulance	$0 on first $4,000
If charges exceed $4,000	20% co-insurance
Urgent Care/Freestanding Medical Centers	$30 copayment
Adult Annual Physical Examination	$0 copayment
One (1) exam per calendar year (unless otherwise directed by a Physician).	
Laboratory Test Resulting From a Routine Annual Physical Exam	$0 copayment
Well Baby/Child Care	$0 copayment
Every month from birth through 5 months of age; Every 2 months from age 6 months through 11 months of age; Every 3 months from age 12 months through 23 months of age; Every 6 months from age 24 months through 35 months of age; and Annually thereafter to age 21.	
Durable Medical Equipment	20% of co-insurance
Restrictions on purchase, rental, and useful life of equipment.	
Diagnostic Laboratory	$20 copayment
If charges exceed $2,000	$200 copayment
X-Ray Imaging	$20 copayment
If charges exceed $2,000	$200 copayment
Physical and Occupational Therapy	$20 copayment
Maximum visits per calendar year	60
Speech Therapy	$20 copayment
To restore normal speech or correct dysphagia or swallowing defects; when speech therapy is for functional purposes such as stuttering, psychoneurotic origin or developmental (learning) speech delay, coverage is limited to 12 sessions per calendar year.	
Chiropractic Services	$20 copayment
Maximum visits per calendar year	25
Outpatient Mental/Behavioral Health Services	$20 copayment
If charges exceed $2,000	$200 copayment

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In-Network Benefit	You Pay
Inpatient Mental/Behavioral Health Services	$500 copayment/admission
Outpatient Alcohol/Substance Abuse Treatment If charges exceed $2,000	$20 copayment $200 copayment
Inpatient Alcohol/Substance Abuse Treatment	$500 copayment/admission
Allergy Visits For testing and related services; copayment is waived for allergy shots.	$20 copayment
Maternity, Obstetrical, Midwifery Available for a female Participant or spouse.	Covered Medical Expense
Organ/Tissue Transplants Limited to coverage recognized by the Plan's stop-loss insurance policy.	Covered Medical Expense
Skilled Nursing Facility Maximum days per confinement	$500 copayment 120
Home Health Care Maximum visits per calendar year	$0 copayment 120
Hospice Care	$500 copayment/admission
Infertility Services Lifetime Maximum (Combined Participant and Spouse) Advanced Reproductive Technology.	 Two (2) attempts

Certain services require precertification. Failure to pre-certify such services or to satisfy the requirements of the Utilization Review Program will result in a 20% reduction in benefits. (Refer to Section 21 for details.)

Medical Benefits Out-of-Network (Active Participants and Eligible Dependents)

Individual Deductible	$200 per calendar year
Family Deductible	$400 per calendar year
Out-of-Network Out-of-Pocket Maximum	None

For all Out-of-Network services, except emergency room and ambulance services, you are reimbursed 80% of the Allowable Amount, after the deductible is met. You are responsible for any balance of charges in excess of the Allowable Amount.

Certain services require precertification. Failure to pre-certify such services or to satisfy the requirements of the Utilization Review Program will result in a reduction in benefits. (Refer to Section 21 for details.)

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Prescription Drug Benefits (Active Participants and Eligible Dependents)

Out-of-Pocket Maximum (Prescription Drugs Only)	$1,500 per person per calendar year
Retail Pharmacy (Up to a 30-day supply)	
Tier 1 (Typically Generic Drugs) Copayment	$10 per prescription
Generic Contraception for Women	$0 per prescription
Tier II (Typically Preferred Brand Name Drugs) Copayment	$25 per prescription
Tier III (Typically Non-Preferred Brand Name Drugs) Copayment	$40 per prescription
Mail Order Program (Up to a 90-day supply)	
Tier I (Typically Generic Drugs) Copayment	$15 per prescription
Generic Contraception for Women	$0 per prescription
Tier II (Typically Preferred Brand Name Drugs) Copayment	$40 per prescription
Tier III (Typically Non-Preferred Brand Name Drugs) Copayment	$80 per prescription

You must obtain a generic prescription drug when one is available or you will be responsible for the brand name drug's copayment plus the difference in cost between the generic and brand name drug. An override of this provision is available in the event you have tried the generic prescription and your physician indicates a medical reason to take the brand name drug.

No payment will be made by the Fund for any prescription drugs obtained from a non-network pharmacy.

Dental Benefits (Active Participants and Eligible Dependents)

Individual Deductible	$50 per calendar year
Family Deductible These deductibles apply only to Basic and Major Dental Services.	$150 per calendar year
Calendar Year Maximum (per individual) This does not apply to children under the age of 19.	$2,000
	Plan Pays
Preventive Care Services	100% of Allowable Charges
Basic Services	80% of Allowable Charges
Major Services	50% of Allowable Charges
Orthodontia The Orthodontic Expense Benefit is available only to eligible dependent children under age 19. A $4,000 maximum benefit applies for cosmetic orthodontia.	50% of Allowable Charges
Temporomandibular Joint Dysfunction	80% of Allowable Charges

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Hearing Care Benefit (Active Participants and Eligible Dependents)

	Plan Pays
Hearing Evaluation	100%

One exam every three (3) years, or more frequently if recommended by a University of Connecticut or Anthem network audiologist. Includes evaluation, medical examination and molds.

Hearing Appliance	100%
Maximum Benefit	$3,500
Once every three (3) years.	

Benefits are only payable if provided through the Speech and Hearing Clinic at the University of Connecticut or an Anthem network audiologist.

Vision Expense Benefit (Active Participants and Eligible Dependents)

(Exclusive benefit only provided through Davis Vision)

Exam and Benefit Schedule

Eligible dependent children up to age 19	once every 12 months
Participant and eligible dependents age 19 and older	once every 24 months
Active Members Only-- Prescription Safety Eyeglasses	once every 12 months

Eye Examination	100%
Other than a Davis Vision participating provider, up to	$75

Eyeglasses (Frames and Lenses)	Designer Collection – 100%

There are fixed copayments for premium frames, anti-reflective coatings, and other features such as photosensitive lenses, high-index lenses, scratch-resistant coatings, polarized lenses, etc.

Eyeglasses (Frame, Lenses or contact lenses) Out-of-Network
You can receive eyeglasses or contact lenses from other than a Davis Vision provider and be reimbursed up to $175.00 for eyeglasses and frames or contact lenses once every 24-months.

Safety Eyeglasses for Members Only
Active members can receive safety eyeglasses, in addition to regular eyeglasses or contact lenses, from a Davis Vision provider only once every 12-months.

Contact Lenses are available in lieu of eyeglasses to adults every 24 months and to dependent children up to age 19 every 12 months from Davis Vision at no cost.

Laser Vision Correction Surgery
Davis Vision provides a discount through its provider network of participating Laser Providers; laser surgery is not a covered expense under the Plan.

No payment is made for the replacement of lost or stolen eyeglasses; however, Davis Vision provides a one-year guarantee for broken eyeglasses.

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Retiree Benefits Program (For Retirees and Covered Dependents Under Age 65 or Otherwise Not Eligible for Medicare)

In-Network and Out-of-Network Hospital, Medical, and Prescription Drug benefits are the same as those provided for Active Participants

Life Insurance	$10,000

Dental Benefit — Preventative Services Only

Oral examination, prophylaxis (cleaning of teeth), and x-rays once every six months. If you utilize an Anthem network dentist for other dental services, you are entitled to receive the discounted charges for other services when the claim is submitted to the Fund Office for processing.

Vision Benefit — Eye Examination Only

Available only at a Davis Vision provider once every 24 months. Retirees are also entitled to receive the same discounts on services from a Davis Vision provider but expenses are not covered by the Fund.

No benefits for Accidental Death, Weekly Disability, Orthodontics, and Hearing.

Retiree Medicare Supplemental Plan (For Retirees and Covered Dependents Eligible for Medicare Parts A and B)

	Plan Pays
Medicare Parts A and B Deductibles. plus 80% of any remaining balance after Medicare's payment as the primary payor.	80%
Annual Physical Examination One (1) exam per calendar year.	100%

The Retiree Medicare Supplemental Plan covers Hospital and medical expenses for which Medicare is the primary payor.

Prescription Drug Benefit — Same Copayments as Active Participants

Insured by Aetna Life Insurance Company.

Retail Pharmacy (Up to a 30-day supply)	
Generic Drugs Copayment	$10 per prescription
Preferred Brand Name Drugs Copayment	$25 per prescription
Non-Preferred Brand Name Drugs Copayment	$40 per prescription
Mail Order Program (Up to a 90-day supply)	
Generic Drugs Copayment	$15 per prescription
Preferred Brand Name Drugs Copayment	$40 per prescription
Non-Preferred Brand Name Drugs Copayment	$80 per prescription
Life Insurance Benefit for Retiree Only	$10,000

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Dental Benefit Preventative Services Only

Oral examination, prophylaxis (cleaning of teeth), and x-rays once every six-months. If you utilize an Anthem network dentist for other dental services, you are entitled to receive the discounted charges for other services when the claim is submitted to the Fund Office for processing.

Vision Benefit Eye Examination Only

Available only at a Davis Vision provider once every 24-months. Retirees are also entitled to receive the same discounts on services from a Davis Vision provider but expenses are not covered by the Fund.

No benefits for Accidental Death, Weekly Disability, Orthodontics, and Hearing.

ALL THE REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS THAT APPLY TO ACTIVE PARTICIPANTS (AS DESCRIBED IN THIS SPD) ALSO APPLY TO RETIREE BENEFITS.

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1. ELIGIBILITY PROVISIONS

You and your dependent(s) will become eligible for coverage in accordance with the following rules, provided sufficient contributions have been received by the Health Fund made by a participating Employer. No medical examination is required in order to become covered under this Plan. Eligibility is based on contributions received by the Health Fund and not based on hours worked if your employer has not remitted contributions for such work in Covered Employment.

Initial Eligibility

You and your dependent(s) will become eligible for coverage on the first day of the second calendar month following the month in which the Fund Office receives contributions on your behalf for at least 390 hours of work performed within the preceding 24 months.

Example:

Let's assume you worked 390 hours during the period July 1, 2014 through June 30, 2016 and your Employer made contributions on your behalf during that period. You became eligible for coverage on August 1st.

Bank of Hours

Each hour you work in Covered Employment for which the Fund receives contributions from a participating Employer on your behalf are credited to your bank of hours. Whenever you are credited with more than 130 hours during a month, either through work in Covered Employment or reciprocal transfer of contributions, the excess hours are added to your bank of hours' accumulation.

Skip Month

Your eligibility will be continued for one calendar month, immediately following the month in which you fail to maintain 130 hours in your bank. You are entitled to one (1) skip month every twelve (12) months. If you lose active coverage by failing to have 130 hours in your bank after a skip month, you will be offered the opportunity to continue your coverage through COBRA by making self-payments as described in Section 9.

Continuation of Coverage

Hours reported by a participating Employer for which contributions have been received by the Health Fund on your behalf will be credited to your bank. Each month that one hundred and thirty (130) hours can be deducted from your bank, you will maintain eligibility for coverage for that month.

You will be allowed to accumulate excess hours in your "hour bank" up to a maximum of six months of coverage (780 hours) after deduction for the current month's coverage.

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Eligibility While Disabled

- If you are disabled and receive Weekly Disability Income Benefits from the Plan, the Fund will credit your bank of hours with 32.5 hours per week for the period you are receiving the Weekly Disability Income Benefits up to a maximum of 26 weeks. The crediting of these hours should continue your coverage under the Plan during the period of disability, as though such hours were worked in Covered Employment. If you are still disabled after 26 weeks, the Fund will begin deducting 130 hours per month from your bank of hours to maintain your eligibility. Once your bank has been exhausted, you will be offered the option to elect COBRA continuation coverage (refer to Section 9).
- If you are disabled on the job and receive benefits through Workers' Compensation, you will not be credited with hours for your period of disability. If you are receiving Workers' Compensation, you will have hours deducted from your bank for continued coverage until your bank is exhausted. Then you will be offered the option to elect COBRA benefits and continue your health coverage.

In both instances above, your eligibility will terminate on the first day of the second month in which you do not have 130 hours in your bank of hours (skip month). However, you will be allowed to continue coverage by making COBRA self-payment.

If you are paid or receive benefits after the date your coverage under this Plan terminates and you or a dependent were not covered under COBRA, the Fund will seek reimbursement from you for the cost of those benefits and any payments the Fund made to providers, in addition to attorney and administrative fees incurred to obtain reimbursement.

Termination of Coverage

Your coverage will terminate on the last day of the month in which your bank of hours (contributions made on your behalf for work in Covered Employment) has less than 130 hours. ***Only one skip month is available to you in any twelve (12) month period.***

Any hours under 130 at the beginning of the skip month will be deducted from your bank of hours for eligibility purposes.

Under the following circumstances, your coverage will terminate on the last day of the month for which contributions are paid to the Fund:

- When a collective bargaining agreement or other agreement requiring an Employer to contribute to the Fund is terminated and you continue to work for that Employer;
- When an Employer ceases to be a contributing Employer to the Fund and you continue to work for that Employer; or
- When an Employer's contribution rate is determined by the Board of Trustees to be insufficient to support the Fund benefits, and you continue to work for that Employer.

In addition, if you are not performing work in Covered Employment or withdraw from the Local and elect to be covered by another insurance program, your coverage will terminate on the last day of the month for which contributions are paid to the Fund. Once your coverage has terminated, you will be required to satisfy the initial eligibility rules (contribution received for 390 hours) to reinstate your participation.

If your coverage terminates, you will be offered a COBRA self-payment option to maintain benefits.

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Reinstatement of Eligibility

If your eligibility is terminated due to a lack of credited hours in your bank, your eligibility will be reinstated on the first day of the second month following the date on which you have accumulated at least 390 hours in your bank. The same initial eligibility provisions apply to regaining eligibility.

Example of Bank of Hours:

1St of the month	Bank of hours	Monthly deduction for benefits				Contributions received for hours worked		Bank of hours –end of month total		Eligible for benefits?
July									390	Yes
August	390	–	130	=	260	+	200	=	460	Yes
September	460	–	130	=	330	+	0	=	330	Yes
October	330	–	130	=	200	+	0	=	200	Yes
November	200	–	130	=	70	+	0	=	70	Yes
December	70	–	130	=	0	+	0	=	0	Yes (skip month)
January	0	–	130	=	0	+	135	=	135	No
February	135	–	0			+	0	=	13	No
March	13	–	0			+	200	=	335	No
April	335	–	0			+	200	=	535	No
May	535	–	130	=	405	+	200	=	605	Yes
June	605	–	130	=	475	+	200	=	675	Yes
July	675	–	130	=	545	+	200	=	745	Yes
August	745	–	130	=	615	+	200	=	745	Yes (maximum bank)
September	780	–	130	=	650	+	200	=	780	Yes (maximum bank)
October	780	–	130	=	650	+	0	=	650	Yes
November	650	–	130	=	520	+	0	=	520	Yes
December	520	–	130	=	390	Disability 3 weeks = 90		=	480	Yes
January	480	–	130	=	350	Disability 4 weeks = 120		=	470	Yes
February	470	–	130	=	340	+	0	=	340	Yes
March	340	–	130	=	210	+	0	=	210	Yes
April	210	–	130	=	80	+	0	=	80	Yes
May	80	–	130	=	0	+	0	=	0	Yes (skip month)
June	0	–			0	+	200	=	200	No
July	200	–			0	+	200	=	400	No
August	400	–	130	=	270	+	200	=	470	Yes reinstated

Note: *One skip month every twelve (12) months.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child.
- You need to care for a seriously ill spouse, parent, or child.
- A qualifying emergency, or urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

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

- Your spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in the armed forces; and
- An outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits will be determined by your contributing Employer. However, you are eligible for a leave under FMLA if you:

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

The Fund will maintain your prior eligibility status until the end of the leave, provided your contributing Employer properly grants the leave under federal law, notifies the Fund, and continues to make hourly contributions on your behalf for 40 hours each week you are on an approved leave.

If you and your Employer have a dispute over your eligibility under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Board of Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Call your Employer to determine if you are eligible for FMLA leave.

Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contributions from your Employer while you are out on leave; however, federal authorities may assist you regarding your continued coverage.

Benefits Upon Your Death - Widow's Coverage

If you die, your surviving eligible dependent spouse and eligible dependent child(ren) will continue to be eligible for Plan benefits based on your bank of hours. Upon exhausting your bank of hours, your eligible dependent spouse and eligible dependent child(ren) may maintain their eligibility for up to 36 months by making the necessary COBRA self-payments (refer to Section 9).

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If you could have otherwise retired as of the first day of the month of your death (accrued 30 Pension Credits or attained age 55 and accrued 10 Pension Credits in the Connecticut Plumbers and Pipefitters Pension Fund), your widow (if applicable), after running out your active bank of hours, will be eligible to continue his/her coverage for life under the Retiree Benefits Program by making the required monthly self-payment. If not a participant in the Connecticut Plumbers and Pipefitters Pension Plan, retire coverage is available to your spouse if you were active in the Health Fund at the time of your death, participated in the Health Fund for at least 10 years, and have attained age 55.

Eligibility for Coverage During Military Service

If you enter qualified military service (such as active or inactive duty training or active duty in the United States armed forces or national guard), any hours worked in Covered Employment for which contributions have been received by the Health Fund on your behalf may be protected during the qualified military service leave of absence. If you elect, the hours in your Bank will be frozen, and used to maintain your eligibility upon your discharge. However, in accordance with Uniformed Services Employment and Reemployment Rights Act (USERRA), you must return to work or seek re-employment with an Employer following a discharge, under not less than honorable conditions, within the minimum time period allowed. If you do not return to work in Covered Employment or seek re-employment in Covered Employment within the required time period, you will forfeit your continued eligibility rights. In order to ensure protection of your rights under USERRA, you must notify the Fund Office as soon as you are called up for qualified military service.

If you are covered under the Plan at the time your qualified military service leave of absence begins, your health coverage will be continued by the Fund during your first 31 days of military service. If you are on uniformed services leave for more than 31 days, you will be permitted to continue benefits for yourself and your eligible dependents by running out your bank. You also have the option to freeze your bank to be used when you return from military service. If you have exhausted your bank, the Plan will offer you to make self-payment to continued coverage in the amount permitted under COBRA. If you elect coverage under USERRA, you may continue coverage for yourself and your eligible dependents for up to 24 months.

Your right to maintain and reinstate coverage by reason of qualified military service will be administered and interpreted by the Plan in accordance with the requirements of USERRA. The contributions, if any, credited to you or accumulated in your bank of hours will be kept on the Plan's records during the qualified military service leave of absence, and your coverage and your eligible dependents' coverage will be reinstated, provided you return to work in Covered Employment or seek re-employment with an Employer within the time period protected under USERRA.

Non-Jobsite Participation Eligibility Rules for Non-Collective Bargaining Employees

With the prior approval of the Board of Trustees, a contributing Employer may, under a Participation Agreement, include all of its non-bargaining, regular full-time Employees (excludes part-time or summer help, etc.) who do not work in Covered Employment and are not members of another union as non-jobsite Participants in the Fund.

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A contributing Employer in good standing must submit a request to the Board of Trustees before contributions will be accepted on behalf of its non-collective bargaining Employees. A contributing Employer must include all non-collectively bargained personnel, unless they have provided evidence that they are covered under a spouse's employer's group insurance program that provides creditable coverage. An "opt-out" form must be submitted and approved by the Fund Office to exclude a full-time, regular employee from participation. In addition, only part-time or summer help may be excluded from participation.

Eligibility is established for non-jobsite Participants on the first day of the calendar month after contributions are received. Contributions must be continuous without interruption regardless of the number of hours worked. Eligibility will terminate the last day of the month contributions have been made on behalf of a non-jobsite participant. There is no bank of hours extended to non-jobsite Employees. Monthly contributions are payable at the current hourly contribution rate set forth in the Local No. 777 collective bargaining agreement multiplied by 135. Non-jobsite participation in the Health Fund is independent of participation in any other fringe benefit fund.

There is also the availability for a union member that has worked in Covered Employment for an extended period of time to enter into an Alumni Participation Agreement. Alumni Participants are owner operators that no longer work under the terms of a collective bargaining agreement. Participation in the Plan under an Alumni Agreement is subject to prior approval by the Board of Trustees. Initial and continued eligibility is determined in the same manner as that for a journeyman.

Contributions must be made monthly without interruption. An Employee working part-time in the type of work recognized as "Covered Employment" under a collective bargaining agreement with Local No. 777 and part of the time as a non-jobsite Participant must abide by the hours reported to the Pension/Annuity Funds, but in no event less than 135 hours per month.

Newly Organized Contractor, New Member of Local for First Time, New Apprentice – Available Initial Eligibility Contract

On a once in a lifetime basis, if you work in Covered Employment for the first time, you have the option to enter into a contract with the Fund for a loan of 390 hours into your "bank of hours" to establish immediate coverage in the Health Fund. This option is only available to individuals that begin work in Covered Employment in the jurisdiction of Local No. 777 for the first time or have not been a member of Local No. 777 for at least three (3) years.

The following requirements must be satisfied in order to qualify for this loan of "hours" from the Fund to establish initial eligibility:

- The new Employee must provide evidence that he/she maintained health insurance coverage for the month preceding the request for coverage in the Connecticut Pipe Trades Health Fund through another employer group plan. There can be no lapse in coverage between prior insurance coverage and commencement of eligibility for coverage in this Plan;
- The new Employee must enter into a contract with the Fund to repay the hours extended to qualify for coverage under the Fund. The value of the loan is equal to 390 hours multiplied by the hourly contribution rate set forth in the collective bargaining agreement with Local No. 777 at the time the new Employee terminates work in Covered Employment;

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- A new Employee must apply to the Local No. 777 and request coverage under this provision within 30 days of the date he/she began work in Covered Employment;
- The loan will be paid off by having hours worked in excess of 130 in a month applied to reduce the 390 hours loaned;
- If the Employee fails to work at least 1,000 in Covered Employment after signing the contractual loan agreement within twelve-months from entering into the agreement, the Board of Trustees has the right to call the loan and request reimbursement of all Claims paid by the Fund less contributions received on the new Employees behalf for work in Covered Employment; and
- If the new Employee leaves work in Covered Employment or otherwise loses coverage in the Fund, the loaned hours must be paid in full before the Fund will accept COBRA self-payment.

All new Employees that request a loan to establish initial eligibility enter into a formal contract that is subject to approval by the Board of Trustees. Loan agreement forms are available by contacting the Fund Office.

The Plan will not cover, at any time, a condition previously attributable to an Injury or Illness covered by Workers' Compensation, regardless of the time of such Injury or Illness.

Newly Acquired Spouse and/or Dependent Child(ren)

If you are eligible in the Plan and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may enroll your newly acquired spouse and/or any dependent child(ren). If you notify the Fund Office of your newly acquired dependent within 31 days of the date of marriage, birth, adoption or placement for adoption, eligibility will be retroactive to the date marriage, birth of the child or adoption. Failure to notify the Fund Office in a timely manner may establish eligibility for coverage of the dependent prospectively from the date the Fund Office is notified. Contact the Fund Office for information on how to enroll a new spouse or child.

If you did not enroll your spouse and/or any dependent child(ren) for coverage within 31 days after the date on which you or they first became eligible for coverage in this Plan for any reason, you may enroll your spouse and/or dependent child(ren) prospectively by notifying the Fund Office. For example, if you did not enroll your spouse and/or any dependent child(ren) because they were covered by other health insurance or group health plan coverage but they subsequently lose eligibility for that coverage or the employer stops contributing toward your dependents' other coverage, then you may enroll them. **Coverage will be provided the first of month following receipt of the appropriate documentation.**

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2. DEPENDENT ELIGIBILITY

Effective Date of Coverage for Eligible Dependents

- On the date you become eligible for coverage in the Plan, your eligible dependents also become covered under the Plan.
- If you marry after the date you initially become covered under the Plan, your spouse will become covered on the first day of the month after your marriage.
- If you have a newborn biological child, an adopted child or a child placed with you for adoption, such child will become covered on the date of birth (for a newborn biological child) or on the date the child is adopted or placed in your home (for adopted children).

To ensure a new dependent receives coverage, you must notify the Fund Office within 31 days after you acquire a new dependent through marriage, birth, or adoption to ensure coverage for your dependent. **Failure to give timely notice will establish eligibility for coverage of that dependent the first of the month following receipt of the appropriate documentation.**

Definition of Eligible Dependent

Your eligible dependents include:

- Your **spouse,** to whom you are legally married, provided your spouse is recognized as such by the laws of the state of Connecticut. Common law marriages and licensed civil unions are not recognized. Your spouse may remain an eligible dependent until the last day of the month in which divorce, annulment, or legal separation occurs. The Fund does not recognize Domestic Partner, Civil Unions, or Common Law marriages. The exception is if you reside in a State that recognizes Common Law marriages.
- Your **biological child(ren), adopted children, children placed with you for adoption, foster children, or stepchildren,** provided the child satisfies the following Dependent Eligibility Rules, if applicable. The term "placed with you for adoption" means you have assumed and retained the legal obligation for the total or partial support of the child in anticipation of adoption of such child. Placement for adoption terminates upon the termination of such legal obligation. Your child may remain an eligible dependent until the last day of the month following the month in which the child reaches age 26.

Dependent Eligibility Rules

- The Fund will cover your biological children, adopted children (and children placed with you for adoption), foster children or stepchildren. If you are eligible for coverage, your children can be covered under this Plan the first of the calendar month after you enroll them.
- If your eligible dependent child is employed and becomes eligible for other group health coverage, the plan (other than this Plan) under which he/she is an Employee will be considered the primary plan for coverage. This Plan will pay secondary.

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- If a dependent child age 26 or older is incapable of self-sustaining employment because of a mental or physical disability and is financially dependent upon you for support (51% or more), his or her coverage may be continued under this Plan provided the disability began prior to the dependent child attaining age 26. You must submit proof of your dependent child's disability to the Fund Office no later than the date the child obtains age 26. You will be required to provide proof of the child's disability periodically by the Fund Office.
- In order for adopted children, children placed with you for adoption, or foster children to be considered eligible dependents, you must provide the Fund Office with appropriate documentation, satisfactory to the Plan in its sole discretion, such as adoption papers or a court order appointing you as the legal guardian for the child.
- In order for a stepchild to be considered an eligible dependent, the Fund requires the natural parents to provide a copy of any and all documentation, including paternity papers, court order, state order, and/or divorce decree setting forth the relationship with the child (for example, a copy of the child's birth certificate or certificate of adoption).
- If a dependent child is eligible for benefits under this Plan as an active Participant, he/she will not be considered an eligible dependent. However, if a dependent spouse is eligible for benefits under this Plan as an active Participant, benefits will be payable for the spouse first as a Participant, then as a dependent. In no event will benefits exceed 100% of Covered Charges incurred.
- If a dependent child loses dependent eligibility status, the child may only regain eligibility by satisfying all of the requirements included in the Plan's definition of an eligible dependent and these Dependent Eligibility Rules.

The Fund Office will require all Participants to provide documentation substantiating an individual's right to status as an eligible dependent. Documentation required by the Fund Office may include:

- A marriage license;
- Birth Certificate showing both parents' names;
- Court (legal) documents showing legal guardianship/adoption;
- Acknowledgement of paternity; or
- Notarized affidavits.

Change in Family Status

After your coverage becomes effective, it is necessary to notify the Fund Office in writing of any of the following changes in your family status:

- Marriage;
- Birth or adoption of a child;
- A child no longer meeting the definition of an eligible dependent under the Plan; and
- Death, divorce, or legal separation.

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This is very important because the COBRA election period to continue coverage by self-payment is for a limited time and **failure by you or your eligible dependent to notify the Fund Office** of such a change may result in a loss of COBRA rights for which you and/or your dependent could have been eligible.

In addition, failure to file the required information may delay payment of any benefits to you or your eligible dependents.

Qualified Medical Child Support Orders (QMCSOs)

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs require health plans to recognize state court orders which the Plan finds to be Qualified Medical Child Support Orders, as defined in the Social Security Act, directing a Participant to provide health benefit coverage for dependent children, even if the Participant does not have custody of the children.

Under federal law, a QMCSO is a child support order of a court or state administrative agency that has been received by the Fund Office, 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 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; and
- States the period for 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. For a state administrative agency order to be a QMCSO, state 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 health care coverage for any of your dependent children, the Plan Administrator will determine if that order is a QMCSO as defined by federal law. The Plan Administrator's determination will be binding on you, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, the Plan Administrator will notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage to the dependent child(ren).

Coverage of the dependent child(ren) will be subject to all terms and provisions of the Plan, including any limits on the selection of providers, and requirements for authorization of services, insofar as is permitted by applicable law. The Fund will provide coverage to an alternate recipient (child) under a QMCSO as of the first day of the first month following the Plan Administrator's determination that the order is a QMCSO.

No coverage will be provided for any dependent child under a QMCSO unless all of the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when your coverage terminates for any reason, subject to the dependent child's right to elect COBRA Continuation Coverage (if that right applies).

If you have any questions about QMCSOs, contact the Fund Office.

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Termination of Dependent Coverage

Your eligible dependent's coverage under the Plan will terminate on the earliest of the following dates:

- The date your coverage under the Plan ends;
- The last day of the month during which your dependent no longer meets the definition of our eligibility rules for an eligible dependent; or
- The date the Plan is terminated or amended to exclude coverage for the dependent.

3. RECIPROCAL AGREEMENTS

The Board of Trustees has entered into reciprocal agreements with other United Association local health and welfare funds that provide for the transfer of contributions for hours you work outside the jurisdiction of the Local No. 777 while you are participating in this Fund. Contributions received from a reciprocating fund are divided by the hourly contribution rate in the collective bargaining agreement with Local No. 777 at the time the work was performed by the Participant. This result will determine the number of hours that will be credited to your bank at the time the reciprocal payment is transferred.

Example:

Let's assume you work out-of-state for 300 hours at a contribution rate of $9.00 per hour and the hourly rate to the Fund in the Local No. 777 collective bargaining agreement is $11.30 per hour. A reciprocal transfer of $2,700 is made on your behalf, which is converted to 238.9 hours ($2,700 ÷ $11.30 = 238.9 hours) by dividing the contributions received by the contribution rate in effect for the Fund. In this example, 238.9 hours would be added to your bank of hours for the month the reciprocal payment is received.

The provisions that govern the transfer of contributions on your behalf to this Fund for work performed in the jurisdiction of another local health fund may be unique to each reciprocal agreement although the UA has made strides to standardize the agreements. Each agreement provides for an exchange of hours and contributions necessary in computing eligibility. **Therefore, if you work outside the territory of Local No. 777, you should notify the Fund Office. This will permit the Fund Office to contact that health and welfare fund so that arrangements can be made to have contributions transferred to this Fund in an expeditious manner, and you can receive credit for the hours you worked.**

You should stay in contact with the Fund Office any time you are working outside the jurisdiction of Local No. 777. The Fund Office needs to know the local's jurisdiction where you are working, your Employer, and the amount of hours you have worked, in order to follow-up on reciprocal payments from other locals. Without this information, there is no way to follow-up with other health and welfare funds to assure hours and contributions are reciprocated in a timely manner on your behalf.

Although the Board of Trustees will make every effort to collect amounts due from other funds under reciprocal agreements, they cannot enforce collection from Employers who are not signatory to the collective bargaining agreement with Local 777. Collection can only be enforced by the fund in the jurisdiction where the work was performed.

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4. FILING AND PROCESSING A CLAIM

This section of the booklet describes the procedures for filing Claims for benefits. It also describes the procedures for you to follow if your Claim is denied in whole or in part and you wish to appeal the decision.

Definitions of Terms Used in This Section (also refer to the definitions in Section 23)

Adverse Benefit Determination means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan.

Claim means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a Claim.

A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a Claim. However, requests for prior approval of a benefit where the Plan does require prior approval (e.g., Hospital pre-admission certification, etc.) are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described in the following procedures.

Concurrent Claim means a Claim that is reconsidered after an initial approval is made, resulting in a reduction, termination, or extension of a benefit. (An example of this type of Claim would be an inpatient Hospital stay originally certified for five days that is reviewed at three days to determine if the full five days' stay is still appropriate. In this situation, a decision to reduce, terminate, or extend the Hospital stay is made concurrently within the period of hospitalization).

Disability Claim means a Claim that requires a finding of total disability as a condition of eligibility. This includes Claims for Weekly Disability Income Benefits.

Post-Service Claim means a Claim for benefits that is not a Pre-Service, Concurrent, or Urgent Claim. Specifically, a Claim submitted for payment after health services or treatment has been obtained.

Pre-Service Claim means a Claim for a benefit for which the Plan requires approval before health care is obtained, or approval is required in order to receive the maximum benefit provided by the Plan.

Urgent Claim means a Claim for health care or treatment that if normal Pre-Service standards were applied, would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

How to File a Claim

As stated earlier in this section, a Claim for benefits is a request for Plan benefits made in accordance with the Plan's Claims procedures.

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Network Benefits

If you use network providers, for example, through the Anthem Blue Cross and Blue Shield, your Claim for benefits will go directly from the network health care provider (Hospital, Physician, laboratory etc.), through an automated electronic system, to Anthem then to the Fund Office for processing. Generally, you are not required to file a Claim form for in-network benefits.

Out-of-Network Benefits

If you use out-of-network providers not affiliated with Anthem, you must submit a completed Claim form and follow the Claims procedures outlined in this section, as applicable. You can obtain Claim forms from the Health Fund's website at **www.connecticutpipetrades.com** or by calling the Fund Office at (860) 571-9191 or toll free at (800) 848-2129. Out-of-network reimbursements are made directly to the Participant unless assigned by the member directly to the provider.

The following information must be completed on the Claim form in order for your request for benefits to be considered a Claim, and in order for the Plan to be able to process your Claim.

You complete the Employee portion of the Claim form, providing the following:

- Participant name;
- Patient name;
- Patient Date of Birth; and
- Fund Identification number of the active participant or retiree.

Your Physician (or other provider) may:

1. Complete the following items, as applicable, on the Attending Physician's Statement section of the Claim form:
    - Date of Service;
    - CPT-4 (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
    - ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
    - Billed charge;
    - Number of Units (for anesthesia and certain other Claims);
    - Federal taxpayer identification number (TIN) of the provider;
    - Billing name and address; and
    - If treatment is due to accident, accident details.

Note: Urgent Hospital or medical Claims and appeals must be submitted by making a telephone call to HealthLink, the Fund's Utilization Review vendor, and providing the Claims information in writing within 24 hours. See pages 4 through 6 in this section for the contact information.

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When Claims Must Be Filed

Claims should be filed with all the information necessary to be processed, as soon as reasonably possible, following the date the services or treatment was received and the charges incurred. Stricter filing rules apply to pre-service Claims and urgent care Claims. If a Claim is not received by the Fund Office within 15 months after it is incurred, the Claim will be denied on the basis that it has not been filed in a timely manner. This includes the failure to provide information requested to process the Claim including accident reports, etc.

The incurred date for an inpatient Hospital Claim is the admission date. For all other medical, dental, and vision Claims, it is the date treatment is received.

The incurred date for Disability Claims is the first (1st) day of disability due to Injury or the eighth (8th) day of disability due to Illness measured from the date you first lose time from work and are treated by a Physician because of the disability. The incurred date for a Life Insurance Claim is the date of death.

REMEMBER: All Claims for benefits must be submitted with all the information necessary to be processed absolutely no later than fifteen (15) months from the date the charges were incurred or the Claim will not be paid. The Board of Trustees may under the voluntary appeal provision consider Claims received after this deadline only if substantiating evidence documents the delay was caused by the service provider or primary insurance carrier.

Authorized Representatives

An authorized representative, such as your spouse or adult child, may submit a Claim on your behalf if you are unable to do so yourself and you have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that the person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Claim without you having to complete an authorization form.

Where to file a Claim or Appeal

Claims for benefits or appeals of denied Claims should be submitted as follows:

Weekly Disability Benefit Claims:

Claims: Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109
Telephone (860) 571-9191 or toll free at (800) 848-2129
Fax: (860) 571-9221

Appeals: Connecticut Pipe Trades Health Fund

Life Insurance and Accidental Death and Dismemberment Coverage:

Claims: Connecticut Pipe Trades Health Fund

Appeals: The Union Labor Life Insurance Company
Group Life Claim Department
8403 Colesville Road
Silver Springs, MD 20910
Telephone (202) 682-6768 or toll free (202) 962-2939

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Retiree Life Insurance Claims:

Claims: Connecticut Pipe Trades Health Fund

Appeals: Connecticut Pipe Trades Health Fund

Medical Coverage (except for Pre-Service Claims, Urgent Claims, and Claims secondary to Medicare):

In-Network Claims: You don't file a Claim. They are electronically submitted to Anthem Blue Cross Blue Shield.

Appeals: HealthLink
P. O. Box 411424
St. Louis, MO 03141
Telephone toll free: (800) 624-2356
Fax: (314) 925-6000

Out-of-Network Claims (e.g., Post-Service Claims): The Fund Office

Medical Coverage (Pre-Service and Urgent Claims):

HealthLink
P. O. Box 411424
St. Louis, MO 03141
Telephone toll free: (800) 624-2356
Fax: (314) 925-6000

Retiree Medical Coverage (Claims Secondary to Medicare): Connecticut Pipe Trades Health Fund

Appeals of Hospital and Medical Coverage Denied Claims:

HealthLink
P. O. Box 411424
St. Louis, MO 03141
Telephone toll free: (800) 624-2356
Fax: (314) 925-6000

Dental Coverage:

Claims: Connecticut Pipe Trades Health Fund

Appeals: Connecticut Pipe Trades Health Fund

Prescription Drug Benefit:

Retail Pharmacy

Claims: You are not required to submit a Claim when visiting a participating pharmacy. Simply present your OptumRx (prescription drug) identification card to a retail pharmacy with your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled, that request is not a "Claim" under the Plan's procedures. However, if the pharmacy rejects your request to fill a prescription covered by the Plan, in whole or in part, you may file a Claim by contacting the Fund Office.

Appeals: OptumRx
c/o Appeals Coordinator
CA 106-0286
3515 Harbor Boulevard
Costa Mesa, CA 92626
1-(888) 403-3398

Mail Order Pharmacy

Claims: OptumRx
P. O. Box. 2975
Mission, KS 66201-1375
Telephone toll free: 1-(855) 408-2312

Appeals : c/o Appeals Coordinator
CA 106-0286
3515 Harbor Boulevard
Costa Mesa, CA 92626
1-(888) 403-3398

Vision Benefits:

Claims: Davis Vision. When you use a Davis Vision network provider, your Claim will automatically be sent to Davis Vision by the optometrist. There are no Claim forms to complete.

Out-of-Network Claims:
Davis Vision
(800) 999-5431
www.davisvision.com

Davis Vision, Inc.
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Appeals: Davis Vision, Inc.
159 Express Street
Plainview, NY 11803

Hearing Benefits:

Claims: Your claim will automatically be sent to the Fund Office by the University of Connecticut Speech and Hearing Clinic or an Anthem audiologist to Anthem and then the Fund Office for processing.

Appeals: Connecticut Pipe Trades Health Fund

Note: If you ever need assistance determining where your Claim or appeal should be sent, contact the Fund Office.

Health Care Claims Procedures

The Claims procedures for your health care benefits will vary depending on whether your Claim is a Pre-Service Claim, an Urgent Claim, a Concurrent Claim, a Post-Service Claim, or a Disability Claim, as follows:

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Pre-Service Claim Procedures

As indicated in the definitions on page 4-1, a Pre-Service Claim is a Claim for a benefit for which the Plan requires approval before health care is obtained, or approval is required in order to receive the maximum benefit provided by the Plan. The Plan has hired an independent health benefits administrator, HealthLink, to conduct pre-certifications of Pre-Service Claims for medical care to determine eligibility for payment before treatment is received.

Pre-certification by HealthLink is required for the following types of Pre-Service Claims:

- Inpatient Hospital Admissions;
- Inpatient Mental/Behavioral Health and Substance Use Disorder Treatment;
- Inpatient Surgery;
- Private Duty Nursing Care;
- Home Health Care;
- Convalescent Facility; and
- Hospice Care.

For Pre-Service Claims you must call HealthLink first at (877) 284-0102.

For further information on pre-certification and utilization review, refer to Section 21.

For properly filed Pre-Service Claims, you are notified of a decision within 15 days of receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of HealthLink. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because HealthLink needs additional information from you, you will be notified before the end of the initial 15-day period of the information needed. You (or your doctor) will then have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the period in which you are allowed to supply the additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of 45 days or the date you respond to the request. Once all the information requested is received, there is a 15-day grace period to make a decision on the Claim and notify you of its determination.

If you improperly file a Pre-Service Claim, you are notified as soon as possible, but not later than five days after receipt of the Claim, of the proper procedures to be followed in filing a Claim. You will only receive notice of an improperly filed Pre-Service Claim if there is sufficient information to identify the Participant and respond to the request.

Unless the Claim is re-filed properly, it will *not* constitute a Claim.

IMPORTANT: THE PLAN WILL REDUCE YOUR BENEFIT PAYMENT BY 20% IF PRE-CERTIFICATION OF A PRE-SERVICE CLAIM IS REQUIRED AND YOU FAIL TO PRE-CERTIFY THE CLAIM.

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Urgent Claim Procedures

Urgent Claims for Hospital, medical, mental and behavioral health or substance use disorder treatment must be submitted to HealthLink by calling (877) 284-0102, or FAX 1-(800)-510-2162.

Note: If you or your eligible dependent is confined to a Hospital on an emergency basis, you, your Authorized Representative, a responsible family member, the attending Physician or the Hospital must call HealthLink no later than 48 hours after admission or, if a weekend or holiday admission, the next business day at (800) 848-9200 notifying HealthLink's representative of the confinement and providing the information required to establish an approved Hospital stay. Refer to Section 21 for further details.

HealthLink will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent individual with average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies HealthLink of such, it will be treated as an Urgent Claim.

HealthLink will provide you or your authorized representative, if applicable, with a determination of your Claim by telephone as soon as possible (taking into account the medical exigencies), but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, HealthLink will notify you as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. You must provide the specified information within 48 hours. If the information is not provided to HealthLink within that time, the Claim will be denied.

Notice of the Claim decision will be provided to you no later than 48 hours after HealthLink receives the specified information, or the end of the 48-hour period given for you to provide this information, whichever is earlier.

If you improperly file an Urgent Claim, HealthLink will notify you, or your authorized representative, if applicable, as soon as possible, but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing a Claim. Unless the Claim is re-filed properly, it will not constitute a Claim.

With respect to an Urgent Claim, a health care professional with knowledge of the Covered Person's medical condition will be permitted to act as an authorized representative.

Concurrent Claim Procedures

Reconsideration of a Hospital or medical Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by HealthLink as soon as possible. In any event, the Covered Person will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated. Refer to Section 5, Denial of Claims and Procedures for Appeal, for information on how to file an appeal of a Concurrent Claim.

Any request by a claimant to extend an approved Urgent Claim will be acted upon by HealthLink within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

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Post-Service Claim Procedures

To have your Post-Service Claim processed, you will be required to submit a completed Claim form for out-of-network medical Claims and you may be required to submit a Claim form for dental expenses. A new completed Claim form is also required for a new Injury or Illness and may be required at any time before a Claim will be processed. To assure processing without a delay, you should always submit a completed Claim form with any Post-Service expenses.

REMEMBER: A COMPLETED CLAIM WITH ALL THE NECESSARY INFORMATION MUST BE SUBMITTED WITHIN FIFTEEN (15) MONTHS FROM THE DATE SERVICES IN ORDER FOR THE CLAIM TO BE PAID.

All Post-Service Claims should be submitted to the Fund Office as soon as possible after the date the service or treatment is received.

In order for a request for benefits to be considered a Post-Service Claim, and to avoid a delay in benefit payments, it is important that you provide the following information with each Claim submitted:

1. If there is more than one group health plan involved, your Claim must be submitted in accordance with the Coordination of Benefits procedures described in Section 7;
2. A separate Claim must be submitted for out-of-network Claims for each Covered Person who incurs Covered Charges. Claim submission are typically done by your doctor or dentist on a standardized form;
3. ALL questions must be completed and answered on the Participant's portion of the Claim;
4. Any applicable forms must be signed by the Participant or eligible dependent spouse, if applicable; and
5. The Physician's (or other provider's) portion of the Claim form must be completed by the Physician (or other provider). However, an original or copy of an itemized bill from a Physician or other provider, which includes all of the supporting information as requested on the Claim form, may be acceptable. This itemized bill must be securely attached to the Claim submission and should include the following information:
    - Patient's full name;
    - Date of service;
    - Description of the service or CPT-4 code(s);
    - Diagnosis and ICD-10 code(s);
    - Itemized charges;
    - Number of units (for anesthesia and certain other Claims);
    - Provider's federal taxpayer identification number (TIN); and
    - Provider's billing name and address.

Ordinarily, you will be notified of decisions on Post-Service Claims within 30 days from the date the Claim was received at the Fund Office. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund Office. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

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If an extension is required because the Fund Office needs additional information from you, the Fund Office will issue a request for additional information that specifies the information needed. You will then have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which you are allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the request for additional information until the earlier of 45 days or until the date you respond to the request. The Fund then has 15 days to make a decision on the Claim and notify you of its determination.

If the Fund Office determines that additional information is required, the Fund Office may issue a combined request for additional information and notice of adverse benefit determination. The notice of adverse benefit determination would only be applicable if the claimant fails to provide any information within 45 days. In this case, the Fund Office would not issue a separate notice of adverse benefit determination if you fail to submit any information within 45 days. The combined notice will clearly state that the Claim will be denied if you fail to submit any information in response to the Fund's request, and will satisfy the requirements of both a request for additional information and the notice of adverse benefit determination under the Plan. When the combined notice is used, the timeframe for appealing the adverse benefit determination begins to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

Disability Claims Procedures

Weekly Disability Income Benefit Claims should be submitted to the Fund Office as soon as practicable after the date of disability. The "date of disability" is the first (1st) day of disability due to an Injury, and the eighth (8th) day from the date you first lose time from work and are treated by a Physician because of disability due to an Illness.

Claims must be received at the Fund Office within 15-months of the onset of the disability to be considered "on time" for processing.

Disability Claims must be submitted to the Fund Office in writing, using the appropriate application form. An application form may be obtained by visiting the Health Fund's website at www.connecticutpipetrades.com or by calling the Fund Office at (860) 571-9191 or toll free at (800) 848-2129.

The Fund will make a decision on the Claim and notify the claimant of the decision within 45 days. If the Fund Office requires an extension of time due to matters beyond its control, it will notify the claimant of the reason for the delay and indicate when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days from the time the Fund Office notifies the claimant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Office notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund Office needs additional information from the claimant, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed

to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date the claimant responds to the request (whichever is earlier). Once the claimant responds to the request for information, he or she will be notified of the decision on the Claim within 30 days.

Life Insurance and Accidental Death and Dismemberment Claims

Claims for life insurance or accidental death and dismemberment benefits should be filed with the Fund Office. Please refer to Section 11.

Like your other benefits, these Claims should be filed with all the information necessary for processing, as soon as reasonably possible, following the date of death or accident resulting in a covered Injury. Claims must be submitted within 15-months to be considered filed in a timely manner.

Notice of Initial Benefit Determination (Hospital, Medical, Dental, Prescription Drugs, Vision, Hearing and Weekly Disability Income Benefit Claims)

You will be provided with written notice of the initial benefit determination of your Claim. If your Claim is denied, in whole or in part, an "Adverse Benefit Determination" notice will include:

1. Include information sufficient to identify the Claim involved, including the date of service, the health care provider, and the Claim amount (if applicable).
2. The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the Claim.
3. Reference to the specific Plan provision(s) as described in this booklet on which the determination is based.
4. A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary.
5. A description of the Plan's internal appeal procedures (including voluntary appeals) and external review processes, including applicable time limits and information on how to initiate an appeal.
6. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a copy is available upon request at no charge.
7. If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
8. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).
9. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination.

In addition, other than for Disability Income Benefit Claims, the notice will disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal Claims and appeals and external review processes. The Plan

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will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can deny your Claim on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Allowable Charges

This section describes how the Fund Office determines the amount of reimbursement for Covered Charges. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the Plan's Allowable Charge for the Covered Charge that you receive.

- The Allowable Charge for this Plan is the maximum amount of reimbursement the Connecticut Pipe Trades Health Fund will allow for services and supplies that:
- Meet Our definition of Covered Charges, to the extent such services and supplies are covered under the Plan and are not excluded;
- Are Medically Necessary; and
- Are provided in accordance with all applicable pre-certification, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the Allowable Charge to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Charges from an Out-of-Network Provider, you may be responsible for paying any difference between the Allowable Charge and the Provider's actual charges. This amount can be significant.

When you receive Covered Charges from a Provider, the Fund Office will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Charges. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Fund Office's determination of the Allowable Charge. The Fund Office's application of these rules does not mean that the Covered Charges you received were not Medically Necessary. It means the Fund Office has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Allowable Charge will be based on the single procedure code rather than a separate Allowable Charge for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the Plan may reduce the Allowable Charge for those secondary and subsequent procedures because reimbursement at 100% of the Allowable Charge for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

The Allowable Charge may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

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For Covered Charges performed by an In-Network Provider, the Allowable Charge for the Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Charges. Because In-Network Providers have agreed to accept the Allowable Charge as payment in full for those Covered Charges, they should not send you a bill or collect for amounts above the Allowable Charge. However, you may receive a bill or be asked to pay all or a portion of the Allowable Charge to the extent you have a Copayment or Coinsurance. To locate an Anthem network provider, you may use the online provider directory at **www.anthem.com.**

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Out-of-Network Providers.

For Covered Charges you receive from an Out-of-Network Provider, the Allowable Charge for this Plan will be one of the following as determined by the Fund Office:

1. An amount based on the Anthem Out-of-Network Provider fee schedule/rate, which the Fund Office has established in its' discretion, and which the Fund Office reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Allowable Charge upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by Anthem or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Allowable Charge. You are responsible for paying the difference between the Allowable Charge and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower Out of Pocket costs to you and the Fund.

Payment of Hospital and Physicians' Bills

As previously noted, if you use an Anthem network provider, your Claim for benefits will go directly from your network health care provider (Hospital, Physician, or facility) electronically through Anthem and ultimately to the Fund Office for processing. After adjudicating the claim, Anthem will pay the health care provider directly. The same is true for OptumRx for pharmacy Claims, Davis Vision for vision Claims and the University of Connecticut Speech and Hearing Clinic or an Anthem audiologist for hearing benefits.

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If you use a non-network provider, payment of Hospital bills will be made directly to the Hospital only if you sign the appropriate authorization statement on the Claim form from the Hospital. Payment of bills from Physicians and other providers may be made directly to you, unless you assign the benefit by signing the line on the Claim form that indicates your request that benefits be paid directly to the provider of service.

Even though the Fund may make payment of Claims on behalf of a Covered Person to the provider directly, no provider will have any right, title, or interest to payment from the Fund, and no provider will have a right to any remedies or other procedures provided under the Plan for the benefit of a Covered Person. **Only the Covered Person may exercise any rights provided under this Plan and any assignment, pledge or other agreement between the Covered Person and any provider will not create any rights against this Plan and any such assignment, pledge or other agreement will be null and void as to this Plan.**

Disputes About Hospital and/or Physicians' Bills

Occasionally, a Claim processor will question the amount or the reasonableness of a billing and whenever the amount or reasonableness of a charge is questioned, the Claims processor may investigate the matter. If the dispute cannot be resolved, the Fund Office will first rely on HealthLink for guidance. In some matters, under the voluntary appeal procedures, the Board of Trustees may retain the services of an independent professional medical peer review organization with the appropriate medical expertise to determine the Fund's obligation under the Plan for those charges. The Fund will reimburse only Covered Charges, to the extent that the peer review organization's evaluation supports the charges and/or services as reasonable, customary, and proper.

No Medical Examination or Age Restriction

No medical examination is required of any person to become eligible for Fund benefits and all new Participants and eligible dependents are covered regardless of age.

Notice of Life Insurance or Accidental Death and Dismemberment Insurance Determination

For Life Insurance and/or Accidental Death and Dismemberment Insurance Claims, the insurance carrier, will make a decision and notify your beneficiary (or you) of its decision within 90 days. However, if the insurance carrier requires an extension of time due to matters beyond its control, the insurance carrier will notify your beneficiary (or you) of the reason for the delay and when the decision will be made. The extension will not exceed 90 days.

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5. DENIAL OF CLAIMS AND PROCEDURES FOR APPEAL

Appealing an Adverse Benefit Determination

If your Claim is denied in whole or in part, or if you disagree with the decision made on a Claim, you may appeal the decision.

Post-Service and/or Disability Claims. Appeals of Adverse Benefit Determinations regarding Post-Service Claims and Disability Claims must be submitted in writing within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

- The patient's/Participant's name and address;
- The claimant's name and address, if different;
- A statement that this is an appeal of a decision by the Fund Administrator;
- The date of the Adverse Benefit Determination; and
- The basis of the appeal i.e., the reason(s) why the Claim should not be denied.

Life Insurance and Accidental Death and Dismemberment Insurance Claims. Appeals of Adverse Benefit Determinations regarding Life Insurance and/or Accidental Death and Dismemberment Claims must be submitted in writing within 60 days after receipt of the Notice of Adverse Benefit Determination and must include the same information noted immediately above. Appeals should be sent to the insurance carrier, with a copy to the Fund Office, refer to page 4-4.

Urgent and Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims and Pre-Service Claims may be made orally within 180 days after receipt of the notice of Adverse Benefit Determination.

- For medical Claims, call HealthLink at 1-(877)-284-0102.
- For dental Claims, call the Fund Office at (860) 571-9191 or toll free at (800) 848-2129.
- For vision Claims, call Davis Vision at (800) 999-5431.

Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims may be made orally by calling HealthLink. For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set timeframe for filing an appeal however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim regarding an extension of care, the appeal timeframe **will be the timeframe for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to your appeal.**

Internal Appeals Process

The Internal Appeals Process works as follows:

You will have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination.

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Also, you will be provided upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to your Claim. The term "Relevant Documents" means documents pertaining to a Claim if: (1) they were relied upon in making the benefit determination; (2) they were submitted, considered or generated in the course of making the benefit determination (regardless of whether they were relied upon); (3) they demonstrate compliance with the Plan's administrative processes and safeguards for ensuring consistent decision making; or (4) they constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The reviewer's decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted.

For Life Insurance and/or Accidental Death and Dismemberment Claims, the process works similarly. You will have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination. In addition, you will be provided upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to your Claim.

Timeframes for Notices of Appeal Determinations

Pre-Service Claims. Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by the HealthLink.

Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by HealthLink.

Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent by HealthLink before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent by HealthLink based on the timeframes for an Urgent, Pre-Service, or Post-Service Claim, whichever category applies to the appeal.

Post-Service Claims. Notice of the appeal determination for a Post-Service Claim will be sent within 60 days of receipt of the appeal by the Fund Office.

Disability Claims. Ordinarily, decisions on appeals involving Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, if the request is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than 5 days after the decision has been reached.

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Life Insurance and/or Accidental Death and Dismemberment Claims. Notice of the appeal determination will be sent within 60 days after receipt of the appeal by the insurance carrier, unless an extension of time is needed to properly adjudicate your Claim. If such an extension is needed, notice of the appeal determination will be sent no later than 120 days after the insurance carrier received the appeal.

Content of Appeal Determination Notices (Health Care and Disability Claims).

The determination of an appeal will be provided to you in writing. If denied, the notice of a denial of an appeal will include:

1. Identification of the claim involved, including date of service, provider, claim amount, and a statement with denial codes and their respective meanings;
2. The specific reason(s) for the determination;
3. Reference to the specific Plan provision(s) as described in this Summary Plan Description (Booklet) on which the determination is based;
4. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to the Claim upon request and free of charge;
5. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review (a denied appeal);
6. A description of the Plan's voluntary appeal procedures available;
7. If an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
8. If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
9. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes for external claims; and
10. The following statement: "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

Note: In addition, other than for Disability Income Claims, the Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can issue a denial on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

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Voluntary Appeals (Not applicable to Life and AD&D Claims)

After you have exhausted the initial appeal process, a voluntary level of appeal is available to the Board of Trustees. All requests for a voluntary appeal of denied benefits should be directed to the Fund Office for all benefits coverage.

If you are notified that your appeal of a denied Claim for benefits was rejected (i.e., you receive an Adverse Benefit Determination regarding your appeal), you may file a voluntary appeal with the Board of Trustees if you choose to do so. Subject to verification procedures as the Plan may establish, your Authorized Representative (cannot be a provider) may act on your behalf in filing and pursuing this voluntary appeal. All of the corresponding levels of Claims and appeals previously described in this section must be fully completed before you can file a voluntary appeal. Your voluntary appeal must be filed with the Trustees for their final review within sixty (60) days after you receive an Adverse Benefit Determination under the standard appeal process described above.

If you elect to file a voluntary appeal, any applicable statute of limitations or any other defense based on timeliness will be tolled (“suspended”) while your appeal is pending. The filing of a voluntary appeal will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file a voluntary appeal, the Plan will not assert that you failed to exhaust your administrative remedies because of that choice. No fees or costs will be imposed upon you by the Plan as part of the voluntary level of appeal. Also, your decision to submit a prior denial of benefits to the Board of Trustees as part of your voluntary appeal will have no effect on your rights to any other benefits under the Plan.

If you choose to file a voluntary appeal with to the Board of Trustees, you must do so in writing. You should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with the Plan and the Claims administrator regarding the benefit Claim, including the Explanation of Benefits (EOBs) you received; and
- Any other applicable or new relevant information you have not yet submitted regarding the benefit Claim.

If you file a voluntary appeal, you will be deemed to have authorized the Board of Trustees to obtain any and all relevant information regarding your Claim from the Plan. Mail your written voluntary appeal directly to:

Board of Trustees
Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109

The Trustees will review your appeal within the timeframes previously described relating to eligibility decisions and will notify you in writing of their final determination regarding your voluntary appeal.

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Decision Final and Binding

A decision on review of any Claim made under the Plan in accordance with the above procedures will be considered final and binding on all persons.

Limitation on When a Lawsuit may be Started

You may not seek external review or start a lawsuit to obtain benefits until after you have requested an appeal and a final decision has been reached on the appeal, or until the appropriate timeframe described has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, the law permits you to pursue your remedies under ERISA Section 502(a) without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three (3) years after the end of the year in which the health care services were provided, or if a Claim is for disability benefits, more than three (3) years after the start of the disability.

External Review of Health Care Claims
(Does not apply to Disability Income or Life Insurance claims)

The External Review Process works as follows:

This External Review process is intended to comply with the Affordable Care Act's external review requirements. If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Fund Office at (860) 571-9191 or toll free at (800) 848-2129 for more information.

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE: External review is only available for the following types of denials of claims:

- A denial that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

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External Review of Hospital, Medical, Mental Health/ Substance Use Disorder, Prescription Drug, Dental, Hearing and Vision Claims (Only)

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial. Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

   (a) Within five (5) business days of the Plan's receipt of your external review request for a claim, the Plan will complete a preliminary review of the request to determine whether:

   - You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   - The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
   - You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
   - You have provided all of the information and forms required to process an external review.

   (b) Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

   - If your request is complete and eligible for external review, or
   - If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)), or
   - If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review By Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

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Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

(b) Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which
you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section 1(a), are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section 1(b).

Review By Independent Review Organization

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and

is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements previously set forth in section 2(f), as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may be able to seek judicial review as permitted under ERISA Section 502(a).

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6. MISCELLANEOUS PROVISIONS

Misrepresentation and Fraud

In the event a Covered Person receives benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, such person will be liable to repay all amounts paid by the Fund. Fraudulent Claims includes such person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a Claim submitted to the Fund for payment and Third Party Liability Claims (refer to Section 8). The Covered Person will be prosecuted for fraud and held liable for all costs of collection, including interest and attorney's fees or will have future Claims offset by the overpayments.

Overpayments

If a Claim payment is made to a Participant or assigned to a provider that is later determined to be an overpayment, the Board of Trustees may offset future benefit payments in order to recover said overpayment.

Notices Sent to Addresses of Participants

The Board of Trustees and/or the Fund Office will give notice by mail to Participants of actions taken with respect to eligibility, Claims, and other important matters.

All such notices will be sent to your address, as it appears in the Fund's records. To protect yourself and your rights, **you must be sure the Fund Office always has your current address.**

If you fail to notify the Fund Office of your current address, you may miss receiving an important notice and might lose valuable rights or benefits. You may even lose coverage.

Any notice sent to you at the address in the Fund's records will be deemed to have been received by you. The time in which you must reply to such a notice will not be extended, because you did not give the Fund Office your current address.

Cost Savings Advice

Physician's Fees and Treatment Plans

Whenever possible, you should use an in-network Physician, Hospital, laboratory, or imaging provider. If you use an out-of-network provider, you should ask your Physician about his treatment and medical fees, as it is important to know whether the Fund will recognize these fees as the "Allowable Charge." Remember that coverage under this Plan for out-of-network services is limited to the Allowable Charges for the services in question and subject to out-of-network deductibles and coinsurance. You are liable for charges above Allowable Charges billed by a Physician or other provider and such amounts will not count towards your annual out-of-pocket maximum. You do not have this risk of being billed above the allowance recognized by the Fund if you utilize a network provider.

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Bills and Unnecessary Services

Review your out-of-network medical bills and your Explanation of Benefit (EOBs) forms for in-network Claims to assure correct charges and payments. When deciding upon the methods for treatment, avoid requesting unnecessary services. For example, you may reduce your expenses by:

- Contacting the Fund's Utilization Review Program (refer to Section 21);
- Avoiding weekend Hospital admissions;
- Getting a second surgical opinion;
- Taking advantage of outpatient surgery; and
- Using generic drugs.

By adhering to these suggestions, you may utilize your benefit to its fullest, while simultaneously cutting medical costs.

Cash Payment for Self-Audit of Bills

From time-to-time, a Hospital, Physician, other health care provider, or dentist may charge for services or medications not actually provided. You may be charged for example, for an extra day in the Hospital. If you discover an incorrect billing or duplicate billing, notify the Fund Office. **If the Fund has paid the provider and now recovers an overpayment, you will receive 25% of the recovery by the Fund, up to a maximum of $1,000 per bill or invoice.**

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7. COORDINATION OF BENEFITS

Duplicate Coverage of Medical and Dental Expenses

This section describes the circumstances when you or your eligible dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. It also describes the rules that apply when this happens.

There are several circumstances that may result if you and/or your eligible dependents are reimbursed for your medical and/or dental expenses from this Plan **and** from some other source. This can occur if you or an eligible dependent is also covered by:

1. Another group or individual health care plan;
2. Medicare or some other government program, such as Medicaid, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law;
3. Workers' Compensation; or
4. If a spouse is employed and covered by a high deductible health plan with a Health Savings Account, that spouse cannot be covered by another group health plan.

Duplicate recovery of medical and/or dental expenses can also occur if a third party is financially responsible for your medical and/or dental expenses because that third party caused the Injury or Illness giving rise to those expenses by negligent or intentionally wrongful action, (refer to Section 8 regarding third party lien).

This Plan operates under rules that prevent it from paying benefits that together with the benefits from any other source described above, would allow you to recover more than 100% of medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those medical and/or dental expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your eligible dependent actually recover some or all of your losses from a third party.

Furthermore, under the Coordination of Benefits provisions, an eligible dependent who is also covered under another group plan that includes programs such as a utilization review program, Hospital pre-admission certification, and continued stay review requirement will not receive any payment or compensation from this Fund for reductions in benefits paid by the "other plan" because of the failure of your eligible dependent to utilize the "other plan's" mandatory programs.

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For example, if the "other plan" requires that your eligible dependent call them before a scheduled surgery or Hospital stay, and your eligible dependent fails to do so which results in a reduction in benefits or total denial of benefits from the "other plan," this Plan will not reimburse you or your eligible dependent for what the "other plan" failed to pay. These reductions or penalties may be for example, flat dollar reductions, or reductions of a percentage of benefits otherwise payable. In addition, if your eligible dependents are covered under an HMO or PPO that is considered the "Primary Plan", they must utilize the providers and facilities required under their plan before the Fund will consider secondary payment.

The important thing to remember is that Coordination of Benefits (COB) is designed for just one purpose: to protect the Plan from unnecessary expenditures that are the responsibility of another insurance plan.

Coordination of Benefits (COB) Definitions

Allowable Expense

Allowable Expense means any necessary Allowable Charge item of expense, at least a part of which is provided by one of the plans that covers the person for whom a Claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Plan

"Plan" refers to any of the following plans that provide full or partial health benefits for services on an insured or self-funded basis:

1. Group, blanket, or franchise insurance;
2. Group Blue Cross, group Blue Shield, group practice, and any other group HMO or prepayment plans;
3. Union welfare plans, employer organization plans, or labor-management trustee plans;
4. Governmental programs or coverages required or provided by law. However, "plan" does not include any governmental program coverage that is not allowed by law to coordinate benefits; and
5. Medicare, Title XVII of the Social Security Act of 1965, as amended to the extent permitted by law.

"Plan" will apply separately:

1. To each policy, contract, agreement, or other plan for benefits or services; and
2. To that part of such policy, contract, agreement, or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

Primary Plan

If a plan is considered "primary," it is responsible for paying benefits first in accordance with its benefits provisions.

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Secondary Plan

If a plan is "secondary," it is responsible for paying benefits if any remain, after the primary plan has paid its share.

Coverage Under More Than One Group Health Plan

Many families have more than one family member working outside the home and are often covered by more than one medical or dental plan. If this is the case with your family, **you must let the Fund Office know about all your coverages.**

Coordination of Benefits operates so that the combination of insurance coverage will be shared fairly in a consistent manner. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the Allowable Charge for the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First – Order of Benefit Determination Rules

This Plan does not coordinate benefit payments with an individual plan (that is, a plan purchased by an individual), whether provided through a policy or, subscriber contract.

Group plans determine the sequence in which they pay benefits, or which plan pays first by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules will be deemed by this Fund to be the primary plan.**

If the first rule does not establish a sequence or order of benefits, the next rule is applied and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an Employee, retiree, member or subscriber (that is, other than as a dependent), pays first, and the plan that covers the same person as a dependent pays second.

There is one exception to this rule. If the person is also a Medicare beneficiary:

1. Medicare is secondary to the plan covering the person as a dependent. However, if the dependent is the retiree's spouse and the retiree's spouse is covered under the Medicare Supplemental Program, Medicare is Primary; and
2. Medicare is primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retiree). However, if the plan covers an individual as an Employee and not a retiree, the plan is primary and Medicare is secondary.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if: (i) the parents are married; (ii) the parents are not separated (whether or not they ever have been married); or (iii) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

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If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word **"birthday"** refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first;
2. The plan of the spouse of the custodial parent pays second;
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

If your eligible dependent child is employed and becomes eligible for other group health coverage, the plan (other than this Plan) under which he/she is an Employee will be considered the primary plan for coverage. This Plan will pay secondary in the coordination of benefit payments.

Rule 3: Active / Laid-Off or Retired Employee

The plan that covers a person either as an active Employee (that is, an Employee who is neither laid-off nor retired), or as that active Employee's dependent pays first; and the plan that covers the same person as a laid-off or retired Employee, or as that laid-off or retired Employee's dependent, pays second. An Employee no longer performing work in Covered Employment or withdraws from the Local and elect to be covered by another insurance program, the "bank of hours" provision of this Plan shall no longer apply and coverage will terminate on the last day of the month for which contributions are paid to the Fund.

If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired Employee under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an Employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

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If a person is covered other than as a dependent (that is, as an Employee, former Employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer / Shorter Length of Coverage

If none of the four previous rules determine the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.

The start of a new plan does not include a change:

1. In the amount or scope of a plan's benefits;
2. In the entity that pays, provides or administers the plan; or
3. From one type of plan to another (such as from a single Employer plan to a multiple Employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that were primary. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each Claim as it is submitted had it been the plan that paid first. This has the effect of maintaining this Plan's copayments, coinsurance, and exclusion provisions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

Administration of COB

To administer COB, the Plan reserves the right to:

1. Exchange information with other plans involved in paying Claims.
2. Require that you or your health care provider furnish any necessary information.
3. Reimburse any plan that made payments this Plan should have made.
4. Recover any overpayment from your Hospital, Physician, Dentist, other health care provider, other insurance company, you or your eligible dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a Claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

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If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained outside of an exclusive network of providers, like an HMO, or otherwise reduced by a noncompliance penalty, this Plan will only consider such charges after reducing such charges by what the primary plan would have paid if not reduced by such penalties.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or it always applies the "Gender Rule" in lieu of the "Birthday Rule", or because it does not use the same order of benefit determination rules as this Plan, this Plan may pay one-half of the benefits it would have paid had it been the primary plan expecting the other plan to pay the other half of the expenses.

Coordination of Benefits With Medicare and Other Government Programs

Medicare

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

If you, your eligible dependent spouse and/or your eligible dependent child are covered by this Plan and by Medicare, and you remain actively employed, your health care coverage will continue to provide the same benefits and this Plan pays first and Medicare pays second.

If you cancel your coverage under this Plan, coverage of your eligible dependent spouse and/or your eligible dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. **Refer to Section 9 for further information about COBRA Continuation Coverage.**

If you become totally disabled and entitled to Medicare because of your disability, you will continue to maintain your active coverage until you run out your bank of hours. You will then have the option to either continue coverage under COBRA or if eligible, enroll in the Retiree Medicare Supplemental Program.

If you are covered under Medicare and elect the Retiree Medical Supplemental Program, Medicare pays first and the Plan pays second.

If while you are actively employed, you or any of your eligible dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first, and Medicare pays second for 30 months starting the **earlier** of: (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

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Medicare Advantage Programs

If you choose a Medicare Advantage Program (also referred as Medicare Part C, Medical Replacement Program, or Medicare Risk Program), you agree that no Claim will be submitted to or paid by Medicare for health care services and/or supplies. If you enter into a Medicare Advantage Program you are **not** eligible to participate in the Retiree Medicare Supplemental Program. There is **no** Coordination of Benefits between this plan and a Medicare Advantage Program.

Medicaid

For purposes of coordinating with Medicaid, this Plan will assume primary payor status for any Covered Person 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 Covered Person will be made in accordance with any assignment of rights made by or on behalf of such Covered Person as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If this 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 Covered Person 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.

Veterans Affairs Facility Services

If a Covered Person receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan.

If a Covered Person receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related Illness or Injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowable Charges.

Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Motor Vehicle No-fault Coverage Required by Law

If you or your eligible dependent is involved in an automobile accident and you are required by state law to have basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical, surgical, Hospital, and related charges.

Regardless of whether this Plan is primary or secondary, you or your eligible dependent (if an adult), must sign a Reimbursement Agreement (refer to Section 8) before any Claims relating to the accident will be paid. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

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Coordination of Benefits with Medicare for Active Employees

If you or your eligible dependent spouse are age 65 or older, you are generally eligible for insurance benefits under Title XVIII of the Social Security Act of 1965 (Medicare). You do not have to be retired to receive these benefits. Medicare includes Hospital insurance benefits (Part "A"), supplementary medical insurance (Part "B") and prescription drug coverage (Plan D) administered by pharmacy benefit managers. While you remain eligible for active insurance coverage regardless of your age, you will receive the same benefits from the Fund as an eligible Participant under age 65. Medicare will provide secondary coverage for some care, if the Fund does not pay the full cost. In technical terms, the Fund is "primary" (pays first) for your covered medical and Hospital expenses, while Medicare is "secondary" (pays second).

If a Claim is incurred by an eligible dependent covered by Medicare while you maintain active eligibility, the Fund is "primary" (pays first) and Medicare is "secondary" (pays second).

Coverage for Disabled Participants or Participants' Disabled Dependents

If you or one of your eligible dependents, while under age 65, are entitled to Medicare benefits: (1) solely because you or one of your eligible dependents are in the first 30 months of end-stage renal disease (ESRD) care; or (2) solely on the basis of a total and permanent disability (except ESRD), as defined by the Social Security Administration, this Plan will be primary for meeting your medical expenses, provided you are covered under this Plan as an active Participant or as an eligible dependent of an active Participant, Medicare will provide coverage on a secondary basis. Therefore, any Covered Charges should be submitted to this Plan for payment. Afterwards, any unpaid balance should be submitted to Medicare for consideration.

Medicare Enrollment

If you are an active Participant, Part A Coverage under Medicare is not automatic when you reach age 65 unless you have applied for Social Security Benefits. Since Part A coverage is not automatic, you and your spouse MUST register with Social Security for Part A when you reach age 65. You do not have to apply for Social Security payments (that is, actually retire), but you must apply and establish your entitlement to such benefits in order to be covered by Medicare.

You should also enroll in Part B during the seven-month period beginning three months before and ending three months after your 65th birthday. Failure to apply for Medicare coverage under Part B when you are eligible to do so could result in a higher cost to you for Medicare Part B Coverage when you finally apply. You should contact the Social Security Administration when you are approaching age 65 to obtain enrollment information specific to your situation.

Retirees, please disregard this section and refer to Retiree Benefits, Section 24, for information.

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8. THIRD PARTY LIABILITY AND RIGHT OF REIMBURSEMENT

Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover nor is it liable for any charges or expenses incurred by a participant, his or her parent(s) and eligible dependent(s) or a representative, guardian or trustee of the participant, parent(s) or eligible dependent(s) (hereinafter, collectively "claimant") as a result of an accident or Injury for which one or more third parties (any person or entity) are or may be liable. The Plan is also not liable for any disability income payments if the disability is the result of an accident or Injury for which one or more third parties may be legally liable. Refer to Section 22 for limitations and exclusions. However, subject to the terms and conditions of this section, the Board of Trustees, at their discretion, may advance payment for some or all of a claimant's expenses, and may provide the Participant with disability income payments (if the Participant qualifies) after receipt of a properly executed Reimbursement Agreement and Consent to Lien. In addition, acknowledgement of the Agreement must be provided to the Fund Office by the claimant's attorney. The Reimbursement Agreement and Consent to Lien, and Acknowledgement must be executed without alteration or any other condition.

Where the Plan has made payments for an Injury, irrespective of any signed written agreement, the Plan will have the right to recover from the Participant the full amount of benefits paid without deductions or adjustments of any kind if the claimant obtains any settlement, judgment, arbitration or recovery from a third party or from any insurance provider or other source. In such event, the Plan will have a first lien on any such recovery and must be promptly reimbursed in full within 30 days or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant will first reimburse the Fund out of any recovery before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been or may be provided to the Claimant.

As noted above, the Plan has the right to recover the full amount of benefits paid by the Plan, without deductions or adjustments of any kind. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Plan's lien is not reduced by any such attorney's fees. Regardless of the sufficiency of any recovery, the Plan is not subject to any state law doctrines, including but not limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a Participant's attorney's fees and costs. The Plan is also not subject to the make whole doctrine or other similar doctrines which purport to subject the Plan's recovery to the claimant's full compensation for all of his injuries.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, the Fund will also have the right to withhold future benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection including attorneys' fees.

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Reimbursement and Consent to Lien

Every claimant, on whose behalf an advance may be payable, must execute and deliver to the Fund a Reimbursement Agreement and Consent to Lien in the form provided without alteration. Claimants must do whatever is necessary to protect the Fund in obtaining reimbursement and/or it's subrogation rights. Each such claimant must promptly notify the Fund Office if he or she makes a claim or brings an action against a third party.

If any claimant does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's reimbursement rights if the Fund at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement agreement.

The Fund's standard administrative procedure will be to determine whether a third party might potentially be held liable in connection with an accident or Injury. Claims will not be paid until this determination is made. If it is determined that the Claim may be the result of a third party's negligence, or other misconduct, the Fund will not process any Claims without a properly signed Reimbursement Agreement and Consent to Lien along with acknowledgement by the claimant's attorney, both executed without alteration or other condition.

Cooperation with the Plan by All Covered Persons

By accepting an advance for related Claim payment, every claimant agrees to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Fund's reimbursement rights.

By accepting an advance payment for related Claims to an Injury, every claimant agrees to notify and consult with the Board of Trustees, its Fund Office or designee before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's Injury that resulted in the Fund's advance payment of Claims; or
- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's Injury that resulted in the Fund's advance for Claims related to such Injury.

By accepting an advance in Claim payments, every claimant agrees to keep the Board of Trustees, its Fund Office or designee, informed of all material developments with respect to all such Claims, actions, or proceedings.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

By accepting an advance payment of Claims for an Injury, every claimant agrees to reimburse the Fund for all such advances, by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement, judgment, arbitration or recovery or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Fund. The Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or

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adjustments of any kind including attorney's fees. In such event, the Fund must be fully reimbursed within 30 days of the date proceeds are received by the claimant or his attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Fund may offset future Claims/benefits in order to receive the full amount of benefits paid if full reimbursement is not made.

If any Covered Person fails to reimburse the Fund as required, the Fund will apply any future Claims for benefits that may become payable on behalf of the claimant to the amount not reimbursed. The amount of the offset to future Claims will be based on the charges incurred not the discounted amount paid by the Fund through its PPO network. For example, if you incurred a $20,000 hospital bill, but Anthem's contractual discount was 50% and the Health Fund paid $10,000, your liability will be based on the $20,000 of charges.

Once a Claim is settled, the Fund will not pay future benefits for Claims related to the Injury or accident under Workers Compensation but may consider future benefits not related to Workers Compensation if it is determined by the Board of Trustees that the original settlement was reasonable and the subsequent Claims were not recognized in the settlement.

THIS HEALTH FUND IS A SELF-INSURED EMPLOYEE WELFARE BENEFIT PLAN AND THEREFORE, ERISA PREEMPTS ANY STATE LAW PURPORTING TO RESTRICT THE HEALTH FUND'S RIGHTS UNDER THIS PROVISION. FURTHERMORE, ANY STATE LAW DIRECTED AT INSURANCE COMPANIES SHALL NOT APPLY TO THE HEALTH FUND SINCE IT IS SELF-INSURED.

No-Fault Insurance Coverage

Where the Participant or eligible dependent is involved in a motor vehicle accident covered by a no-fault insurance policy whether or not required by state insurance law, the automobile no-fault insurance carrier will initially be liable for lost wages, medical, surgical, Hospital, and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related Claims will be paid through the Fund, the Participant or his eligible dependent will be required to sign a Reimbursement Agreement.

If the Participant or his eligible dependent fails to secure no-fault insurance as required by state law, the Participant or eligible dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his eligible dependents arising out of the accident.

Refund of Overpayment of Benefits - Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your eligible dependent, you or any other person or organization that was paid must make a refund to the Fund if:

- All or some of the expenses were not paid, or did not legally have to be paid by you or your eligible dependents;
- All or some of the payment made by the Fund exceeds the benefits under the Plan; or

- All or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions. This may include payments made as a result of Claims against a third party for negligence, wrongful acts, or omissions.

The refund will equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Fund may have other rights in addition to the right to reduce future benefits.

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9. COBRA CONTINUATION COVERAGE (SELF-PAYMENT)

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your eligible dependent spouse, and your eligible 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 make monthly self-payments to purchase COBRA continuation coverage.

If you are a Participant, you will become a "qualified beneficiary" if you lose your coverage under the Plan because either one of the following qualifying events happens:

- You lose eligibility under the Plan due to a reduction in work hours; or
- You are no longer performing work in Covered Employment or withdraw from the Local and elect to be covered by another insurance program, the "bank of hours" provision of this Plan shall no longer apply and coverage will terminate on the last day of the month for which contributions are paid to the Fund, or
- Your employment ends for any reason other than your gross misconduct and the bank of hours is exhausted resulting in the loss of eligibility.

If you are the spouse of a Participant, you will become a "qualified beneficiary" if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse experiences a reduction in work hours, which causes a loss of eligibility under this Plan;
- Your spouse's employment ends for any reason other than his or her gross misconduct and the bank of hours is exhausted resulting in the loss of eligibility;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The Participant (parent) dies;
- The Participant (parent) experiences a reduction in work hours, which causes a loss of eligibility under this Plan;

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- The Participant's (parent's) employment ends for any reason other than his or her gross misconduct and the bank of hours is exhausted or eliminated resulting in the loss of eligibility;
- The Participant (parent) becomes entitled to Medicare benefits (Part A, Part B, or both);
- The Participant and spouse become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an eligible dependent upon attaining age 26.

Qualified Beneficiaries

A "qualified beneficiary" under COBRA is any Participant or eligible dependent who on the day before the qualifying event has coverage under the Plan, would otherwise lose such coverage due to the qualifying event and timely elects to receive COBRA coverage, as well as any eligible dependent child who is born to or placed for adoption with a Participant during the period of COBRA coverage.

If a qualified beneficiary with COBRA coverage acquires an eligible dependent, the eligible dependent may be added to coverage for the remainder of the COBRA coverage period. If a qualified beneficiary has a dependent who was eligible but not enrolled in the Plan at the time the qualified beneficiary enrolled for COBRA coverage because the dependent had other group health coverage at that time, and the dependent loses the other coverage due to exhaustion of COBRA coverage, the qualified beneficiary may add the dependent to his or her coverage for the remainder of the COBRA coverage period within 30 days after the dependent's loss of the other coverage. You may also add a dependent as a qualified beneficiary due to birth or adoption of a child during the COBRA coverage period. Of course, adding a dependent to your coverage may cause an increase in your COBRA premiums.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has determined or been notified that a qualifying event has occurred:

- The Participant experiences a reduction in work hours that causes a loss of eligibility under the Plan;
- The Participant's employment ends for any reason other than gross misconduct and the bank of hours is exhausted resulting in the loss of eligibility under the Plan;
- The Participant dies; or
- The Participant becomes entitled to Medicare benefits (Part A, Part B, or both).

YOU MUST GIVE NOTICE TO THE FUND OFFICE OF CERTAIN QUALIFYING EVENTS

You are responsible for providing the Fund Office with timely notice of the following qualifying events:

- **The divorce or legal separation of a Participant from his or her spouse;**
- A beneficiary ceasing to be covered under the Plan as an **eligible dependent child of a Participant (attains age 26);**

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- The occurrence of a "second qualifying event" after a qualified beneficiary previously became entitled to COBRA with a maximum duration of 18 (or 29) months. This second qualifying event could include a Participant's death, entitlement to Medicare, divorce or legal separation or child losing eligible dependent status. (More information about second qualifying events is provided later in this section.);
- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18-month maximum coverage period for a total of 29 months of COBRA coverage; and
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You are responsible for notifying the Fund Office of any of the previously listed events. Failure to provide the proper notice within the required following timeframes may prevent you from obtaining or extending COBRA coverage.

The Fund Office will determine whether a qualifying event has occurred. However, you should promptly notify the Fund Office of any of these qualifying events. This will allow the Fund Office to process your continuation of coverage election efficiently and with little or no interruption in the handling of your Claims.

Procedures for Notifying the Plan of COBRA Qualifying Events

To notify the Fund Office of these qualifying events, a "qualified beneficiary" can send a notice via U.S. First Class mail, fax or email to request to continue coverage **within the later of: 60 days from the date of the qualifying event or the date coverage was lost under the Plan due to the qualifying event.** The notice must be in a form that documents the date sent (e.g., if sending by mail, the request must be postmarked no later than 60 days after the date described above). In the event of divorce or legal separation, you must also submit a copy of the divorce decree or written proof of the legal separation. In the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security disability determination.

If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event.

Notice of a Social Security disability determination must be submitted to the Fund Office before the end of the first 18 months of the COBRA continuation coverage.

If you are providing notice of a Social Security Administration determination that a qualified beneficiary is no longer disabled, the notice must be postmarked no later than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

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Notice may be provided by the Participant or qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the Participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

Address to Notify Plan Administrator of Qualifying Event

Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Attn: COBRA Administrator

You may also fax your notification to the following number: (860) 571-9221.

How is COBRA Coverage Provided?

Once the Fund Office determines or 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.

When the qualifying event is the death of the Participant, and the Participant becomes entitled to Medicare benefits (under Part A, Part B, or both), the Participant and spouse's divorce or legal separation, or a dependent child's losing eligibility as an eligible dependent child, COBRA continuation coverage lasts for up to a total of 36 months for eligible dependents who are qualified beneficiaries. When the qualifying event is the end of employment or reduction of the Participant's hours of employment and the Participant became entitled to Medicare benefits less than 18 months before the loss of coverage caused by the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement.

For example, if a Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months, minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage**

   If you or anyone in your family covered under this Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total 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 original period of continuation coverage.

2. **Second qualifying event extension of 18-month period of continuation coverage**

   If your family experiences another qualifying event (a "second qualifying event") while receiving 18 months of COBRA continuation coverage (or 29 months if disabled), the eligible dependents in your family who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage (7 months if disabled) for a maximum of 36 months, if timely notice of the second qualifying event is properly given to the Fund Office. This extension may be available to any eligible dependents (if they are qualified beneficiaries) receiving continuation coverage if the Participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as an eligible dependent child.

Qualifying Events and Maximum Periods of Continuation of Coverage

Coverage may continue on a self-pay basis as follows:

Qualifying Event	Participant	Spouse	Dependent Child(ren)
(a) Participant terminated *(for other than gross misconduct)*	18 months	18 months	18 months
(b) Participant reduction in work hours (making Participant ineligible for the same coverage)	18 months	18 months	18 months
(c) Participant dies	N/A	36 months	36 months
(d) Participant becomes divorced or legally separated	N/A	36 months	36 months
(e) Participant becomes entitled to Medicare	N/A	36 months	36 months
(f) Dependent child ceases to have Eligible Dependent status	N/A	N/A	36 months
(g) Disability as certified by Social Security Administration of any COBRA covered beneficiary	29 months	29 months	29 months

Self-Payment for COBRA Coverage

You and/or your eligible dependents that elect to continue coverage will be solely responsible for the payment of the monthly self-payment for the continued coverage. If an election is made after the qualifying event, the monthly self-payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the monthly self-payment may be paid in monthly installments within 30 days after the first of the month in which insurance coverage is provided (i.e., the "due date").

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OTHER THAN THE FIRST PAYMENT, UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE SELF-PAYMENT TO THE HEALTH FUND BE PERMITTED ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION. FAILURE TO MAKE THE MONTHLY SELF-PAYMENT WHEN DUE, WILL RESULT IN THE IMMEDIATE TERMINATION OF YOUR COVERAGE WITHOUT ANY PROVISION FOR REINSTATEMENT.

The Fund assumes no responsibility or liability if you voluntarily allow your eligibility for benefits to terminate. If you have any reason to believe that your eligibility will be or has been terminated, you should contact the Fund Office as soon as possible to verify your eligibility status.

The Board of Trustees will set the monthly self-payment rates according to federal law, which allows the monthly self-payment to be set at a level not to exceed the full expected average group cost of such benefits, plus a 2% charge for administrative expenses. If the cost changes, as approved by the Board of Trustees, the Fund Office will revise the monthly self-payment rates (not more frequently than once in a 12-month period), you are required to pay. In addition, if the benefits change for active Participants, your coverage will change as well and the self-pay rates will also change.

More details of COBRA continuation coverage will be furnished to you and your eligible dependents when the Fund Office receives notice that one of the qualifying events has occurred. Therefore, we urge you and your eligible dependents to contact the Fund Office as soon as possible after one of those events.

After an election is made regarding COBRA coverage, no change will be allowed in the level of coverage for the duration of the continuation period.

You have the right to elect self-payment COBRA only for the coverage (plan of benefits) you were receiving or entitled to prior to the termination of eligibility.

Self-Payment Benefit Options

If you choose to continue your coverage, the Fund will give you the option to elect either:

- The same full plan of benefits that is being provided to active Participants and eligible dependents, with the exception that Life Insurance and Weekly Disability Income Benefit are reduced (this is referred to as "Core Plus Non-Core Benefits" or Plan B); or
- A partial plan of benefits for you and/or your eligible dependents, which includes the Medical and Prescription Drug Benefits only. Life Insurance, Accidental Death and Dismemberment, Weekly Disability Income Benefit, Dental, Hearing, and Vision Benefits are EXCLUDED (this is referred to as "Core Benefits" or Plan A).

You can only elect a continuation of the coverage you had previously as an active Participant. You cannot elect Non-Core Benefits independently from basic Core Benefits (medical and prescription drug).

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Plan A - Core Benefits	
Hospital/Medical Expense Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Prescription Drug Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Plan B - Core Plus Non-Core Benefits	
Life Insurance	$10,000
Accidental Death and Dismemberment	$15,000
Weekly Disability Income Benefits	$300 per week, up to a maximum of 26 weeks
Hospital/Medical Expense Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Prescription Drug Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Dental/Orthodontic Expense Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Vision Expense Benefits	Same benefits as those for Active Participants and their Eligible Dependents
Hearing Care Benefit	Same benefits as those for Active Participants and their Eligible Dependents

Termination of COBRA Coverage

Coverage under COBRA will cease on the first of the following dates:

The first of the month you have satisfied the eligibility provisions and have reestablished coverage in the Plan.

- The date the required monthly premium is due and unpaid. (i.e., if payment is not received within 30 days after the first of the month in which coverage is provided)
- The date, after COBRA coverage is elected, on which you and/or your eligible dependents first become covered under Medicare;
- The date, after COBRA coverage is elected, on which you and/or your eligible dependents first become covered under another group health plan;
- The date the applicable period of continuation coverage is exhausted (18, 29, or 36 months);
- The date the Plan terminates; or
- The date the Employer that you worked for before the qualifying event stops contributing to the Plan and:
  - The Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered by this Plan; or
  - The Employer starts contributing to another multiemployer plan that is a group health plan.

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If you retire and run out your bank of hours, you may elect retiree coverage, if eligible (refer to Section 24) or you will be permitted to make COBRA self-payments upon the expiration of your active eligibility.

Upon your retirement, if you are collecting a monthly pension from the Connecticut Plumbers and Pipefitters Pension Fund and are eligible for retiree benefits from the Fund, when you run out your bank of hours, you will be given a choice to receive retiree benefits or COBRA continuation. If you elect COBRA self-payments in lieu of participating in the retiree plan, you will be prevented from participating in the retiree plan at a later date. If you are continuing your coverage by making COBRA self-payments and then retire, you will be given the opportunity to participate in the retiree plan, provided all of the other conditions have been satisfied as set forth in Section 24.

Early Termination of COBRA Coverage

If your COBRA coverage will terminate before the end of the maximum coverage period, the Plan will send you a written notice as soon as practicable following the Plan's determination that COBRA coverage will terminate. The notice will set out why COBRA coverage will be terminated early, the date of termination, and your rights if any, to alternative individual or group coverage.

General Information

Continuation of coverage is optional for you and your eligible dependents. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA coverage. For example, both the Participant and the Participant's spouse may elect COBRA continuation coverage, either together as family coverage or independently as single coverage.

If you waive COBRA coverage during the 60-day election period, you may revoke the waiver and elect COBRA coverage at any time during the 60-day election period; however, COBRA coverage will be provided only from the date of revocation and not retroactive to the loss of coverage.

If you or your eligible dependents provide notice to the Fund Office of your divorce, a Dependent ceasing to be covered under the Plan as an eligible dependent, or a second qualifying event, but you are not entitled to COBRA coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA coverage.

Keep the Fund Office Informed of a Change to Your Address

In order to protect your family's rights, you should keep the Fund Office informed of the current addresses of all covered persons under the Plan who are or may become qualified beneficiaries. You should also keep copies for your records, of any notices you send to the Plan. **Please send any change of address to the Fund Office with a copy of a photo I. D.**

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Plan Contact Information

Information about the Plan and COBRA coverage can be obtain upon request from:

Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Phone: (860) 571-9191
Toll Free: (800) 848-2129

Unavailability of Coverage

If you provide notice to the Fund Office of a qualifying event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Optional Health Care Coverage

The Affordable Care Act provides you with an alternative to employer-sponsored health care coverage and COBRA continuation coverage—the Health Insurance Marketplace (the "Marketplace"). The Marketplace offers health insurance options (called qualified health plans), which include comprehensive health care coverage, including Physician and Hospital-based services, as well as medications. Qualified health plans in the Marketplace present their price and benefit information in simple terms so that you can make apples-to-apples comparisons. For more information about obtaining coverage through the Marketplace, visit www.healthcare.gov, contact EBSA electronically at www.askebsa.dol.gov, or call the HealthCare.gov Help Line at (800) 318-2596.

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10. WORKERS' COMPENSATION BENEFITS

Medical expenses covered by the Fund are for services and supplies received for the treatment of **non-occupational** bodily Injuries and Illnesses. If you incur a work-related Injury or Illness (one which arises out of or in connection with your employment), your Claim for any medical expenses arising out of or in connection with that Injury or Illness must be submitted through your Employer for Workers' Compensation coverage. No benefits are payable by the Fund for such medical expenses unless the Workers' Compensation Commissioner determined that the underlying Injury or Illness is not compensable. Plan provisions will apply in all circumstances where Workers' Compensation insurance is required including individuals that are self-employed.

However, if you have been notified that your Employer is contesting liability for your Workers' Compensation Claim and the Fund has received a formal Notice to Contest Liability from your Employer or its Workers' Compensation insurance carrier, the Fund may, at its sole discretion, pay Hospital and/or medical expenses connected to a claimed work-related Injury or Illness, pending a formal ruling of the Workers' Compensation Commissioner. (The Fund will not pay Weekly Disability Income Benefits.) In any event, before payment for medical expenses arising out of or in connection with a claimed Workers' Compensation Injury will be advanced by the Fund, you will be required to sign a Reimbursement Agreement and Consent to Lien (refer to Section 8). In order for the Fund to consider exercising its discretion to advance payment for Hospital or medical expenses connected to a claimed Workers' Compensation Injury, the Notice to Contest Liability must challenge liability for the underlying Illness or Injury, and not just for particular Hospital or medical expenses that are contested by your Employer or its Workers' Compensation insurance carrier for one reason or another. In other words, the Fund will not advance payment for Hospital or medical expenses connected to a work-related Injury or Illness simply because your Employer or its Workers' Compensation carrier has contested certain specific Hospital or medical expenses.

Although charges relating to an occupational Injury or Illness must be submitted to Workers' Compensation; the Life Insurance and other health benefits will continue for you and your eligible dependents for charges incurred due to non-occupational accidental bodily injuries or Illnesses, as long as you maintain eligibility.

Where a Claim for Workers' Compensation is settled by stipulation or agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid by the Fund in error, you must reimburse the Fund for any payments to you or your eligible dependents or providers, and all costs of collection, including attorney's fees and court costs. Failure to reimburse the Fund in full for all Claims and benefits paid by the Fund determined to be work related will be pursued legally by the Fund to recover all benefits paid that were work related along with all legal and court costs. In addition, any amounts considered an overpayment by the Fund will be used as an offset against future Claim and benefit payments.

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11. LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (FOR ELIGIBLE PARTICIPANTS)

Life Insurance

In the event of your death from any cause while you are an insured Participant—on or off the job—life insurance benefits are paid to your named beneficiary. The Life Insurance benefit shown on the Schedule of Benefits is provided by an insurance company retained by the Board of Trustees

Accidental Death and Dismemberment

Accidental Death and Dismemberment benefits are payable, provided the insurance company retained by the Board of Trustees receives written proof within 90 days after the date of the Injury that the loss occurred as a result of an accidental bodily Injury and independently of all other causes and occurrences.

Loss	Benefit
• Loss of Life	Full Principal Sum shown in the Schedule of Benefits
• Loss of two limbs, sight of both eyes, or loss of one limb and sight of one eye	Full Principal Sum shown in the Schedule of Benefits
• Loss of one limb or sight of one eye	One-half the Principal Sum shown in the Schedule of Benefits

Loss of limb means complete severance at or above the wrist or ankle joint.
Loss of sight means the total and irrecoverable loss of sight.

If more than one of the losses set forth above is suffered as a result of any one accident, not more than the full amount of Accidental Death and Dismemberment benefits will be payable.

Beneficiary

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper form and filing it with the Fund Office. If a beneficiary is designated, that beneficiary's consent is not required to change to another beneficiary. If your beneficiary predeceases you, such beneficiary's interest will automatically terminate. If you name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries. If there is a court order that requires the Participant to name a specific beneficiary, such order will only be recognized if on file at the Fund Office at the time of death. If there is no living beneficiary when you die, the insurance company will make the payment to your surviving spouse; if none, to your surviving children in equal shares; if none, to surviving parents in equal shares; and if none, to your surviving brothers and sisters in equal shares; and if none, to your estate. However, the insurance company at their discretion if no named beneficiary is on file, has the option to make the payment to the administrators of your estate.

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Facility of Payment

If you die and your estate is the beneficiary, but no administrator on your estate has been appointed within a reasonable period of time following your death, or your eligible dependent is not legally capable of giving a valid receipt for a benefit payment, the Fund and/or the insurance company have the right (if no legal guardian is appointed) to pay the party it believes is entitled to such payment by reason of having incurred funeral or other expenses incident to the last Illness or death of the claimant. Payment will not exceed the amount allowed by state law. Once such a payment is made, the Fund and/or insurance company has no further obligation with respect to the amount paid.

Termination of Coverage

When your coverage terminates in accordance with the termination of eligibility rules of the Plan as described in Section 1 of this booklet, your Life Insurance and Accidental Death and Dismemberment benefits will cease.

There is no cash value to either the Life Insurance benefit or the Accidental Death and Dismemberment benefit.

Conversion Privilege

If your eligibility for benefits under the Plan terminates, you will have the opportunity to convert your Life Insurance to an individual policy. You must notify the Fund Office immediately because your rights to convert the policy end 31 days after your coverage under the Plan terminates. There are additional limitations and exclusions that apply, so you should check with the Fund Office for more information.

Assignment

You may not assign your Life Insurance benefits. This means you may not give or transfer your Life Insurance offered through this Plan to any other person.

Limitations and Exclusions

No payment will be made for death or any loss under the Accidental Death and Dismemberment benefits resulting from or caused directly, wholly, or partly by:

1. Bodily or mental infirmity, ptomaines, bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound), or disease or Illness of any kind;
2. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22;
3. Suicide or attempted suicide while sane or insane;
4. Intentionally self-inflicted Injury;
5. Insurrection, act of war for any country;
6. Injury or death during service in the armed forces of any country while such country is engaged in war;
7. Participation in, or as a result of participation in a felony;

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8. Travel or flight as pilot or crew member in any kind of aircraft including, but not limited to a glider, a seaplane, or a hang kite;
9. Travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the Policyholder, a participating Employer or the armed forces; or being operated for any training or instructional purpose;
10. Parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activities except as a fare paying passenger on a commercial aircraft;
11. Voluntary use of controlled substances as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a Physician for the person; or
12. Driving while intoxicated as defined by applicable state law.

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12. WEEKLY DISABILITY INCOME BENEFITS (NON-WORK RELATED) – FOR ELIGIBLE PARTICIPANTS ONLY

If, while maintaining active eligibility and otherwise available for work in Covered Employment, you become Totally Disabled, unable to work, and are under the continuous care of a Physician legally licensed to practice medicine, you will receive the Weekly Disability Income benefits shown in the Schedule of Benefits, provided your total disability is the result of:

- Any Injury **not** arising out of or in the course of employment; or
- Any Illness or disease **not** entitling you to benefits under any Workers' Compensation, occupational disease law, or similar legislation.

However, if you are involved in a motor vehicle accident to which no-fault insurance applies, Weekly Disability Income benefits from the Fund will not be payable for any week for which weekly indemnity is paid or payable under the applicable no-fault insurance law. If the no-fault loss of wages benefit is less than $550 per week, the Fund will pay the difference. Any such payments will be counted towards the 26-week maximum.

No benefits are payable during periods when you are collecting unemployment benefits.

Once you begin collecting a pension from a retirement plan sponsored by Local No. 777 (Connecticut Plumbers and Pipefitters Pension Fund or Plumbers and Pipefitters National Pension Fund), you are not eligible and therefore cannot collect Weekly Disability Income benefits, even though you may continue to be eligible for benefits under the Health Plan until your bank of hours runs out. If you receive both a monthly pension and Weekly Disability Income benefits for the same time period, you are liable and required to repay any such Weekly Disability Income payments to the Fund.

These benefits will commence on the **first day of disability due to Injury** and on the **eighth day due to an Illness** and will continue while you remain totally disabled for a maximum of 26 weeks for any one continuous period of disability due to the same or related cause(s). During your disability period, the Fund will credit 32.5 hours per week to your bank of hours as if you worked in Covered Employment, up to a maximum of 26 weeks. While you are disabled, the Fund will also deduct 130 hours from your bank of hours each month in accordance with the continued eligibility rules of the Fund. If you continue to be disabled after 26 weeks, the Fund will continue deducting hours from your bank (if any) to maintain your coverage. In the event your bank of hours is exhausted before you can return to work, you will be offered COBRA self-pay coverage for a limited period of time.

The Trustees reserve the right, as a condition of continued receipt of Weekly Disability Income Benefits, to require you to be examined by any independent physician, selected and paid for by the Fund.

Successive Disabilities

Separate periods of disability, resulting from the same or related causes, will be deemed one period of disability unless separated by your return to work in Covered Employment for at least two (2) consecutive weeks (80 hours during consecutive work weeks). Separate periods of disability resulting from unrelated causes will be deemed one period of disability unless separated by your return to active Covered Employment for at least one (1) full day. In addition, Weekly Disability Income benefits are limited to a maximum of fifty-two (52) weeks in any one hundred and four (104) consecutive week period.

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Limitations and Exclusions

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a Physician. No benefits are payable for:

1. Any day you are not under the care of a Physician. It is understood that no disability will be considered to have started until you have been treated personally by a Physician;
2. Any day you are receiving compensation or performing work of any kind, anywhere, for compensation or profit;
3. Any day you are released by your Physician to engage in work of any kind;
4. A disability due to accidental bodily Injuries arising out of and in the course of your employment;
5. Those days for which you are receiving compensation for lost wages from automobile reparation (no-fault) insurance or its equivalent, Workers' Compensation, Unemployment Compensation, or any company-sponsored retirement plan;
6. Any day immediately following a request for an independent examination selected and paid for by the Fund to verify the nature and extent of your disability which you refuse; or
7. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22.

Note: Payments received under this benefit are considered taxable income and must be reported on your federal, state or any other applicable income tax returns. The Fund Office will arrange to have taxes withheld from your disability payments upon your request. The Fund will deduct the FICA tax on your behalf and pay it to the appropriate government agency.

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13. IN-NETWORK AND OUT-OF-NETWORK MEDICAL BENEFITS

You and your eligible dependents may obtain health care services from an in-network Anthem Blue Cross/Blue Shield Provider or an out of-network health care provider. The in-network PPO benefits are not available to retirees or their eligible dependents who are eligible for and/or receiving Medicare Benefits.

IN-NETWORK BENEFITS

The Fund has contracted with Anthem Blue Cross and Blue Shield (Anthem) to utilize its Preferred Provider Organization (PPO) network to provide services at a favorable negotiated discounted fee. Covered Persons who elect to utilize the Anthem PPO network of quality Hospitals, Physicians, medical laboratories and other providers receive enhanced benefits in consideration of the Fund receiving negotiated discounted fees.

When you use the services of an Anthem network health care provider for any Medically Necessary services, you are responsible only for paying the applicable copayment. You do not need to meet a deductible or pay an additional coinsurance. The copayment varies depending upon the type of care you receive, as shown in the Schedule of Benefits. In addition, because the Fund has an agreement with Anthem Blue Cross and Blue Shield, its PPO network providers are prohibited from balance billing you for covered services in excess of their contractual discounted fee with the Fund.

To locate an Anthem PPO network provider, you may use the online provider directory at www.anthem.com, or you can contact customer service at the toll-free number listed on your identification card. The Fund Office can also assist you in providing a listing of network providers in your area.

Anthem's Website

We encourage you to visit Anthem's internet site at www.anthem.com. The website has a host of information available and can assist you in finding a network physician among other features. To locate an Anthem network provider, you may use the online provider directory at www.anthem.com. Anthem preferred provider network listings are available on their website.

Annual Out-of-Pocket Maximum for In-Network Medical Services Only

The amount of **out-of-pocket** medical expenses you are responsible for paying each calendar year before the Fund pays 100% of most (but not necessarily all) of your in-network Covered Charges is $1,500. There is a separate annual out-of-pocket maximum for prescription drugs.

Once you (or one of your family members) have reached $1,500 of in-network out-of-pocket hospital and medical expenses, the Plan will pay 100% of the in-network medical expenses you incur for the balance of the calendar year. This provision does not apply to Medicare retirees and does not include Dental, Hearing or Vision benefits. There is a separate annual out-of-pocket maximum for Prescription Drug Benefit. Individuals that have a severe Injury or ongoing Illness are financially protected from catastrophic out-of-pocket expenses, provided they use in-network providers.

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Expenses Not Subject to the Out-of-Pocket Maximum

There are expenses for medical services and supplies that you are always responsible for paying yourself. Under the Plan, each year you will be responsible for paying the following out of your own pocket:

- Copayments for hospital, medical, dental, vision, hearing, and prescription drugs;
- Any out-of-network deductibles and coinsurance;
- All expenses for medical services or supplies that are not covered by the Fund;
- All charges in excess of the Allowable Charges for out-of-network medical and dental services, determined by the Fund;
- All charges in excess of any other limitation of the Plan; and
- Any additional coinsurance applicable because you failed to comply with the Fund's Utilization Review Program.

Out-of-Pocket Maximum When You Do Not Comply with the Utilization Review Program:

If you are required to pay a greater coinsurance amount because you or any of your eligible dependents failed to comply with the Fund's Utilization Review Program (refer to Section 21), the excess coinsurance amount or noncompliance penalty you are required to pay will not count toward the annual out-of-pocket maximum.

No Copayment for Routine Physical Examinations and Related Laboratory Charges

There are no copayments or out-of-pocket expenses for routine in-network physical examinations. In addition, there are no copayments for laboratory tests associated with a routine examination. Refer to Section 14, Covered Medical Expenses, for a complete list of Preventive Services benefits provided at no cost when obtained in-network.

Physician Office Visits, Laboratory Services, and X-rays - $20 Copayment

You are only required to pay a $20 copayment for an office visit with a Physician participating in the Anthem PPO network. The remaining cost of the charges covered will be paid for by the Fund. The $20 copayment applies to all services customarily performed in a Physician office setting. A $20 copayment will also apply when you have laboratory services or x-rays ordered by your Physician performed at a participating laboratory when charges are less than $2,000, not part of a routine examination.

Your $20 in-network Physician office visit copayment will accumulate towards your annual out-of-pocket maximum.

You may be requested to pay the copayment at the time of your Physician office visit. An Anthem in-network provider will submit Claims directly. If, however, you utilize an out-of-network provider, it is your responsibility to submit a completed Claim form before any reimbursement can be made to you or assigned directly to the provider.

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Inpatient Hospital Admissions - $500 Copayment

If you are admitted on an inpatient basis into a Hospital participating in the Anthem Blue Cross and Blue Shield PPO network, you will be responsible for a $500 copayment (for each inpatient admission). For example, if you are admitted to the Hospital for surgery that requires a three-day stay, you will only be responsible for the $500 copayment. The balance of all Covered Charges will be paid in full by the Fund. This assumes all services while hospitalized are provided by network providers.

If while hospitalized you are treated by a non-participating surgeon, anesthesiologist, radiologist, etc., the services and related charges of non-participating providers are subject to the out-of-network deductible and coinsurance requirements of the Plan. This $500 copayment is applied to the annual in-network out-of-pocket maximum. Out-of-network charges do not apply towards the out-of-pocket maximum.

In the case of a maternity admission, only one copayment will be charged if both the mother and newborn are discharged on the same day.

Penalty When You Don't Comply with the Fund's Utilization Review Program

Please refer to the Utilization Review Program requirements in Section 21. If you fail to follow the Plan's Utilization Review Program, the Fund's benefit that would have been payable will be reduced by 20%. For example, if you incur Hospital charges with a contracted discount of $10,000, the Fund would normally pay the entire bill less a $500 copayment ($9,500). However, if you do not comply with the Utilization Review Program, the Fund will reduce your in-network benefit and you will have to pay $2,000.

In-Network Outpatient Hospital and Specialty Services - $20 Copayment if Charges Are Less Than $2,000

The copayment for outpatient Hospital charges at an in-network (Anthem provider) is $20 for services that have a discounted charge of $2,000 or less. Your $20 copayment for these in-network services will apply to the annual in-network out-of-pocket maximum.

In-Network Outpatient Hospital, Specialty Services, and Major Imaging - $200 Copayment if Charges Exceed $2,000

If you are receiving imaging services (MRI, Pet Scans, or CAT Scan, etc.) or care from a participating Hospital or ambulatory surgery center on an outpatient basis, and the discounted charges exceed $2,000, you will be responsible to pay a $200 copayment. Hospital care includes, but is not limited to, outpatient surgery, specialty treatment such as chemotherapy and radiation, special procedures and laboratory tests, and x-rays. The copayment will be applied to the annual in-network out-of-pocket maximum.

Urgent Care/Walk-in-Clinics

If you utilize the services of an urgent care (free standing) or walk-in clinic, in lieu of your primary care physician, and the facility is a network provider, you will be responsible to pay a $30 copayment and the Fund will pay the remaining balance. Make sure when utilizing these facilities, they participate in Anthem's network or the charges for services will be process as an out-of-network benefit.

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Emergency Room - $150 Copayment (True Emergencies)—In- and Out-of-Network

If you seek treatment for a Medical Emergency in any Hospital or free-standing medical/urgent care facility, you will be responsible to pay a $150 copayment and the Fund will pay the remaining balance. A "Medical Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. Examples of medical emergencies include, but are not limited to, the following:

- Difficulty breathing
- Severe burns
- Broken bones
- Unconsciousness
- Excessive bleeding
- Suspected heart attack
- Acute and sudden pain
- Shock
- Any condition for which a Physician advises you to seek treatment in an emergency room

The emergency room copayment will be waived if you are admitted to the Hospital; however, the inpatient Hospital copayment will apply. This emergency room copayment will be applied to the annual in-network out-of-pocket maximum.

Emergency Room - $300 Copayment (Non-emergency)—In- and Out-of-Network

If you utilize the services of a Hospital Emergency Room for other than a "Medical Emergency," you will be responsible for a $300 copayment and the Fund will pay the remaining balance. Treatment that could be received from a general Physician are not medical emergencies and only conditions that meet the criteria of "Medical Emergency" as defined above are classified as such.

Your copayment will be applied to the annual in-network out-of-pocket maximum.

OUT-OF-NETWORK BENEFITS

Out-of-network health care providers have no contractual fee agreements with Anthem Blue Cross and Blue Shield and are generally free to set their own charges for the services or supplies they provide. The Fund will reimburse you based on the Allowable Charges set forth in Section 4. You must submit a Claim before any reimbursement will be made, and out-of-network health care providers may bill you for any balance that may be due in addition to the amount payable by the Fund.

Benefits paid by the Fund to out-of-network providers are subject to Allowable Charge limits. Allowable Charge limits may place a limit on the amount the Fund pays for the health or dental care you receive. Note that if you utilize the services of an **Anthem network provider or Physician, the only balance billing is your copayment, and you do not have the risk/exposure to balance billings above Allowable Charges by service providers.**

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The **"Allowable Charge"** for Medically Necessary services or supplies will be determined by the Fund or its designee as defined in Section 4. The Fund will not pay more than Allowable Charges for a service, procedure or supply. The Allowable Charge may differ by area—so what is an Allowable Charge for a certain surgery in New Haven may differ from the Allowable Charge for the same surgery in Waterbury. If a surgeon charges $4,000 for a certain surgery and the Allowable Charge in the area is only $3,600, the Fund will consider and pay the Claim on the basis of a $3,600 Allowable Charge only. **You would be liable for the excess charges.**

Before incurring medical expenses, check to determine if your doctor, surgeon or pediatrician is in the Anthem Blue Cross and Blue Shield PPO network. You and the Fund will save money by utilizing network providers. If you utilize an out-of-network provider, ask about his/her charge for a particular procedure and if it exceeds the Allowable Charge limit. Otherwise, you may be liable to pay part of the expense out of your own pocket.

Services and Charges Not Covered or Payable by the Fund

Generally, the Fund will not reimburse you for all out-of-network Covered Charges. Usually, you have to satisfy a deductible or pay some coinsurance toward the amounts you incur that are Covered Charges.

Out-of-Network Deductible

Each calendar year, you (and not the Plan) are responsible for paying all of your out-of-network Covered Charges until you satisfy the annual deductible. Then, the Fund begins to pay a percentage of out-of-network Covered Charges. There are two types of deductibles: individual and family. The individual deductible is the maximum amount one Covered Person has to pay before Fund benefits begin paying out-of-network charges. **The individual out-of-network deductible is $200.** The family deductible is the maximum amount that a family of two or more is responsible for paying before Fund benefits begin. **The family out-of-network deductible is $400.** These deductibles do not cover dental expenses.

Out-of-Network Coinsurance

Once you have met your annual deductible for out-of-network Claims, the Fund pays 80% of Allowable Charges, and you (and not the Fund) are responsible for paying the rest. The part you pay (20%) is called your coinsurance.

Note: Certain medical expenses are not covered by the Plan at all. Refer to Section 22, Medical Expenses Not Covered and General Plan Limitations and Exclusions, for details about excluded expenses.

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14. COVERED MEDICAL EXPENSES (FOR ACTIVE AND RETIRED (NOT MEDICARE PRIMARY) PARTICIPANTS, AND THEIR ELIGIBLE DEPENDENTS)

Description of Benefits

Your medical expenses are covered by the Fund, regardless of whether they are incurred in-network or out-of-network or if they result from a prolonged disability, Injury or Illness.

Covered Medical Expense Benefits

Benefits are payable for the Medically Necessary charges incurred while you or your eligible dependent is covered under the Fund for treatment, services, and supplies ordered by a Physician. These include charges as follows:

1. **Hospital expenses** incurred for inpatient treatment, except as otherwise indicated elsewhere in this booklet. Covered room and board charges may not exceed the Hospital's average rate for semiprivate rooms unless it is Medically Necessary to isolate the patient to prevent contagion as the result of any infectious disease. If a Hospital does not have semiprivate rooms, the Covered Charges will not exceed the average rate for such rooms charged by Hospitals located in the surrounding geographic area (for Hospital admissions, please refer to the requirements of the Utilization Review Program in Section 21).

   To be eligible for coverage under the Plan, hospitals and other inpatient facilities are required to be accredited by the Joint Commission, DNV Healthcare, Commission on Accreditation of Rehabilitation Facilities, or another CMS-approved accrediting organization. This requirement applies equally to medical/surgical benefits and mental health and substance use disorder benefits covered by the Plan. Furthermore, such facilities also must meet all applicable licensing standards established by the jurisdiction in which the facility is located.

2. **Hospital** charges for **services and supplies** other than room and board charges incurred during an inpatient confinement.
3. Diagnosis, treatment, and **surgery** performed by a Physician.
4. The purchase or rental of **durable medical equipment** such as wheelchairs and Hospital-type beds when accompanied by a prescription from a licensed qualified Physician. Durable medical equipment is reimbursable at 80% coinsurance. Any out-of-pocket expense is not applied to an individual's out-of-pocket maximum. The Physician must also describe the Medical Necessity for the equipment and a cost comparison between the rental and purchase price of the equipment. The Fund will not pay for the purchase or rental of Durable Medical Equipment that is not approved by the Fund Office, regardless of the Medical Necessity. The Fund Office may require multiple quotes before authorizing durable medical equipment as a covered expense. The benefit limit for renting such equipment will not exceed the purchase costs. The Fund will provide for the basic equipment required; the cost of any enhancements for personal or convenience reasons will be borne by the Covered Person. If the equipment has been purchased by the Fund, the Fund will own the equipment but has no responsibility for repair, upkeep or modifications of the equipment.

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5. **Services of a licensed, qualified Physician,** including a specialist for surgical and non-surgical care in a Hospital, home, Physician's office, or skilled nursing facility (for skilled nursing facility admissions, please refer to the requirements of the Utilization Review Program in Section 21).
6. **Artificial limbs or eyes** for the initial replacement of natural limbs or eyes, along with replacement after the useful life expected of the prosthetics. Prosthetic appliances provided also include the first pair of aphakic lenses (no implant) following cataract surgery and cranial prostheses (wigs) providing that hair loss was the result of Injury or Illness (burns, lupus, Alopecia Totalis, fungus, chemotherapy, or radiation). A wig obtained once every three (3) years will be a Covered Expense and reimbursed at 100% coinsurance, but coverage will not include repair, cleaning, styling or wig stands. Male or female pattern baldness is not considered an Illness.
7. **Initial trusses, braces** or supports, **casts,** Medically Necessary prescribed stockings or elastic bandages, splints and crutches and replacement when Medically Necessary due to normal wear, change in medical conditions, individual outgrows device, etc.
8. Charges made by a registered graduate Nurse (R.N.) or a licensed practical Nurse (L.P.N.) for **private duty nursing,** other than a Nurse who normally lives in your home or is a blood relative. The Plan requires pre-certification by your Physician for the necessity of such care. Services do not include nonmedical or custodial care, such as bathing, grooming, exercising, feeding, and the administration of medication which can usually be self-administered (for private duty nursing care, please refer to the requirements of the Utilization Review Program in Section 21).
9. **Rental of an artificial kidney machine** and any Medically Necessary supplies for dialysis home testing related to the dialysis treatments. Benefits for home hemodialysis do not include furniture, installation charges, or any charges for maintenance purposes.
10. **Diagnostic x-rays, MRIs, CAT scans, and laboratory tests.**
11. Radium, radioactive isotopes, x-ray therapy, and **chemotherapy.**
12. **Anesthesia and its administration,** and inhalation therapy for treatment of a respiratory condition by inhalation of water vapors, oxygen, or other substances.
13. **Local ambulance service** when used to transport you or your eligible dependents from the place where the Injury occurred or where the individual was stricken by an Illness to the nearest Hospital where treatment is rendered; and for local ambulance service from a Hospital to another Hospital, when the discharging Hospital has inadequate facilities for treatment and the receiving Hospital has appropriate treatment facilities. Covered Charges including air emergency ambulance will be reimbursed at 100% coinsurance of the first $4,000 of covered expenses and 80% of the excess.
14. **Blood, including** the cost of blood plasma and blood plasma expanders.
15. **Prescription drugs,** physical therapy, x-rays, and laboratory services rendered in a **skilled nursing** facility, provided that confinement begins within 14 days following a Hospital confinement of at least 3 consecutive days and both the Hospital and skilled nursing facility confinement are for the same Injury or Illness. No other services or supplies, except those presented in the preceding sentence, will be covered when administered in a skilled nursing facility.
16. **Drugs and medicines** while Hospital-confined.
17. Expenses incurred for care in an **intensive care, critical care or neonatal intensive care unit.**

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18. **Medical and surgical supplies,** such as oxygen (requires Medical Necessity approval; refer to Section 21), surgical dressing, and colostomy bags. Items ordinarily found in the home for general use, like adhesive bandages, petroleum jelly, and thermometers are not covered.

19. Charges made by a legally qualified Physician for treatment of **well baby/child care.** Periodic reviews include a medical history, complete Physician examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests. Refer to "Covered Expenses for Children" later in this SPD, for more information about well baby/child care coverage.

20. Charges made by a **Convalescent Facility** or Skilled Nursing Facility for expenses incurred during the first 120 days of confinement per calendar year for all admissions occurring on or after the effective date of coverage, provided that confinement begins within 14 days following a Hospital stay of at least 3 consecutive days, and provided that the Hospital and convalescent confinement are both for the same Illness or Injury (for convalescent confinements, please refer to the requirements of the Utilization Review Program in Section 21).

21. **Chiropractic services** for, or in connection with, the correction by normal or mechanical means of structural imbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is a result of or related to distortion, misalignment or subluxation, or in the vertebral column and not related to an Injury or disability arising out of or in connection with employment. **Such benefits will be payable to a maximum of 25 visits per calendar year.**

22. Charges for services of a **certified nurse-midwife** up to the Allowable Charges, which would have been payable if treatment had been rendered at a Hospital.

23. More than **one operation performed through the same incision,** Covered Charges recognized by the Plan will be the Allowable Charges for the major (largest charge) Surgical Procedure and 50% of the Allowable Charges for each subsidiary Surgical Procedure. If more than one operation is performed in remote operative fields and through separate incisions, payment for surgical fees will consider the Allowable Charges for each totally unrelated, independent Surgical Procedure. This provision does not apply to surgeries of the foot.

24. Charges for services directly related to and arising from an **organ transplant** (includes bone marrow and stem cell) provided such organ transplant coverage is recognized by the Fund's stop-loss insurance carrier. Any related procedures require preauthorization by HealthLink (refer to Section 21). **If you utilize a Hospital that is not approved by the stop-loss insurance carrier as part of its "centers of excellence" network, a penalty (a 10% reduction up to $10,000) will be assessed in the reimbursement of expenses.** Covered Charges will include any organ or tissue procurement or acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a non-living donor, or on behalf of a living donor who is not a person covered by this Fund and who is not covered by any other group or individual health care plan. If a living donor is covered by another group or individual health care plan for the expenses related to the donation of an organ or tissue, the Fund Plan will reimburse that donor for any deductibles, coinsurance, copayments, or reasonable and necessary expenses related to the procurement or acquisition of the donated organ or tissue that are excluded by that donor's health care plan. You should contact the Fund Office to determine if a particular organ transplant will be covered under the Plan.

25. Expenses associated to **search and secure an acceptable organ donor** for a transplant are subject to the utilization review requirements of Section 21.

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26. Charges for **voluntary sterilization** (i.e., tubal ligation or vasectomy).
27. **Maternity charges,** including charges for Complications of Pregnancy and baby circumcision. The length of stay for a normal vaginal birth is 48 hours from the time of delivery and 96 hours for a cesarean birth unless both the mother and provider agree to a shorter stay.
28. **Antepartum** care includes monthly visits up to 28 weeks' gestation; biweekly visits up to 36 weeks' gestation and weekly visits until delivery. Services included are history, examinations, recording of weight, blood pressures, fetal health, urinalysis, and other examinations pertinent to the health of mother and child. Delivery services include admission, management of labor and vaginal delivery, or cesarean delivery. Postpartum care includes Hospital and office visits following vaginal or cesarean section delivery.
29. Charges incurred for **diabetic supplies** (i.e., test strips, lancets and autoclix), as well as ostomy/colostomy supplies and insulin infusion pumps, when Medically Necessary and accompanied by a Physician's letter of Medical Necessity. Most supplies are covered under the Prescription Drug Benefit (refer to Section 15).
30. **Autologous blood donations** in anticipation of major surgery for a specific, foreseeable immediate need. Covered Charges include the drawing, storing, and subsequent transfusion of the blood.
31. **Physical** and **Occupational therapy** by a licensed Physician or physiotherapist, up to a maximum of 60 visits in a calendar year (please refer to the requirements of the Utilization Review Program in Section 21)..
32. **Speech therapy** provided by a licensed speech therapist to restore normal speech or to correct dysphagia or wallowing defects lost due to illness or injury. The maximum sessions are combined with the maximum for physical and occupational therapy of 60 sessions per calendar year. Speech therapy for stuttering, stammering and conditions of psychoneurotic origin or developmental (learning) speech delays etc. are limited to 12 sessions per calendar year.
33. **Mammographic examinations** annually, or at the recommendation of a Physician (refer to the following preventative service item #67).
34. Charges for services or treatment received in an **emergency room** for serious and sudden conditions, which are considered Medical Emergencies under the Fund. There are different copayments predicated on whether treatment is for a medical emergency (refer to the Schedule of Benefits and Sec 13-4).
35. Hospital and other medical expenses incurred in connection with **cosmetic surgery,** which is necessary as a result of a non-occupational accidental bodily Injury or congenital birth defect.
36. Charges recognized in accordance with the **Women's Health and Cancer Rights Act of 1998** including reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prosthesis; surgical brassieres and treatment of physical complications of all stages of mastectomy including lymphedemas.
37. **Surgical assistance** expenses up to a maximum of 20% of the surgical allowance for charges made by a Physician for surgical assistance services given in connection with a covered Surgical Procedure. Surgical assistance services are the services of a Physician for necessary technical surgical assistance given to the operating Physician, while the Covered Person is confined in a Hospital as an inpatient and at the time when surgical assistance is not routinely available as a Hospital service.

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38. Expenses incurred for outpatient emergency medical treatment arising from the **ingestion or consumption of a controlled drug.** Benefits for confinement as an inpatient in a lawfully operated Hospital for expenses arising from the ingestion or consumption of a controlled drug are subject to utilization review, as described in Section 21.
39. Charges incurred for the use of a facility for **ambulatory (one-day) surgery** performed in Hospital operating rooms, outpatient surgical facilities in Hospitals, or freestanding surgical centers.
40. **Cervical cytology screening.** "Cervical cytology screening" is defined as an annual pelvic examination, collection and preparation of a Pap smear, and associated diagnostic and laboratory services in connection with examining and evaluating the Pap smear. Refer to the following preventive services item #67 for a more complete description of this benefit.
41. Charges for diagnosis and treatment of infertility, limited to two attempts for the following procedures per lifetime per couple, provided such procedures are not Experimental. Benefits will be payable for the following:
    - Artificial insemination;
    - In-vitro fertilization and embryo placement;
    - Any cost associated with the attendant sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any, regardless of whether the donor is the insured's spouse.
42. Medical examination required by the **University of Connecticut Speech and Hearing Clinic** or an **Anthem audiologist** to dispense a hearing aid.
43. Charges of an approved **cardiac rehabilitation program** for up to 20 sessions, following discharge from a Hospital with a related cardiac diagnosis.
44. **Inoculations** including but not limited to Hepatitis, Pneumonia, Lyme Disease, Shingles, or any other Medically Necessary preventive vaccines (refer to the following preventative services item #67).
45. **Allergy shots** when administered in a Physician's office and submitted with a diagnosis.
46. **Interferon shots** when administered in a Physician's office and submitted with a diagnosis.
47. Treatment, services or supplies in connection with any instability of the feet, including shoes, inserts, **orthotics,** payable at 80% coinsurance, subject to the Allowable Charge and limited to once every three (3) years. Orthotic expenses are not applied to a participant's in-network out-of-pocket maximum.
48. **Stress tests** when submitted with a Physician's diagnosis.
49. **Sleep apnea** tests when submitted with a Physician's diagnosis stating Medical Necessity.
50. The services of a **naturopath** which otherwise would be provided by a Physician excluding the dispensing of herbal teas or other compounds and vitamins subject to a maximum of $300 per calendar year. Services not covered by the Plan, including naturopathic and related expenses are not applied to a Participant's in-network out-of-pocket maximum.
51. **Annual flu shots.**

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52. **Home health care expenses** as a result of a non-occupational Illness or Injury, paid at 100% coinsurance for in-network and 80% coinsurance for out-of-network services, up to a maximum of 120 visits per calendar year. Out-of-pocket expenses for out-of-network service do not apply to out-of-pocket maximum. In order for benefits to be payable for the Allowable Charges made by a Home Health Care Agency, the following requirements must be satisfied:

    - You or your eligible dependent must be discharged from a Hospital from which the participating Home Health Care Agency has contracted to accept referrals, and you must receive prior approval from the Utilization Review Program (refer to Section 21) in advance of the services being provided; and
    - The home health services must enable you or your eligible dependents to be discharged from the Hospital earlier than would otherwise be possible, and such discharge must be recommended by the attending Physician; or
    - You or your eligible dependent must be essentially confined to home and physically or mentally incapable of obtaining Medically Necessary services and treatment on an outpatient basis ("homebound").

    Benefits are payable for Allowable Charges made by a Home Health Care Agency for necessary services or supplies furnished to you or your eligible dependent in your home, in accordance with the Home Health Care Plan, for care which commences within seven (7) days following termination of a Hospital confinement as a resident inpatient and which is provided for the same or related condition for which you or your eligible dependent was hospitalized:

    - Part-time or intermittent nursing care by a registered graduate Nurse or by a licensed practical Nurse under the supervision of a registered graduate Nurse, if the services of a registered graduate Nurse are not available;
    - Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature, by other than a registered graduate or licensed practical Nurse. The home health aide must be an employee of the Home Health Care Agency or working under supervision of a home health care professional;
    - Physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency;
    - Medical supplies prescribed by a Physician and laboratory services by or on behalf of a Hospital, to the extent such items would have been covered as Medically Necessary if the individual had remained in the Hospital. Such supplies will be limited to a 30-day supply;
    - Medical Social Services provided to or for the benefit of an individual diagnosed by a legally qualified Physician to be terminally ill; and
    - Each visit by a member of a home health care team is considered one visit for the purposes of calendar year maximum. Four hours of home health care aide services are considered one visit. The services for medical supplies, drugs, etc., are payable as long as the 120 visits benefit is still available.

    In no event will Home Health Care Expenses include charges for:

    - Services or supplies furnished to an individual eligible for Medicare;
    - Services such as elastic stockings, sheepskin, lotions, mouthwash, or body powder;

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- Housekeeping services;
- Custodial Care;
- Services of a person who ordinarily resides in the individual's home or is a member of the family of either the Participant or the Participant 's eligible dependent spouse; and
- Any period during which you or your eligible dependent is not under the care of a Physician.

If a Covered Person is eligible for Home Health Care coverage under more than one policy or contract, the Home Health Care benefits will only be provided by the policy or contract that would have provided the greatest benefits for hospitalization, if such individual had remained hospitalized.

53. **Hospice care** if, while insured, such person submits a statement to the Fund Office from a hospice Physician attesting to the fact that he is terminally ill with six (6) months or less to live. Coverage includes both medical and non-medical treatment, when received in a licensed hospice program. Covered Charges of Hospice Care are subject to limitations and restrictions set forth in the Plan. Included in these limitations is coverage for bereavement counseling services by a licensed social worker or licensed minister for the patient's immediate family (spouse and children) to a maximum of $400 and furnished within six months after the patient's death.
54. **Pre-admission testing** on an outpatient basis, prior to a Hospital admission and ordered by a Physician, provided:
    - The tests are related to the scheduled surgery or Hospital admission;
    - The tests are performed in the Hospital where the confinement or surgery will occur and accepted by the Hospital, in lieu of the same tests made after confinement; and
    - The person does not cancel the scheduled surgery or Hospital confinement, unless for reasons beyond the control of the Physician, Hospital, or such person. Other qualifications are set forth in the Plan.
55. Charges for a routine **annual physical examination** for adults by a legally qualified Physician for one (1) medical examination per calendar year. This includes related charges incurred for immunizations. Refer to the following preventive services item #67 for a more complete description of this benefit.
56. Charges in connection with a second surgical opinion from a legally qualified Physician who is not affiliated or associated with the surgeon issuing the initial diagnosis. If a second surgical opinion does not confirm the need for surgery, the Fund will pay for a third surgical opinion. All laboratory and x-ray charges required by a Physician issuing a second or third opinion will be covered provided the following qualifications or restrictions are met:
    - The surgery Consultation must be made by a Physician who is Board Certified in the field of medical specialization concerned with the proposed surgery; and
    - Any Physician who renders the second or third surgical opinion cannot perform the surgery or have a financial interest in the outcome.
57. Charges for the treatment of **sexual dysfunction** due to a spinal cord Injury, prostate surgery, diabetes, vascular disease or medication-induced dysfunction where a change in medication is not possible. The treatment of sexual dysfunction is subject to prior authorization by HealthLink.

58. Charges for the **treatment of morbid obesity** require approval (refer to Section 21) and coverage is limited to one surgery per lifetime. A determination of morbid obesity requires a Physician's determination that the percentage of excess body weight exceeds 100% of the national recommended insurance guidelines for body weight. Coverage excludes any prescription drugs or dietary treatment associated with weight control or reduction. There are a number of criteria that need to be satisfied under the pre-certification guidelines administered by HealthLink (refer to Section 21) before bariatric surgery (gastric bypass surgery) will be approved. The Fund Office and/or HealthLink will require among the criteria that the candidate for such surgery has followed a supervised dietary program and psychological approval before any such surgery will be considered as a Covered Expense.

59. Charges for an educational outpatient disease management program for diabetes, asthma and other approved programs designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health procedures. Covered expenses are payable at 80% coinsurance and will be subject to the following conditions:
    - The program is recommended by a Physician;
    - The Covered Person submits a receipt showing the following information:
        - The cost of the program;
        - The name, address and telephone number of the program sponsor;
        - The dates and times classes were held; and
        - The dates attended by the Covered Person.
    - The training is provided by a certified, registered, or licensed health care professional trained in the care and management of the disease and who is authorized to provide such care within the scope of the professional's practice.

60. **Specialized baby formula** only if all of the following criteria is satisfied with Covered Expenses reimbursed at 50% coinsurance. A Participant's expenses are not recognized toward an out-of-pocket maximum. The criteria are:
    - The infant is diagnosed with an inherited metabolic disease or disorder, such as Phenylketonuria (PKU), but not limited to; and
    - The infant's attending Physician must provide evidence to the Fund Office that the child must receive low protein or amino modified formula as a dietary requirement; and
    - The specialized formula is classified as a low protein or amino modified product approved for the intended use of a medically supervised dietary management of a specific disease; and
    - Bills and receipts must be submitted in the manner required by the Fund Office.

61. Charges for **"medical foods"** for persons with "inherited metabolic disorders" (as defined by the Plan), provided: (i) such medical foods are prescribed by a Physician to treat a diagnosis of "inherited metabolic disorder," and (ii) the patient is under the regular supervision of a Physician to monitor the inherited metabolic disorder. Documentation to substantiate the presence of an inherited metabolic disorder and that the products purchased are medical foods may be required before the Plan will reimburse costs associated with this benefit. Medical foods are not subject to the out-of-network deductible and will be paid at 50% coinsurance with such out-of-pocket expenses and do not apply to the Plan's out-of-pocket maximums.

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An "inherited metabolic disorder" is a genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan.

"Medical foods" do not include natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders.

62. **Charges for genetic testing,** but only for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan. All other genetic testing requires approval for Medical Necessity by HealthLink (refer to Section 21). No benefits are provided for pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents.
63. Charges for **genetic counseling,** but only when provided before and/or after amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis, as described above.
64. Charges for **I.V. Therapy,** subject to prior authorization by HealthLink (under the requirements of the Utilization Review Program, as described in Section 21). Services provided at home will be paid at 100% coinsurance if received from an Anthem network provider, and subject to the applicable copayment if provided at a facility. Services out-of-network are reimbursed at 80% coinsurance of Allowable Charges.
65. Charges for treatment of **mental/behavioral health** and substance use disorder
66. Charges due to participation in an **Approved Clinical Trial.**

    The Plan will cover charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are:

    - Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and
    - Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

    A Participant or dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

    - Satisfies the protocol prescribed by the Approved Clinical Trial provider; and
    - Either:
        (i) The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

        (ii) The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

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An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services (HHS) determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.

67. **Preventive services** as required by the Affordable Care Act (ACA). Refer to Section 22 for the Plan's limitations and exclusions on these services.

If coverage is provided *in-network,* there is no cost sharing (for example, no deductibles, coinsurance or copayments), for the following preventive services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this preventive services benefit.

The following benefits are available under the Plan's preventive services benefit with no cost sharing. In certain circumstances, as determined by the Plan, the preventive benefit is only payable with an appropriate diagnosis.

Non-preventive services are subject to copays or coinsurance. The Plan will impose cost sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Covered Preventive Services for Adults

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked;
- Alcohol misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings;
- Aspirin use for men ages 45 to 79 and women ages 55 to 79 when prescribed by a health care provider to prevent cardiovascular disease. A prescription must be submitted in accordance with Plan rules;
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit;
- Cholesterol screening for men aged 35 and older and women aged 45 and older, men aged 20-35 if they are at increased risk for coronary heart disease, and women aged 20 to 45 if they are at increased risk for coronary heart disease;
- Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure;
- Depression screening for adults;
- Type 2 diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk;
- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting;
- Sexually transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco use screening for all adults and cessation interventions for tobacco users;
- Syphilis screening for all adults at higher risk;
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls; and
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. A prescription must be submitted in accordance with Plan rules.

Covered Preventive Services for Women, Including Pregnant Women

- Well woman office visits for women, for the delivery of required preventive services;
- Anemia screening on a routine basis for pregnant women;
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later;
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will also cover BRCA 1 or 2 genetic tests without cost-sharing, if appropriate as determined by the woman's health care provider;
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older;
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention;
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan;
- Cervical cancer screening for women ages 21 and older with Pap smear (recommended once every three years by the United States Preventive Services Task Force);
- Human papillomavirus testing for women with normal Pap smear results, (recommended once every three years as part of a well woman visit);
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit;
- For women of reproductive capacity, the Plan will cover at least one form of contraception in each of the FDA-approved contraceptive methods (including barrier and hormonal methods and implanted devices) as well as patient education and counseling, when prescribed by a health care provider;

  The FDA-approved contraception methods for women include:

  (i) Sterilization surgery

  (ii) Surgical sterilization implant for women

  (iii) Implantable rod

  (iv) Intrauterine device (IUD) copper

  (v) IUD with progestin

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(vi) Shot/injection

(vii) Oral contraceptives (combined pill)

(viii) Oral contraceptives (progestin pill)

(ix) Oral contraceptives (extended/continuous use)

(x) Patch

(xi) Vaginal contraceptive ring

(xii) Diaphragm

(xiii) Sponge

(xiv) Cervical cap

(xv) Female condom

(xvi) Spermicide

(xvii) Emergency Contraception (Plan B/Plan B One Step/Next Choice)

(xviii) Emergency Contraception (Ella)

- The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing;
- Folic acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. A prescription must be submitted in accordance with Plan rules;
- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors), provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only;
- Counseling for sexually transmitted infections, once per year as part of a well woman visit;
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old woman. The Plan will pay for the most cost-effective test methodology only;
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative;

- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes;
- Tobacco use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users;
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit; and
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

Covered Preventive Services for Children

- Well baby and well child visits as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:

  (i) Developmental screening for children under age 3, and surveillance throughout childhood;

  (ii) Behavioral assessments for children of all ages;

  (iii) Medical history;

  (iv) Blood pressure screening;

  (v) Depression screening for adolescents ages 11 and older;

  (vi) Vision screening;

  (vii) Hearing screening;

  (viii) Height, weight and body mass index measurements for children;

  (ix) Autism screening for children at 18 and 24 months;

  (x) Alcohol and drug use assessments for adolescents;

  (xi) Critical congenital heart defect screening in newborns;

  (xii) Hematocrit or Hemoglobin screening for children;

  (xiii) Lead screening for children at risk of exposure;

  (xiv) Tuberculin testing for children at higher risk of tuberculosis;

  (xv) Dyslipidemia screening for children at higher risk of lipid disorders;

  (xvi) Sexually transmitted infection (STI) screening and counseling for sexually active adolescents;

  (xvii) Cervical dysplasia screening at age 21; and

  (xviii) Oral health risk assessment;

- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns);
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea;
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. A prescription must be submitted in accordance with Plan rules;
- Iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. A prescription must be submitted in accordance with Plan rules;
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status;
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection; and
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

Immunizations

Routine adult immunizations are covered for Participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Immunization vaccines for adults – doses, recommended ages, and recommended populations must be satisfied:

  (i) Diphtheria/tetanus/pertussis;

  (ii) Measles/mumps/rubella;

  (iii) Influenza;

  (iv) Human papillomavirus (HPV);

  (v) Pneumococcal (polysaccharide);

  (vi) Zoster;

  (vii) Hepatitis A;

  (viii) Hepatitis B;

  (ix) Meningococcal; and

  (x) Varicella.

- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations must be satisfied:

  (i) Hepatitis B;

  (ii) Rotavirus;

(iii) Diphtheria/tetanus/pertussis;

(iv) Haemophilus influenza type b;

(v) Pneumococcal;

(vi) Inactivated Poliovirus;

(vii) Influenza;

(viii) Measles/mumps/rubella;

(ix) Varicella;

(x) Hepatitis A;

(xi) Meningococcal; and

(xii) Human papillomavirus (HPV).

Office Visit Coverage

Preventive services are paid based on the Plan's payment schedules for the individual services. However, **there are situations in which an office visit may not be payable under the preventive services benefit.** If the primary purpose of the office visit is not for a preventive item or service, then the Plan will impose cost sharing with respect to the office visit. **The coding of the charges by your physician will determine whether the services were classified as preventative.** For example, if an individual schedules an in-network office visit to discuss recurring abdominal pain, and during the office visit the individual has a blood pressure screening, the office visit will be covered subject to the Plan's cost sharing requirements, e.g. a copayment, because the blood pressure screening was provided as part of an office visit, for which the primary purpose was not to deliver recommended preventive items or services.

Well child annual physical exams recommended in the Bright Futures Recommendations (for children from birth through age 21) are treated as preventive services and paid at 100%.

15. PRESCRIPTION DRUG BENEFITS

The Fund has contracted with **OptumRx** to administer its Prescription Drug Benefit. There is no annual maximum on your prescription drug benefits. However, you must use a participating **OptumRx** pharmacy or the **OptumRx** Mail Order Program to receive this benefit. **This means there is no coverage for prescription medications purchased out-of-network.**

There is an annual $1,500 per person out-of-pocket maximum on prescription drugs, after which the Fund will pay 100% of the Allowable Charge (separately administered from the medical out-of-pocket maximum).

NOTE: ALTHOUGH COPAYMENTS ARE THE SAME, MEDICARE RETIREES PRESCRIPTION DRUG BENEFIT IS PROVIDED BY AETNA. Refer to the Retiree Benefits section, Section 24, for detailed information regarding the Medicare Prescription Drug Benefit.

Retail Pharmacy Benefit

The maximum monthly supply of a prescription at a retail pharmacy that can be dispensed is the lesser of a 30-day supply or 100 doses.

- Tier I - there is a $10 copayment per prescription typically Generic drugs at a retail pharmacy.
- Tier II - there is a $25 copayment per prescription for Preferred Brand Name drugs at a retail pharmacy.
- Tier III - there is a $40 copayment per prescription for Non-Preferred Brand Name drugs at a retail pharmacy.

Mail Order Pharmacy Benefit

The quantity dispensed by the mail order pharmacy is a three-month (90-day) supply.

- Tier I - there is a $15 copayment per prescription for typically Generic drugs purchased through the mail order pharmacy.
- Tier II - there is a $40 copayment per prescription for Preferred Brand Name purchased through the mail order pharmacy.
- Tier III - there is a $80 copayment per prescription for Non-Preferred Brand Name drugs purchased through the mail order pharmacy.

If you are on maintenance prescription drugs, you will save money if you use the Mail Order Prescription Program. At a retail pharmacy, you can only receive a 30-day supply. However, the Mail Order Prescription Program allows you to receive three times the supply (a 90-day supply) for a minimally increased copayment amount.

In addition, using the mail order service eliminates the need for frequent trips to the pharmacy and is less expensive for you if you are taking a maintenance drug. You can order prescriptions up to three weeks in advance and shipping is free. You can obtain a mail order prescription form or order delivery of a prescription by calling **OptumRx** at (855) 408-2312 or for the Specialty Pharmacy (866) 218-5445. When ordering dispensing and delivery of a prescription, be prepared to supply your prescription information (medication name and dosage) and your doctor's name and telephone number. Mail order prescriptions are usually filled within seven days and delivered to your home. Refills are usually filled within 48 hours of your calling. Your prescription will be sent to you First Class mail or UPS. Note that instructions for refilling your prescription will be included with your first order.

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If your medication must be taken without delay, fill your prescription immediately at a participating Pharmacy. If your prescription is for an extended period of time, ask your doctor for a second prescription that can be sent to the **OptumRx** Mail Service Pharmacy so you can also submit your prescription to the mail order program to obtain refills.

If you have any questions or concerns, you or your eligible dependents should call the Fund Office at (800) 848-2129 or "**OptumRx**" Customer Service at (855) 408-2312.

Your Physician can contact **OptumRx** Mail Order Pharmacy directly to arrange for your maintenance prescription. Please have your Physician contact the Fund Office to obtain the information necessary to make these arrangements.

Generic Drug Dispensing

The generic equivalent of all prescriptions will be dispensed, unless no generic equivalent exists or your Physician strictly prescribes the brand name drug. You must obtain a generic prescription drug when one is available or you will be responsible for the brand name drug's copayment **plus** the difference in cost between the generic and brand name drug.

Your Prescription Drug Identification (ID) Card

Your Fund prescription drug ID card is required to access this benefit. You must present your ID card to a local retail pharmacy when filling your prescription or refills of an existing prescription. New Participants will receive identification cards shortly after becoming eligible.

In order to use your prescription drug ID card, simply go to any participating pharmacy. Present your ID card to the pharmacist, sign the Claim form or signature log, and pay the lesser of the price of the prescription or the applicable copayment ($10 for a generic drug or $25 for preferred brand name drug or $40 for a non-preferred brand name drug). The remainder of the charge will be billed directly to and paid by the Fund. Your required copayment is not reimbursable by the Fund so a request for reimbursement should not be submitted to the Fund Office. Your copayments are not applied to your out-of-pocket maximum and are not applied in coordinating benefits with other insurance programs.

Network Pharmacies

For information on network Pharmacies in and outside of Connecticut, call **OptumRx** customer service toll free at (855) 408-2312. Additional information about **OptumRx** can be obtained from its website, **www.optumrx.com.**

If you obtain prescription drugs through a non-participating pharmacy or do not present your ID card at the time of purchase, the Fund will not reimburse any amount of that prescription. You will be responsible for the full payment.

This Prescription Drug Benefit is not intended to pay for or reimburse you or your eligible dependents for the prescription copayments of another plan you may be covered under.

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Covered Prescription Drugs

Payment will be made for the following prescription drugs you or your enrolled eligible dependents obtain through a participating pharmacy upon presentation of your valid Fund ID card:

1. All drugs bearing the legend “Caution: Federal law prohibits dispensing without a prescription” and drugs requiring a prescription under applicable state law.
2. Prescribed injectable insulin, including syringes for diabetics, diabetic supplies (blood/urine tests).
3. Specialty medications. Some specialty drugs may also be covered under the medical benefit. Contact the Fund Office if you need a specialty medication.
4. Compounded medications of which at least one ingredient is a Federal legend drug. All compounded medications costing more than $50 require prior authorization from OptumRx to be recognized as a covered expense.

Limitations and Exclusions

No payment will be made for:

1. Any non-legend drugs other than insulin.
2. Any drugs, vitamins (other than as provided for under the Preventive Services benefit), diet supplements, anorexiants, etc., whether or not prescribed by a Physician, unless deemed Medically Necessary and prior authorization is received from **OptumRx.**
3. Any weight loss medication or supplements, unless deemed Medically Necessary and prior authorization is received from **OptumRx.**
4. Smoking cessation products requiring a Physician’s prescription. Smoking cessation products that do **not** require a prescription will not be covered.
5. Growth hormones and anabolic steroids, unless deemed Medically Necessary and prior authorization is received from Prescription Solutions.
6. Investigational or experimental drugs (compounded medications for non-FDA approved use) and the prescription must be FDA approved for the treatment of the specific diagnosis.
7. Drugs intended for use in a Physician’s office or another setting other than home use.
8. Therapeutic devices or appliances or support garments.
9. Prescriptions for animals.
10. Drugs payable under any Workers’ Compensation Law.
11. Drugs that an eligible person is entitled to receive without charges under local, state, or federal programs.
12. Drugs dispensed during confinement in Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent facility, nursing home, or similar institution that operates on its premises a facility for dispensing pharmaceuticals.
13. Immunological agents.

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14. Over-the-counter medications (other than insulin or as otherwise provided for under the Preventive Services benefit. Where covered, a prescription is required except for insulin).
15. Prescriptions to treat sexual dysfunction, in excess of six pills per month.
16. Any medication used strictly for cosmetic purposes.
17. Charges for injection or administration of drugs.
18. Drugs not received from a licensed Pharmacy.
19. Certain medications including but not limited to such as Imitrex and Ritalin require a medical diagnosis and prior authorization of Medical Necessity by OptumRx.
20. Methadone treatments; unless prescribed for pain relief and prior authorization is received from OptumRx.
21. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22.

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16. WELLNESS BENEFITS

The Employee Assistance Program (EAP)

The Connecticut Pipe Trades' Employee Assistance Program (EAP) is designed to provide prompt, professional assistance to you and your eligible dependents who need help coping with mental health related problems and other personal and family difficulties. We encourage you to take advantage of the professional help available to assist you to address problems including but not limited to:

- Alcoholism.
- Drug use.
- Family difficulties.
- Marital problems.
- Child and adolescent concerns.
- Parenting teens.
- Illness or loss of a family member.
- Financial pressures.
- Job stress.
- Any problem that professional guidance, information, coaching and resources can help in dealing with these challenges.

All of the above issues can be overwhelming and disrupt your life and the lives of your family members and coworkers. This benefit is designed to be a resource to begin the process of obtaining the professional assistance available to address the issues that can be disruptive in our lives.

The Board of Trustees has contracted with the Lower Hudson Valley to provide you and your eligible dependents with **confidential,** professional assistance. You have unlimited, toll-free telephonic access to the EAP dedicated staff 24 hours a day and anything that you discuss with a counselor will be kept confidential. You can reach the EAP by calling (800) EAP-2799 or (914) 245-6300. When you call, a trained professional will help you identify and evaluate your problem and, if necessary, refer you to the best and most appropriate resource. If inpatient treatment is required, you will be referred to an approved facility. Benefits will be paid on all emergency Hospital admissions provided the confinements are reviewed by the Fund's Utilization Review Program through HealthLink within 72 hours of admission, they are determined to be Medically Necessary, and an agreed upon length of stay is determined.

In most cases, Lower Hudson Valley will utilize providers that are in the Anthem PPO network to assure whenever possible that referrals are made to in-network mental health professionals. These professionals have been selected by Lower Hudson Valley based on their credentials and demonstrated commitment to providing the highest quality of care in their field of expertise. Lower Hudson Valley is an independent and separate entity not affiliated with or under the control of the Trustees of the Fund. The Trustees do not take responsibility for the results of the counseling received through the EAP nor will the Trustees interfere in any professional relationship between a participant and his/her provider.

Remember, you must contact HealthLink before being admitted to an inpatient mental health or substance abuse facility, as for all other inpatient services covered by the Fund.

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Future Moms Program

Anthem provides mothers to be with assistance in education concerning proper care, coordination of health care providers, lifestyle management, counseling, and postpartum contact to address concerns or issues. Additional information is available on the Fund's website.

24/7 Nurse Line

You have access to trained health professionals (trained registered nurses) 24 hours a day who you can call to determine the appropriate action or level of care necessary to treat your particular circumstances. The nurses can also refer you to available, relevant services and assist you in coordinating with other utilization review and wellness services. Information is available on the Fund's website.

Quit for Life Smoking Cessation Program

The Fund has an arrangement with a company called *Alere Wellbeing* to provide you and your dependents with "quit smoking" assistance. The program covers prescription drugs and includes counseling and support to overcome the addiction.

You can access the *Quit for Life Program* at **www.quitnow.net** or at 1-866-QUIT-4-LIFE (1-866-784-8454). The process is strictly confidential; however, if you would like assistance in the process, you can contact the Fund Office and other options may be available to assist you in this endeavor.

Anthem's Website

We encourage you to visit Anthem's internet site at www.anthem.com. The website has a host of information available and can assist you in finding a network Physician, performing a health assessment, comparing costs of the same procedures at different facilities, and accessing discounts at fitness centers, among other features.

If you have difficulty registering on the website, Anthem has a Help Desk at 866-755-2680. The Fund's website can be accessed at connecticutpipetrades.com.

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17. TREATMENT FOR MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDERS

Outpatient treatment for mental health and substance use disorders are covered under the same provisions that apply to outpatient medical treatment, meaning that office visits with Anthem network providers will be subject to the same copayments and visits to non-participating providers will be covered at a percentage of allowable charges, as shown on the Schedule of Benefits.

Inpatient treatment will also be covered the same as other inpatient medical treatment and subject to the same provisions that apply to services received in-network or out-of-network.

If you or your eligible dependents are seeking any treatment for mental health and/or substance use disorders, we strongly encourage you to contact the Employee Assistance Program that Lower Hudson Valley provides, where you will receive referral assistance (refer to Section 16).

Please note that to be eligible for coverage under the Plan, hospitals and other inpatient facilities are required to be accredited by the Joint Commission, DNV Healthcare, Commission on Accreditation of Rehabilitation Facilities, or another CMS-approved accrediting organization. This requirement applies equally to medical/surgical benefits and mental health and substance use disorder benefits covered by the Plan. Furthermore, such facilities also must meet all applicable licensing standards established by the jurisdiction in which the facility is located.

Treatment Benefits

For benefits to be payable for inpatient treatment (in-network or out-of-network), the confinement must be recommended by a Physician as being Medically Necessary for treatment of the diagnosed condition and approved by HealthLink (refer to Section 21). Covered Charges include those for treatment recognized by the medical profession as appropriate methods to treat mental and behavioral health disorders and/or substance use disorder, in accordance with broadly accepted standards of medical practice. If private accommodations in a facility are used, covered medical expenses will not exceed the facility's average daily rate for semi-private accommodations.

If you or your eligible dependents incur charges for treatment of mental or behavioral health and/or substance use on an outpatient basis by an Anthem PPO network provider, benefits will be paid in-full subject to a $20 copayment per office visit or session. Your copayment amount increases if the network discounted charges exceed $2,000, as shown on the Schedule of Benefits.

Outpatient treatment of mental and behavioral disorders will cover expenses of a certified psychiatric-mental health clinical nurse specialist or social worker providing psychiatric or psychological services in a guidance setting. The term "mental and behavioral health disorder" includes psychoneurotic and personality disorders.

Benefits Payable for Services of a Non-Participating Provider

Coverage for treatment you receive from non-Anthem PPO network providers will be based on the Allowable Charges for such treatment, recognized as appropriate methods in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual.

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Effective Treatment of Alcoholism

Effective treatment of alcoholism that has produced positive health outcomes is a program of alcoholism therapy that meets both the following tests:

- It is prescribed and supervised by a Physician who certifies that a follow-up plan has been established which includes therapy by a Physician or group therapy under a Physician's direction, at least once a month; and
- It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of alcoholism.

Effective Treatment of Substance Use Disorder or Drug Addiction

Effective treatment of substance use disorder or drug addiction that has produced positive health outcomes includes diagnostic evaluation, medical, psychiatric and psychological care, counseling, and rehabilitation when prescribed and supervised by a Physician for incapacitation by, or physiological or psychological dependence on, drugs.

Definition of an Alcoholism or Drug/Substance Use Disorder Treatment Facility

When applied to the treatment of alcoholism, a treatment facility is an institution (or distinct part thereof) which meets fully all of the following tests:

- It is primarily engaged in providing, for compensation from its patients and on a full-time basis, a program for diagnosis, evaluation and treatment of alcoholism.
- It provides, or has a formal agreement with a Hospital in the area to provide emergency care services, including, but not limited to, detoxification and medical treatment services continuously on a 24-hour basis.
- It is under the continuous supervision of a staff of Physicians on a 24-hour basis, and it continuously provides Skilled Nursing Services on a 24-hour basis under the direction of a full-time registered graduate Nurse, with licensed nursing personnel on duty at all times.
- It provides, or has a formal agreement with a Hospital in the area to provide diagnostic x-ray, laborat
- It prepares and maintains a written plan for admission, care, treatment, and discharge for each patient. The plan must be based on the diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the direction of a Physician.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

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18. DENTAL AND ORTHODONTIC BENEFITS (FOR PARTICIPANTS AND ELIGIBLE DEPENDENTS)

Dental Benefits

Covered dental expenses included under the Plan are the Allowable Charges of a dentist that you are required to pay while you are eligible for coverage.

If two (2) or more dental services are rendered, payment will be made for each dental service, subject to the Allowable Charge amount for a particular combination of dental services.

For many dental conditions, there is more than one method of satisfactory treatment. Covered dental expenses will not exceed the Allowable Charge amount for the services and supplies usually employed in such treatment, which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the overall current oral condition of the patient.

How to Use the Program

Before visiting a Dentist, check to see whether the Dentist participates in Anthem Dental's network. At the time of your first appointment, tell your Dentist that you are covered under the Anthem Copay/Flex Dental Plan. Show him/her your ID card (showing the Plan's group name and group number).

Why Select a Network Dentist?

Anthem participating Dentists have agreed, to accept Anthem's fee schedule and claims are submitted to and processed by the Fund Office. The following provisions apply to the Anthem Dental network:

- Participating Dentists have agreed to accept the lesser of their actual charge, their pre-filed fee, or Anthem Dental's maximum allowable fee for the program as payment in full and not to charge patients amounts in excess of their fee schedule.
- Participating Dentists agree to abide by Anthem Dental processing policies. Nonparticipating Dentists are not bound by such policies.
- Participating Dentists will, in the case of dental services that have been completed, receive payment directly from the Health Fund, after being processed by the Fund Office for that portion of the services covered by the Plan. You will receive a notification from the Fund Office, in the form of an Explanation of Benefits, a detailed description of covered benefits and the amount of your obligation.
- If you utilize a non-participating Dentist, you will be responsible for payment. The Fund Office will issue payment to you or the provider (if assigned) for the portion of your services covered by the Plan.

We advise that you check with your Dentist to confirm whether s/he participates in the Blue Cross program. While a Dentist may participate with Anthem, s/he may not participate in all of their dental programs.

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Locating a Dentist

You can locate a participating Dentist by search the Internet at **www.anthem.com** or you can call the Fund Office for a list of participating Dentists in your area.

Using either method, you can request a list of Anthem participating Dentists within a designated area. You can specify listings of general Dentists only or specialists only. Participating Dentist information can be obtained for Dentists nationwide.

Benefits incurred with a network Dentist are payable based on the contractual fee schedule, and subject to any applicable coinsurance or calendar year maximum. Benefits will be payable while coverage is in force for the treatment of non-occupational accidental Injury or disease of the teeth, gums, or jaw not related to a work accident.

If two (2) or more dental services are rendered, payment will be made for each dental service. For many dental conditions, there is more than one method of satisfactory treatment. If this is the case, the covered dental expenses will be limited to the services and supplies that are usually employed nationwide in the treatment of the disease or Injury and which are recognized by the profession to be appropriate methods of treatment, in accordance with broadly accepted nationwide standards of dental practice, taking into account the overall current oral condition of the individual

Calendar Year Maximum

There is a calendar year maximum of $2,000 per individual. This maximum does not apply to children under the age of 19. There is a separate Orthodontic Services lifetime maximum of $4,000 for children.

Deductibles

Annual deductibles apply to Basic and Major Dental Services. The annual deductible is $50 for an individual and $150 for a family. Preventive Services are not subject to the annual deductible.

Eligible Expenses

Eligible expenses are the reasonable services for dental care. Coverage for services provided by an In-Network Dentist will be allowed in accordance with the Anthem contractual allowance, but only to the extent that the services are reasonable taking into consideration the following:

- The services most frequently performed for that condition or diagnosis;
- The prevailing protocol for that condition or diagnosis in the locality for similar services by dentists of similar training and experience; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with the dental service or procedure.

Preventive Care Dental Services (Type A Expenses)—Retirees are Eligible for Preventive Dental Care Only

The Dental Benefit pays 100% of the Anthem's Allowable Charge for in-network services and 100% of the Allowable Charges for out-of-network for Preventive Care services rendered or supplies furnished by a dentist, subject to the following benefit maximums:

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1. Oral examinations once every six (6) consecutive months.
2. Prophylaxis (cleaning of teeth) once every six (6) consecutive months.
3. X-rays determined necessary and within guidelines maintained by the American Dental Association. A full mouth series is available once every 36 months and bite wing x-rays are covered every six (6) consecutive months.
4. Space Maintainers – including all adjustments within six (6) months after installation–limited to initial appliance only and children under age 19.
5. Fluoride Treatments – for eligible dependent children only under age 19 once every six (6) consecutive months
6. Sealants for eligible dependent children under age 19, subject to a maximum of $100 per calendar year.

Basic Dental Services (Type B Expenses)

The Dental Benefit pays 80% of the Anthem Allowable Charge for in-network services and 80% of the Allowable Charges for out-of-network Basic services rendered or supplies furnished by a dentist, after the annual deductible, subject to the following benefit maximums:

1. Non-routine Visits–Emergency palliative treatment per visit; consultation by other than the attending dentist.
2. Extractions–Uncomplicated (single); each additional tooth; surgical removal of erupted tooth (including tissue flap and bone removal).
3. Impacted Teeth–Removal of tooth, impacted soft tissue; partially by bone, completely by bone.
4. Alveolar or Gingival Reconstructions–Alveolectomy–per quadrant; excision of pericoronal gingiva, per tooth; removal of palatal torus; removal of mandibular tori, per quadrant.
5. Cysts and Neoplasms–Removal of cyst or tumor.
6. Drug–Injectable antibiotics.
7. Anesthesia–General, in conjunction with oral Surgical Procedures only; no limit on number of teeth.
8. Periodontics–Gingivectomy (including postsurgical visits) per quadrant; gingivectomy, treatment per tooth (fewer than six teeth); subgingival curettage, root planing, per quadrant (not prophylaxis); occlusal adjustment, related to periodontal surgery, per quadrant.
9. Endodontics–Pulp capping–direct, excluding final restoration; vital pulpotomy, excluding final restoration; apicoectomy (performed as a separate Surgical Procedure); apicoectomy (performed in conjunction with endodontic procedures).
10. Amalgam Restorations Primary or Permanent Teeth–Cavities involving one surface, two surfaces, three or more surfaces.
11. Synthetic Restorations–Silicate cement filling; acrylic or plastic filling; composite resin–one surface.
12. Crowns–Stainless steel (when tooth cannot be restored with a filling material).
13. Re-cementation–Inlay; crown; bridge.

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14. Denture Re-linings and Re-basings–Upper or lower denture duplication (jump case) per denture (limited to one in any 36 consecutive months); denture reline (includes full and partial); office, cold cure (limited to one in any 12 consecutive months); denture reline (includes full and partial); laboratory (limited to one in any 12 consecutive months).
15. Denture Adjustments–Adjustments to denture more than six months after installation or if by dentist other than the original provider.
16. Osseous Surgery.

Major Dental Services (Type C Expenses)

The Dental Benefit pays 50% of the Anthem Allowable Charges for in-network services and 50% of the Allowable Charges for out-of-network Major services rendered or supplies furnished by a dentist, subject to the following benefit maximums:

1. Restoration Inlays–One, two, three or more surfaces; only, in addition to inlay allowance.
2. Restorative Crowns –Acrylic; acrylic with gold; porcelain; porcelain with gold; gold (full cast); gold (3/4 cast); cast post and core (in addition to crown).
3. Pontics–Cast gold (sanitary); case with semiprecious metal (sanitary); slotted facing; slotted pontic; porcelain fused to gold; porcelain fused to semiprecious metal.
4. Removable Bridge (Unilateral)–One-piece chrome casting clasp attachment (all types), per unit including pontics.
5. Denture and Partial Dentures–Complete Maxillary denture; Complete Mandibular denture; Upper or lower partial, with two chrome clasps with rests, acrylic base; with chrome lingual bar and clasps, acrylic base.
6. Adding Teeth to Partial Denture –First tooth; First tooth with clasp; Each additional tooth and clasp.
7. Implants or occlusions for the replacement of missing teeth.

Orthodontic Services (Type D Expenses)—For Eligible Dependent Children Under Age 19

A $4,000 per individual lifetime maximum applies for cosmetic orthodontia for dependent children under age 19. (Note: This limit does not apply to Medically Necessary orthodontia treatment.)

The Orthodontic Expense Benefit pays 50% of the initial molds, fittings, and appliances, then 50% of the quarterly charges for Orthodontia services required by one or more of the following conditions:

- Overbite or overjet;
- Maxillary (upper) or mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp; or
- Cross bite.

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The Orthodontic Expense Benefit will be paid for your eligible dependents through age 18. Covered Charges will be payable in equal quarterly installments of 50% of the Allowable Charges incurred throughout the estimated duration of the treatment plan. However, the initial payment for the molds, appliances, etc., will be limited to 25% of the Allowable Charges incurred. Upon submission of invoices from the orthodontist, payments will be made by the Fund no more frequently than quarterly. If the orthodontic care is for cosmetic reasons, the Plan will reimburse 50% of the Allowable Charges, up to a lifetime maximum of $4,000. Note: this lifetime maximum does not apply to Medically Necessary orthodontia.

Orthodontic Treatment Plan

An orthodontic treatment plan must be submitted to the Fund Office before any expenses will be considered for payment. After the Fund Office has reviewed the treatment plan, you and your orthodontist will be advised of an estimate of benefits payable under the Plan. A treatment plan consists of: (1) a description of the malocclusion classification; (2) recommended and prescribed treatment; (3) an estimate of the duration of treatment (completion date); (4) an estimate of total charges for appliances and active treatment; and (5) supportive evidence such as cephalometric x-rays, study models, or other material the Fund Office deems necessary.

Dental Limitations and Exclusions

In addition to excluding any services not set forth in the Schedule of Benefits, no benefits are payable under this section for the following dental care services or supplies:

1. Charges for any dental procedures that are included as covered medical expenses under the Fund's Medical Benefits.
2. Charges for treatment by someone other than a dentist, except that cleaning or scaling of teeth may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of the dentist.
3. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.
4. Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while you or your dependents were not eligible under the Fund, or which were ordered while you or your eligible dependents were insured under the Fund, but which are finally installed or delivered more than sixty (60) days after termination of coverage.
5. Charges for the replacement of a lost or stolen prosthetic device.
6. Charges in connection with an occupational accidental bodily Injury or Illness that can be claimed under Worker's Compensation.
7. Consultations, if the dentist is or will be performing additional treatment.
8. The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five (5) years of the date of the last placement of such appliance, crown, inlay or onlay restoration or fixed bridge, unless such replacement is required as a result of accidental bodily Injury.
9. Charges in connection with temporomandibular joint dysfunction (TMJ). Refer to the separate benefit on page 18-8.

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10. Charges that you have no legal obligation to pay.
11. Treatment that does not have a reasonable favorable prognosis.
12. Dentures, crowns, inlays, bridgework or other devices or services if their sole purpose is to increase vertical dimension or to restore occlusion.
13. Crowns, inlays, onlays or gold fillings, unless the extent of the disease or fracture prevents the use of an amalgam, silicate, acrylic, synthetic porcelain or composite filing.
14. Any orthodontic services received before your dependents were eligible for such coverage under this Fund.
15. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22.

Pre-Determination of Benefits

This Plan contains a Pre-Determination of benefits provision. The intent of this provision is to determine, in advance, the likely expenses and how much of these expenses will be covered for a "course of treatment." **It is important to note that a pre-determination of benefits does not guarantee eligibility for dental benefits.**

Before beginning a course of treatment for which dental charges are expected to exceed $500, a description of the proposed services and supplies and the estimated charges should be submitted to the Fund Office. You and your dentist will then be notified by the Fund Office of the amount of the benefit payable for the proposed course of treatment. Emergency treatment, oral examinations, prophylaxis, and dental x-rays are considered part of a course of treatment for the purpose of pre-determination, but these services may be rendered before a pre-determination of benefits is made. Failure to submit a request for pre-determination may result in benefit payments of less than what you might otherwise expect.

Whether or not you have submitted a course of treatment for pre-determination of benefits, you are responsible for furnishing all diagnostic and evaluative material, as may be required by the Fund, to evaluate its liability. This material may include, but is not limited to, dental x-rays, models, charts, and other reports. A pre-determination does not guarantee payment of the Claim unless you are eligible when services are provided.

Extended Benefits Upon Termination

No payment will be made by the Fund Office for dental services or supplies furnished on or after the date of termination of an individual's coverage hereunder, whether such termination is on an individual basis or upon termination of this benefit, except under the following specified circumstances:

1. In the case of appliances or modification of appliances not related to orthodontic treatment, if the master impression was taken by a dentist while dental coverage was in force, Covered Charges will be payable if the appliance was delivered or installed within sixty (60) days after the termination of coverage.
2. In the case of a crown, bridge or inlay or onlay restoration, if the tooth or teeth were prepared while dental coverage was in force, Covered Charges will be payable if such crown, bridge, or cast restoration was installed within sixty (60) days after the termination of coverage.

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3. In the case of a crown, bridge or inlay or onlay restoration, if the tooth or teeth were prepared while dental coverage was in force, Covered Charges will be payable if such root canal therapy is completed within sixty (60) days after the termination of coverage.
4. In the case of orthodontic treatment commencing while orthodontic coverage was in force, benefits will be payable through the end of the month in which coverage terminated, based on prorating the applicable quarterly installment.

The above benefits are subject to all other conditions, limitations, and exclusions of the Fund.

Temporomandibular Joint Dysfunction Benefit

The Fund will provide payment for diagnosis, x-rays, Consultation, appliances, and treatment for Temporomandibular Joint Dysfunction (TMJ) at 80% of Allowable Charges, with coverage for these services subject to mandatory precertification for Medical Necessity, without prior approval charges will not be considered for payment by the Fund.

TMJ Limitations and Exclusions

No payment will be made for:

1. An office visit charge on the same day an appliance is inserted.
2. Any other dental services performed on the day an appliance is inserted.
3. Services or treatment rendered by a medical doctor, unless x-rays are submitted to the Fund Office and the condition is found to be medical in nature.
4. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22.

The TMJ Benefit is the only payment for TMJ provided by the Fund. Coverage for TMJ is not provided under any other benefit available through the Plan, including Medical Expense Benefits or Dental Expense Benefits.

Opt-Out Election

Participants may elect to opt out of the dental benefits of the Plan. Please be aware that there are no financial advantages to you by opting out. You and your eligible dependents will not receive any benefit by opting out of these benefits. If you do nothing, your current benefits will remain unchanged. However, if you wish to opt out of the Plan's dental benefits for you and your dependents, please provide a written notice to the Fund Office.

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19. VISION EXPENSE BENEFITS

The Fund provides vision benefits for you and your eligible dependents, exclusively through Davis Vision.

Eye Examination

Both **Active** and **Retired** Participants and their covered dependents can receive a complete eye examination once every 24 months. Dependent children under age 19 can receive an eye examination once every 12 months. The examination includes a dilation as professionally recommended. Fitting and follow-up of contact lenses are included when an active member or dependent selects plan lenses. Unless a participating provider or ophthalmologist recommends that a more frequent examination be rendered, subject to the approval by Davis Vision, eye examinations are limited to the aforementioned frequency. In no event will a re-examination be authorized for a patient that is no longer eligible under the Plan.

After an eye examination is performed and you make your selection, your eyeglasses will be delivered to your provider from the laboratory, generally within five business days. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions, or a participating provider's frame is selected.

Examinations are paid in-full by the Plan only if they are performed by a Davis Vision participating network provider.

If you are an **active Participant**, you and your covered dependents have the option of having an eye examination performed by an optometrist or ophthalmologist that is <u>not</u> in Davis Vision's network of providers. The maximum reimbursement for such an out-of-network (other than a Davis Vision provider) eye examination will be $75. However, the maximum reimbursement does not apply for dependent children under age 19, and this out-of-network benefit is not available to retired Participants and their dependents.

Participating Providers

Participating providers are licensed optometrists located throughout Connecticut, as well as nationally. They have agreed to provide high quality, comprehensive vision care services that are carefully monitored by Davis Vision's optometric experts. Stringent standards have been established for eye examinations, testing equipment and all other professional services rendered.

Davis Vision is an independent and separate entity, not affiliated with or under the control of the Board of Trustees of the Health Fund. The Trustees cannot take responsibility for the results of the examinations received through Davis Vision providers nor will the Trustees interfere in the professional relationship. Providers who participate in the Davis Vision network are licensed practitioners that are both in private practice and in retail locations and who are credentialed to ensure that quality standards are maintained. To locate a Davis Vision network provider, visit www.davisvision.com and utilize the "Find a Doctor" feature, or call (800) 999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

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Out-of-Network Providers

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit if you select an optometrist who participates in the Davis Vision network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a Claim for reimbursement to:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one Claim per service may be submitted for reimbursement once every 24 months, except for dependent children once every 12 months. To request Claim forms, visit the Davis Vision website at www.davisvision.com or call (800) 999-5431.

Eyeglasses (Lenses and Frames)

Active Participants and dependents can receive eyeglasses once every 24 months. Dependent children (up to age 19) can receive eyeglasses once every 12 months.

Most Davis Vision participating provider's offices have a "designer" selection of frames, which are paid in full by the Plan. The frame collection includes a wide assortment of high-quality, current designer frames. There are some eyeglass frames in the "Premier collection" that require a $25 copayment and for premier safety frames $20 copayment.

If you choose not to obtain eyeglass frames from a selection of frames not in the Davis Vision collection, but available from a Davis Vision provider, you can receive a $75 credit toward the network provider's own eyeglass frames.

If you choose to purchase eyeglasses from an out-of-network provider, you will be reimbursed up to $175 for the frames and lenses. The $175 allowance is the maximum allowed every 24-months. The Plan will also reimburse you 50% of any expenses over (exceeding) $175, which are associated with eyeglasses purchased for children under age 19 from an out-of-network provider, once every twelve (12) months.

If you are a retired Participant, you and your eligible dependents can purchase eyeglasses from the Davis Vision collections and pay the discounted prices the Fund has negotiated with Davis Vision. The average discount is approximately 30%, but it can be significantly greater for some lens options.

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied through the Davis Vision collection. Eyeglasses from the collection will be repaired or replaced (if they are damaged beyond repair) at no cost to you, provided the damaged eyeglasses are returned to the participating provider office where they were originally dispensed. There is no warranty for lost or stolen eyeglasses.

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Safety Eyeglasses

If you are an **active Participant**, you can receive safety eyeglasses only from the Davis Vision collection once every 12 months. This is an in-network benefit only with the cost of the safety eyeglasses paid in full by the Plan.

You may select from the "designer selection" of frames from the exclusive "Safety Collection." One pair of safety eyewear may be received in addition to regular eyeglasses.

Contact Lenses

If you are an **active Participant**, you can receive contact lenses every 24 months and your dependent children under age 19 can receive contact lenses every 12 months. In lieu of eyeglasses, you (as an active Participant) and/or your dependents can receive disposable or planned replacement contact lenses, including fitting/follow-up charges when selecting from the Davis Vision Contact Lens Collection. Disposable contact lens wearers will receive four (4) multi-packs of lenses. Planned replacement contact lens wearers will receive two (2) multi-packs of lenses.

Once the contact lens option is selected and lenses are fitted, they may not be exchanged for eyeglasses. If you cannot be fitted with plan-supplied contact lenses, you will receive a $130 allowance toward other types of contact lenses from the provider's own supply.

If you choose to obtain services from a non-participating provider, the Plan will provide a reimbursement of up to $175 for the contact lenses and related charges.

A substantial discount is available to obtain replacement contact lenses through a mail-order facility in conjunction with Davis Vision through *Lens 1-2-3.* This is available only for replacement contact lenses. Information regarding mail-order contact lenses is available by calling Davis Vision or visiting its website.

Laser Vision Correction Surgery

Active Participants and their eligible dependents can obtain discounted services from an exclusive network of Laser Providers. You and your covered dependents are entitled to receive up to a 25% discount off the usual and customary charges or 5% off any advertised special. For a listing of laser providers participating in Davis Vision's network, please refer to their directory.

The following are the lenses and or coatings that are included as part of the Davis Vision program:

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
- Glass grey #3 prescription lenses.
- Oversize lenses.
- Post-cataract lenses.
- Side shields (fixed or removable) for safety eyewear.
- Fashion, sun, or gradient tinted plastic lenses.

The following optional frames, lens types, and coatings are also available**.** You will be charged the discounted fixed fee indicated below for the optional additional services listed:

	Dress Eyeglasses	Safety Eyeglasses
• Premier Frame	$25	$20
• Anti-reflective coating		
• Standard	$35	$35
• Premium	$48	$48
• Ultra	$60	$60
• Plastic photosensitive lenses	$65	$65
• High-index lenses	$55	N/A
• Scratch-resistant coating	Included	Included
• Ultraviolet (UV) coating	Included	Included
• Photochromic glass lenses	Included	$20
• Blended invisible bifocals	Included	$20
• Intermediate vision lenses	Included	$30
• Polycarbonate lenses	Included	Included
• Polarized lenses	$75	$75
• Progressive addition • Multifocal lenses**		
• Standard types	Included	$50
• Premium types	$40	$90
• Ultra types	$90	$140

***Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses, however, the copayment is not refundable.*

How to Use the Vision Benefit

When you want to take advantage of this Vision Benefit, all you have to do is:

1. Call a network provider of your choice and schedule an appointment,
2. Identify yourself as a Davis Vision participant covered by the Connecticut Pipe Trades Health Plan, and
3. Provide the office with your Health Fund I.D. number, your name, and the date of birth of the individual you wish to schedule for an eye examination and possibly need eyeglasses.

The provider's office will verify your eligibility for services, and no Claim forms or I.D. cards are required.

For more information about Davis Vision, you can visit the Davis Vision website for more information about this company and the network of providers that participate in this program:

www.davisvision.com
or call (800) 999-5431

If you have not yet registered on the Davis Vision website, please select the "First Time Registrant" button to establish a user name and password. When completing the registration form, your I.D. number is the number on your Health Fund I.D. card.

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Limitations and Exclusions

1. Covered eye examinations in excess of one every 24 months for eligible members and retirees and their dependents, except for dependent children age 19 and younger are entitled to access benefits every 12 months.
2. Benefits are limited to maximum reimbursements as stated when utilizing other than a Davis Vision network provider.
3. Benefits extended to retirees are **ONLY** available through a Davis Vision network provider.
4. Special procedures, such as orthoptics or vision training and special supplies, such as non-prescription sunglasses or subnormal vision aids are not a covered expense.
5. Charges for services or supplies received while the individual is not eligible, or charges for lenses and frames that are furnished or ordered prior to the date the individual becomes eligible under the Plan.
6. Ancillary services whether performed by an optometrist or ophthalmologist.
7. Services for which benefits are not payable according to the General Plan Limitations and Exclusions in Section 22.

Opt-Out Election

Participants may elect to opt out of the vision benefits of the Plan. Please be aware that there are no financial advantages to you by opting out. You and your eligible dependents will not receive any benefit by opting out of these benefits. If you do nothing, your current benefits will remain unchanged. However, if you wish to opt out of the Plan's vision benefits for you and your dependents, please provide a written notice to the Fund Office.

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20. HEARING CARE BENEFITS

The Fund provides a Hearing Care Benefit that will **pay in-full** (for an active Participant and covered dependents) all charges related to the evaluation of a hearing loss and the fitting and dispensing of a hearing aid or aids, provided the services are received from the University of Connecticut Speech and Hearing Clinic (Hearing Clinic) in Storrs, Connecticut or an audiologist in the Anthem Blue Cross and Blue Shield network of Physicians. **No expenses for hearing testing or hearing aids are covered by the Plan except those provided by the University of Connecticut Speech and Hearing Clinic or an audiologist in the Anthem Blue Cross and Blue Shield network or Physicians.**

Retirees are not eligible for this benefit.

Hearing Evaluations

If you or your eligible dependent would like a hearing evaluation, contact the Fund Office to verify your eligibility. After eligibility has been established, the Fund Office will assist you in scheduling an appointment with the University of Connecticut Speech and Hearing Clinic in Storrs or an audiologist in the Anthem network of Physicians.

At the University of Connecticut Speech and Hearing Clinic, you will be given a series of tests by an audiologist who is licensed by the State of Connecticut Department of Public Health and certified by the American Speech-Language-Hearing Association. Results and recommendations will be explained to you at the time of your appointment, and a written report will be mailed to you at a later date. You can obtain the same services from an Anthem network audiologist.

Eligible Participants and their dependents may receive a hearing evaluation once every three (3) years, or more frequently as recommended by an audiologist from the University of Connecticut Speech and Hearing Clinic or an Anthem audiologist.

Hearing Aids

The Fund will pay 100% of the costs, up to $3,500, for hearing aids dispensed by the Hearing Clinic or an Anthem network audiologist, with approved charges in excess of $3,500 reimbursed at 50% coinsurance. Coverage for hearing aids is limited to once every three (3) years. The reimbursement level applies to whether you obtain one or two hearing aids.

Covered charges for hearing aids include the full range hearing appliances, including any necessary accessories, such as ear molds and an initial supply of batteries, provided the hearing aid or aids are deemed appropriate for the individual with the hearing loss by an audiologist at the Hearing Clinic or an Anthem network audiologist. This benefit also includes all the follow-up sessions for the individual with the hearing loss to adjust to the hearing appliance at the Clinic.

An extensive selection of hearing aids is available through the University of Connecticut Speech and Hearing Clinic.

The Fund will **not** replace lost, stolen, or damaged hearing aids or appliances. Hearing appliances, however, do have warranties. The typical warranty is for one (1) year. The warranty will be explained to you by the staff at the Hearing Clinic and is part of the program the Fund arranges with the Hearing Clinic and the manufacturers of the hearing aids. The Fund will not replace lost, stolen or damaged hearing aids that are beyond their warranty period.

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Medical Evaluation

A medical evaluation by a Physician is required prior to the actual fitting of a hearing aid (instrument or appliance). This evaluation is necessary to assure that you do not have a medical condition which would prevent the use of a hearing aid or which would be aggravated by the use of a hearing aid. The medical evaluation can be provided by the Physician of your choice, or you can request the Hearing Clinic to provide a list of Board Certified Physicians in your area. You will be responsible for arranging this appointment. The Claim for charges incurred for the Physician will be processed in accordance with the provisions of the Plan. We encourage you to use a network provider (Anthem Blue Cross) as the charges will be subject to the standard copayment and submitted directly to the Fund Office for processing.

Return Policy

If you are dissatisfied with the hearing aids dispensed, you can return the hearing aid or aids within 30 days to the UConn Hearing Clinic and you will only be responsible for a $50 payment for the processing and handling. Any fees you paid for the balance of the charges for the hearing aid or aids will be refunded to you as the Fund is responsible for all the charges associated with the evaluation and fittings.

Other Information

1. To assist Covered Persons in effectively managing their hearing impairments, group and individual aural rehabilitative instructive classes are available at the Hearing Clinic.
2. Minor repairs to hearing aids and ear molds will be available at the Hearing Clinic. Major repairs are arranged by the audiologist with the manufacturer or an independent laboratory.
3. The number of ear molds and hearing aids and the frequency of their repair or replacement will be determined by the Hearing Clinic's audiologist, according to the individual's needs and generally accepted guidelines of normal wear and maintenance.
4. In the case of children, a parent or other responsible adult must accompany the child to all appointments.
5. Hearing aids will be provided only through the Speech and Hearing Clinic at the University of Connecticut in Storrs, Connecticut or from an Anthem network Audiologist. If you need directions to the UConn Speech and Hearing Clinic, please contact the Fund Office.

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21. UTILIZATION REVIEW PROGRAM

The Fund retains the services of HealthLink to administer its Utilization Review Program. All proposed scheduled non-emergency hospitalizations and outpatient surgeries must be reviewed before you or your eligible dependent(s) are admitted to a Hospital or have a surgery performed in order for the services to be covered and not be subject to a penalty. Review of your non-emergency hospitalization or surgery may be obtained by calling HealthLink 24 hours a day, any day, at (877) 284-0102**.**

To be eligible for coverage under the Plan, hospitals and other inpatient facilities are required to be accredited by the Joint Commission, DNV Healthcare, Commission on Accreditation of Rehabilitation Facilities, or another CMS-approved accrediting organization. This requirement applies equally to medical/surgical benefits and mental health and substance use disorder benefits covered by the Plan. Furthermore, such facilities also must meet all applicable licensing standards established by the jurisdiction in which the facility is located.

Before obtaining any of the following services, you must pre-certify such services with the Fund's utilization review organization:

- Inpatient Hospital Admission for medical treatment
- Inpatient Mental/Behavioral Health and Substance Use Disorder Treatment
- Inpatient Surgery
- Organ Transplant
- Private Duty Nursing Care
- Home Health Care
- Convalescent Facility
- Rehabilitation Services
- Home Infusion Therapy
- Skilled Nursing Facility
- Bariatric Surgery

Failure to pre-certify your inpatient hospitalization, outpatient surgery or the other services listed above, or to follow the medical treatment plan approved by HealthLink, will result in a 20% reduction of benefits otherwise payable by the Fund.

For any inpatient treatment of a mental health condition, alcoholism, and/or substance use disorder, we recommend contacting the Connecticut Pipe Trades' Participant Assistance Program administered by Lower Hudson Valley to maximize your benefit. Refer to Section 16 for more details.

HealthLink administers the Fund's Utilization Review Program, which is designed to work with you and your Physician to keep medical care costs as low as possible, consistent with good medical care. In many instances, review of the need for hospitalization and exploration of available alternatives will indicate that admission to the hospital may be avoided and quality treatment may be better provided in a less restrictive environment. This program is part of your Fund benefits to help you avoid the inconvenience of a Hospital stay entirely, or spend some of your time recovering in a less restrictive setting, perhaps even in your own home. To achieve the best results, follow the steps described in this section for non-emergency medical care. These procedures are in your best interest, **whether or not this Fund is primarily or secondarily liable for such care.**

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The Utilization Review Program does not apply to Medicare retirees or covered dependents if Medicare is the primary insurer.

ALL TREATMENT DECISIONS REST WITH YOU AND YOUR PHYSICIAN (OR OTHER HEALTH CARE PROVIDER). YOU SHOULD FOLLOW WHATEVER COURSE OF TREATMENT YOU AND YOUR PHYSICIAN (OR OTHER HEALTH CARE PROVIDER) BELIEVE TO BE THE MOST APPROPRIATE, EVEN IF: (1) A PROPOSED SURGERY OR TREATMENT IS NOT CERTIFIED AS MEDICALLY NECESSARY; OR (2) THE PLAN WILL NOT PAY REGULAR PLAN BENEFITS FOR A HOSPITALIZATION.

With respect to the administration of this Plan, your Employer, the Board of Trustees and the Plan are **not** engaged in the practice of medicine, and do not take responsibility either for the quality of health care services actually provided or for the results if the patient chooses not to receive health care services that have not been certified by the Utilization Management Program. With regard to Utilization Management, you should keep in mind the following:

- Not all services proposed or provided by a treating Physician will be considered Medically Necessary;
- Certification of Medical Necessity does not necessarily mean that you or your eligible dependents are eligible or that benefits will be payable;
- Patients should follow whatever treatment is most appropriate, but payment of benefits may be affected by the determination of the Utilization Management Program; and
- You have the right to appeal all adverse determinations made by HealthLink (refer to Section 5).

Non-Emergency Cases

If your Physician recommends that you or your eligible dependent be admitted to a Hospital on a non-emergency basis for day treatment, including outpatient surgery, show the Physician your health benefit identification card. You or your eligible dependent must contact HealthLink at (877) 284-0102 to obtain a pre-admission authorization. Your Physician may also provide the information necessary for the pre-admission approval by calling HealthLink directly.

Federal law prohibits the restriction of benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to no less than 48 hours following a normal vaginal delivery, or no 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).

The professional staff at HealthLink will review the clinical information submitted by your Physician and, if Medically Necessary, approve the Hospital admission or surgery. If an inpatient Hospital stay is necessary, HealthLink will advise your Physician of the recommended length of the Hospital stay. HealthLink's staff will work with your Physician throughout your confinement to assure that your continuing care needs are effectively met. Some outpatient surgeries may require a second surgical opinion or that certain criteria be met before approval is given.

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Emergency Cases

In the event you or your eligible dependent is confined to a Hospital on an emergency admission basis, you, a responsible family member, the attending Physician or the Hospital must call HealthLink no later than 48 hours after admission or (if a weekend admission or holiday) the next business day at the toll-free number, (877) 284-0102 notifying an HealthLink representative of the confinement and providing the information required to establish pre-certification of a Hospital admission.

Emergency hospitalization means a confinement required as the result of an unforeseen medical, mental health or substance use disorder situation that requires immediate medical, mental health or substance use disorder treatment to prevent loss of life or permanent damage to the organs or systems of the body. A Hospital admission or surgery made or performed for the convenience of a patient or Physician is not a medical emergency.

Concurrent Review

Once you are in the Hospital, your case will be reviewed continually. This assessment is called "concurrent review." HealthLink will perform a regular review of your medical progress in consultation with your Physician and Hospital staff. The purpose of concurrent review is to monitor the necessity of continued hospitalization and to ensure that you will receive the needed care or services after your discharge from the Hospital. If you require continued medical care, but not intensive services of a Hospital, HealthLink will work with you, your Physician and the Hospital staff to develop a discharge plan that allows an early and safe release from the Hospital.

Extension of Time

If the initially approved Hospital days have been used and you or your eligible dependent remain confined, you or your Physician or Hospital staff must call HealthLink to obtain authorization for additional time required in the Hospital. If HealthLink's professional staff agrees that continued confinement is Medically Necessary, additional days will be approved.

Organ Transplants

If you or an eligible dependent is a candidate for an organ transplant, you must contact HealthLink so that it may assign a "large case manager" for the procedure. The large case manager will coordinate your care and make sure the procedure is performed at an approved Center of Excellence Hospital that is approved by the Fund's stop-loss insurance carrier as a qualified Hospital that is experienced and specializes in the organ transplant procedure.

Large Case Management

HealthLink also provides a special service designed to assist patients with serious Illnesses or Injuries involving prolonged confinements or expensive treatments. Many people who have used this kind of service have found that it provides valuable assistance and peace of mind during difficult periods or serious Illness. Serious medical cases include:

- Chronic Illnesses requiring Home Health Care
- Acute Catastrophic Injury

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- Infectious diseases
- Burns
- Terminal Illnesses
- Neonatal complications

A case management coordinator from HealthLink will contact you and your family to discuss medical care needs. Your personal case management coordinator will help you by:

- Facilitating communication among the professionals involved in your treatment plan.
- Providing information about your treatment and coverage options.
- Identifying any additional medical resources that may be available to you.

You are encouraged to take advantage of this valuable case management service.

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22. MEDICAL EXPENSES NOT COVERED AND GENERAL PLAN LIMITATIONS AND EXCLUSIONS

In addition to any limitations or specific exclusions described in this Summary Plan Description, there are a number of medical charges and procedures that are not covered, unless otherwise indicated. No payment will be made for expenses incurred by you or any one of your eligible dependents for any of the following:

1. Services or supplies **not listed as Covered Charges.**
2. **Charges in excess** of the limitations (number of visits, etc. applicable to specific benefits.
3. Charges incurred for **dental** services, treatment or supplies, except those allowable under the Dental Expense Benefit (refer to Section 18) or for treatment of tumors or cysts, or for treatment rendered within 90 days of an accidental Injury to natural teeth, or as otherwise specifically included.
4. Elective or **cosmetic surgery,** except as required to correct a condition caused by an accident, surgery, or burn, provided such treatment begins within 180 days of the condition's onset.
5. **Eye** refractions, eyeglasses, contact lenses or their fittings, except as allowable under the Vision Expense Benefit (refer to Section 19).
6. **Hearing aids** or their fittings, except as allowable under the Hearing Care Benefit (refer to Section 20).
7. **Transportation,** except for local ambulance services required due to Medical Emergency.
8. Accidental bodily Injury or Illness arising out of and in the course of your employment.
9. Services and supplies for the diagnosis and/or treatment of weight loss, including diet control, **diet supplements, diet prescriptions, weight loss programs, exercise programs, gym memberships, and nutritional counseling, except as specifically provided.**
10. Non-medical services such as employment counseling, **speech therapy and/or educational therapy** for learning or related disabilities, except as specifically provided.
11. **Vitamins,** except as deemed Medically Necessary, or explicitly covered under the Preventive Services benefit, whether or not prescribed by a Physician, and any prescriptions or medications used for weight control, unless otherwise specifically included.
12. **Prescriptions** for animals.
13. **Prescription drugs,** except as payable through OptumRx, under the Prescription Drug Benefit (refer to Section 15).
14. Any maternity charges incurred for the **pregnancy of** a surrogate mother.
15. Any charges related to the **adoption of a child.**
16. Charges for or in connection with **transsexual** surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, such surgery.
17. Any charges for **telephone consultations** with a Physician.

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18. Charges directly or indirectly related to homemaker services or care primarily for rest, custodial, domiciliary or **convalescent care,** including convenience and comfort items.
19. Charges incurred for **personal or comfort** items such as:
    - Personal care kits provided on admission to a Hospital;
    - Television;
    - Telephone;
    - Infant photographs;
    - Complimentary meals;
    - Birth announcements; and
    - Any other item not strictly provided for the treatment of an Illness or Injury.
20. **Therapeutic devices or appliances,** support garments, and other non-medical substances, regardless of the intended use.
21. Charges incurred for or in connection with treatment, services, or supplies for c**essation of cigarette smoking** (unless covered under the Prescription Drug Benefit; refer to Section 15), or except as identified elsewhere in this Summary Plan Description (refer to Section 16).
22. Any services, treatment, or supplies for or in connection with **temporomandibular joint dysfunction,** except those covered under the TMJ Benefit (refer to Section 18).
23. **Osseous surgery,** unless covered under the Dental Benefit (refer to Section 18).
24. **Massage and/or Rolfing therapy,** unless approved in advance by a licensed Physician and Medical Review (refer to Section 21) as an effective alternative to physical therapy.
25. Services, supplies or treatments that are not prescribed, recommended or **approved as Medically Necessary** by an attending Physician or exceeding the Allowable Charge limits. This exclusion also applies to any Hospital confinement or any part of a confinement not approved by HealthLink (refer to Section 21).
26. Fees which are in **excess of Allowable Charges** for services, supplies or treatment.
27. **Cosmetic surgery,** including but not limited to liposuction, etc., unless required because of:
    - An accidental bodily Injury, provided treatment occurs within one year from the date of the accident;
    - Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or
    - Reconstructive surgery, when required because of a congenital disease or anomaly of an eligible dependent child that has resulted in a functional defect.

    This cosmetic surgery exclusion does not apply to charges recognized in accordance with the Women's Health and Cancer Rights Act of 1998, including reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prosthesis; surgical brassieres and treatment of physical complications of all stages of mastectomy including lymphedemas.

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28. Expenses incurred as a result of past or present services in the **armed forces** of any government.
29. Expenses incurred as a result of participation in a f**elony, riot or insurrection.**
30. **Administrative charges** incurred for the completion of Claim forms, mailing fees and stop payment on check fees.
31. Charges incurred for **handling fees,** unless directly related to test results.
32. Expenses incurred for functional **visual training.**
33. **Genetically engineered biological products,** require prior authorization by HealthLink.
34. Meals, meal preparation, **personal comfort items,** other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, non-prescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds, **convenience items,** housekeeping services, and protective or companion services.
35. Expenses related to **surrogate parenting.**
36. Services rendered by a Physician or any other provider of medical services to an **individual who does not participate in this Plan.**
37. An Injury or an Illness that is **employment related** or that is covered under the Workers' Compensation Law, occupational disease law, or similar laws.
38. Expenses incurred during confinement in a **Hospital owned or operated by the federal Government,** unless required by law.
39. Charges for which you or your eligible dependent are **not legally required to pay,** including charges that would not have been made if no insurance coverage existed.
40. **Charges for Custodial Care,** which are institutional services and supplies, including room and board, that are designed primarily to assist the individual in the activities of daily living, which can be expected to improve the individual's medical condition.
41. Charges for Claims that are **not received by the Fund Office,** along with all required supporting information necessary to process the Claim, **within 15 months** from the incurred date, an exception maybe granted by the Board of Trustees if there is evidence the delay was the result of a provider or other insurance carrier.
42. Loss caused by war or any **act of war** (this exclusion does not apply to life insurance benefits).
43. Any expenses, to the extent that you or your eligible dependent is in any fashion paid or entitled to payment for those expenses by or through a **public program.**
44. **Experimental drugs** or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution limited by federal law to investigational use" or drugs not approved to treat a specific diagnosis, except as may be prescribed during **Approved Clinical Trials.**
45. **Experimental Procedures or treatment** methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society, except as otherwise stated elsewhere in this Summary Plan Description as required coverage under the federal Affordable Care Act (i.e., Approved Clinical Trials).

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46. **Medical treatment or procedures unless proven to be safe, efficacious, scientifically established therapies, or unless found to have a demonstrable benefit for a particular Illness or disease.** Ineffective or Experimental surgical or medical treatments or procedures, research studies or other Experimental health care procedures under continued scientific testing and research with questions to safety and efficacy are not covered unless approved by the Fund's Utilization Review Program and stop-loss insurer.
47. Services, treatments, or supplies f**urnished by or at the direction of the United States Government, any state or other political subdivision** thereof, or any of its agents or agencies.
48. Expenses incurred for **elective abortions,** except those charges directly resulting from complications of such abortion, an abortion where the life of the mother would be endangered if the fetus was carried to term.
49. Laser **vision correction surgery,** including but not limited to PRK, keratotomy or LASIK surgery (a discount may be available under the Vision Expense Benefit; refer to Section 19).
50. Services of a **faith-healer.**
51. Any expenses related to **routine foot care** including, but not limited to treatment, services or supplies in connection with:
    - Corns;
    - Calluses;
    - Nails;
    - Weak, strained, or flat feet;
    - Any instability or imbalance of the feet; or
    - Shoes or any other inserts (except for orthotics);
52. **Travel,** except as emergency ambulance services.
53. Any expenses related to services or treatment received for an accident or Injury resulting **from driving while intoxicated with alcohol or illegal drugs and for which a legal arrest and conviction for "DUI" is imposed.**
54. Services of **interns, residents and Physicians in training.**
55. Charges incurred for **speech therapy,** unless required for rehabilitation due to an accident or Illness. Speech therapy for functional, psychoneurotic origin or developmental (learning) is limited to 12 sessions per calendar year.
56. Diagnosis and treatment of **learning disabilities, including but not limited to educational, training programs, visual training, and speech therapy, unless rehabilitation due to an Injury or Illness to restore lost skills,** unless specifically provided for in the Plan.
57. Medical **treatment of obesity,** including but not limited to specialized medical weight reduction programs and medications, except for individuals determined to be "morbidly obese," which is at least 100% more than the ideal weight of an individual's normal body weight for the individual's age, sex, height and body frame, whereas medical dietary and drug therapy will be recognized as a Covered Expense, subject to the Utilization Review Program's requirements (refer to Section 21).

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58. Any services or supplies for or in connection with **acupuncture,** unless the services are pre-approved as medically appropriate by HealthLink (refer to Section 21). Requests for acupuncture services or supplies should come to the Fund Office where they will be sent to HealthLink for review.
59. Any medical treatment, services or supplies **not covered by the Fund's stop-loss insurance.**
60. Any expenses related to **transsexual surgery.**
61. **Biofeedback** when not in conjunction with other medical services that have been approved by the Utilization Review Program.
62. **Laser therapy** for the purpose of ameliorating or modifying snoring unless significant associated sleep apnea has been demonstrated subject to the approval of the Utilization Review Program (refer to Section 21).
63. Care and **treatment of hair loss** unless the treatment is for alopecia areata or scarring alopecia.
64. Antibacterial **soaps**/detergents, **shampoos,** toothpastes and **mouthwash/rinse.**
65. **Hypnosis/hypnotherapy.**
66. **Magnetic therapy.**
67. **Scleral therapy** as the initial treatment for the diagnosis of varicose veins requires prior authorization by HealthLink (refer to Section 21).
68. **Court-ordered treatment,** unless otherwise recognized by the Plan.
69. **Auto-transfusion and storage of blood,** except autologous blood preparation and transfusion.
70. **Genetic tests**, including pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents, and any associated genetic counseling. However, benefits may be payable if determined medically appropriate and pre-approved by HealthLink (refer to Section 21).
71. Any charges or expenses for which a **third party may be liable** (refer to Section 8).
72. **Pre-parental genetic testing** intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. However, benefits may be payable if determined medically appropriate and pre-approved by HealthLink (refer to Section 21).
73. The following limitations and exclusions apply to **preventive services:**
    - Preventive services are covered (refer to Section 14) only when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services performed for diagnostic reasons are covered under the applicable Plan benefit, not the preventive services benefit. A service is considered diagnostic if the Participant had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
    - The Plan will use reasonable medical management techniques to control costs of the preventive services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.

- Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered unless recommended by a licensed physician, deemed medically necessary, or required by the host country.
- Examinations, screenings, tests, items, or services are not covered when they are investigational or experimental, as determined by the Plan.
- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  (i) when required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes, unless part of a regular routine examination;

  (ii) when related to judicial or administrative proceedings;

  (iii) when related to medical research or trials (other than for Approved Clinical Trials); or

  (iv) when required to obtain or maintain employment or a license of any kind, unless part of a regular routine examination.
- Services related to a man's reproductive capacity, including contraception; however, the Plan does cover vasectomies.

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23. DEFINITIONS

These are some of the terms used in this booklet. Some other terms are described within the booklet when they are used. PLEASE READ THESE TERMS CAREFULLY. They may help you to better understand your benefits.

Allowable Charge means the maximum amount of reimbursement the Connecticut Pipe Trades Health Fund will allow for services and supplies that (1) meet our definition of Covered Charges, to the extent such services and supplies are covered under the Plan and are not excluded; (2) that are Medically Necessary; and (3) that are provided in accordance with all applicable pre-certification, utilization management or other requirements set forth in the Plan. (refer to Section 4 for more details)

Allowable Expense means any necessary, reasonable, and customary item of expense, at least a part of which is provided by anyone of the plans that cover the person for whom a Claim is made. When the benefits from a plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Ambulatory Surgical Facility means any public or private establishment that:

- Is licensed as such by the state;
- Is supervised by a group of Physicians;
- Has permanent facilities;
- Is equipped and operated primarily for the purpose of performing Surgical Procedures; and
- Provides continuous Physician and registered graduate nursing services whenever a patient is in the facility.

An Ambulatory Surgical Facility does not include Physicians' or Dentists' offices, or any facilities whose primary purpose is the termination of pregnancy, or a facility that provides services or other accommodations for patients to stay overnight.

Approved Clinical Trial means participation in either a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Refer to Section 14 for coverage requirements.

Contractual Rate means the Fund's payment for in-network covered medical services, which have been agreed upon by medical and dental providers and Anthem Blue Cross the Fund's PPO network.

Complications of Pregnancy means:

- Conditions requiring Hospital stays when the pregnancy is not terminated and the diagnosis is distinct from pregnancy, but is adversely affected by pregnancy or caused by pregnancy; and
- Non-elective Cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Consultation means a review of the medical history of the patient, review of laboratory and x-ray examinations, an examination of the patient, and a report written by the consulting Physician if requested by the primary care Physician.

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Convalescent and Skilled Nursing Facility means an institution (or distinct part thereof), which meets the criteria:

1. It is licensed to provide and is engaged in providing the following (on an inpatient basis) for persons convalescing from an Injury or Illness:
   - Professional nursing services rendered by a registered graduate Nurse (R.N.) or by a licensed practical Nurse (L.P.N.), under the direction of a registered graduate Nurse (R.N.); and
   - Physician restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or registered graduate Nurse (R.N.).
3. It provides 24-hour nursing services by licensed Nurses under the direction of a full-time registered graduate Nurse (R.N.).
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled persons, custodial or educational care, or care of mental disorders.

Covered Charges means the Allowable Charges that are incurred for the Medically Necessary treatment of conditions that are covered under this Plan.

Covered Employment means employment for which an Employer or Contractor is obligated to contribute to the Fund on behalf of an Employee in accordance with a collective bargaining agreement or participating agreement with Local No. 777.

Covered Person means any active or retired Participant and such Participant's eligible dependent spouse and eligible dependent child(ren) who have completed all required formalities for enrollment for coverage under the Plan and are actually covered by the Plan.

Custodial Care means all supplies, including room and board, which are provided, whether you are disabled or not, primarily to assist in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed. Some examples of such services are: help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

Dentist means a person authorized by law and duly licensed to practice dentistry.

Durable Medical Equipment means equipment prescribed by a Physician that is Medically Necessary and:

- Can withstand repeated use;
- Is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness;
- Is not disposable or non-durable;
- It is appropriate for use in the home; and
- It is not primarily and customarily for your convenience.

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The Fund will not pay for the rental and purchase of any such equipment that is not approved by the Fund, regardless of Medical Necessity. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric Hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. **Durable Medical Equipment does not include air conditioners, exercise equipment, saunas, air purifiers, arch support, articles of special clothing, bed pans, corrective shoes, dehumidifiers, elevators, wheel chair ramps, heating pads, hot water bottles, etc. This list is not exhaustive of items not considered Durable Medical Equipment.**

Employee means anyone hired by an Employer or contractor who is covered by: (1) a collective bargaining agreement that requires his or her participation in the Fund; or (2) a participating agreement executed by his or her Employer requiring contributions to the Fund.

Employer means any Employer signatory to a collective bargaining agreement with Local No. 777 or the U.A. that obligates such Employer to make contributions to the Fund.

Experimental (or Experimental Procedure) means:

- Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is meant to investigate and is limited to research;
- Techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
- Procedures which are not proven in an objective way to have therapeutic value or benefit;
- Any procedure or treatment whose effectiveness is medically questionable;
- Any procedure or treatment that is found by the Fund or its designee not to be in Accordance with generally accepted medical and dental practice; and
- Any procedure or treatment that does not have governmental approval.

Genetic Information means the manifestation of a disease or disorder in an individual's family members.

Home Health Care Agency means an agency or organization that meets each of the following requirements:

- It is primarily engaged in and is federally certified as a Home Health Care Agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;
- Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one registered graduate Nurse, to govern the services provided;
- It provides for full-time supervision of such services by a Physician or by a registered graduate Nurse;
- It maintains a complete medical record on each patient; and
- It has an administrator.

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Home Health Care Plan means a program for continued care and treatment of the Participant or eligible dependent established and approved in writing by such Participant's or eligible dependent's attending Physician within 7 days following termination of a Hospital confinement as a resident inpatient for the same or related condition for which the individual was hospitalized, together with such Physician's certification that the proper treatment of the Injury or Illness would require continued confinement as a resident inpatient in a Hospital, in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospital means an institution that:

- Is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic and therapeutic services for the diagnosis, treatment, and rehabilitation of Injured, disabled, or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of Physicians;
- Has a requirement that every patient be under the care of a Physician;
- Provides a 24-hour nursing service rendered or supervised by a registered graduate Nurse;
- Has in effect a Hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations.

Unless specifically provided, the term "Hospital" does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, Convalescent Facility or facility for the aged or for the care and treatment of drug addicts or alcoholics, except as mandated by state law, nor does it mean any institution that makes a charge that you or your eligible dependents are not required to pay.

Illness means any sickness, disorder, or disease that is not employment-related. Pregnancy is treated in the same manner as an Illness under this Plan for you or an eligible dependent spouse.

Injury means physical damage to you or your eligible dependent's body caused by purely accidental means, independent of all other causes. Only Injuries that are not employment-related are considered for benefits under this Plan, except under the Life Insurance and Accidental Death and Dismemberment benefits.

Medical Social Services means services rendered under the direction of a legally qualified Physician, by a qualified social worker holding a Master's degree from an accredited school of social work, including, but not limited to:

- Assessment of the social, psychological, and family problems related to or arising out of such Covered Person's Illness and treatment;
- Appropriate action and utilization of community resources to assist in resolving such problems; and
- Participation in the development of the overall plan of treatment for such Covered Person.

Medically Necessary (or Medical Necessity) means any service, supply, treatment, or Hospital confinement which:

- Is essential for the diagnosis or treatment of the Injury of Illness for which it is prescribed or performed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a Physician.

The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the expense a Covered Charge.

Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act of 1965, as amended.

Midwife or Nurse-Midwife means a person who is certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered graduate Nurse; and
- A person who has completed a program approved by the state for the preparation of Nurse Midwives.

Network Provider, Preferred Provider Network or **PPN/PPO** means those providers or facilities that have fee payment contracts that have been negotiated on behalf of the Fund (Anthem Blue Cross Blue Shield or it associates or Davis Vision).

Non Network or **Non PPO** means providers, services, or facilities that do not have payment contracts with Anthem Blue Cross Blue Shield or it associates or Davis Vision.

Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N." or "L.P.N."

Organ Transplant means the Medically Necessary removal of a human organ (e.g., heart, lung, or liver) from the recipient, and the insertion of the replacement human organ through surgical means, provided such procedure is not considered Experimental and the Fund's stop-loss insurance carrier recognizes such charges.

Out-of-Pocket means the dollar amount a participant will pay for medical expenses for a calendar year. It does not include payments made for:

- Expenses the Fund does not cover;
- Charges in excess of the allowable charges;
- Reductions in benefits due to Fund limitations;
- Penalties the participant must pay due to non-compliance with the Fund; or
- Dental, Vision, and Hearing charges.

Participant means an Employee who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

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Physician means, with respect to any particular medical care and services, any holder of a certificate or license authorizing such holder or licensee to perform the particular medical or surgical services. This definition of Physician will include a licensed psychologist for the treatment of mental and behavioral disorders and substance use.

Plan means this Connecticut Pipe Trades Health Fund. In any place within this Summary Plan Description where the term "Plan" is used, it has the same meaning as "Fund".

Skilled Nursing Services means one or more of the professional services that may be rendered by a registered graduate Nurse or by a licensed practical Nurse under the direction of a registered graduate Nurse.

Surgical Procedure means any procedure in the categories listed below:

- The incision, excision, or electrocauterization of any organ or part of the body;
- The manipulative reduction of a fracture or dislocation;
- The suturing of a wound; or
- The removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter.

Totally Disabled means that, because of Injury or Illness, a Participant is prevented from engaging in his customary occupation and performing any kind of work for pay or profit.

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24. RETIREE BENEFITS

Eligibility Provisions for Collectively Bargained Employees

You will be eligible for the Retiree Benefits Program after your active eligibility has run out, (i.e., you have exhausted your bank of hours) provided you satisfy **all** of the following requirements:

- You retire and are awarded one of the following:
    1. A Service Pension;
    2. A Total and Permanent Disability Pension; or
    3. You retire after attaining age 55 and receive an Early Retirement or Regular (Normal Retirement) Pension from the Connecticut Plumbers and Pipefitters Pension Fund or the UA. National Pension Fund; and
- You have maintained active eligibility for benefits (including COBRA self-pay coverage) immediately prior to your retirement (eligibility as of the first of the month your monthly pension benefits begin);
- You earned at least 5,000 hours during the seven (7) calendar years prior to your retirement or Social Security disability date based on hours/contributions reported to the Connecticut Pipe Trades' Health Fund (including 30 hours per week for each week you receive Disability Income Benefits or Worker's Compensation subject to maximum of twelve (12) months); and
- You make the required monthly self-payment. The required monthly self-payment must be authorized as an automatic deduction from your monthly pension check from the Connecticut Plumbers and Pipefitters Pension Fund.

If eligible, you must enroll in Medicare Part A and B benefits as soon as you become eligible.

Eligibility Provisions for Non-Bargained Employees

If you are a non-collectively bargained Employee who has maintained coverage under this Plan for at least 10 consecutive years and you maintained active eligibility immediately prior to your retirement (including COBRA coverage), you will be eligible to continue benefits as a retiree provided you make the required monthly self-payments.

Effective Date of Coverage

Your coverage as a retiree becomes effective the first of the month after your coverage as an active Participant with the Connecticut Pipe Trades' Health Fund terminates (bank of hours runs out) provided you have satisfied all conditions of eligibility including the filing of an application and authorization to have the required monthly self-payment deducted from your pension check.

Termination of Insurance

All coverage under the Retiree Benefits Program will cease upon non-payment of the required monthly retiree contribution. If coverage terminates for non-payment of the retiree contribution, coverage in this program may not be reinstated.

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Coverage may be reinstated for a retiree provided the lapse in coverage has not exceeded twelve (12) months, he/she has earned at least 5,000 hours during the seven (7) calendar years prior to retirement or Social Security disability date based on hours/contributions reported to the Connecticut Pipe Trades' Health Fund, and he/she has 35 or more Pension Credits in the Connecticut Plumbers and Pipefitters Pension Fund.

Spousal Continuation Coverage

All coverage under the Retiree Benefits Program will cease upon the retiree's death except that if the retiree's eligible dependent spouse was enrolled in the Plan at the time of the pensioner's death, the spouse may elect to continue participation in the Retiree Program by continuing to make the required monthly self-payment contributions.

Medicare Impact on Coverage

In order for a retiree to be covered by the Medicare Supplement Benefit, YOU MUST enroll in Medicare Parts A and Part B. Retiree medical benefits for a Medicare eligible retiree or spouse who is not covered by Medicare will automatically convert to the Medicare Supplement Benefit effective the first of the month in which the retiree or spouse becomes eligible for Medicare.

Payment of Required Retiree Contribution

The required retiree contribution for coverage must be paid by the tenth day of each month. Payment is required to be authorized by automatic deduction from your monthly pension benefit from the Connecticut Plumbers and Pipefitters Pension Fund. If your monthly pension benefit from the Connecticut Plumbers and Pipefitters Pension Fund is sufficient to cover the cost of these benefits, it is mandatory as a condition of participation that the required premium be deducted from your monthly pension check.

For retirements on and after January 1, 2016 and not yet eligible for Medicare, the monthly self-pay rate for retiree coverage will be a percentage based on the maximum allowable COBRA rate. The following percentages will apply:

Years of Service at Retirement	Percentage of Cost Paid by Retiree
30 or more Pension Credits	50%
20 but less than 30 Pension Credits	55%
19 or less Pension Credits	60%

For Medicare retirees with retirement dates on and after January 1, 2016 the monthly self-payment for retiree coverage will be based on the Pensioners Pension Credits at retirement in accordance with the following schedule:

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Years of Service at Retirement	Percentage of Cost Paid by Retiree
30 or more Pension Credits	40%
25 but less than 30 Pension Credits	50%
20 but less than 25 Pension Credits	60%
15 but less than 20 Pension Credits	70%
10 but less than 15 Pension Credits	80%
less than 10 Pension Credits	85%

The Board of Trustees will evaluate the cost of the Retiree Program each year and adjust the monthly self-pay rates accordingly based on the percentages outlined above.

The required self-payment is due by the tenth (10th) of the month and will be accepted until the last day of the month. If, for any reason, you revoke your authorization for deduction and/or fail to remit the required payment by the last day of the month, **your coverage under this Plan will terminate effective the last day of the month for which payment was made, and there is no provision for reinstatement.**

THE FUND AND THE FUND OFFICE ASSUME NO RESPONSIBILITY OR LIABILITY IF YOU ALLOW COVERAGE TO TERMINATE.

Coverage for Dependent Children

A retiree with an eligible dependent child will be permitted to cover the child under the Retiree Benefits Program. If both the retiree and spouse are receiving benefits under the Medicare Supplement Benefit, any eligible dependent child will continue to receive benefits under the Retiree Benefits Program for retirees younger than age 65 or otherwise not eligible for Medicare.

Retiree Coverage–In General

No benefits or rules described in this booklet or the Plan are guaranteed (vested) for any retiree, Participant, spouse, or dependent. All benefits and rules may be changed, reduced, or eliminated prospectively at any time by the Board of Trustees, at their discretion.

If you do not elect retiree benefits for you and your eligible dependent spouse at retirement, you will not have the option to elect these benefits in the future.

Election at Retirement to Suspend Retiree Coverage

If your spouse is actively employed or either you or your spouse have coverage under another group insurance program through your employment under which you are covered as an Employee or dependent, you may elect to suspend your retiree benefits coverage under this Plan, provided that:

- You and your spouse were covered under the Retiree Benefits Program for at least one month; and
- You provide written evidence of your employment insurance coverage or your spouse's coverage to the Fund Office.

When you or your spouse ceases employment and are no longer eligible for active group insurance benefits through your Employer or her Employer, both of you can be added back on this Retiree Program by providing advanced notice to the Fund Office.

Important: Upon retiring and collecting a pension from the Connecticut Plumbers and Pipefitters Pension Fund, your active eligibility will expire as contributions cannot be made on behalf of retirees. When your active eligibility runs out (no longer having a bank of hours), you will be given an option to either maintain your active benefits by making COBRA self-payments or, if eligible, you may elect coverage under the Retiree Program. If you are retired and elect COBRA coverage, you and your spouse will not be eligible for the Retiree Program when COBRA runs out (typically 18 months). **Retiree benefits are a one-time election and must be a continuation of your active eligibility. If you elect not to participate in the Retiree Program when first available, you will not be given another opportunity.**

Benefits for Retirees Prior to Age 65 (or not Medicare Eligible)

Prior to age 65 or Medicare eligibility, retirees will receive the same Medical and Prescription Drug Benefits provided to active Participants with the following limitations or exclusions:

- The Life Insurance Benefit will be reduced to $10,000;
- Dental Benefits are limited to Preventive Care (Type A Expenses only); and
- Vision Benefits are limited to an eye examination at a Davis Vision provider once every 24 months along with additional discounts on eyeglasses purchased from a Davis Vision provider.

No payment will be made for:

- Accidental Death and Dismemberment Benefits;
- Weekly Disability Income Benefits;
- Orthodontic Expense Benefits; or
- Hearing Care Benefits.

Medicare Supplemental Benefits for Retirees Eligible for Medicare

If you are a retiree age 65 or older, or entitled to Medicare due to a disability, medical coverage under the Plan is provided in conjunction with Medicare and is referred to as a Medicare Supplement Program. Medicare is the primary carrier for retirees and/or spouses age 65 and over or otherwise eligible for Medicare. With the exception of prescription drug, dental, and vision Claims, retirees and/or their spouses who are covered by the Medicare Supplement Program must first submit their Hospital and medical Claims to Medicare. Upon payment of the expenses, along with an explanation of benefits statement, the expenses not paid by Medicare should then be submitted to the Fund Office.

Unlike the coordination of benefits with active coverage, Medicare is considered “Primary” (pays first) for covered medical and Hospital expenses, and your retiree benefits through the Fund are “Secondary” (pays second). The benefits provided under the Retiree Medicare Supplement Program will be coordinated with the benefits payable under Medicare for the same expenses. For example, if a

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retiree or spouse of a retiree is age 65 or over, or otherwise eligible for Medicare, reimbursement will first be made under Medicare, and if there are any expenses remaining unpaid, these expenses will be paid at 80%, including Medicare deductibles.

It is important to note that the benefit levels, limitations, and exclusions for Medicare Part A and B coverage are subject to change by the federal government. The Fund will only reimburse under the Medicare rules in effect on the date the Claim was incurred. With the exception of prescription drugs and services provided by a Veteran's Administration facility, the only covered medical expenses reimbursable by the Fund are those in which Medicare is the primary payor.

If services are provided by a facility that is not eligible for Medicare reimbursements, including a Veteran's Administration facility, facility of the Uniformed Services, or other facility of the federal government, benefits will be determined as if the full amount that would have been payable under Medicare was actually paid under Medicare. That is, Medicare benefits will be determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

This Retiree Benefits Program is designed to increase the reimbursement of expenses not paid in-full by Medicare, plus extend to you prescription drug, preventive dental and eye examination benefits. Except as noted above, **if Medicare does not consider such charges as a Covered Charge, this Retiree Program will not recognize those charges for payment.**

Medicare Prescription Drug Benefit

A retiree or spouse covered by Medicare has a different Prescription Drug administrator than active Participants or retirees not yet eligible for Medicare. The copayments are the same but the administration of the Plan is classified as a Medicare Part D program. Unlike traditional Medicare Part D plans, there are no further cost sharing requirements beyond the applicable copayments outlined in the schedule of benefits. For instance, this plan has full donut-hole coverage meaning your copayment will not change during the donut-hole stage. More detailed plan information will be provided by the Prescription Drug administrator.

Covered Medical Expenses

Medical expenses covered by this program include Hospital charges recognized by Medicare Part A, but not paid in-full, for semi-private Hospital accommodations, outpatient Hospital, and non-Medicare hospitalization charges. Covered Charges also include the Allowable Charge Physician expenses in excess of the amount paid by Medicare Part B. The deductible required by Medicare is also considered a Covered Charge. If a specific benefit is exhausted through Medicare, the Fund will not consider those charges as a Covered Charge. This Plan will recognize all the covered medical expenses paid under the active plan of benefits also recognized by Medicare except:

- Accidental Death and Dismemberment Benefits;
- Weekly Disability Income Benefits;
- Dental Expense Benefits (except Preventive Care);
- Orthodontic Expense Benefits;
- Hearing Care Benefits; and
- Vision Expense Benefits (except Eye Examinations at a Davis Vision Provider).

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In addition, the life insurance benefit is $10,000, for retired members only.

There is a rule you should be aware of if you drop or lose your Fund coverage (including your prescription drug coverage).

If you drop or lose your coverage with the Fund and do not enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later. Specifically, if you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (so-called Creditable Coverage), your monthly premium for Medicare's prescription drug coverage may go up by at least 1% of the Medicare base beneficiary premium (a national benchmark determined by the Centers for Medicare & Medicaid Services) per month for every month that you did not have that coverage. For example, if you go twelve (12) months without Creditable Coverage, your premium will always be at least 12% higher than the Medicare base beneficiary premium. You will have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about your prescription drug coverage options, including the prescription drug coverage offered through the Fund, contact the Fund Office.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov.**
- Call the Connecticut Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling and Eligibility Screening (CHOICES) ((800) 994-9422) or see your copy of the "Medicare & You" handbook for telephone numbers for other states.
- Call (800) MEDICARE ((800) 633-4227). TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or call (800) 772-1213 (TTY (800) 325-0778).

Continuation of Coverage for Widows and Dependents

Upon the death of a retiree, benefits under the Retiree Program will be extended to the retiree's eligible dependent spouse and/or eligible dependent children, if they were covered under this Plan at the time of the retiree's death. A deceased retiree's spouse participating in the Retiree Program will be permitted to continue these benefits for life.

A child no longer satisfying the requirements as an eligible dependent child under the provisions of the Plan, and a divorced or legally separated spouse are not eligible to continue coverage under this Plan, except as provided by COBRA (refer to Section 9).

For a widow/widower to continue insurance coverage they must notify the Fund Office of their election to continue this retiree coverage. Without such notification, this continuation option cannot be made. Coverage must be continuous and under no circumstances will the option to make self-payment to the Fund be permitted on a retroactive basis. The Fund assumes no responsibility or liability should you allow your coverage to terminate. **If you believe that an event has occurred where your retiree coverage has lapsed, it is your responsibility to contact the Fund Office to arrange for continuation of coverage.**

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25. PLAN INFORMATION

Plan Sponsor/Plan Administrator

The Plan is sponsored and administered and maintained by a joint Board of Trustees consisting currently of five (5) Local No. 777 representatives and five (5) Employer representatives. Communications to the Board of Trustees can be submitted to the Fund Office as follows:

Board of Trustees
Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Phone: (860) 571-9191
Toll Free: (800) 848-2129

The Board of Trustees has delegated responsibilities for the Plan's day-to-day operations to the Connecticut Pipe Trades Benefit Funds Administration, Inc. ("Fund Office").

The Name and Address of the Fund
Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318

Contributing Employers

You may request confirmation from the Fund Office whether a particular contractor or Employer is a Contributing Employer with respect to this Plan, including the address of that Contributing Employer. You may obtain a complete list of the Employers and Employee organizations sponsoring the Plan upon written request to the Plan Administrator, and such information is available for examination at the Fund Office.

Collective Bargaining Agreement

The Fund is maintained pursuant to collective bargaining agreements or other agreements with U.A. Local No. 777 which provides for the rate of Employer contributions to the Fund and areas of work for which contributions are payable and certain other terms governing contributions. A copy of the collective bargaining agreement may be obtained upon written request to the Board of Trustees and is available for examination at the Fund Office.

The Type of Plan

The Connecticut Pipe Trades Health Fund is a group health plan that provides additional welfare benefits. This Plan provides Life Insurance and Accidental Death and Dismemberment benefits on an insured basis. The Fund has purchased a policy of stop loss insurance to protect it against catastrophic Claims. All other benefits described in this booklet, including medical and short-term disability income benefits, are provided on a self-insured basis to eligible Participants and their eligible dependents.

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Life Insurance and Accidental Death and Dismemberment Insurance is currently provided through Union Labor Life Insurance Company and the specific stop loss insurance is issued by Union Labor Life Insurance Company. The policies and rates are continually reviewed and the insurance carriers and coverages are subject to change.

Life Insurance and AD &D
The Union Labor Life Insurance Company
111 Massachusetts Avenue, NW
Washington, DC 20001
202-682-0900

Stop-Loss Insurance
The Union Labor Life Insurance Company
8403 Colesville Road
Silver Springs, Maryland 20910

Names and Addresses of the Members of the Board of Trustees

Employer	Union
Mr. Salvatore DeFelice, Co-Chairman Enterprise Plumbing & Heating 801 State Street P. O. Box 1769 New Haven, CT 06507	Mr. John T. Higgins, Jr., Co-Chairman U. A. Local 777 1250 East Main Street Meriden, CT 06450
Ms. Kristen Brainerd Mechanical Contractors Association of CT 200 Executive Boulevard, Suite 4F Southington, CT 06489	Mr. Peter Alfieri U. A. Local 777 1250 East Main Street Meriden, CT 06450
Mr. John Ferrucci F & F Mechanical Enterprises 2 Dwight Street North Haven, CT 06473	Mr. Glenn Chester U. A. Local 777 1250 East Main Street Meriden, CT 06450
Mr. Hillar Kivi Tucker Mechanical 367 Research Parkway Meriden, CT 06450-7148	Mr. Michael Rosario U. A. Local 777 1250 East Main Street Meriden, CT 06450
Mr. John McKenney Mechanical Contractors Association of CT 200 Executive Boulevard, Suite 4F Southington, CT 06489	Mr. Paul Venti 8 South Road Marborough, CT 06442

The right is reserved in the Plan for the Board of Trustees, as Administrator, to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time.

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Employer Identification Number (assigned by the Internal Revenue Service)

06-0660430

Plan Number

In conjunction with the Employer Identification Number, Plan number 501 is used to denote Trust in Government filings.

Name and Address of Designee as Agent for Service of Legal Process

Vincent F. O'Hara, Esq.
Holm & O'Hara LLP
Attorneys at Law
3 West 35th Street, 9th Floor
New York, NY 10001-2204

In addition, legal process may be served upon any Board of Trustee member or the Fund Administrator.

Plan Year

The records of the Plan are kept on the basis of a fiscal year, which begins on July 1 and ends on the following June 30.

The Source of Contributions to the Fund

The Plan's benefits are financed through Employer contributions made in accordance with various collective bargaining agreements, investment earnings, COBRA self-payments and retiree self-payments.

The Identity of Any Organization Used for the Accumulation of Assets Through Which Benefits Are Provided

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Covered Persons and defraying reasonable administrative expenses. The Fund's assets and reserves are held in custody by S E I Investments, which also acts as an investment manager of managers and investment advisor.

Eligibility

The Fund's requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described in Sections 1 and 2.

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Appeal Procedure

If a Covered Person is denied, in whole or in part, any benefits under this Plan, as specified in Section 503 of the Employee Retirement Income Security Act, remedies are available and set forth in the section of this booklet entitled, "Denial of Claims and Procedures for Appeal." Refer to Section 5.

Selection of Physicians and Facilities

The Plan extends the Anthem preferred provider network for Hospital and medical services along with adjudicating Claim payments. The Plan does not provide Hospital or medical services. Accordingly, the Plan is not responsible for any acts or omissions by Hospitals or other facilities, or by Physicians, other medical professionals, or any facility staff member or employee thereof.

No Liability for the Practice of Medicine or Dentistry

The Plan, Trustees or any of their designees are not engaged in practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided to be delivered to you by any Physician, dentist or other provider. Neither the Plan, Trustees, nor any of their designees, will have liability whatsoever for any loss or Injury caused to you by any Physician, dentist or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Qualified Medical Child Support Orders

Upon written request to the Fund Office, you may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to the Plan, you may submit a written request to the Health Fund. You may be charged a reasonable fee to cover the copying cost of any materials you wish to receive. Certain documents pertaining to the Fund, such as minutes of meetings, may be inspected at the Fund Office but copies are not permitted.

Statement of Federal Law Relating to Maternity and Newborn Infant Coverage:

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 insurers 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).

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Statement of Federal Law Relating to Women's Health and Cancer Rights Act of 1998:

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 states or 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 and described previously.

If you would like more information on WHCRA benefits, contact the Fund Office.

Plan Amendment or Termination

The Board of Trustees, acting as a body, and only the Board of Trustees, in its sole discretion, has the right to amend or terminate the Plan of Benefits and the Trust Agreement. Any discretionary action taken by the Board of Trustees in determining any matter, including your rights or benefits under the Plan will be decided in a nondiscriminatory manner, as required by law.

Change or Discontinuance of Benefits

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active, retired, or disabled Participants and their eligible Dependents:

- Are not guaranteed;
- May be changed or discontinued by the Board of Trustees, at their discretion;
- Are subject to the Trust Agreement, which establishes and governs the Fund's operations;
- Are subject to the provisions of the group insurance policies purchased by the Board of Trustees; and
- Are subject to changing legislation.

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

In the event of a Plan termination, only Claims and expenses incurred prior to the termination date will be paid. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding Claims, the Trustees will decide the manner in which the remaining assets will be used.

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All changes adopted by the Board of Trustees to the Plan of Benefits or the rules will be published in writing and circulated to the Participants, as required by law, so that the Participants may have up-to-date information concerning their rights, benefits, and privileges.

Interpretation of Terms of the Plan and Trust

The Board of Trustees, acting as a body, and only the Board of Trustees, has the sole and exclusive authority to interpret and construe the terms of the Plan and the Trust, including ambiguous terms and provisions, such as establishing eligibility for benefits, the manner in which hours of work are credited for eligibility, the continuance or discontinuance of benefits, the status of any person as a covered or non-covered Participant, and the level and type of benefits, as well as all other matters. 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.

Fund Authority

No Local Union officer, business agent, Local Union Employee, Employer or Employer representative, association or association representative, individual Trustee, Fund Office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of this Fund, or to commit or to legally bind the Board of Trustees of this Fund in any matter whatsoever relating to the Fund, unless such person will have been given express written authority from the Board of Trustees to act in such matter. All Participants are warned not to rely upon any opinion or interpretation expressed by any such individual. All inquiries, requests for rulings, interpretations, and decisions **must** be directed to the full Board of Trustees in care of the Fund Office.

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26. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan maintains a "Privacy Notice" describing how your medical information may be used or disclosed, as well as how you may gain access to your medical information and your other rights regarding that information. The Plan's Privacy Notice is reproduced here for your careful review:

Connecticut Pipe Trades Health Fund
Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Connecticut Pipe Trades' Health Fund (the "Fund"), as sponsored by the Board of Trustees of the Connecticut Pipe Trades' Health Fund (the "Plan Sponsor").

The Fund needs to create, receive, and maintain records that contain health information about you to administer the Fund and to provide you with health care benefits. This notice describes the Fund's health information privacy policy with respect to your Medical, Prescription Drug, Dental, Vision, and Hearing Benefits. It tells you the ways the Fund may use and disclose health information about you, describes your rights, and the obligations the Fund has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

The Fund's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Fund protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as **"protected health information" (PHI).** Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Fund

The Fund is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Fund's legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that is currently in effect; and
- Notify you of anything the law defines as a breach of your unsecured PHI, and you have a right to, and will receive, appropriate notifications in the event of any such breach.

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The Fund Will Not Use or Disclose Genetic Information PHI for Underwriting

In accordance with the Genetic Information Nondiscrimination Act ("GINA"), the Fund will not use PHI that is genetic information for underwriting purposes. "Underwriting purposes" are broadly defined to include rules for eligibility, enrollment, cost sharing, computation of premium or computation amounts and incentives for participating in wellness programs, as well as activities related to the creation, renewal, or replacement of health insurance or health benefits.

How the Fund May Use and Disclose Health Information About You

The following are the different ways the Fund may use and disclose your PHI:

- **For Treatment.** The Fund may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Fund may advise an emergency room Physician about the types of prescription drugs you currently take.
- **For Payment.** The Fund may use and disclose your PHI so Claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Fund's terms. For example, the Fund may receive and maintain information about surgery you received to enable the Fund to process a Hospital's Claim for reimbursement of surgical expenses incurred on your behalf.
- **For Health Care Operations.** The Fund may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Fund's participants receive their health benefits. For example, the Fund may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Fund may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Fund may also combine health information about many Fund participants and disclose it to the Plan Sponsor in summary fashion so a decision can be made about the coverages the Fund should provide. The Fund may also remove information that identifies you from health information disclosed to the Plan Sponsor so it may be used without the Sponsor learning who the specific participants are.
- **To the Fund's Trustees.** The Fund may disclose your PHI to designated Fund personnel so they can carry out their Fund-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Trustees ("the Plan Administrator") and/or the members of the Fund's Administrative Office. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Fund to any other individual or office and (2) will not be used for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by your contributing Employers.
- **To a Business Associate.** Certain services are provided to the Fund by third party administrators known as "business associates." For example, the Fund may input information about your health care treatment into an electronic Claims processing system maintained by the

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Fund's business associate so your Claim may be paid. In so doing, the Fund will disclose your PHI to its business associate so it can perform its Claims payment function. However, the Fund will require its business associates, through contract, to appropriately safeguard your health information.

- **Treatment Alternatives.** The Fund may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** The Fund may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Individual Involved in Your Care or Payment of Your Care.** The Fund may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Fund may also advise a family member or close friend about your condition, your location (for example, that you are in the Hospital), or death.
- **As Required by Law.** The Fund will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Fund may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Fund may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law Enforcement.** The Fund may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person, or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' Compensation.** The Fund may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. Armed Forces, the Fund may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety.** The Fund may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public Health Risks.** The Fund may disclose health information about you for public heath activities. These activities include preventing or controlling disease, Injury, or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Health Oversight Activities.** The Fund may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain circumstances, the Fund may use and disclose your PHI for medical research purposes.

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- **National Security, Intelligence Activities, and Protective Services.** The Fund may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the Fund may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funerals Directors.** The Fund may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Fund may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

- Your rights regarding the health information the Fund maintains about you are as follows:
- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your eligibility, Claim and appeal records, and billing records, but does not include psychotherapy notes.

  To inspect and copy health information maintained by the Fund, submit your request in writing to the Plan Administrator. The Fund may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Fund may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.
- **Right to Amend.** If you believe that health information the Fund has about you is incorrect or incomplete, you may ask the Fund to amend it. You have the right to request an amendment for as long as the information is kept by or for the Fund.

  To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Fund may deny your request if you ask the Fund to amend health information that was: accurate and complete, not created by the Fund; not part of the health information kept by or for the Fund; or not information that you would be permitted to inspect and copy.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Fund has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

  To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.
- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Fund uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Fund discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Fund not use or disclose information about a surgery you had.

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To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Fund's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: The Fund is not required to agree to your request.

- **Right to Request Confidential Communications.** You have the right to request that the Fund communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Fund send you explanation of benefits (EOB) forms about your benefit Claims to a specified address.

  To request confidential communications, make your request in writing to the Plan Administrator. The Fund will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

You may exercise your rights through a personal representative. Your personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Plan 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.

Changes to this Notice

The Fund reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Fund already has about you, as well as any information the Fund receives in the future. The Fund will post a copy of the current notice at the Fund's Administrative Office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below.

Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred. You may file a complaint with the. Department of Health and Human Services, Office for Civil Rights (OCR), at the following website:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Alternatively, you can call OCR at (800) 368-1019.

You will not be penalized or retaliated against for filing a complaint.

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Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Fund will be made only with your written authorization. If you authorize the Fund to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Fund will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the Fund will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Board of Trustees
Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Toll Free: (800) 848-2129
Fax: (860) 571-9221

Should you wish a Business Manager, Agent, or a member of the Board of Trustees to assist you in answering any questions regarding a health Claim or to address an issue on your behalf, you must complete and sign an authorization form permitting the Fund to share your protected health information with that individual. A representative of a Local, a Trustee, or any other individual such as an attorney or relative generally cannot have access to any of you or your dependent's information maintained by the Fund without a specific written authorization form completed. This cannot be an open-ended authorization. Regulations require that the authorization be limited (e.g., to a specific Claim or time period).

Limitations on the Use and Disclosure of Genetic Information

This policy is adopted in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Non-Discrimination Act of 2008 (GINA). If the privacy rules are changed by the Department of Health and Human Services, the Plan will follow the revised rules.

The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

Genetic information includes, with respect to an individual, information about:

- The individual's genetic tests;
- The genetic tests of the individual's family members;
- The manifestation of a disease or disorder in family members (described below) of such individual; or
- Any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member (described below) of the individual.

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References to “family members” include: parents, spouses, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, great-grandparents, great-grandchildren, great aunts, great uncles, first cousins, great-great grandparents, great-great grandchildren and children of first cousins, whether by consanguinity (such as siblings who share both parents) or affinity (such as by marriage or adoption). In addition, references to genetic information of an individual or family member includes the genetic information of a fetus carried by the individual or family member, and any embryo legally held by an individual or family member using assisted reproductive technology.

Underwriting purposes is defined broadly to include:

- Rules for, or determination of, eligibility (including enrollment and continued eligibility) for, or determination of coverage for, benefits under the Plan. Among other items, this includes changes in deductibles or other cost sharing mechanisms in return for activities such as completing a health risk form or being in a wellness program;
- The computation of premium or contribution amounts under the Plan. Among other items, this includes discounts, rebates, payment in kind or any other premium differential mechanisms in return for completing a health risk assessment or participating in a wellness program;
- The application of any pre-existing condition exclusion under the Plan; and
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

Underwriting purposes do not include determinations of medical appropriateness where an individual seeks a benefit under the Plan.

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27. STATEMENT OF RIGHTS UNDER ERISA

This statement of your rights under ERISA is required by federal law and regulation.

As a Participant in the Connecticut Pipe Trades Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

Examine, without charge, at the Fund Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Fund Administrative Office, 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 Fund Administrative Office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Fund Administrative Office is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself or your eligible dependent spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible dependents may have to pay for such coverage. 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 an employee benefit plan. The people who operate your Plan are referred to as "fiduciaries". They have a duty to act prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 schedules.

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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 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Office 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 Fund Office.

If you have a Claim for benefits that 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 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.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan by following the appeal procedures described in Section 5 before you may file suit in any court.

Assistance with Your Questions

If you have any questions about your Plan (for example, any questions about the processing of your Claims, or allowances considered by Plan, covered expenses, or questions regarding your eligibility), you should contact the Fund Office below:

Connecticut Pipe Trades Health Fund
Connecticut Pipe Trades Benefit Funds Administration, Inc.
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Phone: (860) 571-9191
Toll Free: (800) 848-2129

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at (866) 444-EBSA (3272) or visit the EBSA website at www.dol.gov/ebsa.

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28. IMPORTANT: FUND NOTIFICATION

NOTIFY THE FUND OFFICE AT:

Fund Office
Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
Phone: (860) 571-9191
Toll Free: (800) 848-2129

IF:

- You get married
- A child is born
- A child reaches the age of 26
- You, your spouse or dependent become eligible for medical or dental coverage from any other source
- You are or become divorced or separated
- You change your address
- You want to change your beneficiary
- You or your spouse reach age 65
- You or your spouse become covered by Medicare

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