

PLUMBERS LOCAL UNION
NO. 519
HEALTH AND WELFARE FUND

Summary Plan Description

Effective July 1, 2001

**PLUMBERS LOCAL UNION
NO. 519
HEALTH AND WELFARE FUND**

FUND OFFICE

7950 N.W. 53rd Street, Suite #202
Miami, Florida 33166
(305) 591-0061
(800) 842-5899

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
PHIL TRUCKS, JR.	DOUGLAS ORR
WALLACE BROWN	SAM BLOOM
RICHARD LINDSTROM	RAYMOND P. VIENS
STEPHEN FRISCHHOLZ	LARIE C. MEARS

ADMINISTRATIVE MANAGER
National Employee Benefits Administrators, Inc.

FUND COUNSEL
Howard S. Susskind
Sugarman & Susskind, PA

FRINGE BENEFIT COORDINATOR
Jeff Penniston
14105 N.W. 58 Court
Miami Lakes, FL 33015
(305) 362-0519

**PLUMBERS LOCAL UNION NO. 519
HEALTH AND WELFARE FUND**

To All Eligible Participants:

At a time when health care is one of our nation's greatest priorities, the Board of Trustees of the Plumbers Local Union No. 519 Health and Welfare Fund continues to afford you and your family financial protection through health coverage provided by the Plan. We are pleased to present you with this updated booklet which describes the major features of your Plan. The terms of this booklet are effective July 1, 2001.

This booklet is designed to give you an easy-to-read reference about the Health and Welfare Plan. It covers the benefits, eligibility rules, claim procedures, and the administration of the Fund as required by federal law. According to law, the Plan is governed by a Plan Document and other insurance contracts (which are always available for your inspection), and we have tried to describe the benefits here just as they are written in those documents. However, if there is any difference between the terms of this booklet and those of the Plan documents, the Plan or contract provisions will control.

We believe the continued success of our program is due to the excellent cooperation from you, the Employers, and the Union. You can be assured that the Trustees will continue to administer the Fund so that you can receive the most comprehensive benefits possible within the resources available to the Fund. And, we want to remind you that your treatment of the Health and Welfare Plan directly affects the Fund's ability to pay your claims. Just as you would prudently spend your own money, we want you to "do your homework" with the health plan wherever possible. Being cost-effective as you look for the best possible medical care for your family is one of the ways we can overcome the problem of rising health costs.

Keep this booklet in a safe place for quick reference after you have read it. Of course, if you have any questions about your eligibility or the benefits to which you are entitled, please contact the Administrative Manager. Finally, please notify the Fund when your beneficiary or current address has changed.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

IMPORTANT INFORMATION ABOUT THE PLAN.....	4
GENERAL DEFINITIONS.....	8
I. YOUR ELIGIBILITY FOR BENEFITS	
1.Bargaining Unit Employees.....	10
2.Dependents.....	12
3.Non-Bargaining Unit Employees.....	12
4.Retired Employees.....	13
II. PLAN PROVISIONS APPLICABLE TO ALL ELIGIBLE PARTICIPANTS	
Continuation of Health, Dental and Vision Coverage.....	15
Maternity Stay Notice.....	17
The Women’s Health and Cancer Rights Act of 1998.....	18
Certificate of Creditable Coverage.....	18
Death Benefits and Accidental Death and Dismemberment Benefits.....	18
Dental Benefits.....	20
Vision Benefits.....	20
III. PLAN PROVISIONS APPLICABLE TO ELIGIBLE HMO PARTICIPANTS.....	21
IV. PLAN PROVISIONS APPLICABLE TO POINT-OF-SERVICE PARTICIPANTS.....	22
V. PLAN PROVISIONS APPLICABLE TO APPRENTICE APPLICANTS.....	24
VI. GENERAL INFORMATION	
Lifetime Maximum Benefit.....	25
Enrollment.....	25
Limitation of Plans.....	25
Change in Job Classification.....	25
Coordination of Benefits.....	25
Subrogation.....	27
Medicare.....	27
Claim Forms.....	28
Notice of Benefit Determination.....	29
Claims Appeal Procedure.....	29
Other Provisions.....	30
VII. STATEMENT OF ERISA RIGHTS.....	33

**IMPORTANT INFORMATION
ABOUT THE PLAN**

This employee benefit plan is intended to comply with the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

PLAN NAME:

Plumbers Local Union No. 519 Health and Welfare Fund.

PLAN YEAR:

The year upon which the records of the Plan are kept is May 1 through April 30.

TYPE OF PLAN

This Health and Welfare Plan offers health, hospitalization, dental, vision, death benefits and accidental death and dismemberment benefits to eligible participants.

ADMINISTRATION

A Board of Trustees is responsible for the administration of this Health and Welfare Fund. The Board of Trustees consists of both Union and Employer representatives, selected by the Union and the Employers who have entered into collective bargaining agreements which relate to the Welfare Fund. A complete list of Employers as well as information as to a particular Employer and the Employer's address may be obtained upon written request to the Administrative Manager and are available for examination. The Board of Trustees may be contacted in care of the Administrative Manager at:

7950 N.W. 53rd Street, Suite 202
Miami, FL 33166
Telephone (305) 591-0061 or
(800) 842-5899

The names and addresses of the individual Trustees are as follows:

UNION TRUSTEES

EMPLOYER TRUSTEES

Phil Trucks, Jr. Plumbers Local 519 14105 NW 58th Court Miami Lakes, FL 33014	Douglas Orr Orr Plumbing 301 Flagler Street Miami Springs, FL 33166
Wallace Brown Plumbers Local 519 14105 NW 58th Court Miami Lakes, FL 33014	Sam Bloom 5333 SW 34th Avenue Fort Lauderdale, FL 33312
Richard Lindstrom Plumbers Local 519 14105 NW 58th Court Miami Lakes, FL 33014	Raymond P. Viens John J. Kirlin, Inc. 5430 N.W. 33rd Avenue, #106 Fort Lauderdale, FL 33309
Stephen Frischholz Plumbers Local 519 14105 NW 58th Court Miami Lakes, FL 33014	Larie C. Mears Trimec NA, Inc. 7171 N.W. 74 Street Miami, FL 33166

ADMINISTRATIVE MANAGER

The day to day administration of the Fund is handled by National Employee Benefits Administrators, Inc., located at:

7950 N.W. 53rd Street, Suite 202
Miami, FL 33166
Telephone (305) 591-0061 or
(800) 842-5899

The Board of Trustees has broad discretionary authority to:

- construe the terms of the Plan,
- determine the status and rights of participants, beneficiaries and other persons,
- make rulings, and prescribe procedures,
- gather needed information,
- exercise all of the power and authority contemplated by ERISA with respect to the Plan,
- employ or appoint persons to help or advise in any administrative functions,
- appoint investment managers and trustees, and
- do all other things needed to operate, manage and administer the Plan.

The plan has other fiduciaries, advisors and service providers. The Board of Trustees may allocate fiduciary responsibility among the plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the plan.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another plan fiduciary, to the extent provided in ERISA.

Death benefits and accidental death and dismemberment benefits are self-funded. Medical coverage is fully insured and dental coverage is both insured and self-funded. Vision coverage is both insured and self-funded. National Employee Benefits Administrators is the claim administrator for the self-insured benefits.

HIP Health Plan of Florida and the American Dental Plan, Inc. insure the insured benefits and their addresses are as follows:

HIP Health Plan of Florida
300 S. Park Road
Hollywood, FL 33021
(954) 986-6225

American Dental Plan, Inc.
P.O. Box 769649
Rosewell, GA 30076-8225
(800) 633-1262

IDENTIFICATION NUMBERS

The plan number assigned to this Plan by the Board of Trustees on instructions of the Internal Revenue Service is 501. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 59-6134291. If you want to write to the Internal Revenue Service or the U.S. Department of Labor about this Plan, you must use these numbers.

SOURCE OF CONTRIBUTIONS

All contributions to the Plan are made by Employers in accordance with collective bargaining agreements with employee representatives. The collective bargaining agreements require contributions to the Plan at fixed rates per hour. The Plan also receives contributions on behalf of certain non-collectively bargaining participants pursuant to written participation agreements between the Fund and Employers, which agreements provide for periodic contributions at fixed rates per month.

A copy of any of the agreements may be obtained by Plan participants or their beneficiaries upon written request to the Administrative Manager, or they may be inspected at the Administrative Manager's office during normal business hours.

AGENT FOR SERVICE OF LEGAL PROCESS

The Fund's agent for service of legal process is:
Howard S. Susskind, Esq.
Sugarman & Susskind, P.A.
2801 Ponce De Leon Blvd., Suite 750
Coral Gables, FL 33134
Legal papers may also be served on any Trustee or upon the Administrative Manager.

FUNDING MEDIUM

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered persons and defraying reasonable administrative expenses. All assets and reserves are held in custody and invested by the Board of Trustees pursuant to fiduciary standards required by federal law.

PLAN INFORMATION

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are briefly described in this booklet.

PLAN AMENDMENT AND / OR TERMINATION

The right to amend, modify, suspend and/or terminate the Plan in whole or in part at any time is reserved to the Board of Trustees and to the Employers and the Union who are signatory to the Plan's Trust Agreement. Circumstances under which the Plan may be terminated include, but are not limited to:

- (a) When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Fund's resources;
- (b) When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;
- (c) When the last surviving participant or beneficiary entitled to receive benefits has died;

- (d) With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement; or
- (e) With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees will within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

The Plans may be amended by the Board of Trustees upon majority vote of the Trustees in attendance and voting at that time. All amendments will be in writing and signed by the Trustees. A Summary of Plan changes describing any material changes or modifications will be distributed to all Plan participants.

If any amendments to the Plan result in a material reduction of benefits under the Plan, then you will receive notification of these reductions within 60 days of the date of adoption of the amendment.

CLAIMS FILING AND APPEAL

Refer to the section entitled How to File a Claim on page 29 for information on filing claims. Refer to the section entitled Claims Appeal Procedures on page 29 for information on appealing denied claims.

GENERAL DEFINITIONS

A **CONTRIBUTING EMPLOYER** is an employer who is required, under the terms of a collective bargaining agreement, to contribute to the Welfare Fund, and also the Union with respect to its employees for whom contributions are made to the Fund.

A **DENTIST** is an individual licensed to practice dentistry in the state where the dental service is performed and operating within the scope of his or her license.

Your **DEPENDENT** means (1) your spouse, not legally separated from you; (2) your unmarried child or children from birth to 19 years of age including natural, adopted and foster children; (3) your unmarried child or children from age 19 up to their 24th birthday who legally reside with you, are wholly dependent upon you for support, are full-time students attending an accredited secondary school, junior college, college or university or a nursing school; and (4) your unmarried children who are physically or mentally incapacitated and who are dependent upon you for support regardless of their age.

For the purpose of this definition, the term "children" includes children born to you, children adopted by you or placed for adoption with you, stepchildren and foster children living with you in a normal parent-child relationship and who are dependent upon you for financial support to the extent they qualify as a dependent as defined in the Internal Revenue Code. "Placement for adoption" means you have assumed a legal obligation for total or partial support of a child in anticipation of adoption.

DISABILITY means an inability to perform any and every duty of your occupation or employment that results from an injury or disease that was incurred as a compensable injury or illness under any state workers' compensation law.

ELIGIBLE INDIVIDUAL means you the Employee and each of your eligible Dependents, if any, provided that you timely enroll.

An **EMPLOYEE** is (1) an individual who works for a Contributing Employer who is required to make contributions to the Health and Welfare Plan on the Employee's behalf; (2) an individual who works in the jurisdiction of a Local Union which has signed a Reciprocal Agreement under this Plan; (3) full-time salaried Corporate Officers; (4) self-employed individuals (including proprietors and partners of any plumbing contractor) who have a collective bargaining agreement in effect with the Union; and (5) salaried Union Officers.

An **EXPENSE** is a charge a person is legally obligated to pay. An Expense is deemed to be incurred on the date the service or supply is furnished.

HEALTH MAINTENANCE ORGANIZATION (HMO) is a state or federally qualified organization or insurance carrier retained by the Board of Trustees through which medical services are provided to covered Employees and Dependents for a negotiated rate. The HMO provides services through a network of participating providers and requires that care be coordinated through a Primary Care Physician.

INJURY means bodily harm which is caused by an accident.

A **MEDICALLY NECESSARY** service is a service which is required to identify or treat the illness or injury which a Physician has diagnosed or reasonably suspects. The service must:

- (a) be consistent with the diagnosis and treatment of your condition;
- (b) be in accordance with standards of good medical practice;
- (c) be required for reasons other than your convenience or your Physician's; and
- (d) be performed in the least costly setting required by your condition.

The fact that a service is prescribed by a Physician does not necessarily mean that service is Medically Necessary.

MEDICARE means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently in force or amended in the future.

PHYSICIAN means an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery. Licensed chiropractors, licensed ophthalmologists and licensed nurse-midwives (with respect to maternity care) are included in the definition of Physician.

PLAN means the Rules and Regulations of the Plumbers Local Union No. 519 Health and Welfare Fund, as adopted and amended in the future.

POINT-OF-SERVICE PLAN (POS) is a medical plan where you have a choice of how to use your coverage each time you need medical care. If you use providers in the HMO participating provider network coordinated through your Primary Care Physician you receive the highest level of benefits. If you use providers outside of the HMO network or care not coordinated through your Primary Care Physician, you receive a reduced level of benefits.

QUALIFIED MEDICAL SUPPORT ORDER: A judgement or decree order issued by a court of competent jurisdiction or state agency which recognizes your child(ren) as eligible dependents. The child who is to be provided coverage is an Alternative Recipient. The order may be in the form of a National Medical Child Support Notice and must contain the following:

- (a) the order specifies your name and last known address, and the Alternative Recipients' name and last known address;
- (b) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- (c) the order states the period to which it applies; and
- (d) the order specifies each plan that it applies to.

It is your responsibility to provide a copy of a Medical Child Support Order to the Administrative Manager's Office. This Order will be reviewed to determine if it meets the requirements to be deemed "Qualified". If further information is needed, you will be asked to provide such information, at your expense to the Administrative Manager's Office. The Plan will notify you and the Alternative Recipient of the procedures for determining if the order is qualified. The final decision regarding the qualifications of the Order will be made by the Board of Trustees.

SICKNESS means a disease, disorder or condition, which requires treatment by a Physician. Sickness includes childbirth, pregnancy or any related condition.

I. YOUR ELIGIBILITY FOR BENEFITS

Your eligibility for medical and/or dental benefits is conditioned upon your actual enrollment with the HMO and/or the Plan. Upon earning initial eligibility you will be provided with a package outlining all benefits, a list of panel providers and an enrollment application. You must complete the enrollment application and return the completed enrollment application to the Fund Office. If you do not return a completed enrollment application to the Fund Office, you will not be eligible for any medical benefits under the HMO or POS.

1. ALL BARGAINING UNIT EMPLOYEES

INITIAL ELIGIBILITY

You will become initially eligible for benefits on the first day of the Benefit Period following receipt of a minimum of 375 hours of contributions worked during the corresponding Eligibility Period. You may use self-contribution hours to earn initial eligibility provided that at least one (1) hour of contributions have been paid on your behalf during the corresponding Eligibility Period.

CORRESPONDING ELIGIBILITY PERIODS AND BENEFIT PERIODS

<u>Eligibility Period</u>	<u>Benefit Period</u>
July, August, September	January, February, March
October, November, December	April, May, June
January, February, March	July, August, September
April, May, June	October, November, December

CONTINUED ELIGIBILITY

You shall remain eligible for benefits for the next Benefit Period following the end of the initial Eligibility Period provided that your Employer has made contributions on your behalf for a minimum of 375 hours worked in the corresponding Eligibility Period.

For the purposes of maintaining continued eligibility only, hours can be accumulated by using one or more of the following:

- (a) Hours worked for which an employer makes contributions;
- (b) Reciprocity hours, pursuant to a reciprocity agreement approved by the Board of Trustees;
- (c) For bargaining unit employees only, self-contributions, if the employee is available for work;
- (d) Disability Hours.

HOW YOUR ELIGIBILITY CAN BE TERMINATED

A bargaining unit employee's eligibility will terminate on the first to occur of the following events:

- (a) A review of the hours contributed on behalf of each bargaining unit employee will be made each January 1, April 1, July 1 and October 1 of each year. Eligibility for benefits will terminate on these dates if you have not accumulated a minimum of 375 hours during the corresponding "Eligibility Period" (as described in the Initial Eligibility section), or on the date the Plan terminates, if earlier.
- (b) If the employee is making self-contributions, eligibility for benefits will terminate on the last day of the month for which the employee made an on-time self contribution.

- (c) The date on which the employee enters the armed forces of any country on a fulltime basis. It is the employee's responsibility to advise the Administrative Manager immediately of his entrance into the military before his actual entry.
- (d) The date the Trustees terminate this Plan of Benefits.
- (e) The date the Trustees terminate benefits for a class of employees to which the employee belongs.
- (f) The date of the employee's death though covered dependents will continue coverage through the end of the Benefit Period; or
- (g) With respect to specific benefits or types of coverage, the date the Trustees decide to limit or eliminate same.
- (h) If you are not working for or available for work with a Contributing Employer.

HOW YOUR ELIGIBILITY CAN BE REINSTATED

If your eligibility terminates completely and then you later return to work for a contributing employer, your eligibility will be reinstated on the first day after contributions are made on your behalf for a minimum of 375 hours worked during an Eligibility Period as set forth in the Initial Eligibility section.

HOW YOU CAN MAKE SELF CONTRIBUTIONS TO CONTINUE YOUR ELIGIBILITY

For the purpose of continued eligibility, **bargaining unit employees** can make self contributions to the Fund. You can make such contributions if you meet the following requirements:

- (a) you have at least (1) hour of paid contributions in an Eligibility Period (see above); and
- (b) you are available for work for a Contributing Employer in the trade and geographic area of the Fund.

“Available for work” means those employees who are registered on the out-of-work list with the Union's Hiring Hall and now are otherwise unemployed. You will not be considered available for work if:

- (a) you are working for an employer within the geographic jurisdiction of the Fund who is not obligated to make contributions to the Fund on your behalf; or
- (b) you are working for an employer outside the geographic jurisdiction covered by the Fund.

If you have hours worked and contributions have been paid on your behalf in an Eligibility Period, **you can make self contributions equal to the difference between your hours paid and the hours required, multiplied by the current Health and Welfare contribution rate for your job classification.**

Your category of coverage (POS) may require an additional self contribution to maintain coverage. If you fail to pay the additional contribution required, your continued coverage will be under the HMO Plan.

If you fail to make the required self contribution, your eligibility for coverage will terminate. If you want to become eligible at a later date, you will have to meet the reinstatement requirements (see above) or the COBRA Continuation of Coverage requirements (discussed later in this booklet).

YOUR SERVICES IN THE ARMED FORCES

If you are called into active military service for up to 31 days you can continue your medical and dental coverage during the leave period if you continue to pay your contributions for that coverage during the period of that leave. If your leave for active duty extends beyond the 31 days you can continue to self-pay for benefits for your dependents for up to 18 months through the COBRA provisions. If you lose eligibility because of your entrance in armed forces, you will be reinstated for benefits when you become reemployed with a Contributing Employer, provided that you secure your employment within 90 days of discharge from the Service.

FAMILY AND/OR MEDICAL LEAVE

You may be entitled by law to have up to 12 weeks each year of unpaid Family and/or Medical Leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. While you are officially on such a Family and/or Medical Leave, you can keep your medical and dental coverage in effect during that Family and/or Medical Leave period because your employer must continue to make contributions on your behalf during that period.

DISABILITY CREDITS

For the purpose of maintaining continued eligibility only, bargaining unit employees will be credited with 125 disability hours for each calendar month of proven Disability provided that such Disability was incurred within the course and scope of the employee's work for an Employer as a compensable injury or illness under any state workers' compensation law. Non-bargaining unit employees and Retirees are not entitled to disability hours.

A month of proven Disability is any calendar month in which the employee can medically prove that he has been totally disabled for a compensable injury or illness under any state workers' compensation law for a minimum of twenty consecutive days.

The maximum credit for any one period of disability shall be limited to six consecutive calendar months each calendar year.

2. DEPENDENTS' ELIGIBILITY

Your Dependents' are eligible for benefits on the day you become eligible for benefits under "Initial Eligibility" (see above), or on the day you first acquire a dependent. Refer to the "Definitions" section for the meaning of Dependent.

TERMINATION OF DEPENDENT'S ELIGIBILITY

Benefits for your Dependents will automatically terminate on the date your benefits terminate, or the date the Dependent no longer qualifies as a dependent. However, if you die, benefits for your dependents will continue through the end of the Benefit Period(s), which you would otherwise have been entitled. A deceased Retiree's spouse may continue coverage under the same benefits through self contribution payments for up to 3 additional months after the end of the Benefit Period the Retiree would otherwise have been entitled to benefits.

3. NON-BARGAINING UNIT EMPLOYEE (INCLUDING SALARIED CORPORATE OFFICERS AND SELF-EMPLOYED INDIVIDUALS)

If you are a non-bargaining unit employee, corporate officer, or a self-employed individual, and your employer has a collective bargaining agreement in effect with the Plumbers Local Union No. 519, you may participate in the Plan, subject to the following provisions:

APPLICATION FOR PARTICIPATION

In order to participate, you (or your employer, as applicable) must first apply to the Board of Trustees, who reserves the right to reject any application. If the Board of Trustees approves your application, you will then be required to sign a Participation Agreement which documents your participation in the Plan.

INITIAL ELIGIBILITY

Once you have been approved by the Board of Trustees to participate in the Plan, you will become eligible for benefits beginning on the first day of the calendar month for which contributions are made on your behalf, provided you have properly enrolled under the Plan.

NO SELF-CONTRIBUTIONS

Non-bargaining unit employees are not entitled to make regular self contributions to continue their eligibility. However, non-bargaining employees and their dependents are entitled to COBRA coverage under the same rules that apply to bargaining unit employees.

TERMINATION OF ELIGIBILITY

Non-bargaining unit will cease to be eligible for benefits on the first to occur of the following dates:

- (a) The last day of the month during which the employee's employment terminates;
- (b) The last day of any month for which an on-time contribution was made;
- (c) The last day of the month in which the collective bargaining agreement or Participation Agreement covering the employee is terminated or expires;
- (d) The date on which the employee enters the armed forces of any country on a full basis;
- (e) The date the Trustees terminate coverage for non-bargaining unit employees under this Plan of Benefits;
- (f) The date the Trustees terminate this Plan of Benefits;
- (g) The date of the employee's death though covered dependents will continue covered through the end of the month; or
- (h) With respect to specific benefits or types of coverage, the date the Trustees decide to limit or eliminate same.

If your benefits terminate, benefits for your Dependents will automatically terminate on the same date, or the date your Dependent no longer qualifies as a Dependent, if earlier.

4. RETIRED EMPLOYEES

RETIREES' ELIGIBILITY

All retirees who retire under the Plumbers Local 519 Pension Trust Fund with at least 10 years of full-time active service and covered by the Plan immediately before retirement (and their Dependents) are eligible for benefits under the Plan, provided self contributions are made to the Plan. Retirees who are also eligible under this Plan as an Active Bargaining Unit Employee are not eligible for retiree coverage.

EFFECTIVE DATE

At retirement, you and your Dependents' benefits will become effective on the first day after you retire and cease being eligible as a bargaining unit employee. Please notify the Administrative Manager within 60 days before your retirement date.

CONTINUED ELIGIBILITY

You and your Dependents' benefits will continue (if you make the required self contributions) until the earlier of the date shown in the subsection entitled Termination of Eligibility.

MAKING SELF CONTRIBUTIONS

The amount of self contributions required is determined by the Board of Trustees and may change from time to time. The initial self contributions must be received by the Administrative Manager no later than the 20th day of the month immediately prior to the date you retire. Thereafter, your self contributions must be received by the Administrative Manager no later than the 20th day of each month prior to the month in which benefits are continued in force.

If you fail to make the required self contributions on a timely basis, you and your Dependents' benefits will automatically terminate and you will not be permitted to make self contributions at a later date to continue coverage.

TERMINATION OF ELIGIBILITY

Your benefits will automatically terminate on the:

- (a) date of your death;
- (b) date you become covered (as an employee or as a dependent) under any other group medical benefits plan;
- (c) last day of the month for which self contributions are received by the Plan;
- (d) date the Plan terminates;
- (e) date you become employed in the plumbing trade; or
- (f) date the Trustees terminate retiree coverage under the Plan.

Your Dependents' benefits will automatically terminate on the:

- (a) date your benefits terminate;
- (b) date your Dependent becomes covered (as an employee or as a dependent) under any other group medical benefits plan;
- (c) date your Dependent no longer qualifies as a Dependent; or
- (d) date the Plan terminates.

NOTE: In the event of your death, your spouse and dependent children's eligibility will continue through the last day of the month for which the self contributions were paid to the Fund. However, after your death, your spouse and dependent children's eligibility may be continued, if continued coverage is elected under the COBRA Continuation of Coverage provisions. A deceased Retiree's spouse may continue coverage through self contribution payments for up to 3 additional months after the death of the Retiree.

RETIREE COVERAGE GENERALLY

While the Trustees hope to be able to continue providing benefits for Retirees under the Plan as long as possible into the foreseeable future, it is important for all Retirees to understand that:

- (a) they have no vested or contractual right to the health and welfare benefits described in this booklet;
- (b) the benefit levels, coverage provisions, retiree contribution rate, and plan provisions may be amended at any time and from time to time by the Board of Trustees; and
- (c) the benefits may be discontinued completely on a prospective basis in keeping with the Board's fiduciary responsibilities to maintain the maximum possible benefits within the limits of the Plan's resources.

II. PLAN PROVISIONS APPLICABLE TO ALL ELIGIBLE PARTICIPANTS

HOW TO CONTINUE YOUR ELIGIBILITY - COBRA CONTINUATION OF HEALTH, DENTAL AND VISION COVERAGE

Federal law (“COBRA”) mandates that employer-sponsored group plans provide individuals with the option of continuing their health coverage when their coverage terminates under the group plan.

The rules relative to COBRA continuation of health coverage are discussed below. **It is important that all family members be aware of these provisions in the event coverage terminates.** Health coverages include medical, dental and vision coverage.

1. ELIGIBILITY FOR COBRA COVERAGE

An employee or dependent whose coverage is terminated due to a “qualifying event” as described below may elect COBRA coverage. COBRA coverage may not be elected by anyone who is not a covered person at the time termination occurs.

2. QUALIFYING EVENTS

You and your eligible dependents have the right to continue group health coverage if it terminates for certain reasons, as long as you or your dependents make the required self-payment of premiums.

For **Employees** and Dependents, continuation coverage is available if coverage terminates due to:

- (a) Termination of the Employee’s employment for any reason; or
- (b) A reduction in hours worked by the Employee.

For Dependents, continuation coverage is also available if coverage terminates due to:

- (c) Death of the Employee;
- (d) Divorce or legal separation of the Employee and spouse;
- (e) A Dependent child ceasing to be a Dependent, as defined on page 12; or
- (f) A Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare Part A or Part B

These occurrences are referred to as “Qualifying Events”.

3. NOTICE REQUIREMENTS

If there is a loss of Dependents coverage due to 2(d) or (e) above, you, your Dependent, or your legal representative must notify the Administrative Manager in writing within sixty (60) days of the event so that the Administrative Manager can provide you and your covered Dependents with notices on COBRA continuation coverage rights, and the terms which apply to the coverage. If you fail to give timely notice of events in items (d) or (e) above, you may lose your right to COBRA coverage. If events in items 2(a), (b), (c) or (f) above occur, your Employer is required to notify the Administrative Manager within 30 days of the event. The Administrative Manager has fourteen days after receiving notice of one of these events from you or your Employer to notify you of your right to continuation coverage. However, if any of those events do occur, you or your Dependents should notify the Administrative Manager as well. You should try to give notification within 7 days of the qualifying event to assure there is no lapse in coverage.

If you do not choose COBRA continuation coverage, your group health coverage will terminate in accordance with the provisions in the booklet. If you choose continuation coverage, you will have the same health coverage for which you are currently eligible.

4. ELECTION REQUIREMENTS

You, your dependents, or your legal representative must elect to make self payment of premiums within the later of 60 days after your eligibility terminates or within 60 days from the date you are notified by the Administrative Manager of your right to maintain your eligibility through COBRA. If an election is not made and postmarked within the time periods stated in the notice, you cannot continue coverage under this Plan.

5. SELF PAYMENT OF PREMIUMS

Self payment, if elected, must be made from the date of termination. No lapse in coverage is permitted.

- (a) If you, or your legal representative elect to continue coverage within 60 days after your eligibility terminates, the initial premiums due for coverage must be postmarked and sent to the Administrative Manager within 45 days after the election; this includes premiums required for months of coverage between the termination date of coverage and the date the initial premium is due.
- (b) After the initial election and payment of premiums, future payments must be postmarked and sent to the Administrative Manager before the first day of the month for which coverage is to be provided. There is a 30-day grace period for receipt of your payment. Once you are initially notified of your obligation to pay COBRA premiums, you will not receive any further notices from the Administrative Manager.
- (c) The premium rate for continuation coverage will be determined according to federal law and is guaranteed not to change during the 12-month period established by the Board of Trustees. The premium rates are subject to change at the beginning of each Plan Year. They may be changed during the year only if benefit modifications are made.
- (d) If benefits provided to active Employees and/or their Dependents changes, your continuation coverage will also change.
- (e) You will be notified of any change in premium rates that you are required to pay.

6. MAXIMUM PERIOD ALLOWED UNDER CONTINUATION COVERAGE

- (a) Up to 18 months (maximum) are allowed from the date coverage would have otherwise terminated, if coverage is being continued for you and your dependents because you stopped working, including retirement or reduced hours of employment for any reason.
- (b) 29 Months - You will be allowed to elect continuation coverage for up to 29 months provided:
 - (i) you are determined to be disabled under the Social Security Act either at the time of loss of coverage, or during the first 60 days of coverage continuation, and
 - (b) you provide notice to the Plan of the Social Security Disability determination within 60 days of receipt and within the first 18 months of coverage.

This coverage may be extended for the disabled person and any other qualified beneficiaries covered under COBRA at the end of the first 18 months. The cost of the additional 11 months after the first 18 months can be 150% of the regular COBRA premium.
- (c) Up to 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for your spouse and/or dependent child(ren) for reasons other than termination of employment or reduction in hours.

If a covered Employee becomes entitled to Medicare after an initial qualifying event, then continuation coverage for the Employee's Dependents will continue for 36 months after the Employee becomes entitled to Medicare Part A or Part B.

With respect to covered Dependents, if another qualifying event occurs within 18 months after the Employee loses coverage due to termination of employment or reduction in hours, then continuation coverage for the Employee's Dependents will continue until the date which is 36 months after the Employee's initial loss of coverage due to termination of employment or reduction in hours.

However, continuation coverage under these provisions may be terminated at an earlier date, as provided in Item 7 below.

If you do not elect to pay premiums for COBRA continuation coverage on a timely basis, you will no longer be covered under the Plan and any claims filed during the election period or following termination for non-payment of premium will not be paid by the Plan. Reinstatement of coverage is not permitted.

Full details of COBRA continuation coverage will be furnished to you and/or your dependents when the Administrative Manager receives notice that one of the Qualifying Events described in Item 2 above has occurred. Therefore, we urge you and your Dependents to contact the Administrative Manager as soon as possible after the occurrence of one of those events.

7. TERMINATION OF COBRA CONTINUATION COVERAGE (ALL INDIVIDUALS)

COBRA continuation coverage will terminate on the earliest of:

- (a) the first day of the month for which premium is not paid on time;
- (b) the date you become entitled to Medicare Part A or Part B;
- (c) the day the Fund stops providing group health coverage;
- (d) the day you become covered under another group health plan which does not contain any exclusions or limitations with respect to any pre-existing conditions which you have; or
- (e) the date your spouse or child ceases to be a “dependent” as defined by the Plan;
- (f) the date the Plan terminates.

You will receive a Certificate of Creditable coverage once coverage ends.

8. NEWLY ACQUIRED DEPENDENTS

If, while under continuation coverage you acquire a new Dependent, your Dependent will be eligible for this continuation coverage provided the required premium is paid, the Dependent is properly enrolled and you notify the Administrative Manager of your newly acquired Dependent within 30 days.

If events 2(c) and 2(d) should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue their coverage. If another qualifying event described in 6 should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued in the manner indicated in 6.

MATERNITY STAY NOTICE

In the event of a birth in your family, your group health plan and health insurance issuer generally may not, according to Federal law, restrict benefits for a hospital stay below a certain number of hours in connection with childbirth (for the mother and newborn child). Specifically, in cases of a vaginal delivery, the mother and newborn child may have a hospital stay of at least 48 hours; and in cases of a cesarean delivery, the mother and newborn may have a hospital stay of at least 96 hours. If, however, the mother, attending physician, and the hospital all agree a shorter length of stay is sufficient, the mother and newborn child may leave the hospital prior to the standard 48 hours or 96 hours prescribed by Federal law. Additionally, group health plans and health insurance issuers generally may not require that a provider obtain prior authorization for prescribing a maternity hospital stay unless it exceeds the 48 or 96 hours required by Federal law.

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women’s Health and Cancer Rights Act of 1998 was enacted on October 21, 1998 and requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Specifically, health plans must cover:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

Benefits required under the Women’s Health and Cancer Rights Act will be provided in consultation between the patient and attending physician. These benefits are subject to the health plan’s regular copayments and deductibles.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law requiring most group health plans to provide certificates automatically when a plan participant’s health care coverage terminates. The primary purpose of the certificate is to show the amount of “creditable coverage” that you and/or your Dependent had under the group health plan. The “creditable coverage” is used to reduce or eliminate the length of time that any preexisting condition limitation might apply in a new plan.

DEATH BENEFITS AND ACCIDENTAL DEATH / DISMEMBERMENT BENEFITS

Journeyman, Apprentices and Non- Bargaining Unit Employees are eligible for the Death and Accidental Death/Dismemberment Benefits. Apprentice Applicants and Retirees are not eligible for Death or Accidental Death/Dismemberment Benefits under this Plan.

A Death Benefit is payable in the event of your death from any cause, at any time or place, while you are eligible under the Health and Welfare Plan. The amount of the Death Benefit is a one-time payment of \$5,000.00.

The Accidental Death and Dismemberment benefit is payable for losses resulting from injuries sustained by you in an accident occurring while you are eligible under the Plan.

The loss must occur within 90 days after the accident and directly result from such injuries independently of all other causes. The injuries must be evidenced by a visible wound or contusion on the exterior body, except in the case of drowning or internal injuries revealed by an autopsy.

BENEFITS PAYABLE

FOR LOSS OF	AMOUNT PAYABLE
--------------------	-----------------------

Life	\$5,000.00
One Hand and One Foot	\$5,000.00
One Hand and Sight of One Eye	\$5,000.00
One Foot and Sight of One Eye	\$5,000.00
One Hand	\$2,500.00
One Foot	\$2,500.00
Sight of One Eye	\$2,500.00

Loss of hand or foot means actual severance through or above the wrist or ankle joint. Loss of an eye means the entire and irrecoverable loss of sight of such eye.

MAXIMUM BENEFIT PAYABLE

Not more than the full amount as shown in the Schedule of Benefits is payable for all losses resulting from injuries sustained in any one accident.

EXCLUSIONS

No payment will be made if the loss results from:

- (a) bodily or mental infirmity; or
- (b) treatment or diagnosis of sickness or injury; or
- (c) ptomaine or bacterial infection unless through a visible cut or wound.

ASSIGNMENT

The Accidental Death and Dismemberment benefits provided by the Plan are not assignable.

NAMING YOUR BENEFICIARY

Your Death Benefit and Accidental Death Benefit will be payable to the beneficiary you name to receive the benefit. If, at the time of your death, there is no named beneficiary with respect to all or any part of your benefit, or if the named beneficiary is not living, the benefits will be paid, at the option of the Trustees, to any one of your following surviving relatives:

- (a) your spouse;
- (b) your child(ren) in equal shares;
- (c) your mother and/or father, in equal shares;
- (d) your sister(s) and/or brother(s), in equal shares;
- (e) the executors or administrators of your estate.

If a beneficiary is a minor, or in the opinion of the Trustees, incapable of giving valid receipt for any payment due, and if no request for payment is made by a duly appointed guardian or committee of the beneficiary, the Trustees, may, at their option, make payment to any person or institution appearing to the Plan to have assumed the custody of and the principal support of the beneficiary.

Payment to anyone described above will release the Plan from all further liability to the extent of the payment made.

You can name a new beneficiary at any time by filing a written and signed request on a form satisfactory to the Trustees. Consent of the beneficiary is not required to change your beneficiary. If you do change your beneficiary, the change will not take effect until it is received by the Administrative Manager, whether you are living or not. When received by the Administrative Manager, the change will take effect as of the date you made the request and signed the form, but without prejudice to the Plan on account of any payment made or any action taken or permitted by the Plan before receipt of the request.

Beneficiary change forms can be obtained from the Administrative Manager.

FACILITY OF PAYMENT

The Health & Welfare Plan, at its option, may pay an amount not to exceed \$1,000 of your Death Benefit to any person who incurs expenses in connection with your fatal illness, death or burial. Such action will be considered a proper payment of your Death Benefit to the extent paid and the beneficiary will be entitled to receive only the remainder, if any, of the proceeds.

DENTAL BENEFITS - SELF-FUNDED OR INSURED DENTAL HEALTH

Journeyman, Apprentices and Non-Bargaining Unit Employees are eligible for the Dental Benefits. Apprentice Applicants and those Retirees who did not purchase the Dental Benefit Coverage are not eligible for Dental Benefits under this plan. The Managed Care Dental Benefits REQUIRE that an enrollment application be completed and submitted to the Fund Office in order to obtain benefits.

Your dental benefits are provided to you through (a) the self-funded dental plan, or (b) a managed care dental program through a company which has a contract with the Trustees.

SELF-FUNDED DENTAL BENEFITS

If you participate in the Plan's self-funded dental benefits program, you can see the dentist of your choice. Your reimbursement for expenses occurs only after you file a claim and, in certain cases, meet a cash deductible. The Plan will reimburse you in accordance with a fixed fee schedule.

See the insert at the back of this booklet entitled "DENTAL BENEFITS - SELF-FUNDED" for a complete description of the benefits, the deductible and fixed fee amounts.

INSURED DENTAL BENEFITS

If you choose to participate in the Plan's Managed Care dental benefits program, your benefits are provided much like those in the HMO. Under this Plan, dental services are provided at participating dental offices at no charge or at the fees listed in the Patient Charge Schedule.

See the insert at the back of this booklet entitled "INSURED DENTAL BENEFITS" for a complete description of the benefits.

Apprentices Applicants and Retirees who did not purchase Dental Benefit Coverage are not eligible for dental benefits under this Plan.

VISION BENEFITS

Journeyman, Apprentices, Non-Bargaining Unit Employees and Retirees are eligible to enroll in the HMO or POS and receive Vision Benefits. Apprentice Applicants are not eligible for HMO or POS Vision Benefits. The HMO & POS Vision Benefits REQUIRE that an enrollment application be completed and submitted to the Fund Office in order to obtain benefits.

Your Vision Benefits are provided to you through (a) the self-funded Vision Plan, or (b) the HMO or (c) the POS.

SELF-FUNDED VISION BENEFITS

Self-funded Vision Benefits are available only to employees enrolled in the POS Plan who live outside the service area of the HMO.

See the insert at the back of the booklet entitled "Self-Funded Vision Benefits" for a description of the benefits.

HMO OR POS VISION BENEFIT

If you choose to participate in the HMO or POS Medical Benefits, Vision care is covered in accordance with the terms of the HMO or POS Benefits.

III. PLAN PROVISIONS APPLICABLE TO ELIGIBLE HMO PARTICIPANTS

MEDICAL BENEFITS PROVIDED THROUGH A HEALTH MAINTENANCE ORGANIZATION.

Journeyman, Apprentices, Non-Bargaining Unit Employees and Retirees are eligible to enroll in the HMO Medical Benefits. Apprentice Applicants are not eligible for HMO Medical Benefits. The HMO Medical Benefits REQUIRE that an enrollment application be completed and submitted to the Fund Office in order to obtain benefits.

DEFINITIONS

Participating Provider means a health care provider who has an agreement with an HMO to provide covered services, including ophthalmology, osteopathy, chiropractic medicine or podiatry. For purposes of maternity care, you can elect as an option, the services of licensed nurse-midwives and midwives, and the services of licensed birth centers if they are in the network.

Primary Care Physician means a licensed physician primarily responsible for your overall medical care, including any medically necessary referral to a Referral Specialist. All Primary Care Physicians at the HMO provide you with direct access to a doctor. You do not need a referral to see a Primary Care Physician.

Referral Specialist means any licensed health care provider who practices medicine or osteopathy and who has an agreement with the HMO to provide covered services and to whom you have been referred by a Primary Care Physician.

Service Area means the geographical area covered by the HMO within which Participating Providers render services to you.

WHAT SERVICES ARE PROVIDED TO YOU

The main focus of providing health benefits through an HMO is **preventive care**. The reason for this is that if you visit the doctor and review your overall health before you get sick, you are less likely to suffer a major illness (and incur large medical bills) if you ever become ill. That is why your routine physical examinations, pelvic examinations and pap smears, well-baby care and immunizations, hearing tests and vision screenings are covered services (with any applicable co-payments). Other covered services include mental/nervous and substance abuse treatment, emergency care, and skilled nursing facility and hospice programs.

There is a schedule of benefits located at the back of this booklet which describes the benefits available within the HMO Network, and the co-payments you will pay to receive the services. You should review this schedule carefully, along with your HMO brochure and Provider Directory, furnished to you separately.

WHERE YOU RECEIVE SERVICES

An HMO made up of individual participating providers, is unlike an HMO where you visit a medical facility for a variety of services. With the HMO, you visit your provider in that provider's office. Your privacy is protected, and the Physician practices in his or her own office.

WHAT HAPPENS IF YOU HAVE AN EMERGENCY

If a medical emergency occurs, you should immediately contact your Primary Care Physician. If circumstances do not permit you to call your Primary Care Physician, please go to the nearest emergency care facility. Call the HMO and your Primary Care Physician within 48 hours, including weekends and holidays. Follow-up care must be arranged through your Primary Care Physician.

It is important for you to review your HMO enrollment materials and provider directory carefully. The material provided to you through the HMO contains complete details of the services provided, your certificate of coverage, and certain exclusions and limitations. Be sure to review those materials along with the contents of this booklet applicable to all Plan participants. If you have any questions, please contact the Administrative Manager.

IV. PLAN PROVISIONS APPLICABLE TO POINT-OF-SERVICE PLAN PARTICIPANTS

POINT-OF-SERVICE BENEFITS

Journeyman, Apprentices, Non-Bargaining Unit Employees and Retirees are eligible to enroll in the Point-of-Service Plan. Apprentice Applicants are not eligible for Point-of-Service Benefits. The Point-of-Service REQUIRES that an enrollment application be completed and submitted to the Fund Office in order to obtain benefits and payment of any additional self contributions that may be required in order to elect the POS Plan.

The new Point-of-Service Plan contracted with the HMO provides a much broader range of coverage than the traditional HMO by allowing you to use the physician of your choice at the point of service. That is why the upgrade to this coverage requires an additional self contribution. These Physicians can be either in the HMO network or outside the network.

At the time you require Medically Necessary services or supplies, you may obtain them:

1. Through the HMO network by contacting your Primary Care Physician; or
2. From any Physician or health care provider of your choice who is not a member of the HMO network.

The amount of Plan Benefits payable on account of those Medically Necessary services or supplies, and the amount you are required to pay for those Medically Necessary services or supplies will be determined by the choice you make. Your out-of-pocket expenses will be smaller if you choose the HMO and larger if you choose an Out-of-Network Provider. A full listing of the benefits payable are included in the Schedule of Benefits located at the back of this booklet. You may wish to review the schedule before choosing a medical provider.

DEFINITIONS

POS Health Care Provider means a health care provider who participates in the Plan's HMO Network . A listing of the Participating Providers were included in the HMO Provider Directory previously sent to you by the Administrative Manager.

NON-Participating Provider means a health care provider who does not participate in the Plan's HMO Network. A listing of the Participating Providers were included in the HMO Provider Directory and the PPO Provider previously sent to you by the Administrative Manager.

HMO Service Area means the geographic area encompassed by the HMO.

Covered charges for services or treatment provided by a health care provider are payable as shown in the Schedule of Benefits.

HOSPITAL UTILIZATION REVIEW PROGRAM

If you are planning on entering a Participating Hospital, your Primary care Physician through the HMO or will contact the HMO to perform the necessary steps for pre-certification and you will not have to bother with any formal procedures. If however, you are planning to enter the hospital or have surgery from a Non-Participating provider, you must contact the HMO for pre-certification (the telephone number is on your Identification Card).

REMEMBER IF YOU DO USE A NON-PARTICIPATING HOSPITAL, you will be subject to an additional charge if you do not take the necessary steps for pre-certification.

DEDUCTIBLE AMOUNT

Benefits for services rendered from Non-Participating Providers become payable after you have satisfied the cash deductible each calendar year. The applicable deductibles are described in the Schedule of Benefits. The deductible applies only once in any calendar year to each individual even though you may have different disabilities.

Family Deductible - No more than three persons from your family need to meet the deductible in any one calendar year.

Per Confinement Deductible - There is an additional deductible (shown in the Schedule of Benefits) if you do not use an HMO Hospital.

Common Accident Deductible - If two or more covered persons of your family are injured in the same accident, the Plan will apply only one deductible for that accident.

Three Month Carryover - Any portion of the deductible applied during the last three months of a calendar year will also apply for the next calendar year.

V. PLAN PROVISIONS APPLICABLE TO APPRENTICE APPLICANTS

Apprentice Applicants are eligible to enroll in the Clinic Medical and Health Services benefits through the Occupational Medical Center.

Benefits include physician visits and diagnostic lab and x-rays provided by the Occupational Medical Center. There is no coverage for services rendered by any providers outside this center.

See the insert at the back of this booklet entitled “Clinic Medical and Health Services The Occupational Medical Center” for a description of the benefits.

VI. GENERAL INFORMATION

LIFETIME MAXIMUM BENEFIT

The amount payable with respect to all Injuries, Sicknesses or diseases during your lifetime and each of your Dependent's lifetime will be the maximums described in the Schedule of Benefits.

ENROLLMENT

Any HMO/insurance carrier or Dental Managed Care provider providing benefits shall provide to eligible participants an open enrollment period of not less than 30 days duration. In the event the HMO/insurance carrier requires employees to file an application or other written documentation in order to establish coverage, no medical coverage will otherwise be provided by this Plan if the employee fails to provide the HMO/insurance carrier with the required written documentation.

LIMITATION OF PLANS

In the event that more than one plan of benefits is offered by this Plan through an HMO/insurance carrier, the Board of Trustees may designate under which plan or plans employees are to be covered so long as such designation applies to a class or group of employees generally and does not discriminate against any individual employee. Any designation of plans adopted by the Trustees shall be in writing, a copy of which shall be provided to all employees in advance of its effective date.

CHANGE IN JOB CLASSIFICATION

If an employees' job classification changes during any Eligibility Period their benefit level will change the 1st day of the corresponding Benefit Period.

COORDINATION OF BENEFITS

The following Coordination of Benefits provision is applicable to all benefits provided under the Plan for employees and dependents not eligible for Medicare.

Often, because both husbands and wives are working, members of a family are covered under more than one plan of group benefits. Thus, there are many instances of duplicate coverage. For that reason, a Coordination of Benefits provision has been adopted which will coordinate the benefits payable as described in this booklet with similar benefits payable under other group health plans, whether insured or self insured, other governmental programs and programs required by state or federal statute unless otherwise declared by law.

Under the Coordination of Benefits provision, if an employee or dependent is also covered under any other group plan, the total payment received for any one person from all such programs combined cannot amount to more than 100% of the Allowable Expenses. In no event will the amount of benefits payable exceed the amount which would have been paid if there were no other plan involved.

When you file your claim, you must report duplicate group health insurance coverage on your claim form you submit to secure reimbursement of medical expenses.

"Allowable Expenses" are the reasonable and customary charges for Medically Necessary services, treatment, or supplies covered by one of the plans under which you or your dependent are covered.

When both a husband and wife are eligible Employees under this Plan, and are covered as dependents of each other along with any dependent children, benefits will be coordinated as described below in the same manner as if the husband and wife were employees under two different plans.

WHO PAYS FIRST?

- (a) When the other group plan does not contain a Coordination of Benefits provision, that plan is considered primary and will pay first, regardless of the coverage provided by that plan. This Fund is considered secondary and will then pay toward the remaining covered expenses.
- (b) When the other group plan contains a Coordination of Benefits provision, the order of benefits will be determined as follows:
- (1) The group plan covering the patient as an employee is primary and pays before the group plan covering the patient as a dependent.
 - (2) The benefits of a plan which covers the patient as an employee who is neither laid off nor retired are determined before the benefits of a plan which covers that person as a laid-off or retired employee.
 - (3) The group plan covering the patient as a dependent of a parent whose birthday (excluding year of birth) falls earlier in the calendar year is primary and pays before the group plan of the parent whose birthday (excluding year of birth) falls later in the calendar year.
 - (4) In situations of divorce, separation and/or divorce and remarriage, benefits for a child's medical expenses will be payable as follows:
 - (i) In case of divorce or separation, the group plan which is primary shifts from that of the natural father to the household where the child resides. This means that if the child lives with the natural mother, her plan pays first and if the child lives with the natural father, his plan pays first.
 - (ii) If the parent with whom the child resides remarries, the order of benefit is as follows:
 - Natural parent with whom child resides,
 - Step-parent with whom child resides,
 - Natural parent not having custody of child.
 - (iii) The order of benefit determination can change if there is a divorce decree requiring one of the parents to be financially responsible for benefits provided by this Fund.

In that case:

 - The Plan of the parent with court-ordered financial responsibility pays first.
 - The plan of the other natural parent pays second, and
 - The plan covering the spouse of the parent with court-ordered financial responsibility pays third.
- (c) When the other group plans do not contain the rule in subsection (b)(2), the group plan covering the patient as a dependent of a male (father) is primary and pays before the group plan covering the patient as a dependent of a female(mother).
- (d) If none of the above rules apply, the Plan which has covered the patient for the longer period of time will pay its benefits first.

SUBROGATION

Subrogation seeks to conserve the assets of the Fund by imposing the expense for accidental injuries to you or your eligible dependents on those responsible for causing them. For example, if you or one of your dependents should receive benefits from the Fund for injuries caused by someone else (such as in an automobile accident), the Fund, through subrogation, has the right to seek repayment from the other party or his insurance company. Or in the event you or your dependent (or your guardian or estate) recover the amount of medical expense paid by the Fund by suit, settlement, or otherwise from any third person or his insurer, the Fund has the right to be reimbursed through subrogation, before any attorneys fees, or other costs are deducted from the settlement or other payment). In addition, this Fund will be subrogated for attorney's fees incurred in enforcing its subrogation rights.

The Fund will provide benefits to you and your eligible dependents at the time of need, but you will be required to sign a Subrogation Agreement or other documents or take such other action as is necessary to assure the rights of the Plan. You must promptly notify the Fund of any claim or legal action which you or your dependents assert against any party or insurance carrier for injuries which you or a dependent sustain. Subrogation does not apply to an individual health insurance policy which you purchase for yourself or your dependents.

In the event the Fund is not reimbursed for benefits paid to you, when a settlement is obtained for medical expenses incurred, the Fund will withhold payment on future claims for expenses you incur, until the full amount has been recouped by the Fund.

MEDICARE

Medicare refers to the federal government's insurance plan that was created by Title XVIII of the Social Security Act of 1965 and which has undergone several amendments since that time. There are two parts to Medicare. The part which pays for hospital bills is called "Part A." The part which pays for doctor bills and other medical care expenses is called "Part B."

Because Medicare is actually administered by the Social Security Administration of the federal government, this booklet should not be considered your only source of information about Medicare. For descriptive booklets and other information about all aspects of the Medicare program, contact the Social Security Administration. Their telephone number and nearest office address can be found in the white pages of your telephone directory.

Generally, Medicare is available to the following groups of people:

- a) All persons, age 65 and over, who are also eligible for Social Security benefits or Railroad Retirement Act benefits.
- b) Certain other persons, age 65 and over, that are not eligible for Social Security or Railroad Retirement benefits but who are resident citizens can enroll in Medicare by paying the necessary Medicare premiums.
- c) Certain persons, regardless of age, who become disabled or who have a kidney condition that can be classified as "End Stage Renal Disease."

The federal government makes no monthly premium charge for a person enrolled in Medicare's Part A (except for people in category (b) above). There is a premium charge for Medicare's Part B. It varies each year and the Social Security Administration can tell you the current amount of that premium and it can also advise you how it can be paid.

Persons who are eligible for Medicare and wish to enroll must contact their nearest Social Security Administration office within three months prior to the time they are first eligible to enroll which, for most persons, is age 65.

As long as you remain actively employed and eligible under this Fund, all benefits provided under the Fund will remain fully in force, whether or not you are eligible for the health benefits provided by the Medicare Program.

MEDICARE AND THIS FUND

Since you and/or your eligible spouse may be eligible for Medicare and also eligible for the health benefits that this Fund provides, this section explains how Medicare and this Fund work together, which depends upon whether you are considered an Active or Retired employee under this Fund.

IF YOU ARE AN ACTIVE EMPLOYEE UNDER THIS FUND, you and your eligible dependents will remain eligible for all the same benefits of this Fund which are provided to all other employees and dependents of any age. However, if you and/or your eligible spouse enroll for Medicare Part A and/or Part B, the Medicare coverage will become “secondary” to the benefits provided by this Fund.

The Coordination of Benefits section of this booklet explains what happens when two group insurance plans are available to provide benefits for the same set of medical expenses, and that same explanation will apply if Medicare covers you, except that this Fund will always be considered to be the Primary Fund and Medicare will always be considered to be the Secondary Fund as long as you are an eligible Active employee.

If your status as an Active employee terminates on or after age 65, and you have not already enrolled in Medicare, you should enroll for Medicare benefits as soon as possible but not later than seven months after the date your eligibility for benefits as an Active employee terminates under this Fund. If you wait longer than that seven-month period, the federal government’s Medicare enrollment rules may require a delay in the effective date of coverage and may impose a premium penalty for the contributory Part B Medicare benefits. Remember, when you reach age 65, you may be eligible for Medicare coverage, whether or not you are an Active employee, so you should do whatever is necessary to enroll in the Medicare program. Please contact your nearest Social Security Administration office for details, forms and proper procedures.

IF YOU HAVE BEEN COVERED AS A RETIRED EMPLOYEE UNDER THIS FUND, you should enroll for Medicare benefits as soon as you become eligible. Contact your nearest Social Security Administration office within three months prior to your 65th birthday but no later than three months after your 65th birthday in order to avoid a delay in the effective date of your Medicare coverage and a premium penalty under the contributory Part B Medicare benefits.

The following briefly outlines the effects of Medicare for the various types of individuals covered by this Fund.

EFFECTS OF MEDICARE

1. ACTIVE EMPLOYEES AND THEIR DEPENDENTS

Benefits provided by this Fund are:

- (a) the same benefits as those provided to Active employees and their eligible dependents under age 65.
- (b) payable before any benefits are payable under Medicare.

2. RETIRED EMPLOYEES AND THEIR DEPENDENTS

- (a) Under Age 65: Benefits provided by this Fund are coordinated with other group insurance coverage.
- (b) Age 65 and over: Benefits provided by the Plan are payable after benefits are paid under Medicare.

CLAIM FORMS

If you obtain services through the Managed Care Dental Program or the medical HMO Plan you will pay the Co-payment stated in the Schedule of Benefits at the back of this booklet. You will not have to file claim forms. The Office staff for the HMO or the Managed Care Dental Provider will handle this for you.

If you obtain medical services through a Non-Participating Provider, you are required to pay the specified co-insurance as provided in the Schedule of Benefits in the back of this booklet. You will be responsible for filing the claim with the HMO/insurance carrier of Managed Care Dental Provider.

If you obtained services under the Self-insured Dental/Vision or are applying for a death or dismemberment benefit, you will have to contact the Fund Office for a claim form and file directly with the Administrative Manager.

TIME OF PAYMENTS OF BENEFITS

Benefits will be paid after the Administrative Manager receives your completed claim form. Do not wait until you return to work before making a claim for benefits - do it immediately. It is your responsibility to provide the Administrative Manager with adequate information to process your claim.

NOTICE OF CLAIM

Your claim must be filed with the Administrative Manager within 90 days after the occurrence of the event on which the claim is based. Written notice of claim given by or on behalf of the Eligible Individual to the Welfare Plan with particulars sufficient to identify the Eligible Individual will be considered notice to the Welfare Plan. Failure to file your claim or give written notice within the 90-day time period will neither invalidate nor reduce any claim if you can show that it was reasonably possible to give written notice within that time, and that written notice was given as soon as reasonably possible.

HOW TO FILE A CLAIM

In order to receive the fastest possible service, all claims should be reported to the Administrative Manager (not your Business Agent), as soon as possible. The Administrative Manager's office will furnish you with the claim forms necessary for filing a claim. The name and address of the Administrative Manager is shown on the front cover of this booklet.

NOTICE OF BENEFIT DETERMINATION AND DENIAL OF CLAIM

The Administrative Manager will give written notice to you or your beneficiary as may be appropriate of the Plan's benefit determination. That notice will be given within a reasonable period of time after receipt of the claim, but not later than 90 days after receipt of the claim by the Plan. If special circumstances require an additional extension of time for processing the claim, the Administrative Manager shall provide the claimant with written notice of the extension prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to make the benefit determination.

In case of an adverse benefit determination that notice will include the following:

1. The specific reason or reasons for the denial.
2. Reference to pertinent provision of the Plan (such as internal rules, eligibility rules, coverage provisions, guidelines, protocols, criteria, etc.) on which the denial is based.
3. A description of any additional material or information, if any, necessary for you to perfect your claim, and where appropriate, an explanation of why that material or information is necessary.
4. An explanation of this Fund's Claim Review Procedures.

CLAIMS APPEAL PROCEDURE

If your claim for benefits under the Plan is denied, in whole or in part, you have 60 days after being notified of the denial to appeal the decision. Your appeal, addressed to the Administrative Manager, must state:

- (a) your name and address

- (b) the fact that you are appealing the decision of the Board of Trustees of (date of decision which you are appealing)
- (c) the basis of your appeal, i.e., the reason(s) you feel your claim should not be denied.

You will have the opportunity to submit written comments, documents, records, and other information relevant to the claim for benefits. You will also have upon request, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be notified in writing of the decision of the Board no later than 60 days from the Plan's receipt of your appeal. However, if an extension of time is required, the Administrative Manager shall provide the claimant with written notice of the extension prior to the termination of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to make the benefit determination. The decision will then be made within 120 days after receipt of the appeal. The decision will be in writing and will include the specific reasons for the decision and reference to the specific Plan provisions on which the denial is based.

A decision by the Board of Trustees is final and binding.

OTHER PROVISIONS

ALTERED OR FORGED CLAIMS

Any claim form submitted by or on behalf of an Eligible Individual that contains a material alteration or forged information, will be rejected by the Plan, which reserves the right to forward the altered or forged document to the local law enforcement agency for whatever legal action such agency deems to be appropriate.

PERSONS TO WHOM BENEFITS ARE PAYABLE

If you want to assign your benefits when permitted, the check will be sent directly to the health care provider instead of to you. To assign benefits, complete the assignment section of the claim form or special forms your health care provider will provide.

PLEASE REPORT CHANGES PROMPTLY

IT IS IMPORTANT TO NOTIFY THE ADMINISTRATIVE MANAGER WHENEVER:

- (a) you acquire a new Dependent; or
- (b) an existing Dependent is no longer eligible (limiting age, etc.); or
- (c) you change your home address;
- (d) you change your beneficiary for life insurance benefits;
- (e) you enter the armed forces; or
- (f) you go on a leave of absence for any reason.

If you or your covered Dependent (spouse or child) fails to give proper notice of his/her change of address, age, marital, dependent or disability status within 60 days, and as a result the Fund pays a claim for a person whose coverage should have been terminated, then the person who signed the Election Form and the person who failed to give the required notice will both be obligated to reimburse the Fund in full for any claims which should not have been paid. If the Fund does not receive full reimbursement, then all amounts due may be deducted from other benefits otherwise payable on behalf of the person who signed the Election Forms, the person who failed to give the required notice, and their covered dependents, whether or not benefits have been assigned.

FACILITY OF PAYMENT OF BENEFITS

If an individual is a minor or otherwise not competent to give a valid receipt of any benefit due him, and if no request for payment has been received by the Fund from a duly appointed guardian or other legally appointed representative of the individual, the Fund will make direct payment to the individual or institution appearing to the Fund to have assumed the custody of or the principal support of the individual

If an individual dies while benefits for services remain unpaid, the Fund will make direct payment to the individual or institution on whose charges claim is based or to any of the following surviving relatives of the individual: wife or husband, mother and/or father, child or children, brothers and/or sisters, or to your executors or administrators.

Any payment by the Fund in accordance with this section will discharge the obligation of the Fund to the extent of the payment made.

PHYSICAL EXAMINATION

The Fund at its own expense will have the right and opportunity, while a claim is pending, to examine any individual whose Injury or Sickness is the basis of claim when and so often as it may reasonably require and to make an autopsy in the case of death where it is not prohibited by law.

TIME LIMITATIONS

If any time limitations set forth in the Fund for giving notice of claims or for furnishing proof of loss is less than permitted by the law of the state in which the eligible individual resides at the time benefits are in effect, then the time limitation will be amended to conform with the minimum requirements by the law of that state.

PHYSICIAN-PATIENT RELATIONSHIP

As part of the Fund's managed care strategies, your choice of doctors and other providers depends on how you use your benefit plan. If you are participating in an HMO or in a POS network (see the earlier discussion on HMO's and POS's), the amount of benefits payable from the Plan are based on whether you visit a provider within your network. Otherwise, there is no disturbance in the physician-patient relationship.

ASSIGNMENT

The benefits provided by the Fund are not assignable, except as previously stated.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Fund may release to, or obtain from any company, organization, or person, any information regarding any person which the Fund deems necessary to carry out the administration, claim determination and payment functions. Any claimant under this Plan will furnish to the Fund any information as may be necessary.

RIGHT OF RECOVERY

If the Fund paid more than it should have, the Fund has the right to recover the excess amount. This can be from the person for whom the payments were made. It can also be from any other insurance company or organization.

LEGAL ACTION

No action at law or in equity will be brought to recover on any benefits prior to the claimant's exhaustion of the Claims Review Procedure previously described.

CONSTRUCTION

All questions of interpretation of this Plan are decided by the Trustees under the express authority granted to them by the Agreement and Declaration of Trust. The Trustees shall be the sole arbiter of questions of eligibility and amounts of benefits. This Plan is intended to comply with the terms and conditions of the Agreement and Declaration of Trust. If a decision of the Trustees or those acting for the Trustees is challenged in court, then such decision will be upheld unless it is determined to be arbitrary and capricious.

VII. STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Plumbers Local Union No. 519 Health and Welfare Trust Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Administrative Manager's office all documents governing the Plan, including insurance contracts and collective bargaining agreements, a list of the employers and employee organizations participating in the Fund, and a copy of the latest Annual Report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Administrative Manager, copies of all 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 an updated Summary Plan Description, and a list of the employers and employee organizations participating in the Fund. The Administrative Manager may make a reasonable charge for the copies. It is suggested you contact the Administrative Manager to determine the cost prior to requesting any copies.

Receive a summary of the Fund's annual financial report. The Administrative Manager is required by law to furnish each Participant with a copy of this summary financial report.

2. 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 and 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.

A Reduction or elimination of exclusionary periods of coverage for preexisting 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, 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 a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Fund Participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. These people are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Fund Participants and they must exercise prudence in the performance of their Fund duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they may have caused the Fund.

Your employer and union may not fire you or discriminate against you to prevent you from obtaining a welfare benefit from the Fund or exercising your rights under ERISA.

4. ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored in whole or in part you have the right to know why this was done, to obtain 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 on the latest Annual Report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In that case, the court may require the Administrative Manager 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 Administrative Manager. If

you have a claim for benefits that is wholly or partly denied, 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 domestic relations order or 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 are unsuccessful in your lawsuit, the court may, order you to pay these costs and fees; for example, if it finds your claim is frivolous.

5. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this Statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

The foregoing has been no more than a brief and very general description of the most important provisions of the Health and Welfare Fund. If there are any discrepancies between the information contained in this booklet and the actual Health and Welfare Plan Document and Trust Agreement, the provisions of the Health and Welfare Plan Document and Trust Agreement will govern. No description such as this can adequately express all the details of the Fund. Should you have any question, which is not covered by this booklet, please contact the Administrative Manager for an answer.