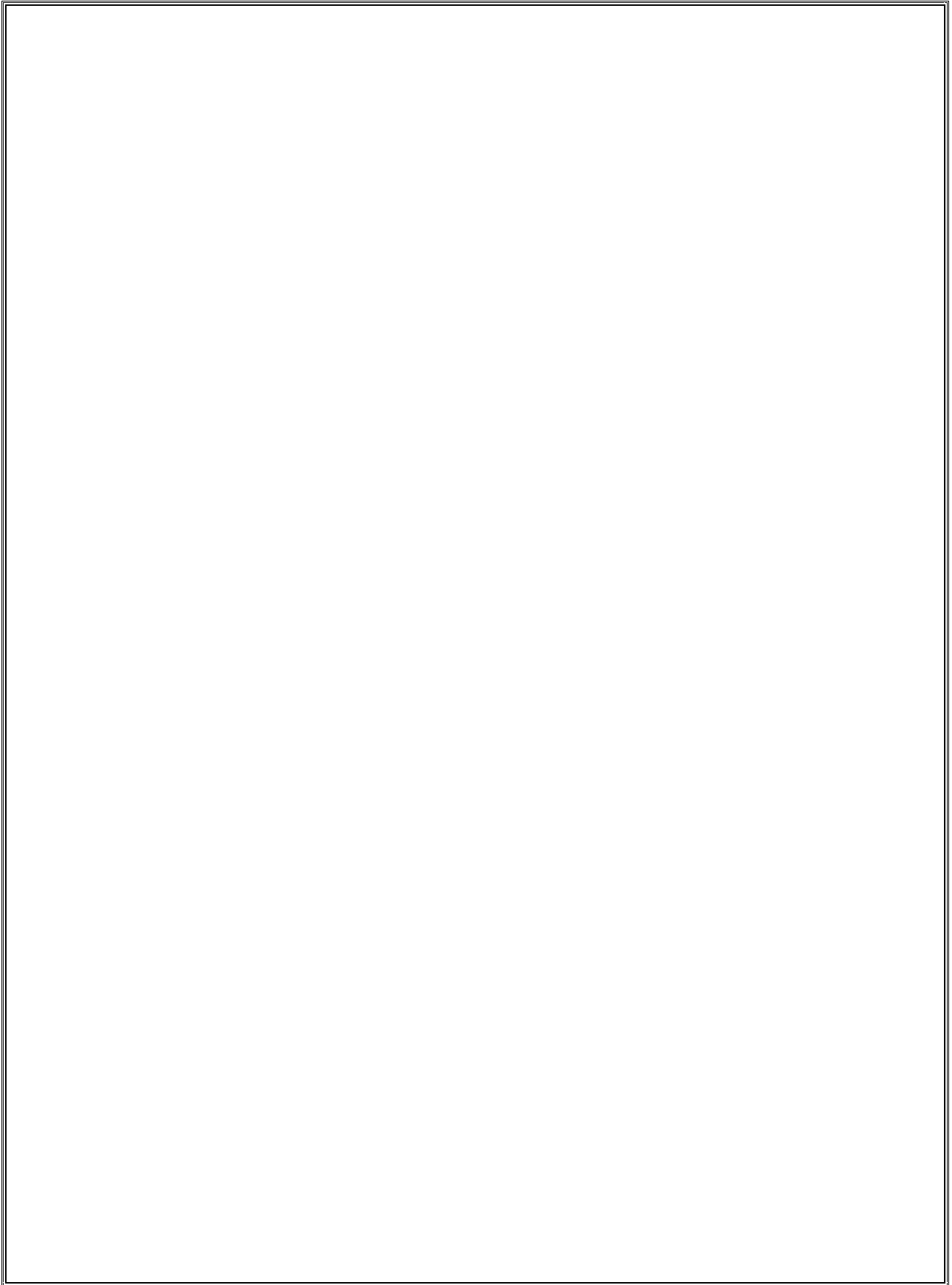


A Guide To Your Benefits

Summary
Plan
Description

Effective January 1, 2006

Northeastern New York District
Council Pipefitters
Welfare Fund



Northeastern New York District Council Pipefitters Welfare Fund

PO Box 1396, 30 Bluebird Road, South Glens Falls, NY 12803

Telephone: 518-792-0586

Facsimile: 518-792-0732

January 1, 2006

Dear Participant:

This booklet is a description of the Northeastern New York District Council Pipefitters Welfare Plan as it is in effect on January 1, 2006. There have been some changes in the Plan since the last booklet was written. We encourage you to familiarize yourself with this booklet and the benefits that are available to you and your family.

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

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

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

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

The Plan Manager, Lawrence J. Gonnely, maintains the daily operation of the Plan. Mr. Gonnely and his staff are available to answer any questions or as a resource to obtain additional information about the Plan.

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

Sincerely,

Board of Trustees
Northeastern New York District Council Pipefitters Welfare Fund

Northeastern New York District Council Pipefitters

Welfare Plan

Directory

BOARD OF TRUSTEES

Employer

Douglas Brockway
Brockway Mechanical Systems, Inc.
102 Trade Road
Plattsburgh, NY 12901

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

David Cornin
C & H North Mechanical, Inc.
3 Third Street
Hudson Falls, NY 12839

William Gordon
RF Gordon Mechanical, Inc.
399 Buttermilk Falls Road
West Fort Ann, NY 12827

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

Employee

Robert J. Barody
33 Palmer Drive
Queensbury, NY 12804

Larry S. Bulman
13 Moreau Drive
South Glens Falls, NY 12803

Terry A. Monroe
32 Boulevard
Queensbury, NY 12804

Evan Myers
60 Hank Wilson Road
Cadyville, NY 12918

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

PLAN PROFESSIONALS

Actuary

S R Thomas Actuarial Associates, Inc.
Golden Crest Corp. Center
2277 State Hwy #33, Suite 409
Trenton, New Jersey 08690

Auditor

D'Arcangelo & Co., LLP
120 Lomond Court
Utica, NY 13502-5950

Attorney

Pozefsky, Bramely & Murphy
90 State Street
Albany, NY 12207

Administrator

Lawrence J. Gonnely
PO Box 1396
30 Bluebird Road
South Glens Falls, NY 12803

Important Notice

Nothing in this booklet is meant to interpret or extend or change in any way the provisions of insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever in their judgment conditions so warrant. This booklet describes the Plan as it exists on January 1, 2006. You will receive updated information if and when the provisions described in this booklet are changed. If any of the changes constitute a material reduction in the benefits under this Plan, you will be notified through a Summary of Material Modifications.

Caution

This booklet and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Fund have not empowered anyone else to speak for them regarding the Welfare Plan. No employer, union representative, supervisor, shop steward or other person is in a position to discuss your rights under the Plan with authority.

Communications

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

No Guarantee Of Income Tax Consequences

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

Table of Contents

SECTION	PAGE
IMPORTANT ASPECTS.....	1
PLAN MODIFICATION OR TERMINATION.....	2
SECTION I. ELIGIBILITY REQUIREMENTS & PLAN PARTICIPATION	
A. GENERAL DESCRIPTION OF THE PLAN.....	3
B. ELIGIBILITY REQUIREMENTS.....	4
1. General Eligibility Requirements.....	4
2. Continuing Eligibility Requirements.....	4
C. LIMITATION ON BENEFITS.....	4
D. DEPENDENTS.....	5
E. PENSIONERS.....	5
F. INACTIVE ACCOUNTS.....	5
G. BENEFITS.....	5
SECTION II. INSURANCE BENEFIT	
A. ELIGIBILITY REQUIREMENTS FOR THE INSURANCE BENEFIT.....	7
1. Enrollment.....	7
2. Continuing Eligibility for the Insurance Benefit.....	7
3. Opt-Out Election for the Insurance Benefit.....	8
4. Termination and Reinstatement of Eligibility for the Insurance Benefit.....	8
5. Qualified Military Service.....	8
6. Continued Coverage by Self-Payment.....	8
B. MEDICAL BENEFIT.....	9
C. PRESCRIPTION DRUG BENEFIT.....	9
SECTION III. POOLED BENEFITS	
A. SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT.....	10
B. LIFE INSURANCE BENEFIT.....	10
C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT.....	10

Table of Contents

SECTION	PAGE
SECTION IV. PERSONAL ACCOUNT BENEFITS	
A. HEALTH EXPENSE BENEFIT	12
SECTION V. CLAIM PROCEDURE	
A. CLAIM PROCEDURE UNDER INSURED BENEFITS	17
B. CLAIM PROCEDURE UNDER OTHER BENEFITS.....	17
C. CLAIM DENIAL – NON-INSURED BENEFITS.....	17
D. TRUSTEES’ INTERPRETATIONS AND DETERMINATIONS – NON-INSURED BENEFITS.....	17
E. CLAIM DENIAL – INSURED COVERAGES.....	17
F. CLAIM DENIAL APPEAL PROCEDURE UNDER NON-INSURED COVERAGES	17
G. CLAIM DENIAL APPEAL PROCEDURE UNDER INSURED COVERAGES.....	18
H. FUND OFFICE CLAIM PAYMENT POLICIES	18
I. INCOMPETENCE.....	19
J. COOPERATION	19
K. CLAIM REPRESENTATIONS	19
L. CLAIMS WHERE THIRD PARTY IS LIABLE	19
1. Rights of Subrogation and Reimbursement.....	20
2. Assignment of Claim.....	20
3. Failure to Disclose and/or Cooperate	20
SECTION VI. COBRA	
.....	21
SECTION VII. QUALIFIED MEDICAL CHILD SUPPORT ORDER	
.....	25
SECTION VIII. YOUR RIGHTS UNDER ERISA	
.....	26

Table of Contents

SECTION	PAGE
SECTION IX. PROTECTED HEALTH INFORMATION	
A. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR	28
B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PLAN SPONSOR	28
C. PLAN SPONSOR CERTIFICATION.....	29
1. Prohibition on Unauthorized Use or Disclosure of Protected Health Information	29
2. Subcontractors and Agents	29
3. Permitted Purposes	29
4. Reporting	29
5. Access to Protected Health Information	29
6. Correction of Protected Health Information	30
7. Accounting of Protected Health Information	30
8. Disclosure to Government Agencies	30
9. Return or Destruction of Health Information	30
10. Minimum Necessary Requests	30
D. ADEQUATE SEPARATION.....	31
E. ADEQUATE SEPARATION CERTIFICATION	31
F. REPORTS OF NON-COMPLIANCE	31
SECTION X. TECHNICAL DETAILS	
.....	32

Important Aspects

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

Plan Modification Or Termination

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

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

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

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

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

In accordance with the Agreement and Declaration of Trust, no Participant, Dependent or Beneficiary has a vested right or contractual interest in the benefits provided. In addition to the right to terminate benefits of Participants at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for Participants, Dependents or Beneficiaries and there shall not be any vested right by any Participant, Dependent or Beneficiary nor contractual rights after the disposition of Plan assets in connection with the termination of the Plan. The provisions for a Participant, Dependent or Beneficiary's coverage shall be reviewed periodically by the Trustees.

I. Eligibility Requirements & Plan Participation

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

A. GENERAL DESCRIPTION OF THE PLAN

The Northeastern New York District Council Pipefitters Welfare Plan is a personal account plan. Employer welfare contributions will be made to the Plan for each hour you work in Covered Employment. Covered Employment means employment covered by a collective bargaining agreement requiring contributions to this Fund.

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

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

Your account will grow with all the contributions that are made to the Plan on your work in the future. Your account will be decreased by any benefit distribution. No more will be paid out to you (or your beneficiary) under this Plan than has come into your personal account by way of contributions made on your work and special allocations, except, perhaps, under the provisions of one of the Insurance Benefit coverages.

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

Once your account is reduced to zero or to an amount which is less than your monthly Insurance Benefit premium, you will stop being a Participant in this Plan unless you elect to self-pay (as described on pages 8 and 9).

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

B. ELIGIBILITY REQUIREMENTS

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

1. General Eligibility Requirements.

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

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

2. Continuing Eligibility Requirements.

Once you are a Participant, you will continue as a Participant until your account is reduced to zero or to an amount which is less than your monthly Insurance Benefit premium. If you are self-paying to the Plan for your Insurance Benefit (as described on pages 8 and 9), you are still a Participant.

If you have once satisfied the general eligibility requirements for this Plan and your participation stops, you must once again satisfy the general eligibility requirements to be entitled to any future benefits.

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

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

C. LIMITATION ON BENEFITS

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

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

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

D. DEPENDENTS

Your eligible dependents include your lawful spouse and your unmarried children who are under age 19 who are not employed on a regular full-time basis and, if not living with you, for whose medical care you are responsible.

If your unmarried child becomes age 19 while he or she is covered as an eligible dependent and is, at that time, incapable of self-sustaining employment due to a physical handicap or mental retardation, he or she will also be carried as an eligible dependent so long as his or her condition remains the same and you continue as a Participant.

Your dependent child's eligibility may continue up to the end of the calendar year in which he or she attains age 23 or 25 (depending upon the health care insurance product you select), if the child is a full-time student at an accredited school and remains your eligible dependent (as described above).

E. PENSIONERS

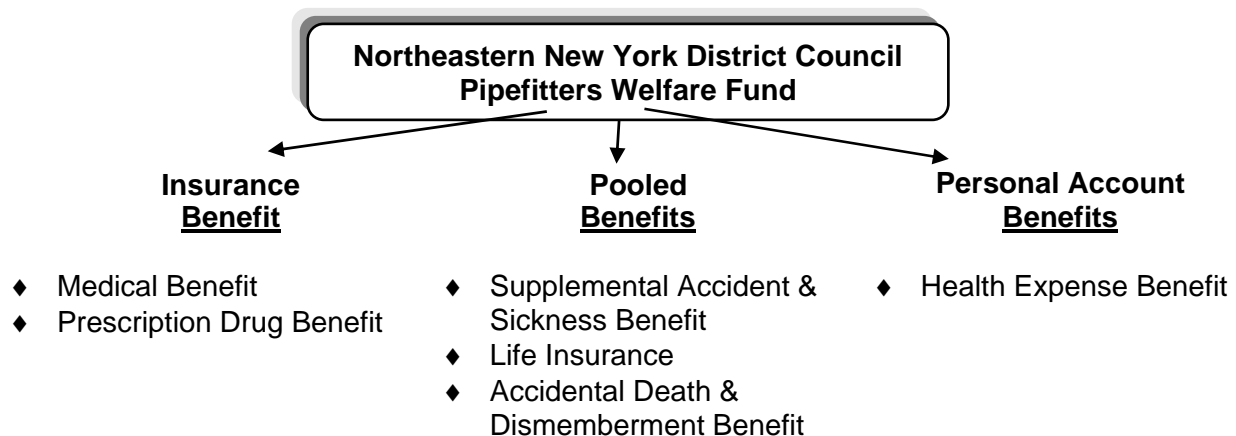
If you are a pensioner under the U. A. Local 773 Pension Plan and a Participant in this Plan eligible for the Insurance Benefit on the date such pension commences, you will continue to be covered under this Plan for as long as your account lasts, and after your account is exhausted, for as long as you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

F. INACTIVE ACCOUNTS

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

G. BENEFITS

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



Northeastern New York District Council Pipefitters

Welfare Plan

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

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

The Personal Account Benefits are designed to pick-up medical expenses not covered by the Insurance Program.

Please read the following sections for details regarding each Benefit.

II. Insurance Benefit

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

Type of Benefit	Persons Covered	Benefit
Medical	<ul style="list-style-type: none"> • Active Members, • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Empire Health Choice, or • Blue Shield of NENY, or • MVP Health Plan
Prescription Drug Benefit	<ul style="list-style-type: none"> • Active Members, • Pensioners, & • Dependents 	<ul style="list-style-type: none"> • Administered by Ullico/Medco co-pays are: <ul style="list-style-type: none"> – \$10.00/generic Rx – \$25.00/brand name formulary Rx – \$50.00/non formulary Rx

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

A. ELIGIBILITY REQUIREMENTS FOR THE INSURANCE BENEFIT

1. Enrollment.

You must enroll for health care insurance coverage under the Plan. You will have 60 days from the date of your eligibility to enroll or opt-out of health care insurance coverage under the Plan. Failure or refusal to comply with enrollment requirements will disqualify you and your eligible dependents for health care coverage; nevertheless, the otherwise applicable health care insurance premium still will be deducted from your account. The premiums which are deducted from your account will not be returned to you, even if you later satisfy the enrollment requirements. In addition, the Welfare Fund's health care insurance will not become available to you or your eligible dependents until the next open enrollment period.

2. Continuing Eligibility for the Insurance Benefit.

As long as you remain available for employment that calls for contributions to this Plan, each month the charges for certain health care coverages will be subtracted from your account as long as your account balance is big enough to cover the total monthly charges (unless you are approved for an "opt-out" from coverage, as described on the next page). If your account runs out, you will be permitted to self-pay your health care insurance charges under certain conditions (as described on pages 8 and 9).

3. Opt-Out Election for the Insurance Benefit.

If your spouse and dependent children are already covered under your spouse's employer's health care plan or some other employer group health care plan, you may elect that you be covered for "single" health care insurance only. If you, yourself, are also covered under your spouse's employer's health care plan, or some other employer group health care plan, you may elect that you also not be covered under the Benefit. However, in order to forego or opt-out of coverage for your dependents or yourself, you (and your spouse, if applicable) must complete and sign the Election and Hold Harmless Agreement and an information sheet at the time of the election. The forms are available at the Fund Office. Health Care Insurance premiums will be paid from your account until the Trustees approve the election. The opt-out shall become effective the first day of the month following the month in which the Trustees approve your election.

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

4. Termination and Reinstatement of Eligibility for the Insurance Benefit.

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

5. Qualified Military Service.

If you leave Covered Employment for full-time Qualified Military Service, as defined by Federal law, you and your eligible dependents are permitted to elect to continue your Insurance Benefit under the Plan's self-payment provisions, subject to certain limitations under Federal law. This coverage, subject to the rules of the Plan, must last for up to *twenty-four (24)* months beginning on the date of your entry into Qualified Military Service. However, the coverage will terminate before the end of the *twenty-four-month* period if you are discharged earlier and you fail to make a timely application for reemployment in Covered Employment upon discharge. You will not forfeit any period of coverage for which you had previously qualified under the General Eligibility Requirement.

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

6. Continued Coverage by Self-Payment.

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

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

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

The spouse of a deceased active or retired Participant will also be permitted to self-pay for his or her coverage and the coverage for all of the deceased Participant's eligible dependents who were covered at the time of the Participant's death.

The spouse of a retired Participant who was covered by the Insurance Benefit on the Participant's Medicare entitlement date may also elect to self-pay on her behalf even if the Participant elects not to participate in this Plan on his/her Medicare entitlement date.

This self-pay period will be deducted from the COBRA continuation coverage period (see Section VI); it is not in addition to such coverage period. The self-pay option for the Participant's spouse and eligible dependents will cease if the spouse remarries or if the spouse and/or eligible dependents otherwise fail to satisfy the Plan's eligibility requirements (unless COBRA applies).

B. MEDICAL BENEFIT

The Medical Benefit (health care insurance) is an insured benefit. You may choose from several insurance products. The products currently offered are Empire Health Choice, Blue Shield of Northeastern New York, and MVP Health Plan. You will be supplied with a description of the coverage according to the product.

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

C. PRESCRIPTION DRUG BENEFIT

Eligible active and retired Participants who are not eligible for Medicare and their eligible dependents will be covered for Prescription Drug Benefits upon proper application. The Prescription Drug Benefit is administered by Ullico/Medco.

Co-payment. A co-payment is applied to each covered pharmacy drug charge as follows:

Generic drug	\$10.00
Brand name formulary drug	\$25.00
Non-formulary drug	\$50.00

If your prescription is for a brand name drug when an FDA approved equivalent is available, you must also pay the difference in prescription cost between the brand name drug and its generic equivalent.

III. Pooled Benefits

A. SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFIT

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

After a one-week waiting period, you will receive payments of \$20 per day (five days per week) for as long as you continue to receive either New York State Disability or Workers Compensation benefits.

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

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

B. LIFE INSURANCE BENEFIT

The Life Insurance Benefit provides a \$40,000 benefit if you die while still an active Participant in this Welfare Plan. If you are receiving a monthly pension from the U.A. Local 773 Pension Fund and you were a Participant in this Plan eligible for the Insurance Benefit on the date such pension commenced, you are covered by the Life Insurance in the amount of \$5,000.

First Reliance Insurance Company currently insures the Life Insurance Benefit for active members. The Life Insurance Benefit for pensioners is self-funded (i.e. paid directly from the Fund).

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

C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

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

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

Northeastern New York District Council Pipefitters

Welfare Plan

Loss	Benefit
Life	\$40,000
One member*	\$20,000
Two members*	\$40,000

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

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

IV. Personal Account Benefits

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

A. HEALTH EXPENSE BENEFIT

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

"Qualified Medical Expenses" are: expenses that have been submitted to and rejected by your Insurance Benefit provider, for which you have filed an appeal with that provider that has been denied in whole or in part; are deductible as medical expenses for I.R.S. purposes; and which the Trustees determine to be reasonable and appropriate for reimbursement. Qualified Medical Expenses do not include premiums for life, accidental death and dismemberment, disability income or other non-medical benefits.

Claims under this Benefit must be submitted in the calendar year during which the expenses are incurred or before July 1 of the following calendar year. An expense is considered to be incurred on the date the service or treatment is received or a purchase is made, rather than on the date the bill is received. Also, your claims must total at least \$200 before they can be submitted to the Fund Office for reimbursement. You may add several bills together in order to reach \$200. In any event, regardless of the size of your covered bills, in the month of December you may submit such bills to the Plan.

Over-the-Counter Medications

ELIGIBLE FOR REIMBURSEMENT

The following over-the-counter (OTC) medications are considered Qualified Medical Expenses and may be reimbursable from individual accounts. In order to receive reimbursement, you must submit an original receipt (a copy is not acceptable). The receipt must include the medication name, the purchase price and the date of purchase. Certain product types are eligible for reimbursement only with a physician's letter (see page 15). The following product types are eligible for reimbursement with no physician's letter:

Product Type

Examples include, but are not limited to:

Acne Medications - pill, liquid, cream, ointment, medicated soaps and cleansing pads

Clean & Clear, Clearasil, Loma Lux Acne, Nature's Cure

<u>Product Type</u>	<u>Examples include, but are not limited to:</u>
Allergy Medicines - pill, liquid, nasal spray (see also "Eye Drops")	Benadryl, Chlor-Trimeton, Claritin, Drixoral, NasalCrom, Tavist Allergy
Antacids (anti-gas, lactose intolerance) - liquids, pills, tablets	Alka-Seltzer, Beano, Gas-X, Lactaid, Maalox, Mylanta, Pepcid, Pepto-Bismol, Phazyme, Roloids, Tums
Antibiotic creams/ointments	Bacitracin, Neosporin, Polysporin
Antidiarrheal - liquids, pills	Imodium, Kaopectate, Pepto-Bismol
Anti-Fungal Creams & Powders	Aftate, Cruex, Lamisil, Lotrimin, Micatin, Tinactin
Anti-Itch Creams (allergy and poison ivy)	Benadryl, Cortaid, Ivarest, Lanacort
Baby Care Products	Diaper rash cream/ointment, rehydration liquids (Pedialyte, PediaSure), teething gel
Braces and supports	Braces and supports for neck, wrist, ankle, elbow, knee, etc.; support stockings
Canker and Cold Sore Remedies	Abreva, Anbesol, Cankaid, Carmex, Kank-A
Cold and Flu Medicines	Cough & sore throat lozenges/drops, cough syrup, decongestants, homeopathic cold medicines, nasal sprays, vapor rubs
Contraceptives/Family Planning	Condoms, contraceptive creams, pregnancy tests, ovulation predictor kits
Diabetic Supplies/Equipment	Alcohol swabs; blood glucose control solutions, monitors, strips and products; lancets and lancet devices, urine testing products

<u>Product Type</u>	<u>Examples include, but are not limited to:</u>
Ear Drops (ear wax removal)	Auro Ear Drops, Debrox Ear Drops, Murine Ear Drops
Eye Care Products	Saline and cleaning solutions, eyeglasses, contact lenses
Eye Drops/Eye Wash Products	Eye wash products to clean out eye or remove foreign objects, Murine, Visine
Feminine Yeast Infection Medicine	Gyne-Lotrimin, Monistat
First Aid	Bandages, dressings, first aid kits, peroxide, rubbing alcohol
Hemorrhoidal Preparations	Preparation H, Tucks
Home Diagnostic Tests or Kits	Cholesterol, colorectal, drug, HIV, ovulation predictor, pregnancy and urine tests; thermometers (ear or standard)
Hot/Cold Packs	ThermaCare
Laxatives (laxatives and fiber therapy)	Citrucel, Dulcolax, Ex-Lax, FiberCon, Fleet, Metamucil, Milk of Magnesia, Peri-Colace
Lice Treatments	LiceFree, Nix, Pronto, Rid
Motion Sickness Medicine	Bonine, Dramamine, motion sickness wristbands
Pain Relievers – Urinary Tract	Cystex, Uristat
Smoking Cessation Medicine - patches and gum	Nicoderm, Nicorette, Nicotrol, Novartis
Wart or Corn Removers - liquid or pads	Compound W, Curad, Dr. Scholl's Corn Remover, Wart-Off

This list provides examples of available drugs and items; however, it is subject to change.

CONSIDERED ELIGIBLE FOR REIMBURSEMENT WHEN DIRECTED IN WRITING BY A PHYSICIAN TO TREAT A SPECIFIC MEDICAL CONDITION

The following product types are eligible for reimbursement if you have a physician's letter. The physician's letter must cite the specific medical condition being treated and indicate that the OTC drug or medication will treat or alleviate it.

<u>Product Type</u>	<u>Examples include, but are not limited to:</u>
Herbs	Black cohosh, echinacea, evening primrose oil, ginkgo biloba, Ginsana, ginseng, goldenseal root, nettle, olive leaf extract, saw palmetto, St. John's wort
Other Supplements	Acidophilus, alpha lipoic acid, amino acids (L-Lysine, L-Arginine, L-Carnitine), chondroitin sulfate, cod liver oil, DHA, DHEA, EFO, flax seed oil, glucosamine complex, glucosamine sulfate, kelp, melatonin, omega-3, shark cartilage
Sleep Induction Medicine	Simply Sleep, Sleepinal, Sominex, Unisom
Vitamins and Minerals	Antioxidants, calcium, chromium, folic acid, iron, magnesium, multi-minerals, multi-vitamins, potassium, selenium, vitamins
Water Retention Products	Aqua-Ban, Diurex
Weight Loss Products	Pills

This list provides examples of available drugs and items; however, it is subject to change.

NOT ELIGIBLE FOR REIMBURSEMENT

The following product types are not eligible for reimbursement:

<u>Product Type</u>	<u>Examples include, but are not limited to:</u>
Bath Products, Cleansers, Soap	Aveeno, Dial, Dove, Softsoap
Creams, Lip Balm, Lipstick, Lotions, Moisturizers	Basis, Biore, Eucerin, L'Oreal, Neutrogena, Nivea, Noxzema, Oil of Olay, PHisoderm
Dental - Miscellaneous	Breath fresheners; dental floss, adhesives, cleansers, gel, gum, rinses; oral cleaning systems (Water Pik); tongue scrapers; whitening products/systems; toothbrushes; toothpaste
Deodorants/Anti-Perspirants	Ban, Brut, Dry Idea, Speed Stick
Feminine Hygiene	Always, douches, feminine lubricants and pads, tampons
Foot Care Products	Arch and insole supports, Dr. Scholl's callus removers, Odor-Eaters, pedicure products, shoes, toenail clippers
Hair Care Products	Conditioner and shampoo (including those used for dandruff), hairspray, styling aids
Hair Removal Products	Hair-removal creams, razors, wax
Medicine Dispensers	Medicine droppers, pill organizers
Powders	Non-fungus fighting foot powders
Shaving and Grooming Products	Aftershave, razors, shaving cream
Snoring Aids	Nose drops and strips
Stimulants (to stay awake)	No Doz, Vivarin
Sunscreen, Sunless Tanning, After Sun Products	Coppertone, Hawaiian Tropic

V. Claim Procedure

A. CLAIM PROCEDURE UNDER INSURED BENEFITS

Please read your Insurance Carrier's Booklet for the claim procedures for the insured benefits provided under the Welfare Fund.

B. CLAIM PROCEDURE UNDER OTHER BENEFITS

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

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

C. CLAIM DENIAL - NON-INSURED BENEFITS

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

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

D. TRUSTEES' INTERPRETATIONS AND DETERMINATIONS - NON-INSURED BENEFITS

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

E. CLAIM DENIAL - INSURED COVERAGES

Please read your Insurance Carrier's Booklet regarding denial of insured coverages.

F. CLAIM DENIAL APPEAL PROCEDURE UNDER NON-INSURED COVERAGES

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

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

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

You, or your duly authorized representative, may appeal the denial of a claim by a written application to the Fund Office made not later than 60 days after receipt of the denial, and submission of such additional information and comments, in writing, as supports your appeal. If you do not receive a decision on a claim within 90 days of filing the claim (or 180 days in special circumstances) you may request a review of that claim.

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

The Trustees will render a written decision specifying the reasons for their decision on the appeal, in a manner calculated to be understood by an average plan Participant, not later than 60 days after receipt of the appeal, unless additional documentation or information is required. In that event, a decision, as aforesaid, will be rendered no later than 120 days after receipt of the appeal.

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

G. CLAIM DENIAL APPEAL PROCEDURE UNDER INSURED COVERAGES

Please read your Insurance Carrier's booklet regarding appeal of a claim denial for insured coverages under the Plan.

H. FUND OFFICE CLAIM PAYMENT POLICIES

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

For all claims, the following will be required:

1. Obtain an appropriate claim form(s) from the Fund Office.
2. Complete your portion of the form(s). Be sure that the Participant's signature and the Participant's social security number are in the proper spaces.

3. Upon completion of the claim form(s), attach all itemized bills and return it to the Fund Office.

I. INCOMPETENCE

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

J. COOPERATION

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

K. CLAIM REPRESENTATIONS

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

L. CLAIMS WHERE THIRD PARTY IS LIABLE

Note: This provision applies to all Employees, Pensioners and their covered Spouses and Dependents, with respect to all of the Benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Employees, Pensioners, covered Spouses and covered Dependents.

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

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

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

1. Rights of Subrogation and Reimbursement.

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

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made to you or on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

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

2. Assignment of Claim.

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

3. Failure to Disclose and/or Cooperate.

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

VI. COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

Qualifying Events for Employees

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account.

Spousal Eligibility for COBRA Coverage

Your spouse may elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.
2. Your spouse’s loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account.
3. Divorce or judicial order of legal separation.
4. Your enrollment in Part A or Part B of Medicare.

Dependent Eligibility for COBRA Coverage

Your dependent children can elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.
2. Your dependent child’s loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or loss of eligibility due to reduction of personal account.
3. Divorce or judicial order of legal separation of the child’s parents.
4. Your enrollment in Part A or Part B of Medicare.
5. The child ceases to qualify as an “eligible dependent” as described in Section I.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

Notifications to the Fund Office

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Plan Manager of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent, or of a determination by the Social Security Administration that a qualified beneficiary is disabled by using the Fund's "Participant's Notice to Plan Manager" form which can be obtained from the Fund Office. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Plan Manager within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notification of COBRA Rights

After the Plan Manager receives notice of the occurrence of one of the above qualifying events, the third-party administrator will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the third-party administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated.

Election of COBRA Coverage

The employee, spouse and dependent children each has independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have at least 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the third-party administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form is received by

the third-party administrator on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the third-party administrator.

Benefits Provided Under COBRA Coverage

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

Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Duration and Termination of COBRA Coverage

If the election is due to termination of your employment or a reduction in hours worked or a loss of eligibility due to reduction in personal account, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If you are the disabled person, your spouse and your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.
2. Failure to pay the monthly premium on time.
3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.
4. The individual enrolls in Part A or Part B of Medicare.
5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the third-party administrator will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

Cost and Payment of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the third-party administrator to continue COBRA continuation coverage. The first payment must be made within 45 days of the date written election of coverage is made. After the first payment is made, future payments must be made within thirty (30) days after the first day of the month.

The monthly premium will be based on the average cost which the Plan incurs annually per Participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled Participants are at a monthly charge based on one and one-half times the average annual per Participant cost incurred by the Plan.

Additional Information about COBRA Coverage

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each Participant when the Participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Plan Manager or the third-party administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep your Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Manager and the third-party administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Manager and/or the third-party administrator.

VII. Qualified Medical Child Support Order

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

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

VIII. Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits.

- ◆ Examine, without charge, at the Plan office all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ◆ Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 Plan 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.

If there is 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.

Prudent Actions by Plan Fiduciaries.

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

Enforce Your Rights.

If your claim for a welfare Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time 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 thirty (30) days, you may file suit in Federal Court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions.

If you have any questions about your Plan, you should contact the Plan 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 plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor at:

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

Or

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

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

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

IX. Protected Health Information

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

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

A. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR.

The Plan shall disclose protected health information to the Plan Sponsor only to the extent necessary for the Plan Sponsor to perform the following Plan administrative functions:

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

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

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

1. Address changes;
2. Eligibility/benefit;
3. Student status;
4. Provider lookup;
5. Billing;
6. New enrollment;
7. Reinstatements;
8. Order I.D. cards;

9. Add dependent;
10. Terminations eligibility;
11. Benefit claims;
12. Monitor personal account balances for the purpose of paying health premiums; and
13. Contact service providers for the purpose of verifying service dates co-pays.

C. PLAN SPONSOR CERTIFICATION.

The Plan agrees that it will only disclose protected health information to the Plan Sponsor (which is the Board of Trustees), subject to the following:

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

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

2. Subcontractors and Agents.

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

3. Permitted Purposes.

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

4. Reporting.

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

5. Access to Protected Health Information.

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

6. Correction of Protected Health Information.

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

7. Accounting of Protected Health Information.

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

8. Disclosure to Government Agencies.

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

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

9. Return or Destruction of Health Information.

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

10. Minimum Necessary Requests.

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

D. ADEQUATE SEPARATION.

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

Lawrence J. Gonnely, Fund Administrator
Kethem K. Wulfken, Fund Secretary

E. ADEQUATE SEPARATION CERTIFICATION.

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

F. REPORTS OF NON-COMPLIANCE.

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

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

X. Technical Details

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

1. **PLAN NAME:** Northeastern New York District Council Pipefitters Welfare Plan.
2. **EDITION DATE:** This Summary Plan Description is produced as of January 1, 2006.
3. **PLAN SPONSOR:** Board of Trustees of the Northeastern New York District Council Pipefitters Welfare Fund.
4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 14-1418020.
5. **PLAN NUMBER:** 501 (assigned by federal government)
6. **TYPE OF PLAN:** Welfare Plan
7. **PLAN YEAR ENDS:** December 31
8. **PLAN ADMINISTRATOR:** Lawrence J. Gonnely, PO Box 1396, 30 Bluebird Road, South Glens Falls, NY 12803, Telephone #: (518) 792-0586.
9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Lawrence J. Gonnely, PO Box 1396, 30 Bluebird Road, South Glens Falls, NY 12803, Telephone #: (518) 792-0586.

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

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

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

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

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

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees (or the Insurance Company, if appropriate) within 60 days of the denial, at the Fund Office asking that a review of the denial be made. You, or your representative, may review the pertinent records and documents and you may appear at the review hearing.

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

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

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

20. TRUSTEES: The Plan Sponsor is the Board of Trustees of the Northeastern New York District Council Pipefitters Welfare Fund. The following are the individual Trustees that make up the Board as of 1/1/2006:

Douglas Brockway
Brockway Mechanical Systems, Inc.
102 Trade Road
Plattsburgh, NY 12901

Robert J. Barody
33 Palmer Drive
Queensbury, NY 12804

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

Larry S. Bulman
13 Moreau Drive
South Glens Falls, NY 12803

David Cornin
C & H North Mechanical, Inc.
3 Third Street
Hudson Falls, NY 12839

Terry A. Monroe
32 Boulevard
Queensbury, NY 12804

William Gordon
RF Gordon Mechanical, Inc.
399 Buttermilk Falls Road
West Fort Ann, NY 12827

Evan Myers
60 Hank Wilson Road
Cadyville, NY 12918

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

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