

To All Participants:

This is the Health and Welfare Plan and Summary Plan Description of the Idaho Pipe Trades Trust. This Plan describes benefits funded by the Trust: medical, prescription drug, dental, vision, and hearing aid benefits. It also summarizes insured benefits: life and accidental death and dismemberment insurance. You may ask the Administrative Office for a copy of insurance contracts, where your insured benefits are described in full. In the event of ambiguity or conflict between an insurance contract and the Plan or other documents, the insurance contract controls. The Plan was adopted for the exclusive benefit of Participants who are employed by certain companies in the pipe trades industry. Costs are funded by contributions from these Employers. Plan benefits are designed to help cover some of your expenses when you become sick, are injured, or die. This written version of the Plan describes benefits on June 1, 2008.

Here are some important tips on using your benefits:

- **To receive benefits, you must complete an annual enrollment form and submit a claim as soon as possible and never later than 12 months after the date of service or when the supply or drug is dispensed.**
- Inform the Administrative Office of any address changes to ensure that you receive updated Plan and self-pay information.
- Inform the Administrative Office of any changes in your Eligible Dependents.
- **Note that capitalized terms in this Document have very specific meanings. Please refer to the definitions section beginning on page 67.**

As your Trustees, we make every effort to administer the Trust carefully and make changes to your Plan as the Trust's financial condition changes. Eligibility provisions and benefits may be increased or decreased from time to time. You will be notified if there are changes.

Important addresses and telephone numbers are listed on page 79 of this Document.

Sincerely,

Board of Trustees

Employer Trustees

Dana Trautner, Secretary

Bill Magnuson

Steve Ferro

Union Trustees

Rodney Fuger, Chairman

Rodney Clay

Mike Breed

The Board has the sole, exclusive, and discretionary authority to make any and all determinations under the Plan, including eligibility for benefits, amount of benefits payable, and the meaning of Plan language. The Plan Administrative Office is the only party authorized by the Board of Trustees to answer questions about the Trust and the Plan. No Trustee, Employer, Employer Association, or Labor Organization, nor any of their employees or representatives, has any authority in this regard. The Trustees reserve the right to change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

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I. Benefits Highlights

The chart below highlights main features of each of the Plan's benefits. See the Definitions section, which begins on page 67, and other applicable sections as noted for details.

Benefits Highlights		
Plan	Highlights	For More Information
Medical *	<p>Plan pays 80% of many Covered Medical Expenses after you pay an annual deductible of \$300 per person. The Plan pays 50% of some Covered Medical Expenses.</p> <p>After you reach an annual out-of-pocket limit of \$7,500 per person, the Plan pays 100% of that person's Covered Medical Expenses for the rest of the calendar year. The out-of-pocket limit applies to Covered Medical Expenses above the annual deductible and office/emergency room co-pays</p> <p>The maximum lifetime benefit is \$500,000 per person.</p>	See page 23, Section IV
Prescription drugs *	<p>You pay a co-payment for each covered prescription (up to a 30-day supply) you fill at a participating pharmacy, as follows:</p> <ul style="list-style-type: none"> • Generic drugs: \$10 co-payment • Preferred brand-name drugs: \$25 co-payment • Non-preferred brand-name drugs: \$50 co-payment Ascend Specialty Therapy: 10% of discounted cost of drug 	See page 35, Section V
Dental *	<p>The Plan pays a percentage of Covered Dental Expenses after you pay an annual deductible of \$50 per person, as follows:</p> <p>Two routine exams every calendar year -80%</p> <ul style="list-style-type: none"> • Other Class A services - 80% (for example: diagnosis, cleanings, extractions, most fillings) • Class B services - 50% (for example: crowns, bridgework, dentures) <p>There is a calendar year maximum benefit of \$1,000 per person.</p>	See page 38, Section VI
Vision *	<p>Eye exams are covered once every calendar year.</p> <p>The Plan pays a portion of the cost of lenses and frames (once every two calendar years). No deductible applies to vision benefits.</p>	See page 40, Section VII
Hearing aid *	<p>The Plan pays 80% of eligible hearing aid expenses; up to \$750 per ear every three calendar years to Covered Participants (dependents are not eligible). No deductible applies to the hearing aid benefits.</p>	See page 42, Section VIII
Life insurance	<p>Active Participants:</p> <ul style="list-style-type: none"> • Employee life insurance-\$10,000 paid to your Beneficiary if you die. • Spouse life insurance-\$2,000 paid to you if your Covered Spouse dies. • Child life insurance-\$2,000 paid to you if your Covered Child dies. <p>Retiree Participants:</p> <ul style="list-style-type: none"> • Employee life insurance-\$5,000 paid to your Beneficiary if you die. • Spouse life insurance-\$1,000 paid to you if your Covered Spouse dies. • Child life insurance-\$1,000 paid to you if your Covered Child dies. 	See page 43, Section IX

<p>Accidental death and dismemberment (AD&D)</p>	<p>Active Participants:</p> <p>AD&D pays a benefit of \$90,000 to a Covered Active Participant's Beneficiary if you die as a result of an accident covered under the Trust's policy with Regence Life and Health, smaller amounts are payable to you for certain accidental dismemberments.</p> <p>Retiree Participants:</p> <p>AD&D pays a benefit of \$5,000 to a Covered Retiree Participant's Beneficiary if you die as a result of an accident covered under the Trust's policy with Regence Life and Health; smaller amounts are payable to you for certain accidental dismemberments.</p>	<p>See page 47, Section X</p>
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* The Plan reimburses only Medically Necessary services and supplies up to a percentage of the Usual, Customary, and Reasonable (UCR) amount. The Plan does not reimburse all health expenses. See page 70 for the definition of Medically Necessary.

II. Eligibility

Participants

For Employees covered by a Collective Bargaining Agreement, eligibility for Plan benefits is determined under an “hour bank” system, which also lets you build up hours of eligibility for use during periods of slack employment or total layoff.

Special Agreement Participants

You and your Employer must satisfy all requirements in the Plan, Trust, and Special Agreement. Like bargained Participants, you must establish your Initial Eligibility by working 300 Covered Hours within no more than five consecutive months. Your coverage will then begin after a one-month lag and the hour bank system also applies to you.

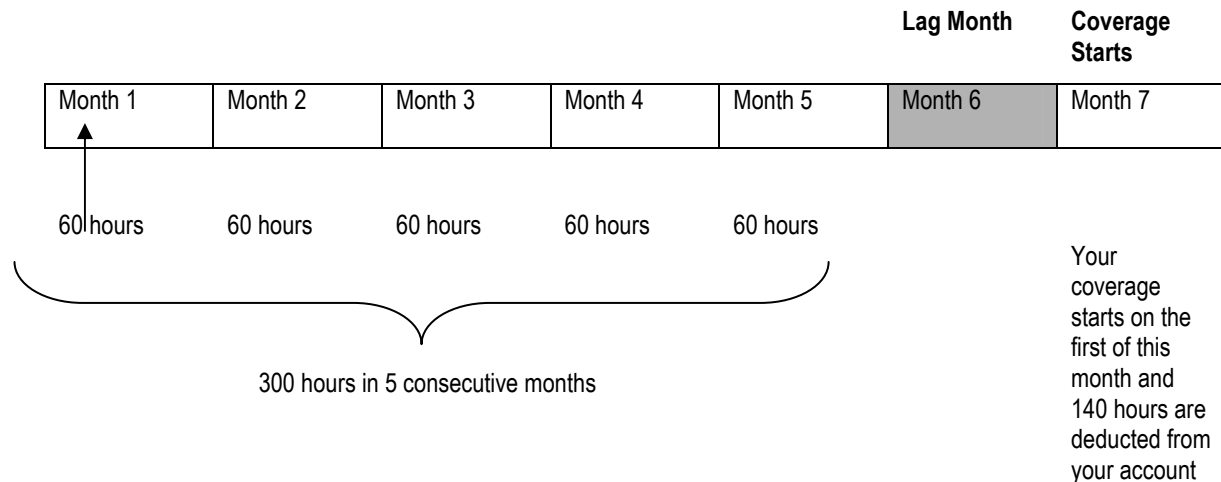
Your coverage continues on a month-to-month basis as long as you meet the requirements in the Special Agreement, you are regularly scheduled to work for your Employer, you have at least 140 hours in your hour bank account, and your Employer continues contributing on your behalf.

Hour Bank Account

When you begin working for a Contributing Employer, the Plan Administrative Office sets up an hour bank account to track your Covered Hours of employment. Covered Hours are your work hours for which your Employer must contribute to the Trust Fund. Your account is credited with your Covered Hours when the Administrative Office receives contributions for those Hours. Once you establish your Initial Eligibility, 140 Covered Hours per month are deducted from your hour bank account to provide your coverage.

INITIAL ELIGIBILITY

To first become eligible, you must work at least 300 Covered Hours within no more than five consecutive months. After a one month lag, 140 hours are deducted from your account and your coverage begins as shown in the example below.



If you build up 300 hours in less than five months, you'll be eligible sooner. For example, if you earn 300 hours in only three months, the fourth month is your lag month and your coverage starts on the first day of the fifth month.

The lag month is necessary for the Plan Administrative Office to receive and process reported hours.

In accordance with Trust Rules and Procedures, the Trustees may waive these initial eligibility requirements for the Employees of a newly-organized Contributing Employer. If a waiver is granted to your Employer, it must make an initial contribution to the Trust in an amount equal to 300 hours times the contribution rate then in effect for each Employee with respect to whom the initial eligibility requirements are waived. To qualify for waiver of the initial eligibility requirements, you must be employed on the date your Employer becomes signatory to a Collective Bargaining Agreement. If your initial eligibility requirements are waived in accordance with the above, you'll become eligible on the first day of the month after your Employer becomes signatory. Such eligibility will continue for two months. After the first two months, your eligibility is determined in accordance with the normal rules (see *Continuing Eligibility*, on page 10).

When Hours Are Credited to Your Bank

Hours will not be credited to your hour bank account until the Plan Administrative Office actually receives your Employer's contributions for them. This can cause you to lose eligibility and coverage even though you worked the necessary hours. If your Employer later makes the required contributions or your contributions are received through reciprocity and the Trust accepts them, your account will be retroactively adjusted. If you have enough Covered Hours, your coverage will be

If You Don't Have Enough Hours for Coverage

When a combination of your prior month's hour bank balance and your hours worked is less than 140 hours, your coverage will automatically end on the last day of the following month. See the section called "When Coverage Ends" on page 12 for more information.

You may choose to continue your health care coverage on a self-pay basis under COBRA (see page 17) or the Lifetime Self-Pay Option, if you qualify (see page 21).

reinstated as if contributions were received on time. **Your reported hours will be posted to the actual work month** and your Employer's payment will be applied first to the earliest hours on which payment is owed.

Continuing Eligibility

After you become eligible for the first time, your coverage will continue as long as you have at least 140 Covered Hours available in your hour bank account.

Building Up Hours for Future Eligibility

For months when you work more than 140 Covered Hours, the extra hours build up in your account. You may use these hours to continue your eligibility during months when you earn less than 140 hours. For example, let's say you work only 100 hours one month but you've built up a balance of 200 hours in your hour bank, so you have 300 total hours available — more than enough for a month's eligibility. 140 hours are deducted from your total hour bank for the month's coverage, leaving a balance of 160 hours in your account. Even if you do not work any hours next month, you have more than enough hours for another month of eligibility.

The maximum number of hours you can have in your hour bank account at any time — after deducting hours for the current month — is 560 (enough for four months of eligibility).

The right to continued eligibility under the Plan based on your hour bank is not vested or accrued. The Board of Trustees has the authority to modify or cancel extended eligibility based on hours in your hour bank account. If your Employer's Bargaining Unit ceases participation in the Plan you will lose eligibility and all accumulated hours, whether you participate pursuant to the terms of a Collective Bargaining Agreement or Special Agreement. This cancellation would be effective as of the last day of the month in which your Employer's Bargaining Unit ended its Plan participation.

Dependents

Eligible Dependents

Eligible Dependents may receive coverage under the Plan's medical, prescription drug, dental and vision benefits, as well as the Plan's life insurance benefit. Dependents are not eligible for coverage under the accidental death and dismemberment insurance or hearing aid benefit.

To add your Dependent to your coverage, you must provide a completed Enrollment Form along with the necessary legal documentation, to the Plan Administrative Office. In general, you must provide these materials within 30 days of your initial eligibility, within 30 days of a marriage or student enrollment, and/or within 60 days of a birth or adoption. *If proper documentation is not supplied within the required time period, claims processing will be delayed for your Dependent until he or she is properly enrolled. Also, note that the Plan will not pay expenses submitted more than 12 months after they are incurred.*

Legal Documentation could include but not be limited to:

Birth Certificates
Marriage Certificates
Final Divorce Decrees

If your Spouse works at least 20 hours per week or 80 hours per month and has group health coverage available through an employer but does not elect that coverage, your Spouse will not be considered an Eligible Dependent and the Plan will not cover your Spouse's claims for benefits under the Plan. This applies whether or not

your Spouse must pay for the other coverage. Your Spouse will again be considered an Eligible Dependent and will again be covered under the Plan as of the date he or she ceases to be eligible for such other coverage. A Certificate of Creditable Coverage will be required by the Administrative Office to determine the coverage effective date.

The definition of Eligible Dependents includes:

If you have stepchildren, see "Coordination of Benefits" on page 51.

- Your Spouse, unless the above paragraph applies and/or a Legal Separation is obtained.
- Your never married **natural and/or adopted** children who depend upon you financially and qualify to be claimed as a dependent on your federal income tax return. "Adopted children" for this purpose includes children who are placed with you for adoption.
- Your never married **stepchildren** when you have custody 51% or more of the time. Your stepchildren must also meet the Plan requirements that apply to natural and adopted children (i.e., they must depend on you financially and qualify to be claimed as a dependent on your federal income tax return). A stepchild ceases to be an eligible dependent if your marriage with the natural parent terminates or a Legal Separation is obtained.

Each January and July, you must submit a special "stepchild enrollment form" that verifies that your stepchild lives with you at least 51% of the year and meets all other Plan coverage requirements for natural and adopted children, before your stepchild's coverage will continue. For other Eligible Dependents, you must submit an annual enrollment form each November. The Plan will not reimburse claims unless and until you have properly submitted the required enrollment form(s). The following age limits apply to the above qualified natural, adopted and step children:

- **Through** age 18 or
- **Through** age 22 if attending college, university, or a vocational, technical, trade, or secondary school on a full-time basis. "Full-time" means taking 12 semester credits or more. The Plan continues to provide coverage during a one semester or one quarter break, but only if the break occurs no more than once every 12 months and the student returns to school as a full time student immediately after the break. The summer session is considered a break. When your stepchild is away from your home temporarily due to schooling and qualifies as a covered dependent as listed above prior to leaving for school, adequate documentation must be presented to the Plan Administrative Office to determine continuing dependent status.
- Any age if the child is incapable of self-sustaining employment due to mental retardation or physical handicap which began before the child was 19. The incapacity must not be caused by or related to illegal activity or commission of a crime, the child must have been covered by the Plan when he or she turned age 19, and you must submit proof of incapacity and dependency within 31 days of the child's 19th birthday. After a two-year period, the Trustees may require subsequent proof once a year.

The Plan also provides coverage to the natural or adopted child of a Participant if required by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Such coverage begins on the date specified in the QMCSO or as required by law. Contact the Plan Administrative Office if you would like a free copy of the Plan's QMCSO procedures.

When Dependent Coverage Begins

Coverage of your Eligible Dependents generally begins on the same date as your coverage. However, you must properly enroll them as described on page 10. If you add a new Dependent (through marriage, birth, or adoption, for example) while covered under the Plan, your new Dependent's coverage begins as follows, subject to their proper enrollment as described on page 10:

- **Spouse or stepchild** — first day *after* your date of marriage. Since coverage is subject to the pre-existing condition limitations, see page 24 for details.
- **Newborn natural child** — date of birth.
- **Adopted child** — earlier of date of adoption or placement for adoption.

Options for Continuing Lost Coverage

You may continue lost health care coverage on a self-pay basis through either the COBRA or Lifetime Self-Pay coverage options described on pages 21 and 22.

Life insurance may be converted to an individual policy as described on page 46.

When Coverage Ends

Eligibility and coverage for you and your dependents will end on the *earliest* of the following:

- The last day of the month following a month in which your hour bank account balance has fewer than 140 Covered Hours.
- The date the Plan is terminated or modified to eliminate your eligibility or coverage.
- On the last day of the month in which your Employer's right to participate in the Plan terminates under your Collective Bargaining Agreement or Special Agreement for any of the following reasons: (1) Nonpayment of contributions, (2) Fraud/intentional misrepresentation of fact by the Employer, (3) Employer's noncompliance with material Plan provisions or Trust rules, and (4) Failure to meet terms of the Collective Bargaining Agreement or Special Agreement or to employ Employees covered by a Collective Bargaining Agreement.

Your Dependents' eligibility and coverage will end on the last day of the month in which:

- Your eligibility ends,
- The Covered Spouse ceases to be an Eligible Dependent, or
- The Covered Dependent ceases to be an Eligible Dependent, or
- The Covered Dependent enters the armed forces of any country.

You are responsible to notify the Administrative Office of any dependent(s) change in status. If you fail to properly notify the Plan when your dependent no longer qualifies as a Covered Dependent and claim payments are made for services incurred after your dependent's coverage ends, **you will be held financially responsible** to reimburse the Plan any and all overpayments.

Restoring Lost Coverage

If you lose coverage because you have less than 140 Covered Hours in your hour bank, you will become eligible again after you accumulate 140 Covered Hours within five consecutive months after coverage ended. A lag month will then apply; coverage is reinstated on the first of the second month following the month in which you have 140 Covered Hours in your hour bank.

If you are unable to build up 140 Covered Hours within five consecutive months after losing coverage, any remaining balance in your hour bank account will be forfeited. As described on page 9, you must re-establish Initial Eligibility again to restore coverage. Please be aware that you will have no coverage for pre-existing conditions, until the requirements for coverage are satisfied, see page 24.

You may also elect to self-pay. See Section III on page 17 for details.

If You Take a Leave of Absence

Generally, coverage ends whenever you do not have enough hours in your hour bank, regardless of the reason. However, under certain circumstances described below, you may retain coverage for a period of time while you are away from work.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations you may be entitled to take up to 12 weeks of leave during any 12-month period, and that in such situations your Employer is required to continue your health benefits coverage. The determination as to whether a leave of absence is a FMLA leave is made by your Employer, not the Plan, and the Plan provides coverage during a FMLA leave only to the extent it receives the appropriate Contributions. If requested, you must submit proof acceptable to your Employer that your leave is in accordance with FMLA provisions.

To be eligible for continued coverage under FMLA, you must work for an Employer with 50 or more Employees within a 75-mile radius. You must also have worked for your current Employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet those requirements, and you have provided your Employer with notice as required by FMLA, your Employer must continue contributing to the Plan while you are on a FMLA-qualified leave. If your Employer is required to contribute on your behalf for a FMLA leave, the Plan will base the Employer's contribution obligation on the amount of contributions reasonably expected on your behalf if you had not been on FMLA leave, considering such factors as your work schedule and your hours of work in the preceding months.

A leave qualifies for FMLA if it is:

- To care for your child after birth or placement for adoption; or
- To care for your child, Spouse, or parent who has a serious health condition; or
- For your own serious health condition that makes you unable to perform your job; or
- For a "qualifying exigency" as defined under Department of Labor regulations arising because your spouse, child or parent is on active duty (or has been notified of a call or order to active duty) in the Armed Forces in support of a specified military operation; or
- To care for your spouse, child, or parent (or other individual for whom you are the next of kin) who is a member of the Armed Forces (including National Guard or Reserves) and who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. A maximum of 26 weeks of leave during a single 12-month period may be taken for this type of FMLA leave. If you are married and both you and your Spouse have the same Employer,

your FMLA continued coverage may not exceed a combined total of (a) 12 weeks if the FMLA leave is related to the birth or placement of a child or caring for a parent with a serious health condition, or (b) 26 weeks if the FMLA leave is related to the care of a sick or injured “covered service member.”

Extended benefits for Total Disability (as described on page 15) run concurrently with extended benefits under FMLA.

Continuation of coverage under FMLA ends on the earliest of:

- The date your employment relationship would have terminated if you had not taken FMLA leave (e.g., your position is eliminated as part of a nondiscriminatory reduction in force and you would not have been transferred to another position);
- The date you inform your Employer of your intent not to return from leave; or
- The date you fail to return from leave or continue on leave after exhausting your FMLA leave entitlement in the 12-month period.

You should contact your Employer as soon as you think you are eligible for a family or medical leave and to find out more about FMLA leave and the terms and conditions on which you may be entitled to it. Note that it is your Employer — not the Plan — that is responsible to determine whether you are eligible for FMLA leave.

When your continued coverage under FMLA ends, you and your Covered Dependents may elect to continue your health coverage through COBRA self-payment (see page 17).

If you do not return to work with your Employer after your leave, the law permits your Employer, under certain circumstances, to recover from you the amount it contributed to the Plan during your FMLA leave. To find out more about FMLA leave and its terms and conditions, you should contact your Employer.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are an Active Participant or a Retiree Participant covered through your hour bank account balance and you leave covered employment to perform certain service in the United States uniformed service (generally the federal armed services, National Guard, Coast Guard, and commissioned corps of the Public Health Service), you and your Covered Dependents may have the right to continue your medical, prescription drug, dental, and vision coverage.

If your uniformed service lasts less than 31 days (for example, active duty for training or a fitness-for-duty determination), the Plan will continue your coverage. If your uniformed service lasts 31 days or longer, you and your Dependents may continue coverage through COBRA self-payments (see page 17) in accordance with your rights under COBRA and USERRA. Coverage under USERRA and COBRA will run concurrently.

You may choose between two payment options to continue your coverage at the beginning of your USERRA leave. Under the first option, if you have enough hours in your hour bank, you may use your hour bank to continue health plan coverage for you and your Covered Dependents until the hours left in your hour bank account are no longer sufficient to do so. You must then begin self-payment. When you return to employment after your USERRA leave, your regular

coverage will resume immediately as long as you meet the requirements summarized below, but any hours deducted from your hour bank will not be restored. Alternatively, you may begin self-payment with the first month of your USERRA leave and not use your hour bank. Under this option, when you return to covered employment, your regular health plan coverage will resume immediately as long as you meet the requirements summarized below, and the hours that were in your hour bank before you left will be restored. If at the time you begin your USERRA leave you have not chosen between these two options or you have not notified the Plan in writing that you wish to discontinue Plan coverage, you will be deemed to have chosen to continue coverage by using your hour bank before beginning self-payment.

Under USERRA, you must notify your Employer and/or hiring hall before taking leave (unless prevented by military necessity or it is otherwise impossible or unreasonable under the circumstances). You may give notice using a form available from the Plan Administrative Office. You may also use that form to elect one of the options described above. You should also tell your Employer and/or hiring hall how long you expect to be gone.

Upon release from military duty, you must report back to work or apply for reemployment by the following deadlines:

- Less than 31 days' uniformed service — report back by the beginning of the first regularly scheduled work period on the following day, taking into account safe transportation plus an 8-hour rest period.
- 31-180 days' uniformed service — apply within 14 days.
- More than 180 days' uniformed service — apply within 90 days.

These deadlines may be extended if reporting or applying for reemployment by the deadline is impossible or unreasonable through no fault of your own. If you're hospitalized or convalescing due to an injury or illness you incurred or aggravated during uniformed service, these reemployment deadlines are extended while you recover (but not longer than two years).

The Trust establishes the premium for continuation coverage under USERRA, which is payable in monthly installments. The maximum length of USERRA continuation coverage is 24 months, or if earlier, the day after you fail to return to employment covered by the Plan as described above.

When you return to covered employment after your uniformed service, you may be eligible to have your medical, prescription drug, dental, and vision coverage immediately reinstated. To qualify, you must have given advance notice of your leave (unless excused – see above), and your uniformed service cannot have exceeded 5 years (with certain exceptions). Certain other limitations and restrictions apply, as explained in the *Participant Rights Under USERRA* you receive when you begin your leave. Depending on whether your hour bank is reinstated (as described above), you may need to make self-payments to resume immediate coverage until you work enough hours to sustain continued coverage under the Plan.

Plan benefits will not be paid for any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred or aggravated during service in the uniformed service.

If You Are Disabled

Certain Plan medical benefits may be extended without cost if you or a Covered Dependent is Totally Disabled when coverage ends. Specifically, the Plan only covers medical benefits for the **disabling condition** for the twelve months immediately following your (or your Covered Dependent's) coverage termination date. Extended benefits for Total Disability run concurrently with extended benefits under FMLA.

“Totally Disabled” means prevented by Illness or accidental Injury from performing any and every duty of your occupation or from performing any occupation for wage or profit.

This extension of benefits will not apply if the disabling condition is covered (or would have been covered if workers' compensation premiums had been paid) by workers' compensation.

If You Die while covered by the Plan

If you die while covered by the Plan, your Covered Dependents who qualify for COBRA will receive **the first six months** of the maximum 36 months of COBRA coverage **without having to pay a premium**. They must still timely elect COBRA following your death. See page 17 for details on COBRA.

If you qualified for the Lifetime Self-Pay option and you were married 12 or more months immediately before your death, your surviving Covered Spouse may elect to continue coverage for himself or herself (and for your Covered Dependent children through age 18, or 22 if attending school or later if disabled, as described in the “*Eligible Dependents*” section beginning on page 10) under the Lifetime Self-Pay option as long as he or she does not remarry. As under the COBRA option described above, the first six months of coverage will be premium free. However, if your Covered Dependents wish to opt-out of the Plan due to other employer sponsored coverage, they must do so during the first month of coverage after your death, see page 21 for details.

III. Self-Pay Options for Continuing Your Coverage

Self-pay rules and rates for health benefits and uninsured welfare benefits are determined by the Trustees. The rules and rates are changed by the Trustees from time to time.

If, after becoming a Covered Participant, your coverage ends due to insufficient hours in your hour bank account, you may continue your coverage if you qualify to make self-payments. A Participant who wishes to self-pay must make timely payments in accordance with the rules of COBRA or Lifetime Self-Pay so that no interruption of coverage takes place. That is, **coverage must be continuous**. Self-payment is the Participant's responsibility. Any break in coverage while on self-pay requires a re-establishment of coverage as described under "Restoring Lost Coverage" on page 12.

Though not part of COBRA's requirements, Covered Participants may convert their existing life and accidental death and dismemberment insurance coverage, and Covered Dependents may convert their life insurance coverage, by electing to add the premium for such coverage to the COBRA self-pay premium at the time you (or they) elect COBRA coverage. The rates and your right to purchase and/or convert these benefits are determined by the insurance contract between the Plan and the insurer. For information on converting your life insurance benefits to an individual policy see page 46.

The safety glasses portion of the vision benefit is *not* available under any self-pay program.

Notification of any changes to your Self-Pay Participant status, such as divorce, Legal Separation, death of a Spouse, marriage, retirement or other insurance coverage eligibility, must be received in writing by the Plan Administrative Office no later than the 20th of the month prior to the month of implementation. **No retroactive adjustments will be made to credit overpaid premiums due to status changes occurring in previous months.**

Please contact the Plan Administrative Office if you have any questions concerning self-pay benefits, costs, payment time periods, etc.

Self-Payment Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Participants and their Covered Spouses and Covered Dependent Children may self-pay and continue their group health coverage in certain situations called "Qualifying Events" where that coverage would otherwise terminate. The health benefits of this Plan are subject to COBRA. The Plan's COBRA policy and COBRA rates may be changed by the Trustees from time to time with reasonable notice to Participants. This is intended to inform you of your COBRA self-pay rights and obligations. **Both you and your family should take the time to read it carefully.**

If you, a Covered Participant, choose self-pay coverage, you are entitled to continue your medical, prescription drug, dental, vision, and hearing aid benefits. Covered Dependents are entitled to continue medical, prescription drug, dental, and vision benefits.

Subject to certain conditions discussed below, COBRA coverage is available to each person who is a "**Qualified Beneficiary**".

If you are a **Covered Participant**, you will become a Qualified Beneficiary if you lose your health coverage under the Plan due to one of the following Qualifying Events:

- Your employment terminates (other than for gross misconduct); or
- Your hours of employment are reduced.

If you are the **Covered Spouse** of a Covered Participant, you will become a Qualified Beneficiary if you lose health coverage under the Plan due to one of the following Qualifying Events:

- Termination of your Spouse's employment (other than for gross misconduct) or reduction in your Spouse's hours of employment;
- Death of your Spouse; or
- Divorce or Legal Separation from your Spouse.

A **Covered Dependent child** of a Covered Participant will become a Qualified Beneficiary if his or her health coverage under the Plan is lost due to one of the following Qualifying Events:

- Termination of the Participant-parent's employment (other than for gross misconduct);
- Reduction in the Participant-parent's hours of employment;
- Death of the Participant-parent;
- Parents' divorce or Legal Separation; or
- Ceasing to be eligible for coverage under the Plan as an "Eligible Dependent".

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrative Office has been timely and properly notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, a reduction of hours of employment or the death of the Covered Participant, your Employer must notify the Plan Administrative Office of the Qualifying Event. For Qualifying Events due to divorce or Legal Separation of the Participant and Covered Spouse or a Covered Dependent child losing eligibility for coverage as an Eligible Dependent, **you or another Qualified Beneficiary must notify the Plan Administrative Office, in writing, within 60 days after the later of the Qualifying Event or the loss of coverage using the Notice Procedures specified below. If these procedures are not followed, or if notice is not provided to the Plan Administrative Office during the 60-day notice period, any Spouse or Dependent child who loses coverage will lose the right to elect COBRA coverage.**

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, and notice by fax or email are not acceptable. You must mail or deliver your notice to the Plan Administrative Office at the address provided in this Summary Plan Description. Your notice must state the name and address of the Covered Participant and the name(s) and address(es) of the Qualified Beneficiaries. Your notice must also state the type of Qualifying Event and the date it occurred, including a copy of the divorce decree or Legal Separation document if applicable.

Once the Plan Administrative Office is properly and timely notified that a Qualifying Event has occurred, each Qualified Beneficiary will receive notice of his or her right to elect COBRA coverage. You will have 60 days to elect COBRA coverage from the later of the date coverage ends due to the Qualifying Event or the date the Plan Administrative Office provides you notice of your right to elect COBRA coverage. Each Qualified Beneficiary may elect COBRA

coverage for himself or herself, even if other Qualified Beneficiaries do not. Covered Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA on behalf of their Covered Dependent children. If a Qualified Beneficiary does not elect COBRA coverage within this 60-day period, he or she will lose the right to elect COBRA coverage. An election is considered made on the date it is postmarked.

If you waive your right to COBRA continued coverage, and within the 60 day election period decide to revoke your waiver, continued coverage will begin the date you elect to continue coverage. However, coverage will not be allowed for the period between the date you elect to waive COBRA and the date that election was revoked.

For each Qualified Beneficiary who elects it, COBRA coverage will begin on the date that health coverage under the Plan would otherwise have been lost. (If a qualified beneficiary has expressly waived COBRA coverage but then revokes that waiver before the election period deadline, COBRA coverage will begin on the date the revocation of the waiver is postmarked.) COBRA requires Participants or other Qualified Beneficiaries to make timely payment, or lose coverage. You have 45 days from the date you elect COBRA coverage to pay your initial self-payment. *This initial self-payment must include the COBRA payments due from the date you lost coverage through the end of the last full month before you pay. (This could mean payment for more than one month of coverage is due at one time.)* Subsequent payments are due on the first of each month. All payments must be made by check timely sent to the Plan Administrative Office at the address shown in this SPD. Coverage will be cancelled if the Plan Administrative Office does not receive your payment within the 30 days of each payment due date. If mailed, your payment is considered made on the date it is postmarked.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is death of the Covered Participant, the Covered Participant's divorce or Legal Separation, or a Covered Dependent child losing eligibility as an Eligible Dependent child, COBRA coverage can last up to 36 months. When the Qualifying Event is the end of employment or reduction of the Covered Participant's hours of employment, and the Covered Participant becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the Covered Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her Covered Spouse and Covered Dependents 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 8 months). Otherwise, when the Qualifying Event is termination of employment or reduction of the Covered Participant's hours of employment, COBRA coverage can last up to 18 months. However, there are two ways in which this 18-month period can be extended.

If you or anyone in your family experiences another Qualifying Event while receiving 18 months of COBRA coverage, the Covered Spouse and Covered Dependent children in your family can get up to an additional 18 months of COBRA coverage, up to a total maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Covered Spouse and Covered Dependent children if the former Covered Participant dies, gets divorced or obtains a Legal Separation. This extension is also available to a Covered Dependent child when that child stops being eligible under the Plan as an Eligible Dependent child. These extensions are only available if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You or another Qualified Beneficiary must notify the Plan Administrative Office within 60 days of the second Qualifying Event **following the Notice Procedures specified above, or there will be no extension of COBRA coverage due to the second Qualifying Event.**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage, you and your entire family can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months if your disability lasts at least until the end of the 18-month period of continuation coverage. In order to be entitled to this extension, the Qualified Beneficiary must have been determined by the Social Security Administration to be disabled at any time during (or before) the first 60 days of COBRA continuation coverage and the disability must last at least until the end of the 18-month period of COBRA coverage. **You must provide written notice of disability within the 60-day time frame specified above, following the Notice Procedures specified above. The notice must include a copy of the Social Security Administration's determination. If you fail to do so, there will be no disability extension of COBRA coverage.**

Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit under Section 201 of the Federal Trade Act of 2002. These participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the Plan Administrative Office for additional information.

If during the period of COBRA coverage you have a newborn child, adopt a child or have a child placed with you for adoption, that Dependent child may be enrolled for COBRA coverage. You must notify the Plan Administrative Office and enroll the child no later than 30 days after the birth, adoption, or placement for adoption. The new child's coverage will be the same as your Covered Dependents on COBRA, and will terminate when their coverage ends (or would have ended).

COBRA coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation period under any one of the following circumstances:

- Payment is not made on time (taking into account the 30-day grace period);
- The date a Qualified Beneficiary becomes, after the date he or she elected COBRA coverage, covered under another group health plan (except Medicare) that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;
- The date the Trust no longer provides group health coverage;
- The first day of the month that is 30 days after the date of a determination by the Social Security Administration that a person on extended disability coverage is no longer disabled. This applies to the extended disability coverage of all Qualified Beneficiaries, but only to

the 19th through the 29th month of extended disability coverage;

- The first day of the month that follows the date the Covered Participant's Employer stops maintaining the Plan and starts maintaining another group health Plan for Employees.

If you have any questions about COBRA coverage, please contact the Plan Administrative Office at the phone number or address shown on page 79. For more information about your rights under ERISA, including COBRA, the Health Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the 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 Offices are available through EBSA's website.) In order to protect your family's rights, you should keep the Plan Administrative Office informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrative Office.

Lifetime Self-Pay Option

Retired Participants are eligible to make lifetime self-payments in the following circumstances:

- If on the date your hour bank drops below 140 hours, you participated in the Idaho Plumbers and Pipefitters Pension Plan (or in the Idaho Pipe Trades Health Plan if you do not participate in the Pension Plan) for at least 10 years pursuant to a Collective Bargaining Agreement, including the 5 years immediately preceding that date, as a Covered Participant.
- If on the date your hour bank drops below 140 hours, you participated in this Plan under a Special Agreement, and you satisfy one of the following:
 - You have 20 years of service in the plumbing and pipefitting industry with an Employer that participates in this Plan and have been continuously covered as a Special Agreement Participant under this Plan for the 5 years immediately preceding termination as a Covered Participant.
 - Be continuously covered as a Special Agreement Participant under this Plan for the 120 months immediately before termination of your employment under the Special Agreement.

You must submit your Lifetime self-pay premium payment within 30 days of losing coverage due to a reduction in your hour bank. Monthly premiums are due the 1st day of each month thereafter, for that month's coverage. If the Plan Administrative Office does not timely receive your self-payment (the premium must be received and/or postmarked on or before the last day of the coverage month), your coverage will be dropped and may only be reinstated as described in *Restoring Lost Coverage* on page 12.

The amount, timing, and other rules related to payment for Lifetime self-pay coverage are established by the Trustees and reviewed annually. After coverage is lost under the hour bank system, the self-pay premium rates for Retirees will apply to each Dependent added more than 30 days after your initial retirement self-pay election. Therefore, a self-pay premium equal to that of the retiree will apply to each added dependent.

Preserving the Lifetime Self-Pay Option

If you become eligible for Lifetime Self-Pay coverage (not COBRA), and if you and/or your Covered Spouse are eligible for coverage through your Spouse's Employer-sponsored health

plan, you and/or your Covered Spouse may opt-out of coverage from the Plan. If you opt-out, you must do so at the time you or your Spouse initially become eligible for Lifetime Self-Pay coverage (whether premiums are paid, or coverage is premium free for your Spouse and your other Covered Dependents due to your death) or when your Spouse's employer-sponsored coverage becomes effective. You must complete an opt-out form electing your deferral and it must be received by the Administrative Office within 60 days of the qualifying event.

The "opt-out" option will work differently depending on whether your self-pay category covers the entire family for one premium or if it is based on how many family members are covered under the Plan.

- **Premium based on number of Dependents** — If your Spouse has other employer-sponsored coverage, you have the option of opting out of the Plan coverage as does your Covered Spouse and/or any other Covered Dependents, since the self-pay premium is based on how many family members are covered under the Plan. No coverage would be available through the Plan for those family members who have opted out of Plan coverage.
- **Flat rate premium for entire family** — If your Spouse has other employer-sponsored coverage, and you (the Participant) opt-out of coverage in the Plan, the entire family must opt-out, because the self-pay premium for this category of coverage provides coverage for the entire family. No coverage would be available through the Plan, only through the Spouse's employer-sponsored plan.

You, your Spouse, and/or any other Eligible Dependents will be allowed to renew coverage in the Plan only after you have **provided the Plan Administrative Office satisfactory proof** that the other employer-sponsored coverage has terminated, and that it has not terminated due to your failure to pay a premium or otherwise fulfill your obligations under the other coverage. If the other coverage is COBRA under another employer's plan, you must continue COBRA coverage for the maximum period allowable under that plan before you will be allowed to renew coverage in the Plan.

You must make your self-payment to the Plan Administrative Office **within 30 days of the other coverage's termination**. The premium rules and rate will be determined by the Plan's policy at the time you opt back in.

IV. Medical Benefits

Plan medical benefits are designed to help you pay the cost of Covered Medical Expenses for you and your Covered Dependents. In most cases, you will pay a portion of the cost of covered medical services you receive. Because not all services are covered, it's important to read this Plan carefully and understand your benefits before you receive services, whenever possible.

How the Plan Works

The Plan Reimburses you for a portion of the cost of Covered Medical Expenses after you pay an annual deductible. Many, but not all, services are covered at 80%. Usual, Customary, and Reasonable (UCR) limits and other exclusions also apply.

Here are some highlights of the medical Plan's main features:

Medical Benefits Highlights	
Annual deductible	\$300 per person. <i>The Plan starts to pay benefits after you pay the deductible each calendar year. The deductible applies to all services unless otherwise noted. Co-payments do not count toward the deductible.</i>
Medical office visit co-payment	80% after a \$15 co-payment (co-payment is waived on wellness visits). <i>The medical office visit co-payment does not count toward satisfying the annual deductible and does not apply to the out-of-pocket maximum.</i> The \$15 Medical office visit co-payment applies to all Health Care Provider services unless otherwise noted.
Lifetime maximum benefit	\$500,000 per person. <i>If you exhaust the lifetime maximum, \$5,000 is restored each January 1.</i>
Out-of-pocket maximum	\$7,500 per person per calendar year. <i>After you reach the out-of-pocket maximum, the Plan Reimburses 100% of Covered Medical Expenses for the rest of the calendar year. The out-of-pocket maximum applies to Covered Medical Expenses above the annual deductible and office/emergency room co-pays.</i>
Physician services	80%
Lab and x-ray	80%
Adult routine physicals	100% with no deductible, no co-payment and no dollar limitation, for Covered Participant and Covered Spouse per calendar year. Please refer to Covered Expenses beginning on pages 30-31 for benefit schedule.
Well child care	100% with no deductible or office visit co-pay, up to these maximums: <ul style="list-style-type: none"> • Six exams – age 0 to 12 months • Three exams – age 1 to 2 years • One exam per calendar year – age 2 to 19 years • Immunizations per Health & Human Services (HHS)/Center for Disease Control (CDC) schedule • Paid at 100% • Deductible and co-pays are waived <i>Office visits to administer immunizations will count against well child exam limits if separate office visit charges apply</i>
Maternity care	Covered the same as any other condition for the Covered Participant or Covered Spouse only. Maternity charges are not subject to pre-existing condition limitations. This benefit is not available for Covered children.
Emergency room	80% after a \$50 co-payment (co-payment is waived if admitted as an inpatient).

Medical Benefits Highlights	
	<i>The emergency room co-payment does not count toward satisfying the annual deductible and does not apply to the out-of-pocket maximum.</i>
Ambulance services	80% for: <ul style="list-style-type: none"> • Immediate, direct transport to the Hospital where first treated, or • Roundtrip ambulance or regularly-scheduled commercial airline flight to the closest Hospital providing treatment (equipment and/or services) required for your condition that is not available at the nearest Hospital, when specifically requested in writing by your licensed MD.
Hospitalization <i>(including room and board, outpatient surgery, drugs while a patient, and necessary services and supplies)</i>	80% You or your doctor may call CareAllies at (800) 327-6845 before an In-patient admission to obtain an assessment of Medical Necessity.
Mental health services	Inpatient: 80% for Hospital stays lasting at least 24 hours. Outpatient: 50% ; treatment must be provided by an MD, Psychologist (PhD), MSW, or Licensed Professional Counselor (LPC).
Substance abuse treatment	80% up to a lifetime maximum benefit of \$4,000 for treatment by covered Health Care Provider/Substance Abuse Treatment Facility of alcoholism or chemical dependency only.
Chiropractic services	80% up to a maximum benefit of \$500 per person per calendar year when provided by a licensed chiropractor to detect and correct structural imbalance, distortion, misalignment, subluxation of or in the vertebral column and resulting nerve interference by manual or mechanical means (including related x-rays) only.
Physical and occupational therapy	80% up to a maximum benefit of \$1,500 per person per calendar year when provided by a licensed physical or occupational therapist.
Speech therapy	50% up to a maximum benefit of \$2,000 per person per calendar year.

Important Medical Benefit Provisions

Deductible

The deductible is the amount of Covered Expenses you must pay each calendar year before the Plan Reimburses you for Covered Medical Expenses. The deductible is \$300 per person. The deductible applies separately to each covered person.

Lifetime Maximum

The lifetime maximum benefit under the medical Plan is \$500,000 per person. However, if you or a Covered Dependent exhausts this maximum, benefits may be gradually restored over time. Each January 1, up to \$5,000 of medical benefits is automatically reinstated. However, the substance abuse treatment benefit maximum, once used, is not restored.

Coverage for Pre-existing Conditions

For the period of time stated below, this Plan excludes Medical, Prescription Drug, Dental and Vision benefits for any health condition for which medical advice, diagnosis, care, or treatment was recommended or received in the six months before you began earning Covered Hours towards your Initial Eligibility. In the case of a new Dependent added by marriage after your initial enrollment, the period begins six months prior to the Dependent's enrollment in the Plan. Coverage of these conditions will begin after the end of 12 consecutive months following the first day of the month in which you

There is no pre-existing condition exclusion period for pre-existing conditions related to pregnancy or for pre-existing conditions of newborns or newly adopted children (or children newly placed for adoption)

earn your first Covered Hour which counts toward your Initial Eligibility, or 12 months after the date of enrollment in the case of a Dependent added by marriage after your initial enrollment, reduced by any prior creditable health coverage. If you or a Dependent have lost coverage under the Plan and again establish Initial Eligibility (see page 9) and/or re-enroll as a student, a new 12-month exclusion period for any pre-existing conditions (reduced by any prior creditable health coverage) will apply.

One day of prior creditable coverage is granted for each day of prior health coverage under many group and individual health plans and insurance policies. If you had a significant break in coverage (63 days or more) only coverage after the break is counted to reduce the Plan's pre-existing condition exclusion period.

A leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) will not count toward a break in coverage. You must provide certification of any prior creditable coverage you wish to have considered by the Plan. Contact the Plan Administrative Office if you have questions about your situation.

Note: No pre-existing condition exclusion period will be imposed on pre-existing conditions related to pregnancy or on pre-existing conditions of newborns or newly adopted children (or children newly placed for adoption).

Certificate of Creditable Coverage

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) limits the length of time plans may exclude coverage of pre-existing health conditions to a maximum of 12 months.

If your Plan coverage ends and you become eligible for a new health plan which excludes pre-existing conditions, the length of time you were covered under this Plan may reduce the length of your new plan's exclusion period.

To help you prove your Plan coverage, the Plan Administrative Office will automatically send you a "certificate of creditable coverage" when your coverage ends, either as an Active, Retired, or Self-Pay Participant (or Covered Dependent). If your new plan has a pre-existing condition exclusion, present the certificate to your new plan so your new plan's administrator can apply your creditable coverage under this Plan to the new plan's pre-existing condition waiting period.

You can request a certificate of creditable coverage at any time while you are covered under the Plan and up to 24 months after your coverage ends. To request a certificate, call or write the Plan Administrative Office. See page 79 for address and telephone information.

Pre-Admission Approval for Hospital Stays

Before being admitted to a Hospital, you may obtain an assessment of whether inpatient treatment is considered to be Medically Necessary. You, your doctor, or the Hospital may call the Trust's utilization management organization, **CareAllies**, at **(800) 327-6845** before admission.

If you are covered by Medicare, you should also follow Medicare's pre-certification procedure.

If CareAllies denies your case for any reason, you can appeal the decision to CareAllies who will have your case reviewed by a physician specialist who was not involved in the original denial. If, after review, CareAllies upholds the original denial decision, you may still request a second review by a same specialty physician reviewer. If after this second review, your case is still denied, should you choose to proceed in obtaining the care or procedure denied by CareAllies, claims should be submitted to the Administrative Office for payment. In the event that the claim is denied by the Administrator, you will still have the right to appeal to the Board of Trustees by following the procedures on page 61 under “Procedure for appeal denied claim-Medical or Disability Claims”.

CareAllies’s pre-certification of Medical Necessity does not guarantee coverage. Coverage is provided only to the extent it is otherwise promised under the Plan.

Individual Case Management (ICM)

The Plan, through individual case management, may authorize coverage of specific services, supplies, or treatments that would not ordinarily be covered if it appears that this alternative care will reduce costs. The Trust will not provide benefits for alternative care to persons who have received the lifetime maximum benefit allowed under Plan provisions.

Acceptance of alternative benefits by the Covered Participant or Covered Dependent is voluntary. The Plan may cease to allow alternative benefits at any time if the expected reduction of cost and/or effectiveness of the treatment are not met. At that time, the Trust will send written notice to the covered person.

The Trust’s decision to provide alternative benefits will be made on a case by case basis. Such a decision shall not be construed to alter or change other provisions of the Plan, nor shall it be construed as a waiver of the Trust’s right to administer the Plan in strict accordance of its terms in other situations.

For more information or questions on individual case management, please contact the Plan Administrative Office.

Covered Expenses

Covered Medical Expenses are the Usual, Customary, and Reasonable (UCR) charges for the following services, supplies, and treatments when Medically Necessary and ordered by a Physician or other Health Care Provider. *Covered Medical Expenses are subject to the annual deductible (unless otherwise noted), co-pays, and other limits on benefits by the Plan.*

- **Ambulance services** — covered at 80% for:
 - Immediate, direct transport to the Hospital where first treated.
 - Round-trip ambulance, a regularly scheduled commercial airline flight, or reasonable air ambulance charges, to the closest Hospital providing treatment (equipment and/or services)

What Are “Usual, Customary, and Reasonable” (UCR) Charges?

Many health plans, like this one, look at the rates doctors, dentists, Hospitals, and other healthcare providers charge in certain locations for specific services and procedures to determine what is a “Usual, Customary, and Reasonable” charge for that service. The plan’s benefits pay a percentage of the Usual, Customary, and Reasonable (UCR) charges. You pay the remaining percentage plus the full amount of charges above UCR limits.

For example, let’s say the UCR charge for a service your doctor provided is \$100, but your doctor charges \$120. The benefit is 80% of the UCR amount, or \$80 (80% of \$100), rather than 80% of the full charge. You pay the remaining \$40.

For more information, see the “Definitions” section beginning on page 67.

required that is not available at the nearest Hospital, if specifically requested in writing by a licensed MD.

- There is no coverage for transportation to a Physician or institution of greater renown or degree of specialization.
- **Anesthesia** including supplies and administration by an anesthesiologist or anesthesiologist is covered at 80%.
- **Birth control devices** requiring a prescription and medical services, including sterilization, are covered at 80% for Covered Participant or Covered Spouse only. Abortion, and any services and expenses related to abortion and/or Norplant are excluded from this medical benefit. (Oral contraceptives *may* be covered under the *Prescription Drug Benefit* as described in Section V, see page 35.)
- **Chiropractic treatment** by a licensed chiropractor to diagnose and correct structural imbalance, distortion, misalignment, or subluxation of or in the vertebral column, and resulting nerve interference by manual or mechanical means (including related x-rays) is covered at 80% up to a maximum benefit of \$500 a calendar year per person. (Tests ordered but not performed by a chiropractor are covered under the diagnostic x-ray and lab benefit.)
- **Diagnostic x-ray and lab tests** are covered at 80%.
- **Diabetes education** and self-management training are covered at 100%. The deductible and co-pays are waived. Usually, this type of training is provided by a hospital, health agency or provider specializing in diabetes management.
- **Durable medical equipment** rental (or purchase if pre-approved by the Administrative Office) when prescribed by a Physician, including equipment required for the administration of oxygen, hospital bed, wheelchair, walker or similar hospital-type equipment, and replacement when purchased equipment is no longer serviceable as documented by a Physician, is covered at 80%. Maintenance of equipment or deluxe items are not covered.
- **Emergency room treatment** is covered at 80% after a co-payment (see page 23); this co-payment is waived if you are admitted to the Hospital. The co-payment does not count toward the medical Plan's \$300 annual deductible or out-of-pocket maximum. Charges must be Incurred at a Hospital emergency room, not a stand-alone urgent care or minor emergency center, for the co-payment to apply.
- **Home health care** provided in your home by an approved Home Health Care Agency is covered at 80% up to a maximum of 70 days or \$35,000 per condition, whichever is greater. (This benefit is in lieu of, not in addition to, the Skilled Nursing Facility benefit which is described later in this section.) The following conditions apply:
 - Services must be for the treatment of a covered Illness or Injury and specially ordered by a Physician.
 - Your Physician must establish and periodically review a written treatment plan and periodically certify that inpatient care in a Hospital or convalescent/Skilled Nursing Facility would be required in the absence of home health care benefits.
 - You must be homebound, which means that leaving home involves a considerable and taxing effort and you are unable to use public transportation without assistance.
 - Medical supplies, drugs, and medicines must be prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital or convalescent/Skilled Nursing Facility

will be covered only to the extent that they would have been covered if you remained hospitalized or remained in the convalescent/Skilled Nursing Facility.

Home health care is limited to medical services and supplies that would have been provided on a Hospital/skilled nursing or convalescent facility inpatient basis performed by registered and Licensed Practical Nurses, Certified Nurse Assistants, registered physical therapists, certified speech therapists, and certified inhalation therapists acting within the lawful scope of their licenses.

The following are excluded from the home health care benefit:

- Homemaker or housekeeping services.
 - Supportive environmental materials such as hand rails and wheelchair ramps.
 - Services performed by household member, family, or friends.
 - Psychiatric care for family members.
 - Maintenance or Custodial Care.
 - Unnecessary and inappropriate services.
 - Social services.
 - Separate transportation charges.
 - Any service or supply not specifically mentioned as covered.
- **Hospice care** by an approved hospice is covered at 80% up to a maximum of six months. Hospice care is available only for the terminally ill with a life expectancy of six months or less. The Physician must establish a written treatment plan describing the hospice care to be provided and review the plan every two months. Hospice care in the home is only covered if inpatient care at a hospice facility or Hospital would be required without it. Except for Physicians, all providers must be employees of a Hospice Agency and their services must be billed by a Hospice Agency.

The following are excluded from the hospice care benefit:

- Homemaker or housekeeping services.
 - Supportive environmental materials such as hand rails and wheelchair ramps.
 - Services performed by household members, family, or friends.
 - Psychiatric care, bereavement counseling, and other services for family members.
 - Service of volunteers.
 - Food, clothing, or housing (other than room and board at a hospice facility).
 - Financial or legal counseling.
 - Any service or supply not included in the written treatment plan or not specifically mentioned as covered.
 - Spiritual counseling.
- **Hospital** charges for room and board and services and supplies to treat an Illness or Injury are covered at 80%. Covered Hospital services include care in a coronary or intensive care unit. Other covered services include outpatient surgery at a Hospital and medication while an inpatient.

- **Maternity benefits** for you or your Spouse including childbirth and complications of pregnancy are covered the same as any other condition. As required by federal law, the Plan does not restrict Hospital benefits for covered mothers and newborns to less than 48 hours following normal delivery (96 hours following cesarean delivery). You may call CareAllies for coverage questions if a longer stay is medically required. Dependent children are not covered for expenses related to their pregnancy, giving birth or related complications.
- **Medical supplies** prescribed by a Physician are covered at 80%. Covered medical supplies include but are not limited to the following:
 - Casts.
 - Splints.
 - Braces.
 - Crutches.
 - Diabetic blood sugar testing devices and supplies.
 - Ostomy supplies.
 - Oxygen.
 - Blood transfusions, including cost of blood and blood plasma if not available free from a blood bank or voluntary donor.
- **Mental health treatment to treat a Mental Illness** is covered as follows:
 - Outpatient treatment by a Physician (MD), psychologist (PhD), social worker (MSW), or licensed professional counselor (LPC) is covered at 50%; consultations with an MD for medication evaluations only are covered at 80%.
 - Inpatient care during a Hospital stay of at least 24 consecutive hours is covered the same as any other health condition.

If the Mental Illness is related to, accompanies, or results from substance abuse, treatment is covered under the substance abuse provisions rather than the mental health benefit.

- **Nursing services** by a Registered Graduate Nurse, Licensed Practical Nurse, and/or Certified Nurse's Assistant acting within the lawful scope of their licenses are covered at 80%.
- **Outpatient facility charges**, including fees for ambulatory surgical facilities and minor emergency centers, are covered at 80%.
- **PKU (phenylketonuria) prescribed food supplement charges** incurred by Covered Dependent children, are covered at 80% up to \$200 per month maximum benefit.
- **Physical/Occupational therapy**, charges by Doctors of Medicine, licensed physical therapists, or licensed occupational therapists to restore an ability that was lost or impaired due to Illness or Injury, are covered at 80% with a calendar year combined maximum benefit of \$1,500 per person.
- **Physician and covered Health Care Provider** services to treat an Illness or Injury are covered at 80% except as provided in the Mental health outpatient treatment benefit.
- **Prescription drugs** that can be obtained only by a Physician's written prescription, except insulin, *while you are an inpatient at a Hospital* are covered at 80%. In addition, when a

Participant or Covered Dependent has other prescription drug coverage not sponsored by the Idaho Pipe Trades that pays as primary, covered outpatient prescription drug unpaid expenses (co-pays) will be Reimbursed by the Medical Plan, see page 54.

- **Prostheses** (artificial limbs and eyes) required as a result of an Illness or Injury are covered at 80%.
- **Reconstructive breast surgery** and associated procedures after a Medically Necessary mastectomy (regardless of when the mastectomy was performed) determined in consultation with the patient and attending physician is covered at 80% for:
 - Reconstruction of the breast on which the mastectomy was performed.
 - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.
 - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Routine physicals and diagnostic screenings for the Covered Participant and Covered Spouse are paid as follows at 100% with no dollar limit and based on guidelines published by the Department of Health and Human Services, the Center for Disease Control and the American Cancer Society :

Routine Physicals/Wellness Exam (Age 19+)

- One physical exam per year including screenings, laboratory, and x-ray services ordered by a physician (Note: cancer screenings are outlined separately below)
- Paid at 100%
- Deductible and co-pays are waived

Breast Cancer Screening

- One mammogram per year
- Paid at 100%
- Deductible and co-pays are waived

Cervical Cancer Screening

- One Pap test and routine pelvic exam per year
- Paid at 100%

Deductible and co-pays are waived

Colon and Rectal Cancer Screening

- Yearly fecal occult blood test
- Flexible sigmoidoscopy every 5 years or colonoscopy every 10 years
- Paid at 100%
- Deductible and co-pays are waived

Prostate Cancer Screening

- One prostate-specific antigen (PSA) blood test per year
- One digital rectal exam (DRE) per year
- Paid at 100%

Deductible and co-pays are waived

Immunizations (Age 19+)

- Influenza – one dose per year up to a maximum of \$30 per dose.
- Pneumonia – one dose per lifetime
- Tetanus/Diphtheria booster – once every 10 years
- Chicken Pox – two doses per lifetime
- Measles, Mumps, Rubella booster – two doses per lifetime
- Hepatitis A – two doses per lifetime
- Hepatitis B – three doses per lifetime
- Meningitis – two doses per lifetime
- Tuberculin Skin Test – one per year
- HPV – one series per lifetime
- Paid at 100%
- Deductible and co-pays are waived
- Charges for an office visit solely to administer an immunization are not covered

Dependent children (under age 19) are not covered under this benefit (see Well child care, on page 23 and described later in this section).

- **Skilled Nursing Facility** room and board is covered at 80% up to a **maximum of 70 days or \$35,000 per condition**, whichever is greater. (This benefit is in lieu of, not in addition to, the Home health care benefit described previously in this section.) The following conditions apply:
 - Services must be for the treatment of a covered Illness or Injury.
 - You must be receiving therapeutic treatment which could not be administered in the home by an unskilled person, such as a friend or relative.
 - You must have been hospitalized for at least five days and be admitted to the Skilled Nursing Facility within 14 days after Hospital discharge. This requirement may be waived by the Trustees. See *Individual Case Management* on page 26.
 - Custodial Care is not covered.
- **Speech therapy** by a certified speech therapist is covered at **50%** up to a **maximum benefit of \$2,000 a year** when ordered by a Physician to restore lost or impaired speech due to Illness or Injury.
- **Substance abuse treatment** is covered at 80% up to a **lifetime maximum benefit of \$4,000** for room, board, general nursing care, prescriptions and other services and supplies. You must receive services at an approved Substance Abuse Treatment Facility (see the “Definitions” section beginning on page 67) for inpatient or outpatient treatment of alcoholism or chemical dependency. There is no coverage for recovery houses that provide an alcohol or drug-free residential setting, alcohol or drug information, educational materials or programs, referral services, school programs, or smoking cessation programs.
- **Veteran’s Administration hospital, medical facility, and/or prescription drug charges** are paid at 80% unless otherwise stated in the Plan. Charges are subject to the annual deductible.

- **Well child care** for Covered Dependent children is covered at 100% with no medical deductible or office visit co-pay up to the following annual maximums:
 - Six exams – age 0 to 12 months
 - Three exams – age 1 to 2 years
 - One exam per calendar year – age 2 to 19 years

Immunizations as defined on page 31 are paid at 100% with co pays and deductibles waived. Office visits to administer immunizations will count against the well child exam limits.

- **X-ray, radium, and radioactive isotope therapy** (including CT scans, MRI, PET scans and other imaging studies) is covered at 80%.

Medically Necessary

Throughout this booklet you will see the terms “Medically Necessary” and “Medical Necessity.” Under the terms of the Plan, services and supplies are covered only if they are Medically Necessary. Please see page 70 for a complete definition.

Exclusions

The following treatments and supplies are not covered under the medical Plan and do not apply to your annual deductible and/or out-of-pocket maximums, even if they are considered to be Medically Necessary. No benefits will be paid for:

- Expenses Incurred or treatment received before your coverage begins, or after it has ended.
- Acupuncture or acupressure.
- Appliances or equipment primarily for comfort, convenience, environmental control or education; including but not limited to, air filters, athletic or fitness equipment, blood pressure cuffs, commodes, heat lamps, humidifiers, shower benches, tanning lights, and whirlpools.
- Birth control, sterilization, pregnancy or related complications for Dependent children.
- Blood storage (autologous blood charges) unless related to a planned surgical or ongoing cancer treatment.
- Charges submitted to the Plan for payment more than 12 months after the date Incurred. A charge is Incurred when the service is rendered or the supply is dispensed.
- Charges for preparing reports or forms, and submitting claims.
- Charges for missed appointments, telephone or internet consultations when patient is not physically seen by a physician.
- Cosmetic surgery and any complications from such treatment, except that benefits will be provided within Plan limits:
 - For Emergency surgery that is needed due to an accidental Injury.
 - For Covered Dependent children, when related to a congenital condition.
 - For mastectomies as described under **Reconstructive breast surgery** in the *Covered Expenses* section beginning on page 26.
- Custodial Care, except for the terminally ill if approved as part of a written treatment plan through the hospice care benefit.
- Dental treatment and services (*may* be covered under the *Dental Benefit* as described in

Section VI, see page 38), except for the repair of damage to tissues of the mouth or jaw caused by Injury, or for services to remove tumor, cyst, torus or redundant tissue of the mouth.

- Drugs available without a Physician's prescription, except insulin, and outpatient drugs that are payable under the *Prescription Drug Benefit* as described in Section V, see page 35.
- Drugs, devices or supplies not approved for marketing or for prescribed use by the Food and Drug Administration.
- Educational programs, except diabetic nutrition education.
- Experimental or Investigational procedures, services and supplies.
- Foot care that is routine, Palliative, or cosmetic, such as paring calluses or corns and trimming toenails.
- Hearing aid benefits of any type (*may* be covered under the *Hearing Aid Benefit* as described in Section VIII, see page 42).
- Habilitative, education, or training services or supplies for dyslexia, attention deficit disorder, and nervous system based condition - including neurodevelopment delay, a learning disability, and delays in a child's language, cognitive, motor, or social skills. (Diagnostic and/or medication management services are not excluded).
- Illness or Injury resulting from military service, declared or undeclared war, invasion, civil insurrection, riot, or hostilities.
- Infertility treatment - Services, drugs, supplies, and any natural or artificial means to induce pregnancy or treat infertility (male or female), such as artificial insemination, in vitro fertilization, embryo transfer, gamete intrafallopian transfer, embryo implant, and surrogate motherhood .
- Marriage, sexual, or family counseling.
- Massage or massage therapy.
- Naturopathy, homeopathy or midwife services or supplies.
- Obesity or weight control treatment, including drugs and surgery, and any complications from such treatment, even if you have other medical conditions related to or caused by obesity or its treatment. Obesity includes morbid or gross obesity.
- Organ and bone marrow transplant expenses and any complications as a result of such procedures, regardless of whether you are the donor or the recipient.
- Orthognathic surgery, treatment or supplies to correct Malocclusion and/or temporomandibular joint disorder (TMJ).
- Orthopedic shoes, orthotics, lifts, shoe inserts and casting for orthotics or inserts.
- Replacement of a lost or stolen prosthesis.
- Routine physical exams; Charges for routine physical exams that exceed the benefit limitations described in Well Child Care (page 23) and Routine Physicals (beginning on page 30)

See the Prescription Drug Section

Outpatient prescription drugs are covered under the Prescription Drug Benefit, unless you have other primary prescription drug coverage through a plan that does not coordinate drug benefits. See page 54 for details.

- Services of a personal nature, such as radio, television, telephone, guest meals.
- Services or supplies that are not Medically Necessary.
- Services or supplies that exceed UCR or other Plan limits.
- Services and supplies, for which benefits are recoverable under motor vehicle or other insurance, see page 55.
- Services provided by a relative (by blood or marriage) who is a licensed Physician or Health Care Provider and ordinarily resides in your home, or by an individual who is not a Health Care Provider practicing within the confines of their license.
- Services performed outside the scope of a Health Care Provider's license.
- Services or Supplies not listed as a Covered Expense
- Services or supplies for which coverage is available or furnished under any federal, state, or other government program, except as required by law.
- Smoking cessation programs, drugs, supplies or services.
- Sterilization reversal, whether sterilization was voluntary or involuntary.
- Transsexual surgery, and any services and expenses related to sexual reassignment.
- Travel, lodging, or transportation except as described on page 26.
- Treatment, service or supply incurred to treat:
 - An Injury or Illness resulting from committing or attempting to commit a felony or crime, or received while incarcerated.
 - Expenses incurred in connection with suicide, attempted suicide, or any intentionally self inflicted injury, if the Plan participant was sane when he/she committed the act.
 - Injuries, Illnesses or complications caused by a medical service or procedure for which the Plan provides no benefits.
 - An Illness or Injury arising from, contributed to, or caused by, any work for compensation or profit. Participant and Dependent medical benefits exclude any Illness or Injury Incurred while engaged in an activity for wage or profit covered (or would have been covered if workers' compensation premiums had been paid) under workers' compensation law or by occupational disease law.
- Vision treatment or services (except surgical and medical treatment for diseases of the eye, such as cataract, strabismus and glaucoma) including orthoptics, eye therapy, visual training or eye surgery to correct refractive issues such as lasik or radial keratotomy.
- Vitamins, food, and dietary supplements, except as allowed for the treatment of Phenylketonuria (PKU) as described in the *Covered Expenses* section beginning on page 26. Prenatal vitamins *may* be covered under the *Prescription Drug Benefit* as described in Section V, see page 35.

V. Prescription Drug Benefit

The Plan covers prescription drugs through a Pharmacy Benefit Manager (**PBM**) drug card program. The current PBM contact information can be located on page 79. This program features a network of participating pharmacies (excluding Walmart).

Prescription drugs dispensed while you are an inpatient at a Hospital are covered under the medical benefits section of the Plan which begins on page 23.

If You Use a Participating Pharmacy

When you use a participating pharmacy, simply take your prescription and your Drug Identification Card to the pharmacy and make the appropriate co-payment to receive up to a 30-day supply; no claim forms are required. The co-payments are:

Type of Drug	Co-payment
Generic drug	\$10
Preferred brand-name drug	\$25
Non-preferred brand-name drug	\$50
Specialty Drugs (self-injectable medications excluding insulin) or medications for cancer)	10% of the discounted cost of the drug through NMHC Ascend Program.

If you receive a non-preferred brand-name drug when a preferred brand-name drug is available, you will have to pay the higher co-payment. Your participating pharmacy can tell you if a preferred drug is available.

If you choose to purchase a brand name drug when a generic equivalent is available, the plan will only pay the amount it would have paid for the generic drug. In addition to the co-pay listed above, you will have to pay the additional cost of the brand drug.

Ascend Specialty Therapy Management Program

Self-injectable medications (**excluding insulin**) or medications for oncology (cancer) are no longer covered under the retail pharmacy benefit. These drugs are dispensed through the *NMHC Ascend Specialty Therapy Management Program* and will send your medications directly to your home, and provide you with unlimited access to skilled specialty pharmaceutical consultation. The co-pay will change for these types of medications. Instead of paying 20% through the Major Medical Plan, or a co-pay of \$10, \$25, or \$50 through NMHCRx Retail Pharmacy Plan, the co-pay will be 10% of the discounted cost of the drug through the *NMHC Ascend Program*.

If you are not currently taking any of these medications, but need to at a later date, the first time you take your prescription to a retail pharmacy you will be able to fill it. *NMHC Ascend* will then send you information on how to fill the prescription in the future. Again, please note that the co-pay for these medications will be 10% of the discounted cost of the drug.

Maintenance Drugs

For maintenance drugs — those drugs you use on an ongoing basis that are listed on the PBM's maintenance list — you can fill up to a 60-day supply by paying two (2) co-pays as shown above. In order to ensure the drug will be effective for you, the *first* time you fill a prescription for a maintenance drug, the PBM will authorize only a 30-day supply. After that, your maintenance drugs can be filled for a 60 day supply at a time for two (2) co-pays.

Prior Authorizations (PA) may be required for certain drugs. If you are advised by your pharmacist that a PA is required on a particular drug, please call the PBM's Help Desk telephone number listed on page 79, to request a PA form be faxed to your Physician for completion.

Participating PBM Pharmacies

To find a participating pharmacy, call the PBM's Help Desk telephone number listed on page 79. A few of the current participating pharmacies include:

- Albertsons/Savon
- Costco Pharmacy
- Fred Meyer
- K-Mart
- Rite Aid Drug
- Safeway
- Shopko
- Smith's
- Walgreens

There are also many independent pharmacies in the network. Keep in mind, the list of participating pharmacies shown above may change from time to time. If you're not sure if your pharmacy participates, ask your pharmacist or call the PBM's Help Desk telephone number listed on page 79.

If You Use a Non-Participating Pharmacy

If you fill your prescription at a pharmacy (other than Walmart) *outside* the network or if your eligibility is not currently effective but is later reinstated, the same co-payments generally apply — \$10 for generic, \$25 for preferred brand-name, or \$50 for non-preferred brand name — **but you must pay the full cost of the drug up front when you make the purchase**. Then, submit a claim form and the receipt to the PBM for Reimbursement. Claim forms are available from the Plan Administrative Office or by calling the PBM (see page 79).

If your non-network pharmacy charges more than the PBM's maximum rate for the same drug, you pay the difference. For example, let's assume the PBM's maximum rate for your generic prescription drug is \$50, but your non-network pharmacy charges \$85. At the time of purchase, you will need to pay the full \$85 cost. Then, you may file a claim. You must pay the \$10 generic drug co-payment plus the \$35 difference between the non-network pharmacy cost and the PBM's maximum allowance for this drug. The PBM will Reimburse you \$40; your final cost is \$45.

If you or your Covered Dependent has other primary prescription coverage, your prescription drug co-pays may be reimbursed under the medical Plan. See page 54 for more information.

Exclusions

The following are not covered under the Prescription Benefit Plan:

- Any prescription filled at Walmart including co-pay reimbursement.
- Anabolic steroids, unless deemed Medically Necessary by a covered Physician.
- Diaphragms (*may* be covered under the *Medical Benefits* as described in Section IV, see page 27).
- Drugs and medicines prescribed for birth control for Dependent children.
- Drugs not requiring a Physician's written prescription except insulin.
- Drugs, devices or supplies not approved for marketing or for prescribed use by the Food and Drug Administration.
- Drugs the FDA has not approved for marketing or sale to individuals with, or for treatment of, your Illness or Injury.
- Drugs received while you are an inpatient (*may* be covered under the *Medical Benefits* as described in Section IV, see page 29).
- Fluoride preps.
- Minoxidil topical applications such as Rogaine.
- Norplant.
- Nutritional and dietary supplements, except for a prescribed food supplement to treat (PKU) Phenylketonuria which *may* be covered under the *Medical Benefits* as described in Section IV, see page 29.
- Prostheses (*may* be covered under the *Medical Benefits* as described in Section IV, see page 30).
- Smoking cessation drugs such as Nicorette and Nicoderm or any other drug, medication or services for the treatment of smoking cessation.
- Vitamins, except prenatal vitamins which are allowed during pregnancy for Covered Participants and their Covered Spouses only.
- Weight loss drugs.
- All drugs related to services and supplies that are excluded under *Medical Benefits*. Medical Plan exclusions (beginning on page 32) apply to the Prescription Drug Plan, except as specifically provided to the contrary under this Section V.

VI. Dental Benefit

The Dental Plan pays a percentage of Usual, Customary, and Reasonable (UCR) Covered Dental Expenses after a deductible, up to \$1,000 per person per calendar year.

Before the Plan pays benefits, you must pay an annual deductible of \$50 per person. Your dental benefits are calculated by subtracting this \$50 from your Covered Dental Expenses.

Covered Expenses

Dental Benefit Highlights	
Annual deductible	\$50 per person.
Annual maximum benefit	\$1,000 per person.
Class A expenses <ul style="list-style-type: none"> • Routine services (two exams every calendar year) including: <ul style="list-style-type: none"> – Exam – X-rays, except panoramic or full mouth, which are covered once every 24 months – Prophylaxis and fluoride – Periodontal scaling/prophylaxis (cleaning requires pre-approval with treatment plan if more than twice every calendar year. • Fillings other than Class B fillings (see below) • Extractions • Root canal therapy • Root planing • Oral and periodontal surgery (tissue supporting teeth) • Anesthetics administered for Oral Surgery or another covered dental service. If administered by an anesthesiologist or anesthesiologist, charges are covered under the Medical Plan • Sealants (no age limit) • Surgical placement of implants (surgical procedure only) 	Covered 80%* after the deductible.
Class B expenses <ul style="list-style-type: none"> • Inlays, onlays, crowns and gold fillings • Repair or recementing of crowns, inlays, bridgework, or dentures • Implant hardware • Mouth/nightguards • Bridgework and dentures (full or partial), if the loss of one or more teeth occurs while you are covered, or after the end of 12 consecutive months following your first Covered Hour that counts toward your Initial Eligibility or following the first coverage month for dependents newly added by marriage (reduced by any prior creditable coverage as described on page 25); including: <ul style="list-style-type: none"> – Initial installation – Additions following extraction of injured or diseased natural teeth – Replacement or alteration of bridgework or dentures when necessary after treatment that is covered by the medical Plan to repair an Injury. Replacement or alteration must be completed within 12 months after the accident, repositioning, or tissue removal – Replacement or relining of a full denture because of structural change within the mouth, if done more than five years after installation. Relining is covered no more than once in any 24 month period 	Covered 50%* after the deductible.

*Usual, Customary, and Reasonable (UCR) limits apply.

You should discuss charges with your Dentist before receiving any treatment. If the expected charges for any course of treatment total more than \$200 in one or more sessions, you may first submit your Dentist's written estimate for the Administrative Office to review.

Extension of Benefits

If you incur a dental expense within 90 days after losing eligibility, and the expense relates to a dental procedure that started while you were still eligible, the Plan will cover that expense as if you were still eligible, provided the Dental Plan still covers that expense. For this purpose, x-rays and prophylaxis are not considered a start of dental procedure. The 90-day extension does not apply to Prosthetic devices; rather, they must be delivered within 30 days after termination of coverage.

Exclusions

The Dental Plan does not cover:

- Orthodontic care, including space maintainers.
- Services and supplies not specifically listed above.
- Treatment for cosmetic purposes, including but not limited to bleaching or veneers.
- The *Medical Benefits* exclusions (beginning on page 32) including the pre-existing condition limitations explained on page 24 also apply to the Dental Plan, except as specifically provided to the contrary under this Section VI.

VII. Vision Benefit

The Plan pays for a vision exam and either glasses or contact lenses up to specific Plan limits. In addition, for Active and Retiree Participants eligible through their hour bank account balance**, the Plan covers prescription safety glasses. Vision benefits are summarized as follows:

Vision Benefit Highlights	
Eye exam (every calendar year)	Covered 100%*.
Lenses (one pair every two calendar years) <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal and Progressive • Lenticular 	The Plan pays up to: <ul style="list-style-type: none"> \$ 70. \$100. \$140. \$160.
Frames (once every two calendar years)	The Plan pays up to \$50.
Contact lenses instead of glasses (every two calendar years)	The Plan pays up to \$150 (including the contact lens fitting).
Lenses for safety glasses (one pair every two calendar years, available for Collectively Bargained Participants eligible through their hour bank** only) <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal and Progressive • Lenticular 	Same as regular lenses.
Frames for safety glasses (every two calendar years, available for Collectively Bargained Participants eligible through their hour bank** only)	Same as regular frames.

*Usual, Customary, and Reasonable (UCR) limits apply.

**No coverage for Special Agreement Participants and Self-Pay Participants.

Charges for Photo-Grey No. 1 and No. 2 tinted lenses are covered as long as payment does not exceed the maximums listed above.

Exclusions

The Plan does not cover, and no benefits are paid for:

- Services and supplies not specifically listed above.
- Services and supplies, including but not limited to:
 - Special procedures (other than an eye exam and test for glaucoma) such as orthoptics, eye therapy, or visual training.
 - Keratotomy or lasik surgery.
 - Other medical or surgical treatment for diseases of the eye (*may* be available under the *Medical Benefit* as described under **Vision treatment or services** in the Exclusion section beginning on page 32).
- Services or supplies an Employer is required to provide under a labor agreement.
- Sunglasses, including Photo-Sun, even if prescribed.

- Replacement of lost, stolen, or broken lenses or frames.
- Vision exams by someone who is not a Physician or optometrist, and vision aids prescribed by someone who is not a Physician or optometrist.
- The *Medical Benefit* exclusions (beginning on page 32) also apply to the Vision Plan, except as specifically provided to the contrary in this Section VII.

VIII. Hearing Aid Benefit

For Covered Participants, the Plan pays 80% of Usual, Customary, and Reasonable (UCR) covered hearing aid expenses up to \$750 per ear in any one consecutive period of every 36 months. There is no deductible. Covered Dependents are not eligible for this benefit (medically necessary hearing tests may be covered under Major Medical).

Covered Expenses

The following expenses are covered:

- Otologic exam by a Physician
- Audiological exam and hearing evaluation by a certified or licensed audiologist and follow-up exam
- Hearing aids prescribed as a result of the exam, including:
 - Ear molds
 - Hearing aid instruments
 - Initial batteries, cords, and other necessary accessories
 - Warranty
 - Follow-up consultation within 30 days after delivery of hearing aid

Exclusions

The Plan does not cover, and no benefits are paid for:

- Replacement of a hearing aid unless 36 months have elapsed since your last one.
- A hearing aid ordered before you become eligible under the Plan.
- Batteries or other accessories obtained after purchase of a hearing aid.
- Charges not meeting professionally accepted standards of practice.
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss.
- Repair of a hearing aid.
- Charges for any services or supplies Incurred by a Dependent of a Covered Participant.
- The *Medical Benefit* exclusions (beginning on page 32) including the pre-existing condition limitations explained on page 24 also apply to this benefit except as specifically provided to the contrary in this Section VIII.

IX. Life Insurance

The Plan provides life insurance benefits for you and for your Covered Dependents as described in the Regence Life and Health Insurance Company (Regence Life and Health) contract. For more details, you may request a copy of a Life Insurance Certificate from the Plan Administrative Office. Your coverage will depend on your classification as an Active Participant or Retiree Participant.

If you die without timely delivering a designation of Beneficiary form (as required by Regence Life and Health), if your Beneficiary does not survive you, or if your Beneficiary can't be located within one year of death, Regence Life and Health will make payment to the first of the following that survive you:

- Your Spouse.
- Your natural or adopted child or children in equal shares.
- Your parent or parents in equal shares.
- Your estate. (note: Regence does not list siblings in their order of surviving beneficiaries)

Be Sure to Designate (and Update) Your Beneficiary

To designate or change your Beneficiary, obtain a Beneficiary designation form from the Plan Administrative Office, complete it, sign it, and submit it to the Administrative Office. Your designation is effective when the Plan Administrative Office receives it, and the Plan Administrative Office must receive it before your death.

It's very important to update your Beneficiary designation from time to time, especially if you have a major life event such as marriage, divorce, or having a baby.

Your Beneficiary will be paid in a single lump sum, unless some other method of payment has been requested in writing and approved by Regence Life and Health.

Eligible Dependents

Individuals covered by life insurance are generally the same individuals eligible for Medical benefits.

Active Participant Life Insurance

Active Participant Life Insurance continues so long as your regular medical benefits continue. Benefits end when your hour bank account drops below 140 hours. The life insurance benefit pays your Beneficiary \$10,000 if you die while you are covered under the Medical Plan or if you continue this life insurance benefit while self-paying.

You will receive the amount shown below if your Covered Dependent dies:

Covered Dependent	Amount of Insurance
Covered Spouse	\$2,000
Covered Dependent Child <ul style="list-style-type: none">• Birth to Age 23	\$2,000

Upon the death of the participant, **all dependent life insurance ends**. The participant's covered spouse will have conversion privileges as explained on page 46.

Retired Participant Life Insurance

For Retired Participants, the life insurance amounts are different for both yourself and your Dependents. A Participant who has applied for and is receiving a pension benefit or permanent disability benefit under the Idaho Plumbers and Pipefitters Pension Plan or any other retirement plan is considered a Retired Participant. This includes Retiree Participants still working and covered through their hour bank account balance (see page 8) or under a Special Agreement (see page 8) in addition to Self-Pay Retirees.

Your Beneficiary will receive \$5,000 if you die. You will receive the amount shown below if your Covered Dependent dies:

Covered Dependent	Amount of Insurance
Covered Spouse	\$1,000
Covered Dependent Child <ul style="list-style-type: none">• Birth to age 23	\$1,000

Upon the death of the retiree, **all dependent life insurance ends**. The retiree's covered spouse retiree will have conversion privileges as explained on page 46.

Waiver of Premium if You Become Totally Disabled

Subject to the following conditions which follow, your life insurance will continue if Regence Life and Health receives Proof of your Total Disability while this insurance is in force:.

As defined by Regence Life and Health "Totally Disabled or Total Disability means that as a result of an illness or injury, you are unable to perform the material duties of any occupation for which you are or become reasonably suited by education, training, or experience and under the regular care of a physician". As further defined by Regence Life and Health, the regular care by a Physician means attended by a Physician whose treatment is:

- Consistent with the diagnosis of the disabling condition; and
- According to guidelines established by medical, research and rehabilitative organizations; and
- Administered as often as needed to achieve the maximum medical improvement.

Premiums for you must be paid to Regence Life and Health during the first six months of your continuous Total Disability. If you submit Proof of Total Disability acceptable to Regence Life and Health, Life Insurance will be continued without further payment of premium:

- For the period of continuous Total Disability beyond six months; and
- For as long as the required proof of continuous Total Disability is given to Regence Life and Health, subject to the following:
 - You are no longer Totally Disabled;
 - You fail to give the required Proof of continuous disability;
 - You refuse to undergo a medical exam at Regence's request;
 - You are disabled for one year;

- You convert to an individual policy.

Regence will refund up to 12 months of premiums that were paid for Life Insurance after the date you became Totally Disabled.

Qualifying for Extended Insurance

To qualify for extended insurance, you must:

- Be Totally Disabled due to injury or illness;
- First become Totally Disabled while insured for Life Insurance under this Policy;
- Have been Totally Disabled for at least six consecutive months;
- Be under 60 on the date the Total Disability began;
- Give Regence written Proof of Continuous Disability within 12 months after the date the Total Disability began; and

If Proof of continuous Total Disability cannot be given to Regence Life and Health within these times:

- It must be given as soon as is reasonably possible; and
- It must be given within three months after the time it is otherwise required.

Regence has the right to require that you undergo an exam by a Physician of their choice or approved by Regence. This exam will be done at Regence Life and Health's expense.

For Participants over Age 60

If you become Totally Disabled on or after your 60th birthday, but otherwise meet the above conditions, of extended insurance, your Employer may continue to pay premium for you, subject to conditions contained in this section titled "When Extended Life Insurance Ends".

If You Die While on Extended Insurance

If you die prior to the date satisfactory Proof of Total Disability is furnished, Regence Life and Health will pay the amount that would otherwise have been continued, if:

- The Total Disability began while you were covered under the Policy; and
- Your death occurred within one year after the Total Disability began; and
- Regence Life and Health is given Proof of continuous Total Disability within one year after the date you died; and
- Regence is given Proof of death.

When Extended Life Ends

Extended Life Insurance will end on the earliest date you:

- Are no longer Totally Disabled;
- Fail to give Regence Life and Health the required Proof of continuous disability;

- Refuse to undergo a medical exam at Regence Life and Health's request;
- Are disabled for one year; or
- Convert to an individual policy.

Conversion Privileges if Your Eligibility Ends

As a Covered Participant, your life insurance coverage ends when your hour bank account drops below 140 hours and/or you fail to pay the appropriate premium for coverage. If your life insurance benefit is reduced due to your retirement or your eligibility ends while the Plan's group master policy with Regence Life and Health is in force, you may convert your group life insurance to an individual policy, up to the amount of the reduction, without medical examination. You must apply to Regence Life and Health and pay the first premium **within 31 days** after your life insurance coverage under the Plan is reduced or ends.

This conversion privilege is available to any person insured under this Policy in the following circumstances:

- Termination of employment;
- Termination of membership in an eligible class;
- Termination of dependent coverage upon death of participant;
- Ceasing to be eligible according to the eligibility provisions of the Plan as listed above;
- Retirement.

For further details on conversion coverage, premiums, and other benefit terms, you may obtain a copy of the Regence Life and Health contract from the Plan Administrative Office. Rights to benefits, to continuation, and to convert are dictated by the insurance contract in force at the time of the applicable event (death, retirement, disability, and/or loss of coverage).

Accelerated Death Benefit (Active participants only)

For active participants only, Regence Life and Health also offers an accelerated benefit for terminal illness under the Life benefit. This means that if you are diagnosed as having a medical condition that causes your life expectancy to be twelve months or less, after submitting satisfactory proof, you may request payment of up to 80% (or \$8,000) of the life insurance value in effect on your life, less the cost of the benefit, which is 12 months of interest.

X. Accidental Death and Dismemberment (AD&D) Insurance

Accidental death and dismemberment (AD&D) insurance pays benefits to covered Participants, including Self-Pay Participants if premiums are paid, in the event of accidental death or dismemberment resulting within 365 days from an accident.

These benefits are insured through Regence Life and Health.

Rights to benefits and other terms are dictated by the insurance contract in force at the time of the accident, death, and/or dismemberment. For a copy of the contract, contact the Plan Administrative Office. Injury means bodily injury resulting directly from an accident and independently of all other causes which occurs from sickness, disease, or medical or surgical treatment of a sickness or disease.

Active Participant Benefit Amount

Regence Life and Health will pay the full principal amount of \$90,000 on behalf of Active Participants for the accidental:

- Loss of life.
- Double dismemberment, which means loss of:
 - Both hands
 - Both feet
 - Sight of both eyes
 - Hearing in both ears and speech, or
 - Any *two* of the following: one hand, one foot, sight of one eye, hearing in both ears, and speech.
- Quadriplegia (loss of movement of arms and legs).

Who Is the Beneficiary for AD&D?

If you die, payment is made to the same Beneficiary you named for your life insurance.

Payment for any other loss is made to you.

Regence Life and Health will pay $\frac{3}{4}$ of the principal amount (\$67,500) for paraplegia (accidental loss of movement of both legs).

Regence Life and Health will pay $\frac{1}{2}$ of the principal amount (\$45,000) for accidental:

- Hemiplegic (loss of movement of both the arm and the leg on one side of the body).
- Single dismemberment, which means loss of:
 - One hand
 - One foot
 - Sight of one eye
 - Hearing in one ear, or
 - Speech.

Regence Life and Health will pay $\frac{1}{4}$ of the principal amount (\$22,500) for loss of a thumb or the index finger.

Loss of a hand or foot means complete severance through or above the wrist or ankle joint, and loss of a thumb or index finger means complete severance through or above the metacarpophalangeal joint. With respect to sight, hearing, or speech, loss means entire and irrecoverable loss. Loss of movement of an arm or leg means complete and irreversible paralysis.

The **maximum** payable for any individual's losses due to the same accident is **\$90,000**.

Additional Benefits

Regence Life and Health also offers a variety of **additional benefits** included in their **AD&D** contract. Below is a list of those extra benefits:

- **Adaptive Home and Vehicle Benefit** - If an insured suffers an Accidental Bodily Injury which results in a Covered Loss, Regence will pay an additional Adaptive Home and Vehicle Benefit equal to the lesser of 5% of the Principal Sum, \$5,000, or the actual one time cost for alterations and/or modifications to the insured's principal residence and/or private automobile to make the residence accessible or the vehicle drivable or rideable. The alterations and/or modifications must be incurred within 2 years from the date of the accident.
- **Air Bag Benefit** - If the Seat Belt Benefit is payable, Regence will pay an additional Air Bag Benefit equal to 50% of the Seat Belt Benefit, not to exceed \$5,000, if a factory-installed air bag was properly deployed as verified on the police report.
- **Child Education Benefit** - If an insured dies as a result of an Accidental Bodily Injury, Regence will pay an additional Child Education Benefit equal to the lesser of 5% of the Principal Sum, \$5,000, or the actual tuition expense for any one school year to each child who qualifies as a student. The benefit will be paid for a maximum of four years for each child enrolled at a school of higher learning. If no Dependent qualifies as a student, Regence will pay \$2,500 in accordance with the insured's beneficiary designation.
- **Coma** - If an insured suffers an Accidental Bodily Injury and becomes Comatose within 31 days of the accident and remains continuously Comatose for at least 30 days, Regence will pay a monthly benefit equal to 1% of the Principal Sum, less all other payments for all losses which are due to the same accident, for up to 100 benefit payments.
- **Day Care Benefit** - If an insured dies as a result of an Accidental Bodily Injury, Regence will pay an additional Day Care Benefit equal to 5% of the Principal Sum, not to exceed \$5,000 per year, for eligible child(ren), less than age 7, enrolled in a qualified Day Care Program. The benefit will be paid for a maximum of four years for each child who qualifies for Day Care Benefits. If no Dependent qualifies for Day Care Benefits, Regence will pay \$2,500 in accordance with the insured's beneficiary designation.
- **Exposure and Disappearance** - Exposure to the elements which results in a Covered Loss will be presumed to be an Accidental Bodily Injury if it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the insured was traveling. Under these same circumstances, an insured will be presumed dead and a loss of life benefit will be paid if the body is not found within one year of the disappearance.
- **Felonious Assault** - If an insured suffers an Accidental Bodily Injury due to a violent or criminal act directed at them during the course of a robbery, hold-up, kidnapping or criminal assault or an attempt at any of the foregoing, and the Accidental Bodily Injury results in a Covered Loss within 180 days after the date of the Accidental Bodily Injury, Regence will

pay an additional Felonious Assault Benefit equal to 10% of the Principal Sum. The assault must not be committed by fellow employees or members of the insured's family or household.

- **Rehabilitative Benefit** - If an insured suffers an Accidental Bodily Injury which results in a Covered Loss, Regence will pay an additional Rehabilitation Benefit equal to the lesser of 5% of the Principal Sum, \$5,000, or the Expense Incurred for Rehabilitative Training. The expense must be incurred during the 2 year period that begins on the date of the accident.
- **Repatriation Benefit** - If an insured dies as a result of an Accidental Bodily Injury and death occurs outside the territorial limits of the state or country of the insured's place of permanent residence, Regence will pay an additional Repatriation Benefit. The benefit payable is equal to the lesser of 5% of the Principal Sum, \$5,000, or the expense incurred for preparation of the insured's body for burial or cremation and transportation of the insured's body to the place of burial or cremation.
- **Seat Belt Benefit** - If an insured dies as the result of an Accidental Bodily Injury and was properly wearing a seat belt at the time of the accident as verified on the police report, Regence will pay an additional Seat Belt Benefit equal to the lesser of the Principal Sum or \$10,000.
- **Spouse Education Benefit** - If an insured dies as the result of an Accidental Bodily Injury, Regence will pay an additional Spouse Education Benefit to the surviving Spouse for the purpose of providing education and/or professional or trade training to prepare your spouse for an occupation for which he or she would not otherwise be qualified. Your spouse must enroll within one year of the date of your death, and the expenses must be incurred within two years of your death. Regence will pay the lesser of 5% of the Principal Sum, \$5,000, or the Expense Incurred for Occupational Training. If there is no surviving Spouse, Regence will pay \$2,500 in accordance with the insured's beneficiary designation.

Retired Participant Benefit Amount

For Retired Participants, the principal amount is \$5,000 and all other benefits are adjusted proportionately. A Participant who has applied for and is receiving a pension benefit or permanent disability benefit under the Idaho Plumbers and Pipefitters Pension Plan or any other retirement plan is considered a Retired Participant. Retiree Participants, even if covered through their hour bank account balance (see page 8) or under a Special Agreement (see page 8), receive the Retiree Participant Benefit.

Exclusions

Even though a loss results from Accidental Bodily Injury, no payment will be made under this section if either the Accidental Bodily Injury or the loss caused by, or incurred as a result of, any of the following:

- Suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane;
- War or act of war, whether declared or undeclared;
- Injury suffered while serving in the military forces of any country;
- Committing or attempting to commit an assault or felony;

- Any sickness, disease, pregnancy existing at the time of the Accidental Bodily injury, or any medical treatment for such sickness, disease or pregnancy;
- Heart attack (including, but not limited to, myocardial infarction) or stroke (including but not limited to cerebrovascular accident);
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an Accidental Bodily Injury sustained while you were covered under this section of the Policy;
- Taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines, or hallucinogens unless prescribed for you and used and consumed in accordance with the directions of the prescribing physician or administered to you by a licensed physician; or

Extension of Benefits: In the event you suffer a covered loss due to dismemberment, paralysis, loss of sight, speech or hearing after this policy terminates as a result of a disabling condition that occurred while this policy was in effect, benefits for such dismemberment, paralysis, loss of sight, speech or hearing will be payable under this policy in accordance with the terms, limitations and exceptions as if this policy had not terminated.

Review Procedure

A claimant has the right to a review of any denial by Regence of all or any part of the claim. To obtain a review for life insurance claims, a written request for review should be sent within 60 days after the claimant receives notice of the denial. To obtain a review for disability claims, a written request should be sent within 180 days after the claimant receives notice of the denial. No special form is required. Please send written comments and provide additional documentation in support of the claim to:

**Regence Life and Health
100 SW Market Street
Portland, OR 97201**

Regence will review the claim promptly after receiving the request. For life insurance claims, a written notice of the decision will be sent within 60 days after the request for review is received or within 120 days if special circumstances require an extension. For disability insurance claims, Regence will send the claimant written notice of their decision within 45 days after the request for review has been received, or within 90 days if special circumstances require an extension. The notice will include the reason for denial and will refer to the specific provisions of the Policy on which the decision is based.

Another person may be authorized to act for the claimant under this review procedure.

XII. Coordination of Benefits and Plan Recovery for Overpayments and from Third Parties

Many people enroll in more than one health care plan in order to protect themselves against the high costs of medical or dental care. To keep the cost of Plan benefits as low as possible, the Administrative Office coordinates benefit payments with other health care plans, Medicare, other governmental plans, and coverage under this Plan where both Spouses are Covered Participants.

If you or your Dependents are covered under another health plan, Medicare, or other governmental plan, you must submit identical itemized bills to both plans. The Administrative Office and your other plan will determine which plan pays first (primary). When this Plan is primary, it pays its regular benefits in full. When the other plan is primary, this Plan pays a reduced amount (see page 53).

Coordination of Benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the Covered Expenses Incurred. Sometimes the combined benefits that are paid will be less than total Covered Expenses.

In no event will the Plan Reimburse an expense that is or should be covered by another plan, government program, insurance, or other source. If both you and a Dependent are covered by the Plan, the Plan will reimburse a Covered Expense only once. If you have otherwise obtained reimbursement for a health expense, the Plan will not again reimburse you for that same expense.

To administer coordination of benefits, the Plan has the right to exchange information with other plans involved in paying claims, require that you, your physician, or your Health Care Provider furnish information, reimburse any plan that made payments this Plan should have made, and recover overpayments.

Coordination With Other Health Plans

The following rules determine which plan is primary. If the first rule does not determine which plan is primary, the next rule is applied, and so on until the order of benefits is determined.

- If the other plan does not have a coordination of benefits provision, or if it has a coordination of benefits provision different from these rules, that plan is primary.
- The plan covering the person as an Employee, member, or subscriber (that is, not as a Dependent) is primary.
- For children of married parents, the plan of the parent whose birthday comes first in the calendar year is primary. If the parents' birthdays are the same, the plan of the parent that has provided coverage to that parent for the longer period is primary.

Where children of divorced or legally separated parents are covered by a court order that provides joint custody but designates neither parent as financially responsible for the child's health care, this "birthday" rule also applies.

- For children of divorced or legally separated parents not covered by the preceding rule, benefit payments are made by the plans in the following order:

- Parent (or Spouse of the parent) with court-ordered financial responsibility for the child’s healthcare, if the designated parent has actual knowledge of the court order.
- Parent with custody.
- Spouse of the parent with custody.
- Parent without custody.
- A plan covering the person (or a Dependent) as an active Employee or subscriber is primary over a plan covering the person (or a Dependent) as a retired or laid-off person. However, if the other plan does not have this rule — resulting in conflicting orders of benefit determination — this rule will not apply.
- The plan that has covered the person for the longer period of time is primary.
- **If none of the above rules determines which plan is primary, expenses shall be shared equally between the plans.**

If You Are Eligible for Medicare

When you or your Spouse reaches age 65, Medicare Part A (Hospital coverage) is generally automatic if you apply for Social Security benefits. Medicare Part B (Physician coverage) requires enrollment and monthly premium payments.

If you are eligible to enroll in Part A and Part B but choose not to, the Plan will calculate its benefits as if you were Medicare-eligible. The amount Medicare would have paid will be subtracted from the eligible charges and benefits will be paid on the balance. You will be responsible for the unpaid charges. (You do not have to enroll for Part D.)

Coordination With Medicare

Medicare is primary if:

- You or your Dependent are covered by Medicare on the basis of age (65 or over), and you are not a working Participant, or
- You or your Dependent are covered by Medicare on the basis of a disability, and you are not a working participant, or
- After being covered by Medicare on the basis of age (65 or over) or disability, you or your dependent become covered by Medicare because of end stage renal disease (ESRD), and you are not a working participant. In these circumstances, Medicare will continue to pay benefits as the primary provider.

This Plan is primary if:

- You or your Dependent are covered by Medicare on the basis of age (65 or over) and you are a working Participant (unless the exemption below applies), or
- You or your Dependent are covered by Medicare on the basis of a disability, and you are a working Participant, or
- You or your Dependent become covered by Medicare as a result of having end-stage renal disease (ESRD). Medicare acts as the secondary payer for the first 30 months after you become eligible for ESRD-based Medicare coverage. After 30 months, Medicare becomes primary.

An exemption may apply that allows working Participants and their Dependents who are receiving Medicare benefits on the basis of age to receive Medicare benefits as primary benefits, and for this Plan to be secondary. This exemption can only be applied if the participant works for a Contributing Employer with fewer than 20 Employees in the prior calendar year and the current calendar year, and the Plan has received documentation of that fact from the Employer, the Plan has applied for an exemption with the government identifying the Employer and Employees involved, and the exemption request has been granted. The exemption cannot be applied if, in 20 or more weeks in either the prior year or the current year, the Employer had 20 or more Employees. The exemption ceases to apply as soon as an exempt Employer reaches the 20-Employee level.

When This Plan Is Not Primary

This plan will Reimburse Covered Medical Expenses that are not reimbursed by your other plan, according to the terms, limitations, exclusions, and all requirements of this Plan. The Plan treats the *unreimbursed amount* as the *total charge* incurred for the service or supply, and pays benefits on those charges only to the extent they would have been payable if this Plan were primary. If your primary plan reduced benefits because this Plan exists and/or because you did not comply with that plan's provisions, such as failure to obtain precertification or preadmission approval, the amounts of those reductions will be treated as if they were reimbursed by the primary plan.

If this Plan advances an amount equal to the benefits it would have paid had it been the primary plan and later determines that it is the secondary plan, this Plan will be subrogated to all the rights the Participant may have against the other plan, and the Participant shall execute any documents required or requested by this Plan to pursue its claims for reimbursement of the amount advanced.

Coordination with Medicaid, TRICARE, Veterans Affairs facility, or other state or federal coverage

This Plan is always primary to Medicaid and Champus/TRICARE. So if you are covered both by this Plan and by Medicaid or TRICARE, this Plan pays first and Medicaid or Tricare pays second.

Military service-related Illnesses or Injuries, whether related to U.S. or other military service, are not payable by this Plan.

If you receive care in a U.S. Department of Veterans Affairs Hospital or facility on account of any Illness or Injury that is not related to military service, benefits are payable by this Plan to the extent that care is a Covered Medical Expense.

If you are eligible for benefits under both this Plan and by coverage provided through any state or federal law (other than Medicaid or Tricare, and Medicare in certain situations), the other coverage pays first and this Plan is secondary.

If your other health plan or Medicare pays first, this Plan will reimburse a portion of any remaining balance of Covered Expenses. If you or your Covered Dependent have not elected Medicare benefits even though they are available, or if you are eligible for Veterans benefits, this Plan pays as if Medicare paid as primary.

Example I

After the primary plan pays its medical benefits, assume the balance on Covered Medical Expenses is \$1,000. This Plan would apply the \$300 medical benefit deductible and then pay its regular percentage (80% for most Covered Expenses) of the remaining \$700. In other words, the Plan would pay \$560 and the out-of-pocket expense to the Participant would be \$440.

Coordination with other Prescription Drug coverage

If you have other prescription drug coverage that pays as primary, the Plan reimburses Covered Medical Expenses for outpatient prescription drugs (e.g., co-pays) the other plan did not pay. The Plan's reimbursement is 100% up to \$200 per covered person per calendar year, and no medical deductible will apply. After the Plan reimburses \$200, it reimburses any remaining expenses at 80%, also with no medical deductible.

Example II

If you have prescription drug co-pays from your primary plan totaling \$300, this Plan would reimburse you 100% of the first \$200 and 80% of the remaining \$100. In other words, it would pay \$280 of your \$300 co-pay and the out-of-pocket expense for you would be \$20.

Plan's Rights to Recovery

Payment is made for claims based upon your representations and those of your Covered Dependents and/or providers concerning the services rendered and is contingent upon benefits being covered under the terms of the Plan.

By accepting benefits, you and your Covered Dependents agree:

- To promptly refund to the Plan any amount that exceeds the amount covered by the Plan or any amount that is subject to the Plan's subrogation or reimbursement rights, discussed in the following section,
- That the Plan may reduce or deny coverage of your claims or the claims of your Covered Dependents as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and
- To reimburse the Plan in full for any benefits from the Plan to which the individual is later found not to be entitled.

The Plan may also recover interest on the amounts paid by the Plan from the time of the payment until the time the Plan is reimbursed.

Furthermore, whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan will be authorized to pay such benefits to the other party. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you. Any participant or individual who receives (or whose family receives) benefits from the Plan to which he or she is later found not to be entitled will be required to reimburse the Plan in full.

Plan's Right to Subrogation, Reimbursement, and Equitable Lien

The Plan does not pay health expenses for your or your Covered Dependent's Injury or Illness if the expenses are recoverable from a third party. This applies regardless of whether the Illness or Injury results from your negligence or actions, or from the negligence or actions of someone else. For example, if your expenses are recoverable under automobile or motor vehicle insurance, uninsured or underinsured motorist insurance, umbrella insurance, homeowners insurance, personal injury protection coverage (PIP), or any other type of insurance, or under a workers' compensation program, the Plan will not cover your expenses, regardless of who maintains the insurance or coverage.

If you make a claim for recovery against an insurer or other third party, you must promptly notify the Administrative Office. The Plan will advance the payment of your health expenses if you and/or your Covered Dependents sign the Reimbursement Agreement provided by the Administrative Office under the Reimbursement Agreement, you and/or your Covered Dependents agree to refund to the Plan the amount of any health expenses advanced by the Plan for the injury or illness, and not to release any party from liability for payment of medical expenses without first obtaining written consent by the Plan. If you, your Covered Dependents, or any attorney for you or your Covered Dependents does not cooperate with the Plan in providing information about the claim or in protecting the Plan's reimbursement rights, the Plan will stop advancing payments. If you or your Covered Dependents fail to pay the Plan the amount that is owed from any recovery, the Plan will offset this amount from any future benefits for you and your Covered Dependents. The Plan may also take legal action against you and your Covered Dependents to recover these amounts.

By accepting benefits under the Plan, you and your Covered Dependents are deemed to agree that the Plan will have a first priority claim and equitable lien on any recovery from a third party for an Injury or Illness sustained by you or your Covered Dependents, regardless of how the recovery is characterized, and regardless of whether the recovery results from a court judgment, settlement, or otherwise. This lien applies regardless of whether the recovery you receive makes you or your Covered Dependents whole, without regard to any state insurance laws or doctrines regarding "made whole" status or an implied "common fund." The recovery will be deemed to be held in a constructive trust on behalf of the Plan, and the Plan is entitled to restitution from the amounts held in the constructive trust. During the time period that you, your Covered Dependents, or your attorney holds funds recovered from a third party (such as an insurer), you, your Covered Dependents, and your attorney must take steps to ensure that the funds are preserved until amounts owed to the Plan for expenditures on your behalf are repaid to the Plan. In addition to these rights, the Plan has a right to sue the third party (if it chooses to do so) in your name or in the name of your Covered Dependents, if applicable, to recover the amount of benefit payments advanced.

The Plan is not required to limit its recovery for any expenses or attorney's fees incurred in making the claim that produces a recovery requiring reimbursement to the Plan. In its sole discretion, the Plan may compromise its rights to reimbursement, subrogation, and/or equitable lien.

XIII. How to File a Claim

This section tells you how to file a claim for benefits under the Plan. If you have coverage under another health plan which is primary payer, submit your claim to the other plan first. Then file a claim with the Administrative Office for the unpaid balance. To find out which plan is primary, see page 51 or call the Administrative Office. If you or your service provider or other agent submit a claim that is fraudulent or knowingly false, you and your Beneficiaries will cease to be eligible for Plan benefits, and will lose eligibility for benefits paid that relate to the false or fraudulent claim. In addition, the Plan reserves the right to take all legal and criminal action to recoup and prevent losses related to false and fraudulent claims.

Medical Benefit

- You ***must*** complete and submit an enrollment form to the Plan Administrative Office each calendar year before your claims will be processed. If you do not have a form to complete, please call the Plan Administrative Office at 208-288-1610 or the form can be downloaded from the website at www.iptt.org.
- Obtain your *itemized* Hospital and doctor bills showing your name, diagnosis, and all services and supplies you received.
- Check your bills for accuracy — after the claim has been processed by the Administrative Office, any Participant detecting and reporting an overcharge receives half the amount saved by the Plan, to a maximum of \$500 per Participant.
- Submit the itemized bills to the Administrative Office, see page 79, within 12 months of the date you incur the expense; claims made after this deadline will *not* be Reimbursed. You must incur the expense when services are rendered or supplies and equipment are dispensed.
- If your claim is denied and you wish to appeal the denial, follow the claim review and appeal procedure (see page 57).

If you are also eligible for Medicare benefits or covered by another medical plan, please contact the Plan Administrative Office so primary payer status may be determined and benefits coordinated. If this Plan is determined to be the primary payer, follow the steps outlined above.

If Medicare or the other medical plan is determined to be primary payer:

- Be sure the annual IPTT enrollment form is completed, then obtain itemized Hospital and doctor bills as described above.
- Hold these billings until you receive the other plan's Explanation of Benefits (EOB).
- Submit the itemized bills and EOB to the Administrative Office, see page 79, within 12 months of the date you incur the expense; claims made after this deadline will *not* be Reimbursed.

Prescription Drug Benefit

See page 36 for information on filing a claim under the prescription drug benefit. You must file your claim within 12 months of the date you fill the prescription, or expenses will not be Reimbursed.

Dental, Vision, and Hearing Aid Benefits

Ask your Dentist to submit a standard American Dental Insurance Form or comparable form to the Administrative Office showing:

- Covered Participant's name, social security number and/or unique identifier (UID)
- Patient's name and relationship to the Covered Participant
- Dates of service
- ADA code and tooth numbers (if applicable), and
- Itemized charges.

For vision benefits, you must file a statement or billing with the Administrative Office showing:

- Covered Participant's name, social security number and/or unique identifier (UID).
- Patient's name and relationship to the Covered Participant, and
- Itemized charges (for example, cost and type of lenses, frames, or exam).

For hearing aid benefits, you must file an itemized bill with the Administrative Office showing the Covered Participant's name, social security number and/or unique identifier (UID), and itemized charges.

You must file your dental, vision, or hearing aid claim within 12 months of the date you incur the expenses, or expenses will not be Reimbursed.

Other Benefits

Contact the Plan Administrative Office to obtain insurance forms to file a claim for a life insurance or accidental death and dismemberment insurance benefits. See page 76 for the insurance companies that insure these benefits.

If Your Claim Is Denied

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Administrative Office. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. All references to Plan Administrator in these claim procedures include any designee allocated claim administration responsibilities by the Plan Administrator, or such other person or entity specified in the applicable Component Documents. Certain benefits under this Plan, such as life insurance and accidental death and dismemberment, are insured through an insurance company. In such instances, your written request for a benefit must be submitted to the applicable insurance company rather than the Administrative Office. In addition, the insurance company will serve as the Plan Administrator for purposes of deciding the initial claim for benefits and any appeal from an initial claim denial. The Board of Trustees does not decide claims for insured benefits. Copies of insurance contracts regarding these insured benefits can be obtained from the Plan Administrative Office.

Medical Benefit Claim Determinations

The following procedures apply to any claim for medical benefits (including dental, vision and prescription drug). Medical claims that you elect to obtain pre-certification before service or treatment are handled differently than medical claims that are post-service.

Timing of written notice of benefit determination — Claims before service or treatment

The Plan's Prescription Benefit Manager (PBM) may require Prior Authorization for certain drugs.

The Plan does not require that you get prior approval for other medical services or procedures as a condition to receiving Reimbursement — a review program known as pre-certification. You may choose to contact CareAllies to obtain an assessment of medical necessity. **Please refer to page 25 under Pre-Admission Approval for Hospital Stays for further information.**

Urgent pre-certification claims

If your pre-certification claim is determined by the Plan Administrator to be a claim involving urgent care (as defined below), notice of the Plan's decision will be provided to you no later than 72 hours after receipt of your claim by the Plan Administrator, unless you do not provide sufficient information to decide your claim. In that case, notice requesting specific additional information will be provided to you within 24 hours of receipt of your claim. The Plan's decision regarding your claim will then be issued no later than 48 hours after the earlier of the Plan's receipt of the requested information or the expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours). Benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within 3 days after the oral notice.

A "claim involving urgent care" is a claim for pre-certification where application of the normal time periods for deciding your claim could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought. If a Physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the Plan as involving urgent care.

Regular pre-certification claims

If your pre-certification claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the Plan Administrator. If matters beyond the control of the Plan Administrator so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to you before the end of the initial 15-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Failure to follow pre-certification procedures

If your communication to the Plan Administrator concerning pre-certification does not comply with the Plan's procedures for filing pre-certification claims, notice of the proper procedures will be provided to you within five days of the communication. If, however, the communication involves urgent care, notice will be provided within 24 hours. Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service or product being requested. Notice may be oral, unless you request written notice.

Timing of written notice of benefit determination — Claims after service or treatment

If your claim for a benefit does not require pre-approval in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the Plan Administrator. If matters beyond the control of the Plan Administrator so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Timing of written notice of benefit determination — Concurrent care decision

Reduction or termination of ongoing course of treatment

If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated.

Extension of ongoing course of treatment involving urgent care

If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the Plan Administrator within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

Non-Medical or Disability Claim Determinations

The following procedures apply to any claim for non-medical benefits (such as life insurance or accidental death and dismemberment) or disability benefits.

Timing of written notice of benefit determination — Non-Medical Claims

If your claim is for non-medical benefits other than disability benefits, a written denial notice will generally be provided to you within 90 days after the date your claim is received by the Plan Administrator. However, if special circumstances require an extension of time for processing the claim beyond the initial 90-day period, written notice of the extension will be furnished to you

before the end of the initial 90-day period. An extension of time will not exceed a period of 90 days from the end of the initial 90-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

Timing of written notice of benefit determination — Disability Claims

If your claim is a disability claim, a written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan Administrator. If matters beyond the control of the Plan Administrator require an extension of the time for processing your disability claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan Administrator may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days).

Contents of Written Notice of Benefit Denial

If your claim for a benefit is denied, you will be notified in writing by the Plan Administrative Office (or the Plan Administrator in the case of non-medical benefits). The written notice will include the following:

- The specific reason or reasons for the denial.
- References to the specific Plan provisions on which the denial is based.
- A description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed.
- An explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review (claims involving urgent care will have a description of expedited appeal procedures).
- A statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal.

In addition, if your claim is a medical or disability claim, the written notification will also include:

- A copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- If the decision was based on a Medical Necessity or Experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

Appeal Procedures

Procedure for appeal of denied claim — Non-Medical Claims

If you wish to appeal an initial denial of a claim for non-medical benefits, you or your authorized representative must file a written appeal with the Plan Administrator within 60 days after receipt of written notice of the denial.

You or your authorized representative may submit a written statement, documents, records, and other information. You may also have reasonable access to and copies of Relevant Documents free of charge upon request. The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

Procedure for appeal of denied claim — Medical or Disability Claims

The appeal procedures set out above for non-medical claims apply to medical or disability claims except that you have 180 days instead of 60 days in which to appeal a denial of a claim with the Plan Administrator. If, however, your claim is medical and concerns the reduction or termination of a previously approved ongoing course of treatment, you may be required to file a written appeal within a shorter time period that permits the Plan Administrator to issue an appeal decision before the treatment is reduced or terminated. In addition, the following apply to medical or disability claims:

- The appeal decision will not defer to the initial decision denying your claim and will be made by the Plan Administrator who is not a person who made the initial decision, nor a subordinate of such person.
- If the initial denial decision was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person.
- Any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon.
- If your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method.

Timing of written notice of appeal decision — Medical Claims before service or treatment

Urgent Care Pre-certification Claims: The Plan will notify you of the decision by the Trustee Appeals Committee as soon as possible, but no later than 72 hours after an appeal is received.

Regular Pre-certification Claims: The Plan will notify you of the decision by the Trustee Appeals Committee no later than 30 days after the appeal is received.

Timing of written notice of appeal decision — Medical Claims after service or treatment, Disability Claims, or Non-Medical Welfare Claims

For appeals not related to insured benefits, such as life or accidental death and dismemberment insurance: Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Trustees after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received.

For appeals related to insured benefits: If based on a determination a of disability, your claim will generally be decided within 45 days, unless special circumstances require additional time, in which case the determination will be made within 90 days. Non-disability claims will generally be decided within 60 days, unless special circumstances require additional time, in which case the determination will be made within 120 days.

Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of the date the Plan receives your response to a request for additional information or the date set by the Plan for your requested response (at least 45 days from the date of the request).

Optional second stage appeal requesting a hearing

If your appeal is denied by the Trustees at your first stage appeal review and your claim is not a pre-certification claim, you may request a second stage appeal hearing before the Trustee Appeals Committee. Either you or a representative may present your claim at the appeal hearing. You must request such a hearing to the Plan Administrator within 60 days after notice of the first stage appeal decision. Your appeal will be addressed by the next quarterly meeting of the Board of Trustees, unless your appeal is received within 30 days prior to such a meeting, in which case it will be addressed by the second regularly scheduled quarterly meeting after it is received.

The second stage appeal hearing is optional, and you are not required to undertake it before pursuing legal action. If you request a second stage appeal hearing, any applicable statute of limitations or other timelines will be tolled while the appeal is pending. The Trustee Appeals Committee will be impartial. Whether or not you seek a second stage appeal hearing will have no effect on your rights to any other benefits under the Plan or information about applicable rules. If you choose not to request a second stage appeal hearing, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice. You will not be charged a fee for the second stage hearing appeal.

Contents of written notice of appeal decision

If your claim is denied on appeal, the decision on review will be in writing and will include the following information:

- The specific reason or reasons for the decision.
- Reference to the specific Plan provisions on which the decision is based.
- A statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents.
- A statement of your right to bring a civil action under Section 502(a) of ERISA.

In addition to the above information, in the case of a medical or disability claim, the written decision on review will also include:

- A copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and that a copy will be provided free of charge upon request
- If the decision on review was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- The following statement: “You and your Plan may have other voluntary alternative 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.”

Relevant Documents

Relevant Document means any document, record or other information that:

- Was relied upon in making a decision to deny benefits.
- Was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits.
- Demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals.
- If your claim is a medical or disability claim, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

If you have any questions regarding the claim procedure, please contact the Plan Administrative Office.

HIPAA Privacy and Security

This section is intended to meet the requirements of 45 C.F.R. § 164.504(f) and other applicable provisions of the Privacy and Security Rules of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and shall be construed and administered in accordance with applicable laws and regulations. The Trustees shall have access to PHI and Electronic PHI from the Plan only as permitted under this section of the Plan and Summary Plan Description or as otherwise required or permitted by HIPAA.

Definitions.

For purposes of this section, the following definitions apply:

Protected Health Information. The term “Protected Health Information” (“PHI”) has the same meaning as in 45 CFR § 164.501.

Electronic PHI. The term “Electronic PHI” has the same meaning as in 45 C.F.R. § 160.103, and generally refers to PHI that is transmitted or maintained in an electronic media.

Summary Health Information. The term “Summary Health Information” has the same meaning as in 45 C.F.R. § 164.504.

Permitted Disclosure of Enrollment Information and Summary Health Information.

The Plan may disclose to the Trustees information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

The Plan may disclose Summary Health Information to the Trustees, provided that the Trustees request the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

Request, Use and Disclosure of PHI by Trustees.

Subject to the Trustee Certification requirement described below, the Plan may provide to the Trustees, and the Trustees are permitted to receive, use, and disclose PHI and Electronic PHI from the Plan, to the extent necessary to perform plan administration functions (as defined in 45 C.F.R. § 164.504(a)) on behalf of the Plan, such as quality assurance, claims appeals, auditing and monitoring.

Trustee Certification.

The Plan shall disclose PHI to the Trustees only upon the receipt of a certification by the Trustees that the Plan has been amended to incorporate, and that the Trustees agree to the conditions of disclosure set forth in, the provisions of 45 C.F.R. § 164.504(f)(2)(ii). To that end, the Trustees agree with respect to any PHI received from the Plan (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508, which are not subject to these restrictions) that:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this amendment or required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA.

- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- The Trustees will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in a designated record set, in accordance with 45 C.F.R. § 164.524.
- The Trustees will make a participant's PHI available to the participant to amend or correct PHI contained in a designated record set that is inaccurate or incomplete, and the Trustees will incorporate any such amendments, in accordance with 45 C.F.R. § 164.526.
- The Trustees will make a participant's PHI available to permit the Plan to provide an accounting of disclosures, in accordance with 45 C.F.R. § 164.528.
- The Trustees shall ensure that the adequate separation between the Plan and the Trustees (i.e., the firewall) required by 45 C.F.R. § 164.504(f)(2)(iii) is established.

The Trustees further agree that if they create, receive, maintain, or transmit any Electronic PHI on behalf of the Plan (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508, which is not subject to these restrictions) that:

- The Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Trustees shall ensure that the adequate separation between the Plan and the Trustees (i.e., the firewall) required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- The Trustees shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- The Trustees shall report to the Plan any security incident (as defined in 45 C.F.R. § 164.304) of which it becomes aware, as required by HIPAA.

Minimum Necessary Requests.

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

Adequate Separation.

The Trustees may employ individuals with responsibility to carry out plan administration functions. Any such employees will only perform plan administration functions on behalf of the Board of Trustees, and will only have access to and use of PHI to the extent necessary to perform such functions. The Trustees shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain or transmit Electronic PHI on behalf of the Plan

Effective Mechanism for Resolving Issues of Noncompliance. The Trustees certify that any individual or entity who suspects an improper use or disclosure of PHI may report that occurrence to any Trustee or the Privacy Contact Person. A Trustee who has improperly used or

disclosed PHI may be barred from receiving further PHI, barred from Trust conferences, and/or reported to the entity which appointed him.

XIV. Definitions

When used in this Plan, certain terms have specific meanings. These terms are defined below:

Administrative Office or Plan Administrative Office: The Trust administrative office in Meridian, Idaho.

Bargaining Unit: A group of Employees working for an Employer and represented by the Union.

Beneficiary: The individual named on the last form provided by the Administrative Office, properly completed and signed by the Participant, and received by the Administrative Office prior to the Participant's death

Collective Bargaining Agreement or Collectively Bargained: An arms-length contract between an employer and Idaho Plumbers and Pipefitters Local Union No. 296 or 648 that provides the employer will contribute to the Trust for a Bargaining Unit, and that is accepted by the Trustees in writing

Contribution: The amount an Employer is required by Collective Bargaining Agreement or Special Agreement to contribute to the Trust

Covered Dental Expenses: UCR charges Incurred for Medically Necessary dental services and supplies that the Plan Reimburses.

Covered Dependent: An Eligible Dependent (see page 10) whose Dependent coverage has begun and not been lost.

Covered Hours: The hours you work for which your Employer must contribute (and has contributed) to the Trust Fund, under a Collective Bargaining Agreement or Special Agreement that is accepted by the Trustees.

Covered Medical Expenses: UCR charges Incurred for Medically Necessary services and supplies that the Plan Reimburses.

Covered Participant or Participant: A person who is currently eligible for and has performed all tasks (including completed all required forms and paid all amounts) required to obtain Plan coverage as a result of his or her own past or current employment as follows:

- **Active Participant:** An Employee who is currently entitled to participate in the Plan due to his or her hour bank account balance (see page 8). Benefits for Collectively Bargained Active Participants include medical, prescription drug, dental, vision (including safety glasses), hearing aid, life insurance and accidental death and dismemberment insurance benefits. Plan benefits are the same for active Special Agreement Participants (those covered by virtue of an approved Special Agreement) except that safety glasses are not included. When Active Participants become Self-Pay Participants, they are not eligible to continue the safety glasses benefit. Covered Dependents (of all Active Participants) are eligible for the same benefits as Active Participants except that safety glasses, hearing aids and accidental death and dismemberment insurance benefit coverage are not available; life insurance benefits are limited (see page 43); and Dependent children do not have coverage for contraceptives, pregnancy, birth of a child, or related complications.

- **Retiree or Retired Participant:** A Participant who is receiving a pension benefit or permanent disability benefit under the Idaho Plumbers and Pipefitters Pension Plan or any other retirement plan. When Retiree Participants become Self-Pay Participants covered through COBRA or Lifetime Self-Pay (see Section III page 17), they receive the same benefits as Active Participants except that safety glasses benefits are not available, **and** the life and accidental death and dismemberment benefits are limited (see Section X through XII including the conversion information). Retiree Participants still working and covered through their hour bank account balance (see page 8), receive the same benefits that Active Participants have except that the life and accidental death and dismemberment benefits are limited.

Covered Dependents of all Retiree Participants are eligible for the same benefits as Covered Dependents of Active Participants, except that life insurance and AD&D benefits are limited (see page 44).

- **Self-Pay Participant:** A Participant by virtue of COBRA or Lifetime Self-Pay (see Section III page 17).

Covered Spouse: A Spouse whose coverage has begun and not been lost.

Custodial Care: Care that is designed primarily to assist you in activities of daily living. This includes institutional care that primarily supports self-care and provides room and board. Types of Custodial Care include, but are not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and the supervision of medications that are ordinarily self-administered.

Dentist: A duly licensed person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Licensed Denturists are also included in this definition. The Plan covers Dentist services only when the Dentist is acting within the lawful scope of his or her license.

Dependent/Eligible Dependent: A person eligible for coverage as the Participant's Spouse or child. See page 10.

Emergency: An unforeseen Injury or Illness that requires immediate medical attention to avoid serious risk to health.

Employee: An employee on behalf of whom an Employer is required to contribute to the Trust pursuant to Collective Bargaining Agreement or Special Agreement.

Employer/Contributing Employer: A business entity that is required by a Collective Bargaining Agreement or Special Agreement to make payments into the Trust. The Board of Trustees must accept a Collective Bargaining Agreement or Special Agreement before the Plan may cover an Employer's Employees.

Experimental or Investigational: A service or supply (including any treatment, drug, equipment or device) is Experimental or Investigational if, at the time ordered, it comes within any one of the three following categories:

- It has not received a required approval by the Food and Drug Administration or other agency of the United States for general public use for treatment of your condition.

- The Centers for Medicare and Medicaid Services (CMMS) will not reimburse expenses for the service or supply under Medicare because CMMS has determined (as published in its Coverage Issues Manual or any update) that the service or supply is not reasonable and necessary to diagnose or treat you.
- The service or supply has not been scientifically demonstrated by the medical profession to be effective and efficient in terms of the condition being treated, or it is not rendered by an institution or provider in the United States that has demonstrated proficiency in the provision of the service or supply.

Explanation of Benefits (EOB): A printed statement addressed to the participant and provider itemizing services performed and benefit payment information related to those services.

Generic Prescription Drug: Drugs approved by the FDA to be considered as Generic and that contain the same active ingredients as the equivalent brand name drug.

Health Care Provider: Physician, Dentist, Nurse; and certified or licensed physical therapists, occupational therapists, speech therapists, inhalation therapists, anesthetist, audiologist, optometrist, and dental hygienist. The Plan covers services by the before mentioned only when the Health Care Provider acts within the lawful scope of his or her license.

Providers whose services are not covered under the Plan include, but are not limited to, massage therapist, hypnotist, acupuncturist, doctors of naturopathy and/or homeopathy, midwives, Christian Science or other religion-based practitioners, any therapist not listed in the above paragraph and any practitioner for whom the state in which the individual practices does not require a medical-related license.

Home Health Care Agency: A public or private agency or organization that administers and provides home health care and is certified by Medicare or an appropriate state agency.

Hospice Agency: A public or private agency or organization that administers and provides hospice care and is certified by Medicare or an appropriate state agency.

Hospital: A place which is licensed as a Hospital (if licensing is required by law), operated for the care and treatment of resident inpatients, and has a laboratory, Registered Graduate Nurses always on duty and an operating room where major surgical operations are performed by legally qualified Physicians.

For the purpose of paying benefits for nervous or mental disorders, the term “Hospital” also includes a place — other than a convalescent, nursing or rest home — with accommodations for resident bed patients, facilities to treat nervous or mental disorders, and a resident psychiatrist always on duty if it typically charges patients for the expense of confinement.

The term “Hospital” does not include an institution or part of an institution which is used principally as a clinic; convalescent, rest, or nursing home; or as a home for the aged or for persons suffering from substance abuse.

Illness: A disease or infection and all related symptoms or conditions related to the same Illness.

Incurred: Expenses are Incurred on the date the covered service or supply is rendered or obtained.

Initial Eligibility: The Participant must accumulate 300 Covered Hours within no more than five consecutive months. This is required for new participants or those who have been without coverage under the Plan for seven or more consecutive months.

Injury: Condition resulting from an external violent force and all related symptoms and conditions resulting from the same force, independent of sickness and all other causes.

Legal Separation: A decree of Legal Separation in lieu of divorce.

Malocclusion: Abnormality in the positioning and relationship of teeth.

Medically Necessary or Medical Necessity: A supply or service is Medically Necessary or meets Medical Necessity if it meets all of the following:

- Must be ordered by a licensed physician. *However, the fact that a physician has performed, prescribed, ordered, recommended, or approved a service does not, in itself, establish Medical Necessity for purposes of the benefit provisions of this Plan.*
- Must be provided in the most appropriate setting and must be provided at the most appropriate level of service and care for the patient's medical condition.
- Must not be experimental or investigational or provided for medical or other research.
- Must be required to diagnose or treat the patient's condition.
- Must be consistent with the symptoms or diagnosis and treatment.
- Must be appropriate as good medical practice.
- Must be in accordance with accepted medical practices and standards and appropriate in the amount, duration, and frequency for the symptoms, diagnosis, or treatment of a non-occupational injury or illness.
- Must not be possible to safely provide the service or supply on an outpatient basis (relevant when determining Medical Necessity of inpatient treatment).

Mental Illness: Those disorders listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other nonpsychotic mental disorders. No other disorders or conditions are included in the term "Mental Illness" for purposes of the benefit provisions of this Plan.

Non Preferred Brand-Name Drug: Drugs that are not Generic and are not included on the Preferred Drug List maintained by the Pharmacy and Therapeutics Committee of the PBM.

Nurse: A Registered Nurse (RN), Nurse Practitioner (NP), Licensed Practical Nurse (LPN), or Certified Nurse's Assistant (CNA) acting within the lawful scope of his or her license.

Oral Surgery: Tooth extractions and similar operations, including pre-operative and post-operative care.

Orthodontics: Correction of malposed teeth, for any reason.

PBM: Prescription Benefit Manager.

Palliative Care: Care primarily for the relief or control of symptoms, not the cure.

Pension Plan: The Idaho Plumbers and Pipefitters Pension Plan.

Periodontics: Treatment of tissues supporting the teeth.

Physician/Health Care Provider: The Plan covers Physician/Health Care Provider services only when the Physician/Health Care Provider is duly licensed and acting within the lawful scope of his or her license. A Physician/Health Care Provider may be one of the following (but not limited to): Doctor of Medicine (MD), Doctor of Medical Dentistry (DMD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Nurse Practitioner (NP), Physician's Assistant (PA) Doctor of Psychology (PhD), Masters of Social Work (MSW), Master of Counseling (MSC), Licensed Mental Health Counselor (LMHC) or Licensed Professional Counselor (LPC).

Plan: Idaho Pipe Trades Health and Welfare Plan.

Preferred Brand-Name Drug: Brand drugs included on the Preferred Drug List maintained by the Pharmacy and Therapeutics Committee of the PBM.

Preferred Provider Organization (PPO): A [health care organization](#) composed of physicians, hospitals, or other providers which provides health care [services](#) at a reduced [fee](#)..

Preventive: Necessary or helpful to prevent the occurrence of a medical abnormality or disease.

Prosthetics: Artificial replacement of limbs, eyes or natural teeth and/or associated structures.

Reimbursement/Reimburses: Payments made within the limits and provisions of the Plan.

Skilled Nursing Facility: A facility primarily providing convalescent care for patients transferred from a Hospital and which has approval of the Joint Commission on Accreditation of Healthcare Organizations.

Special Agreement: A written agreement between a Contributing Employer and the Trustees obligating the Employer to contribute to the Trust Fund for the purpose of providing Plan benefits to non-Bargaining Unit Employees, that is accepted by the Trustees in writing. Contributions for Special Agreement Participants will not be accepted by the Plan Administrative Office if the Employer is delinquent in contributing for Collectively Bargained Employees. More information is available from the Plan Administrative Office in the "Rules and Procedures for Admitting Non Bargaining Unit Employees".

Spouse: The person to whom a Participant is legally married and who is recognized as a spouse under the Tax Code. For purposes of the Plan, a "Spouse" does not include a spouse by a common law marriage or a spouse who is the same gender as the Participant. See the **Dependents** section (beginning on page 10) for spouses who are eligible for coverage.

Substance Abuse Treatment Facility: A facility that provides treatment for chronic alcoholism or other substance abuse and is operated under the direction and control of the appropriate licensing or regulatory agency in the jurisdiction where it is located.

Totally Disabled: Prevented by Illness or accidental Injury from performing any and every duty of your occupation and from performing any occupation for wage or profit.

Trust, Trust Agreement, or Trust Fund: The Idaho Plumbers and Pipefitters Health and Welfare Fund Trust Agreement

Trustees: Those persons designated as Trustees pursuant to the terms of the Trust Agreement, and their successors.

UID: unique identification number assigned to participants by the Administrative Office.

Union: Idaho State Pipe Trades Association Local Union 296 or 648.

Usual, Customary, and Reasonable (UCR): This term means:

- Usual — most consistent charge by a Physician or other provider for a given service.
- Customary — within the range of usual charges for a given service billed by most Physicians or providers with similar training and experience within the provider's geographic region.
- Reasonable — meets the usual and customary criteria within reasonable utilization limits, is justifiable under the circumstances, and is the most efficient and economical service to treat the Illness or Injury as determined in accordance with generally accepted medical practice.

XV. Important Information

Reciprocity and Transfer of Assets and Liabilities

- (a) If the Trustees enter into reciprocity agreements with other employee benefit plans and trusts in which assets are transferred to the Plan and Trust on behalf of an employee whose employer is contributing into the transferor plan and trust, the employee will be credited with the contributions applicable to his employment with the contributing employer for purposes of determining participation eligibility and benefits in the Plan, but only pursuant to the terms of the Plan.
- (b) If employer contributions on behalf of an employee into the Plan and Trust are to be transferred pursuant to a reciprocity agreement to another plan and trust, that employee shall not be credited in any way with hours of service or contributions under the terms of the Plan and Trust for any purpose, including but not limited to calculating participation, eligibility and benefits. Nothing in the foregoing, however, is intended to impair the right of the Plan and Trust to enforce delinquent contributions from a contributing employer whose contributions are to be transferred pursuant to a reciprocity agreement.
- (c) The calculation of all hours credited under the Plan shall be calculated in the following manner. To establish hours of credit, the contributions received from the transferor plan and trust will be divided by the hourly contribution rate of the participant's home local during the applicable work month. The converted hours will then be posted to the participant's hour bank for the month the work was performed.

If contributions have not been received by the Plan from the transferor plan, the traveling participant can receive temporary credit, as calculated above, if:

- The participant contacts the transferor plan and requests that they submit proper documentation of their intended transfer on his behalf to the Administrative Office, and
- The actual transfer is received by the Administrative Office within 90 days of the documentation.

If temporary credit is posted and contributions are not received within the required 90 day time period, any claim payments made for services incurred during the temporarily credited coverage month(s) will be considered overpayments. The participant will be financially responsible for reimbursing the Plan for any and all overpayments.

Administration of the Plan

Governing Law

This Plan is construed in accordance with applicable federal law, ERISA, and to the extent not otherwise preempted, the laws of the State of Idaho.

Severability

If any provision of this Plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of Plan, which shall be construed as if such illegal or invalid provision had never been included.

Name of Plan

This Plan is known as the Idaho Pipe Trades Health and Welfare Plan.

Plan Administrator

This Plan is maintained and administered by a joint labor-management Board of Trustees:

Board of Trustees
Idaho Pipe Trades Trust
575 N. Ralstin, Suite B
Meridian, Idaho 83642
(208) 288-1610
(800) 808-1687
(208) 288-1670 fax

Participants and Beneficiaries may obtain a complete list of the Employers and Employee organizations sponsoring the Plan or whether a particular Employer or Employee organization sponsors the Plan and the Sponsor's address, by writing to the Trustees. You may also examine this list at the Plan Administrative Office or your local Union office upon 10 days advance written request. The Plan may impose a reasonable charge for providing copies. If you wish, you can ask the Plan Administrative Office the cost before requesting copies.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of its employees at the Plan Administrative Office and a Prescription Drug Vendor. The Trustees may, from time to time, contract with other third parties. All fully insured benefits are administered by the applicable insurer.

Plan Administrative Office:
Idaho Pipe Trades Trust
575 N. Ralstin, Suite B
Meridian, Idaho 83642
Phone (208) 288-1610
Toll free (800) 808-1687
Fax (208) 288-1670

Identification Numbers

The employer identification number assigned to the Trust by the Internal Revenue Service is 82-6030679. The Plan number is 501.

Type of Plan

This Plan is an Employee Welfare Benefit Plan providing medical, prescription drug, dental, vision, and life insurance benefits for Covered Participants and Covered Dependents; hearing aid and accidental death and dismemberment coverage for Covered Participants only.

Plan Year

This Plan operates on a June 1 through May 31 plan year.

Board of Trustees

The members of the Board of Trustees are:

Employer Trustees

Dana Trautner, Secretary
L&L Mechanical, Inc.
579 West 75 South
Blackfoot, ID 83221

Bill Magnuson, Trustee
RM Mechanical, Inc.
5998 West Gowen Road
Boise, Idaho 83709

Steve Ferro, Trustee
Atlas Mechanical, Inc.
1380 Enterprise Street
Idaho Falls, ID 83402

Union Trustees

Rodney Fuger, Chairman
Local 648
456 North Arthur Ave, Suite 4
Pocatello, Idaho 83204

Rodney Clay, Trustee
Local 296
575 North Ralstin, Suite A
Meridian, Idaho 83642

Mike Breed, Trustee
Local 648
456 North Arthur Ave, Suite 4
Pocatello, Idaho 83201

Service of Legal Process

The name and address of the person designated as agent for the service of legal process is Susan Shepherdson, Idaho Pipe Trades Trust, 575 N. Ralstin, Suite B, Meridian, ID 83642. Legal process may also be served upon the Plan Administrator or any member of the Board of Trustees.

Collective Bargaining Agreements

This Plan is maintained under Collective Bargaining Agreements. These agreements specify the rate at which Employers must contribute to the Idaho Pipe Trades Trust to provide Plan coverage for their Collectively Bargained Employees.

Participants and Beneficiaries may obtain a copy of relevant Collective Bargaining Agreements by writing to the Trustees. You may also examine these agreements at the Plan Administrative Office or your local Union office upon 10 days advance written request. The Plan may impose a reasonable charge for providing copies. If you wish, you can ask the Plan Administrative Office the cost before requesting copies.

Source of Contributions

This Plan is funded through Employer contributions as specified in Collective Bargaining Agreements and Special Agreements (for nonbargained Employees). Self-payments by Participants are also permitted as described in this Document (see Section III beginning on page 17). The amount of self-payments is fixed from time to time by the Board of Trustees.

Funding Medium and Administration

All Employer contributions and self-payments are held by the Trust pending the payment of benefits, insurance premiums, and administrative expenses. Medical, dental, vision, and hearing aid benefits are paid directly from Trust assets by the Administrative Office. Prescription drug benefits are administered by **NMHC Rx**, 26 Harbor Park Drive, Port Washington, NY 11050. Life insurance coverage is insured by **Regence Life and Health Insurance Company**, 100 SW Market Street, Portland Oregon 97201. Stop Loss coverage is insured by **Canada Life Assurance Company**, 6201 Powers Ferry Road NW, Atlanta, Georgia, 30339. Accidental death and dismemberment benefits are insured by **Regence Life and Health Insurance Company**, 100 SW Market Street, Portland Oregon 97201.

Your Rights as a Plan Participant

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

Receive Information About Your Plan Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Coverage

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage

ceases if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to

pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Hospital length of stay for newborns and mothers

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the 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.

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 Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, 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.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, 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 publications hotline of the Employee Benefits Security Administration.

XVI. Contact Information

Following is some useful contact information:

Administrative Office

The Administrative Offices are your resource for virtually all your questions. Call the Plan Administrative Office for eligibility, self-pay questions and claim questions. Call the Prescription Benefit Manager's help desk for prescription drug and participating pharmacy questions, and also to request a claim form if you filled a prescription at a nonparticipating pharmacy. Contact Beech Street/First Choice to obtain the names of providers and facilities who participate in the network and offer discounted rates to participants in our Plan.

Administrative Office (Meridian)

Idaho Pipe Trades Trust
575 N. Ralstin, Suite B
Meridian, Idaho 83642
Phone (208) 288-1610
Toll Free (800) 808-1687
Fax (208) 288-1670
www.iptt.org

Pharmacy Benefit Manager (PBM)

NMHC RX
26 Harbor Park Drive
Port Washington, NY 11050
Help Desk (866) 510-2866
Phone (800) 645-3332
Fax (516) 605-6983
www.nmhcrx.com

Hospital Preadmission, Utilization Management and Case Management

You, your doctor or the Hospital may call CareAllies at **(800) 327-6845** before Hospital admission to obtain an assessment of Medical Necessity and determine if case management services are required.

Preferred Provider Organization (PPO)

You can access a list of preferred providers through the **Beech Street/First Choice** network online at www.beechstreet.com or by calling **(800)-877-1444**.

Written communication to the Plan, the Administrative Office, the Trustees, or their agents or representatives, must be received before the expiration of any time period expressed in the Plan or in this Document. These parties' records determine whether a communication has been received and the date of such receipt, unless you procure a United States Postal Service return receipt. So the common law 'mailbox rule' does not apply to determine receipt by these parties. The common law mailbox rule does apply for all other purposes under the Plan.

A complete copy of the Health and Welfare Summary Plan Description is also available on the website – www.iptt.org.