Tri-County Building Trades Health Fund

Summary Plan Description

and

Plan Document

2017 Edition

TRI-COUNTY BUILDING TRADES HEALTH FUND

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BOARD OF TRUSTEES
(ADMINISTRATOR AS DEFINED BY LAW)

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THIRD PARTY ADMINISTRATOR
AND
AGENT FOR SERVICE OF LEGAL PROCESS

BeneSys, Inc.

FUND COUNSEL

Johnson & Krol, LLC

CONSULTANT

Horizon Actuarial Services, LLC

CERTIFIED PUBLIC ACCOUNTANTS

Tramer, Shore & Zwick, CPA's

A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this updated booklet describing your health benefits under the Tri-County Building Trades Health Fund, effective May 1, 2017 unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document, the Plan's official rules and regulations.

This booklet describes the benefits and the Plan's eligibility rules. Important terms used throughout this booklet are capitalized and defined. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Third Party Administrator.

This booklet replaces and supersedes any previous written explanation of the Plan.

IMPORTANT REMINDERS

- Tell your family, particularly your spouse, about this booklet and where it is located.
- Please notify the Third Party Administrator promptly if you change your address.
- Only the full Board of Trustees is authorized to interpret the benefits described in this booklet.
- No Employer, Union, nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan, nor can any such person act as agent of the Trustees.
- The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. You will be notified in writing of any Plan changes.

PLAN VENDOR INFORMATION AS OF MAY 1, 2017

The **Third Party Administrator** is responsible, under the oversight of the Board, for providing various administrative services for the Plan, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and for providing various reports and other services that the Plan requires. ***The Trustees selected BeneSys, Inc. as the Third Party Administrator.*** At www.sheetmetalworkers33benefitfunds.org you will receive unique passwords that will allow you to access your personal eligibility/claims history and to view the Plan/SPD 24 hours a day, 7 days a week. The site contains additional links and services you will find valuable in understanding and using your coverage effectively. Please take full advantage of this service. Additionally, BeneSys will be available for any questions members may have regarding Plan benefits in general, as well as questions specific to an individual member's eligibility at (248) 641-4902, Monday through Friday 8:00 a.m. to 4:30 p.m. EST.

The **Preferred Provider Organization (the "PPO" or "network")** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. ***The Trustees selected Anthem as its PPO.*** The Anthem ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call the number provided on your Anthem ID card, the Third Party Administrator or visit www.anthem.com to identify PPO providers.

The **Care Management Organization** helps you and the Plan reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admissions and other medical expenses. ***The Trustees selected Health Plan Advocate to provide pre-certification, case management and utilization review services to the Plan.*** You may contact Health Plan Advocate for any questions and/or to request pre-certification at (866) 942-1394.

The **Pharmacy Benefit Manager ("PBM")** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs in exchange for the Plan's coverage of such services at a higher level than for non-participating pharmacies or mail order providers. ***The Trustees selected EnvisionRx to provide the Plan's preferred Prescription Drug coverage.*** Call EnvisionRx at (800) 361-4542 or visit www.envisionrx.com for answers to your Prescription Drug questions.

Certain **Medicare Retiree Benefits** are exclusively provided through a contract with an insurer. Benefits are provided pursuant to the terms provided in the policy. ***The Trustees selected Humana to provide medical and Prescription Drug benefits to Medicare Retirees.*** Call Humana at (800) 733-9064 or visit www.humana.com for further information regarding available benefits.

The **Death Benefit and the Accidental Dismemberment Benefit** are provided through an insurance carrier and paid in accordance with the terms of the applicable policy. ***The Trustees selected the Union Labor Life Insurance Company ("ULLICO") to provide the Plan's Death Benefit and Accidental Dismemberment Benefit.*** Call the Third Party Administrator for further information regarding the terms and limitations of these policies.

The Trustees contracted with **VSP** to provide access to a discount vision program. Call VSP at (800) 877-7195 or visit www.vsp.com for more information regarding the VSP Vision Savings Pass.

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SECTION 1: SCHEDULES OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice versa. This Section provides information for each type of Participant under the Plan.

1.01 Schedule of Benefits for Active Employees.

The following Schedule of Benefits provides an overview of benefits available under the Plan for Active Employees and their Dependents. Generally, Active Employees have three plans from which to choose: (1) Premier Plan; (2) Standard Plan; and (3) Basic Plan. If an Active Employee does not choose a plan when he or she initially becomes eligible for coverage, the Active Employee shall automatically be enrolled in the Standard Plan (i.e., the "Default Plan"). The amounts listed in the Schedule of Benefits reflect the Covered Medical Expenses paid by the Fund up to the Usual, Customary and Reasonable Charges ("UCR"), unless otherwise noted:

Major Medical Benefit						
	Premium Plan		**Standard Plan**		**Basic Plan**	
	PPO	***Non-PPO***	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***
Calendar Year Deductible	$400/person $800/family	$800/person $1,600/family	$500/person $1,000/family	$1,000/person $2,000/family	$1,100/person $2,200/family	$2,200/person $4,400/family
Out-of-Pocket Maximum per Calendar Year*	$1,500/person $3,000/family	$3,000/person $6,000/family	$3,000/person $6,000/family	$6,000/person $12,000/family	$4,000/person $8,000/family	$8,000/person $16,000/family
Covered Medical Expenses	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***
Physician Office Visit	100% after $20.00 Co-Payment (not subject to Deductible)	70%	100% after $20.00 Co-Payment (not subject to Deductible)	60%	100% after $20.00 Co-Payment (not subject to Deductible)	50%

* Once you reach the out-of-pocket maximum, the Plan pays 100% of covered expenses for the calendar year up to the maximum benefit listed. Expenses that apply towards the Non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa. The maximum does not include morbid obesity payments, Prescription Drug payments or pre-certification penalties.

Major Medical Benefit						
	Premium Plan		**Standard Plan**		**Basic Plan**	
Covered Medical Expenses	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***
Telemedicine Services	100% after $20.00 Co-Payment (not subject to Deductible)	Not Covered	100% after $20.00 Co-Payment (not subject to Deductible)	Not Covered	100% after $20.00 Co-Payment (not subject to Deductible)	Not Covered
Routine Physical Examinations	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Prostate Specific Antigen (PSA) Test and Prostate Examination	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Routine Gynecological Examination and Pap Smear	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Routine Immunizations	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Routine Bilateral Mammogram	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Routine Colonoscopy	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Well Child Care	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Additional Preventive Services	100% (not subject to Deductible)	70%	100% (not subject to Deductible)	60%	100% (not subject to Deductible)	50%
Emergency Room Visit	100% after $100.00 Co-Payment* *Co-Payment is waived if admitted to Hospital or if Emergency care is for accidental injury.		100% after $100.00 Co-Payment* *Co-Payment is waived if admitted to Hospital or if Emergency care is for accidental injury.		100% after $100.00 Co-Payment* *Co-Payment is waived if admitted to Hospital or if Emergency care is for accidental injury.	

Major Medical Benefit						
	Premium Plan		**Standard Plan**		**Basic Plan**	
Covered Medical Expenses	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***
Emergency Medical Transportation	90%	70%	80%	60%	70%	50%
Non-Emergency Care in Emergency Room/Facility	90% after $100.00 Co-Payment (not subject to Deductible)	70% after $100.00 Co-Payment (not subject to Deductible)	80% after $100.00 Co-Payment (not subject to Deductible)	60% after $100.00 Co-Payment (not subject to Deductible)	70% after $100.00 Co-Payment	50% after $100.00 Co-Payment
Urgent Care Center	100% after $20.00 Co-Payment (not subject to Deductible)	70%	100% after $20.00 Co-Payment (not subject to Deductible)	60%	100% after $20.00 Co-Payment (not subject to Deductible)	50%
Hospital/Facility	90%	70%	80%	60%	70%	50%
Mental/Nervous Disorders and/or Substance Abuse Office Visit	100% after $20.00 Co-Payment (not subject to Deductible)	70%	100% after $20.00 Co-Payment (not subject to Deductible)	60%	100% after $20.00 Co-Payment (not subject to Deductible)	50%
Mental/Nervous Disorders and/or Substance Abuse Inpatient/Outpatient Treatment	90%	70%	80%	60%	70%	50%
Skilled Nursing Care Facility	90%	70%	80%	60%	70%	50%
Home Health Care	90%	70%	80%	60%	70%	50%
Private Duty Nursing	90%	70%	80%	60%	70%	50%
Hospice	90%	70%	80%	60%	70%	50%

Major Medical Benefit						
	Premium Plan		**Standard Plan**		**Basic Plan**	
Covered Medical Expenses	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***	***PPO***	***Non-PPO***
Hearing Aids	50% of all services, exams, fittings, and appliances up to $2,500 every three years		50% of all services, exams, fittings, and appliances up to $2,500 every three years		50% of all services, exams, fittings, and appliances up to $2,500 every three years	
All Other Covered Medical Expenses	90%	70%	80%	60%	70%	50%
Gym Membership	Up to $200 per person/family per calendar year for reimbursement of basic membership cost to a recognized gym or fitness facility (e.g., YMCA or Planet Fitness)		Up to $200 per person/family per calendar year for reimbursement of basic membership cost to a recognized gym or fitness facility (e.g., YMCA or Planet Fitness)		Up to $200 per person/family per calendar year for reimbursement of basic membership cost to a recognized gym or fitness facility (e.g., YMCA or Planet Fitness)	

Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year	$3,150 per person $6,300 per family	
Your Co-Payment Amount	***Retail (34-day supply)***	***Mail (90-day supply)***
Generic	Lesser of $10 or 20%	$25
Preferred Brand	Greater of $20 or 30%	$45
Non-Preferred Brand	Greater of $30 or 40%	$70
Proton Pump Inhibitors	Plan pays 25% up to $50.00 maximum	Plan pays 25% up to $50.00 maximum
Specialty	Covered under the Major Medical Benefit payment structure.	

1.02 Schedule of Benefits for Pre-Medicare Retirees.

The following Schedule of Benefits provides an overview of benefits available under the Plan for Retired Employees and their Dependents that are not yet eligible for Medicare ("Pre-Medicare Retirees"). The amounts listed in the Schedule of Benefits reflect the Covered Medical Expenses paid by the Fund up to the Usual, Customary and Reasonable Charges ("UCR"), unless otherwise noted.

Pre-Medicare Retiree Plan		
Major Medical Benefit		
Deductibles for Covered Medical Expenses	***PPO***	***Non-PPO***
Calendar Year Deductible	$600 per person $1,200 per family	$1,200 per person $2,400 per family
Out-of-Pocket Maximum per Calendar Year	***PPO***	***Non-PPO***
Once you reach the out-of-pocket maximum, the Plan pays 100% of covered expenses for the calendar year up to the maximum benefit listed. Expenses that apply towards the Non-PPO out-of-pocket limits apply towards the PPO out-of-pocket limits and vice versa. (The maximum does not include morbid obesity payments, Prescription Drug payments or pre-certification penalties).	$3,500 per person $5,000 per family	$7,000 per person $10,000 per family
Covered Medical Expenses	***PPO***	***Non-PPO***
Physician Office Visit	100% after $20.00 Co-Payment (not subject to Deductible)	65%
Telemedicine Services	100% after $20.00 Co-Payment (not subject to Deductible)	Not Covered
Routine Physical Examinations	100% (not subject to Deductible)	65%
Prostate Specific Antigen (PSA) Test and Prostate Examination	100% (not subject to Deductible)	65%
Routine Gynecological Examination and Pap Smear	100% (not subject to Deductible)	65%

Major Medical Benefit		
Covered Medical Expenses	***PPO***	***Non-PPO***
Routine Immunizations	100% (not subject to Deductible)	65%
Routine Bilateral Mammogram	100% (not subject to Deductible)	65%
Routine Colonoscopy	100% (not subject to Deductible)	65%
Well Child Care	100% (not subject to Deductible)	65%
Additional Preventive Services	100% (not subject to Deductible)	65%
Emergency Room Visit *Co-Payment is waived if admitted to Hospital or if Emergency care is for accidental injury.	100% after $100.00 Co-Payment*	100% after $100.00 Co-Payment*
Emergency Medical Transportation	85%	65%
Non-Emergency Care in Emergency Room/Facility	85% after $100.00 Co-Payment (not subject to Deductible)	65% after $100.00 Co-Payment (not subject to Deductible)
Urgent Care Center	100% after $20.00 Co-Payment (not subject to Deductible)	65%
Hospital/Facility	85%	65%
Mental/Nervous Disorders and/or Substance Abuse Office Visit	100% after $20.00 Co-Payment (not subject to Deductible)	65%
Mental/Nervous Disorders and/or Substance Abuse Inpatient/Outpatient Treatment	85%	65%
Skilled Nursing Care Facility	85%	65%
Home Health Care	85%	65%

Major Medical Benefit		
Covered Medical Expenses	***PPO***	***Non-PPO***
Private Duty Nursing	85%	65%
Hospice	85%	65%
Hearing Aids	50% of all services, exams, fittings and appliances up to $2,500 every three years	
All Other Covered Medical Expenses	85%	65%
Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year	$3,650 per person $9,300 per family	
Your Co-Payment Amount	***Retail (34-day supply)***	***Mail (90-day supply)***
Generic	Lesser of $10 or 20%	$25
Preferred Brand	Greater of $20 or 30%	$45
Non-Preferred Brand	Greater of $30 or 40%	$70
Proton Pump Inhibitors	Plan pays 25% up to $50.00 maximum	Plan pays 25% up to $50.00 maximum
Specialty	Covered under the Major Medical Benefit payment structure.	

1.03 Schedule of Benefits for Medicare Retirees.

The following Schedule of Benefits provides an overview of benefits available under the Plan for Retired Employees and their Dependents that are eligible for Medicare ("Medicare Retirees"). The amounts listed in the Schedule of Benefits reflect the Covered Medical Expenses paid by the Medicare Advantage and Prescription Drug ("MAPD") Plan, unless otherwise noted.

Medicare Advantage and Prescription Drug Plan		
Major Medical Benefit		
Calendar Year Deductible	$147 per person	
Out-of-Pocket Maximum per Calendar Year		
Covered Medical Expenses		
Inpatient Hospital Care	100%	
Skilled Nursing Care	100% up to 100 days	
Primary Care Provider Office Visit	100%	
Specialist Office Visit	100%	
Outpatient Surgical Care	100%	
Ambulance	100%	
Emergency Room Visit	100%	
Urgent Care Center	100%	
Hearing Exam	100% up to $50 maximum once every 24 months	
Hearing Aid	100% up to $3,000 for hearing aids every 36 months after calendar year deductible	
Prescription Drug Benefit		
Your Co-Payment Amount during Initial Coverage and Coverage Gap	***Retail (30-day supply)***	***Mail (90-day supply)***
Generic	$5	$0
Preferred Brand	$20	$40
Non-Preferred Brand	$50	$100
Specialty	$80	Not Covered
Your Co-Payment Amount during Catastrophic Coverage	***Retail (30-day supply)***	***Mail (90-day supply)***
Generic	Greater of $3.30 or 5%; $80 maximum	Greater of $3.30 or 5%; $100 maximum
All other Drugs	Greater of $8.25 or 5%; $80 maximum	Greater of $8.25 or 5%; $100 maximum

1.04 Schedules for Optional Benefits Packages.

The following Schedules of Benefits provide an overview of the various Optional Benefits Packages. The amounts listed in the Schedules of Benefits reflect the expenses paid by the Fund up to the Usual, Customary and Reasonable Charges ("UCR"), unless otherwise noted.

A. Active Bargaining Unit Employees.

Dental Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$2,000 per family	$4,000 per family
Benefit Amount	80%	80%
Vision Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$600 per family	$1,200 per family
Benefit Amount	80%	80%
Short-Term Disability Benefit	***Option 1***	***Option 2***
Weekly Amount	$300 per week up to a maximum of 26 weeks	$400 per week up to a maximum of 26 weeks
Death Benefit	***Option 1***	***Option 2***
Benefit Amount	$25,000	$25,000
Accidental Dismemberment Benefit	***Option 1***	***Option 2***
For loss of:		
Both hands, both feet, or sight of both eyes	$5,000	$5,000
Speech and hearing in both ears	$5,000	$5,000
One hand and one foot, one hand and sight of one eye, or one foot and sight of one eye	$5,000	$5,000
One hand, one foot or sight of one eye	$2,500	$2,500

B. Active Non-Bargaining Unit Employees.

Dental Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$2,000 per family	$4,000 per family
Benefit Amount	80%	80%
Vision Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$600 per family	$1,200 per family
Benefit Amount	80%	80%
Death Benefit	***Option 1***	***Option 2***
Benefit Amount	$25,000	$25,000

C. Pre-Medicare Retirees.

Dental Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$2,000 per family	$4,000 per family
Benefit Amount	80%	80%
Vision Benefits	***Option 1***	***Option 2***
Calendar Year Maximum Benefit	$600 per family	$1,200 per family
Benefit Amount	80%	80%

D. Surviving Spouses and Disabled Retirees.

Dental Benefits	***Option 1***
Calendar Year Maximum Benefit	$2,000 per family
Benefit Amount	80%
Vision Benefits	***Option 1***
Calendar Year Maximum Benefit	$600 per family
Benefit Amount	80%

SECTION 2: ELIGIBILITY

2.01 Eligibility for Active Hourly Rate Bargained Employees.

A. General Eligibility Provisions.

To be eligible for benefits under the Plan, you must have sufficient Employer Contributions in your Reserve Dollars Bank to cover the monthly cost of coverage for your selected plan. You may select your plan during the open enrollment period each year. The amount of Employer Contributions necessary to cover the cost of coverage depends on the plan you select, which is determined by the Trustees and may be subject to change from time to time.

B. Initial Eligibility Requirements.

You will become eligible for benefits on the first day of the third month following a period of six consecutive months in which your Reserve Dollars Bank accumulates Employer Contributions that equal the monthly cost of coverage under the Standard Plan or any other more expensive plan.

You may also become eligible for benefits before your Reserve Dollars Bank is credited with sufficient Employer Contributions by making a Self-Payment equal to the monthly cost of coverage for your selected plan.

C. Continued Eligibility Requirements.

Once you meet the Initial Eligibility Requirements, you will continue to be eligible for benefits if you have sufficient Employer Contributions in your Reserve Dollars Bank to cover the cost of coverage for your selected plan. Employer Contributions will be used to determine eligibility during the third month following the month in which the Contributions were made.

D. Reserve Dollars Bank.

The Reserve Dollars Bank is an account that is established for an Active Hourly Rate Bargained Employee. When you work for an Employer, the Contributions that you earn are credited to your Reserve Dollars Bank.

If you have sufficient Employer Contributions in your Reserve Dollars Bank to cover the cost of coverage for your selected plan, the monthly premium will automatically be withdrawn from your Reserve Dollars Bank to pay for your coverage. Any Employer Contributions made on your behalf above the amount required for the monthly cost of coverage will accumulate in your Reserve Dollars Bank. Once you accumulate more than $10,000.00 in your Reserve Dollars Bank, you may request reimbursement by the Plan for certain reimbursable expenses as explained in Section 11.

1. Using Your Reserve Dollars Bank to Maintain Eligibility.

You can use your Reserve Dollars Bank to maintain your eligibility for future calendar months in the event you do not accumulate sufficient Employer Contributions to cover the cost of coverage for your selected plan.

2. Forfeiture of Your Reserve Dollars Bank.

If you resign as a member of the Union, take a "withdrawal card," or fail to obtain reinstatement to the Union within ninety (90) days of suspension by the Union, your Reserve Dollars Bank will be forfeited and cannot be used in the future.

3. Freezing Your Reserve Dollars Bank.

If you switch from an Employer who participates in the Hourly Rate Program to the Flat Rate Program, your Reserve Dollars Bank will be frozen. Your Reserve Dollars Bank will unfreeze when you again work for an Employer who participates in the Hourly Rate Program.

However, you may continue to use the HRA component of your Reserve Dollars Bank for reimbursable expenses as set forth in Section 11.

4. Your Reserve Dollars Bank is not a Vested Benefit.

The Reserve Dollars Bank is merely a record keeping account with the purpose of keeping track of Employer Contributions. Your Reserve Dollars Bank consists solely of Employer Contributions. The Reserve Dollars Bank is not a vested benefit for you or your Dependents. The Reserve Dollars Bank shall not be subject to alienation, sale, transfer, assignment, pledge, attachment, qualified domestic relations order, or encumbrance of any kind. The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

5. Surviving Dependents Use of Your Reserve Dollars Bank Upon Your Death.

If there is a balance in your Reserve Dollars Bank on the date of your death, your surviving Dependents may use your Reserve Dollars Bank. Your surviving Dependents may use your Reserve Dollars Bank for reimbursable expenses as set forth in Section 11 until your Reserve Dollars Bank reaches a balance of less than $10,000.00. Once your Reserve Dollars Bank reaches a balance of less than $10,000.00, your surviving Dependents may only use it to continue eligibility under the Plan.

If you die and you do not have any surviving Dependents, your Reserve Dollars Bank will be forfeited.

E. Maintaining Coverage by Self-Payment.

If you receive a notice from the Fund which states that you are eligible to make a Self-Payment, you may make Self-Payments to continue your coverage under the Plan. If you fail to make a timely Self-Payment or you are no longer eligible to make a Self-Payment, your eligibility will terminate. Thereafter, you may be eligible for COBRA Continuation Coverage.

1. Partial Self-Payments.

If you do not accumulate sufficient Employer Contributions in your Reserve Dollars Bank to cover the cost of coverage for your selected plan, then you may make a Self-Payment to continue your eligibility under the Plan. The amount of the Self-Payment is the difference between the amount of the Employer Contributions in your Reserve Dollars Bank and the monthly cost of coverage of your selected plan or the Standard Plan if you did not select a plan.

There is no limit to the number of partial Self-Payments you are permitted to make to continue your eligibility, provided that you have some hours reported to the Plan on your behalf.

2. Full Self-Payments.

If you are actively seeking work through the Union and you are laid off, unemployed, or on strike, then you may make a Self-Payment to continue your eligibility under the Plan for up to twelve (12) consecutive calendar months. An additional six (6) month extension may be granted by the Trustees upon submission of

satisfactory documentation. The amount of the Self-Payment is equal to the monthly cost of coverage of your selected plan.

To be actively seeking work, you must (1) maintain your membership through the Union and register your availability to work at least every thirty (30) days with the Union, or (2) be available for work referred by the Union within the trade to a job which is identified as lasting at least one (1) week.

3. Self-Payments for Disabled Employees.

If you are disabled, so as to prevent you from performing any type of gainful employment, you will be able to continue your eligibility under the Plan during the disability for up to twelve (12) consecutive calendar months by making Self-Payments. If the Trustees determine that you are still unable to resume work in Covered Employment after the first twelve (12) months of your disability, you may continue to make Self-Payments for an additional twelve (12) months.

If you suffer from a disabling condition which prohibits you from performing any work which is covered under a Collective Bargaining Agreement, but you are able to perform other gainful employment, you may continue your eligibility under the Plan while you are seeking other employment or you are being retrained to perform other employment. You may continue to make Self-Payments in these circumstance for up to twelve (12) consecutive calendar months. An additional six (6) month extension may be granted by the Trustees upon submission of satisfactory documentation.

You may be asked to provide periodic proof of your continuing disability from performing work in Covered Employment, and/or proof that you are seeking other employment or are being retrained for other employment during this extended Self-Payment period. If you become eligible to participate in Medicare due to your disability or age while making Self-Payments, you will automatically be enrolled in the Medicare Advantage and Prescription Drug Plan.

Once you have exhausted the maximum time period that you are eligible to continue your coverage through making Self-Payments, you may be eligible for COBRA Continuation Coverage.

F. When Coverage Ends.

Your coverage for Active Employee Benefits under the Plan will end on the last day of the calendar month upon the earliest of the following events:

1. You fail to qualify for eligibility under any of the Plan's eligibility rules;

2. You fail to make a timely Self-Payment;

3. You are not eligible to make a Self-Payment;

4. Your Reserve Dollars Bank is forfeited under Section 2.01(D)(2);

5. Your Employer ceases to be signatory to a Collective Bargaining Agreement with the Union;

6. Your death; or

7. The Trustees discontinue the Plan.

G. Reinstatement of Eligibility.

If you lose eligibility under the Plan because you do not have sufficient Employer Contributions in your Reserve Dollars Bank or you fail to make a Self-Payment, you must meet the Initial Eligibility Requirements for Active Hourly Rate Bargained Employees.

2.02 Eligibility for Active Flat Rate Bargained Employees.

A. General Eligibility Provisions.

An Employer that performs primarily residential or production work may elect to participate in the Flat Rate Program. The Flat Rate Program allows an Employer to make a single, pre-established premium payment to the Fund on behalf of all its eligible Employees.

The Board of Trustees determines the flat rate premium. Any change in the amount of the flat rate premium will be communicated to Employers by the Trustees at least thirty (30) days prior to the effective date of the change.

B. Initial Eligibility.

Under the Flat Rate Program, you will become eligible for benefits on the first day of the month as long as Contributions are received by the Fund prior to the 20th day of that month. You will become eligible for benefits on the first day of the following month if Contributions are received by the Fund on or after the 20th day of that month.

C. Continued Eligibility.

Flat Rate Bargained Employees are not eligible to establish a Reserve Dollars Bank. Accordingly, you will continue to be eligible for benefits under the Plan for each calendar month in which your Contributing Employer submits the required Contributions on or before the last day of the previous month.

D. When Coverage Ends.

Generally, your coverage for Active Employee Benefits under the Plan will end on the last day of the calendar month during which Contributions were contributed on your behalf. However, your eligibility under the Plan may be extended (not including COBRA Continuation Coverage) under the following circumstances:

1. If you are laid off or your Employer switches from the Flat Rate Program to the Hourly Rate Program, your coverage under the Plan will be extended for two (2) additional months.

2. If you quit or you are terminated with cause during a month, your Employer shall be responsible for the flat rate premium for the remainder of the month of your quit/termination.

If you switch from an Employer who participates in the Flat Rate Program to the Hourly Rate Program, then you must meet the Initial Eligibility Requirements for Active Hourly Rate Bargained Employees.

2.03 Eligibility for Active Non-Bargaining Unit Employees.

A. Initial Eligibility.

As an Active Non-Bargaining Unit Employee, you and your Dependents are eligible to participate in the Plan on the first day of the month following the month in which your Contributing Employer submits the required Contributions on your behalf and your Contributing Employer has executed a participation agreement.

B. Continued Eligibility.

You will continue to be eligible for benefits under the Plan for each calendar month in which your Contributing Employer submits the required Contributions on or before the last day of the previous month. The Board of Trustees determines the amount of Contributions required for eligibility.

C. When Coverage Ends.

Your coverage for Active Employee Benefits under the Plan will end on the last day of the calendar month during which Contributions were contributed on your behalf. In the event that you lose coverage under the Plan, the only methods of coverage available to you are to re-establish initial eligibility and/or elect COBRA Continuation Coverage.

2.04 Effect of Military Service on Eligibility.

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into active service, your coverage under the Plan will not be affected during the initial 31-day period. Your coverage under the Plan will be suspended at the end of this initial 31-day period under Option 1 below (the default option), unless you elect otherwise.

In order to exercise your options, you must notify the Fund in writing when you are called to active service. The Fund will send you an election form with three options regarding your Plan benefits as follows:

Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION.**

Option 2: Suspend active coverage under the Plan for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

Option 3: Continue active coverage for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

If your failure to provide advance notice when called to active service is excused under USERRA because of military necessity, then you can make a retroactive election to continue coverage, provided you pay any unpaid amounts that are due.

Option 1

If you elect Option 1 (suspend eligibility and rely on military coverage), your eligibility and Reserve Dollars Bank will be frozen until you are discharged from active military service. In order to reinstate active eligibility, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the following chart.

Length of Active Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

Once you provide the Fund with your discharge papers, your Reserve Dollars Bank, which was suspended when you went into active military service, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund, for the balance of the current month of coverage. Your eligibility for subsequent months will be determined as of the corresponding determination dates under the Plan's Continued Eligibility Requirements.

Option 2

If you elect Option 2 (suspend active coverage and elect COBRA), your eligibility and Reserve Dollars Bank will be frozen until you are discharged from active military service. Under this option, you and your Dependents can pay the monthly COBRA premium for up to 24 months of COBRA coverage. The standard election and payment deadlines under COBRA apply.

In order to reinstate active eligibility upon discharge, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the above chart.

Once you provide the Fund with your discharge papers, your Reserve Dollars Bank, as of the end of the initial 31-day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund. Your eligibility for subsequent periods will be determined under the Plan's eligibility requirements.

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as your Reserve Dollars Bank permits. Thereafter, you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

Under USERRA, you must provide the Fund with a copy of your discharge papers within the time periods provided in the above chart.

If active eligibility has been exhausted under Option 3, then upon discharge you will not qualify for active eligibility until you satisfy the Initial Eligibility Requirements.

In the meantime, you will have the opportunity to pay for COBRA coverage as of the date of discharge, or a later date as agreed to by the Fund. Upon discharge, you can pay for COBRA coverage until the later of (1) the end of six months of payments, or (2) the end of the original 24-month period.

2.05 Eligibility under the Family and Medical Leave Act (FMLA).

When you take leave under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. Your Employer will submit a copy of the approved application to the Trustees so that your rights to health care coverage are protected during your leave.

During your absence, you will continue to receive coverage under the Plan. If you return to work for a Contributing Employer within the FMLA guidelines, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

If your coverage terminates, you will then be eligible to purchase COBRA Continuation Coverage. Contact the Third Party Administrator for additional information about your coverage during a FMLA leave or continuing your coverage under COBRA. Your rights under the FMLA are summarized below.

You have the right to take unpaid leave if you meet the following criteria:

1. You worked for the same Contributing Employer for at least 12 months;

2. You worked at least 1,250 hours during the previous 12 months; and

3. You work at a location where at least 50 employees are employed by your Contributing Employer within a 75-mile radius.

The duration of leave available to you will depend upon the reasons for which you are taking the leave.

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.

2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service-member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service-member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26 week leave is the maximum time period allowed and is not in addition to the 12 week leave provided above.

2.06 Retiree Benefits.

A. General Eligibility Provisions.

Once you retire and are no longer eligible for benefits as an Active Bargaining Unit Employee, you and your Dependents will be eligible for Retiree Benefits if you meet all of the following requirements:

1. You are receiving a pension benefit from a qualified retirement program acceptable by the Board of Trustees or social security retirement benefits from the Social Security Administration;

2. You were covered under the Plan as an Active Bargaining Unit Employee for (a) at least ten (10) years out of the last fifteen (15) years immediately preceding the date on which you retire, or (b) at least seven (7) years out of the last fifteen (15) years immediately preceding the date on which you retire AND you have been an Active Bargaining Unit Employee under the Plan for at least twenty-four (24) consecutive months preceding your retirement;

3. You enrolled for coverage within thirty (30) days following the date your Active Bargaining Unit Employee coverage terminates; and

4. You continuously and timely pay the applicable Retiree Self-Payment as required under the Plan.

Retiree Benefits are in lieu of COBRA Continuation Coverage. If you elect Retiree Benefits, you will not be eligible to receive COBRA Continuation Coverage once your coverage terminates under the Plan for any reason.

B. Eligibility Provisions for Disabled Retirees.

If you are disabled and you maintained continuous eligibility under the Plan through Self-Payment during your disability, you will be eligible for Retiree Benefits if you meet all of the following requirements:

1. You are receiving a disability pension benefit from the National Sheet Metal Pension Plan or the Sheet Metal Local Union No. 33 Pension Plan and/or a disability award from the Social Security Administration;

2. You were covered under the Plan as an Active Bargaining Unit Employee for at least five (5) years out of the last seven (7) years before your disability date; and

3. You continuously and timely pay the applicable Retiree Self-Payment as required under the Plan.

Disabled Retirees are eligible for coverage under the Standard Plan, and dental and vision benefits under Option 1 of the Optional Benefits Package. Once a disabled Retiree is eligible for Medicare, he or she will automatically be enrolled in the Medicare Advantage and Prescription Drug Plan.

C. Retiree Self-Payments.

A Retiree Self-Payment is a payment that you are required to make in order to maintain your eligibility for Retiree Benefits.

1. Amount of Retiree Self-Payments.

The amounts of the required Retiree Self-Payments are determined by the Board of Trustees and are subject to change from time to time and are generally based on the cost of the benefits. For a current list of Retiree Self-Payments, please contact the Third Party Administrator. Please be aware the Retiree Self-Payment does not include the Optional Benefits Package.

2. Automatic Deduction of Retiree Self-Payments from Reserve Dollars Bank.

If you have a balance in your Reserve Dollars Bank when your Active Employee Benefits end, the Third Party Administrator will automatically deduct the Retiree Self-Payment amount directly from your

Reserve Dollars Bank to enable you to maintain Retiree Benefits under the Plan. Once your Reserve Dollars Bank is exhausted, you will be required to begin making monthly Retiree Self-Payments.

3. Failure to Make Timely Self-Payment.

If you fail to make the required Retiree Self-Payment **at any time**, you and your eligible Dependents' eligibility for Retiree Benefits will terminate and you will not be allowed to re-enroll at a later date, unless you regain coverage as an Active Bargaining Unit Employee.

D. Medical and Prescription Drug Benefits Available After Retirement.

The Plan offers two types of Retiree Benefits: Pre-Medicare Retiree Benefits and Medicare Retiree Benefits. What type of benefits you and your Dependents are eligible for depends on each individual's Medicare status.

1. Pre-Medicare Retiree Benefits.

Any individual covered under Retiree Benefits who is not eligible for Medicare is covered under the Pre-Medicare Retiree Plan. The Medical and Prescription Drug Benefits individuals receive while enrolled in the Pre-Medicare Retiree Plan are generally the same Medical and Prescription Drug Benefits offered under the Plan for Active Employees. The amounts of the Pre-Medicare Retiree Benefits are provided in the Schedule of Benefits.

2. Medicare Retiree Benefits.

Any individual who is eligible for Retiree Benefits and Medicare is enrolled in the Medicare Advantage and Prescription Drug Plan. You **MUST** be enrolled in Medicare Parts A and B and pay your Medicare Part B premium to be eligible for coverage under the Medicare Advantage and Prescription Drug Plan.

E. Ancillary Benefits Available after Retirement.

1. Optional Benefits Packages Available after Retirement.

If you are eligible under the Pre-Medicare Retiree Plan, then you may purchase the Optional Benefits Package for an additional monthly premium. The Optional Benefits Package for Pre-Medicare Retirees includes the Dental Benefit and Vision Benefit. You must purchase a complete package of optional benefits. You cannot choose the Dental or Vision Benefit individually.

If you are eligible for Medicare Retiree Benefits, you may not purchase any Optional Benefits Package.

2. Reserve Dollars Bank.

As a Retiree, you are not eligible to receive Contributions credited towards your Reserve Dollars Bank unless you are working in Covered Employment. However, your Reserve Dollars Bank will be used to maintain your coverage under the Plan and/or to reimburse you for qualifying medical expenses as explained in Section 11.

F. When Retiree Benefits End.

Retiree Benefits under the Plan are not vested and will not vest at any time. Accordingly, your eligibility for Retiree Benefits will terminate on the first of the following dates to occur:

1. The date you stop meeting the Retiree eligibility requirements under the Plan;
2. The last day of the month for which you fail to submit a timely Retiree Self-Payment;
3. The date the Trustees discontinue Retiree Benefits;
4. The last day of the month in which a Medicare eligible individual is enrolled in Medicare Parts A and B; or
5. The date of your death.

2.07 Dependent Eligibility.

A. Dependents' Initial Eligibility.

Your Dependents will become eligible for benefits on the later of the following to occur:

1. The date you are eligible for coverage; or
2. The date he or she meets the definition of Dependent under the Plan.

B. When Dependent Eligibility Ends.

Your Dependents' coverage will end on the earliest of the following to occur:

1. The date your eligibility ends for a reason other than death;
2. The date he or she no longer meets the definition of a Dependent under the Plan;
3. The date the Trustees terminate Dependent benefits under the Plan;
4. The date your Dependent enters military service; or
5. The date the Trustees terminate the Plan.

C. Dependent Eligibility in the Event of Your Death.

After your death, your surviving Dependents may be able to run out your eligibility under the Plan and exhaust your Reserve Dollars Bank. Once those benefits are exhausted, they may be eligible to make either Self-Payments to continue eligibility **OR** elect COBRA Continuation Coverage. However, if you were an Active Non-Bargaining Unit Employee, your surviving Dependents will only have the option of electing COBRA Continuation Coverage.

If your surviving Dependents elect to continue coverage by making Self-Payments, those payments are subject to the following rules:

1. Your surviving Dependents must elect to continue coverage by making Self-Payments within sixty (60) days of your death.

2. The amount of the Self-Payments will be determined by the Trustees and is subject to change at any time.

3. Your surviving spouse is eligible to make Self-Payments for himself or herself and for his or her Dependents until (a) he or she remarries, or (b) the date the surviving spouse becomes eligible for benefits under another medical plan (except Medicare).

4. Dependent children may continue to make Self-Payments until they no longer meet the definition of a Dependent under the Plan.

5. Surviving Dependents must maintain continuous eligibility under the Plan to maintain coverage. Self-Payments must be made on or before the first day of the month for which continued coverage is desired. If a payment is not made on time, coverage will terminate and the payment may not be made up at any future time.

6. Your surviving Dependents are eligible for coverage under the Standard Plan, and they will receive dental and vision benefits under Option 1 of the Optional Benefits Package. Once your surviving Spouse is eligible for Medicare, he or she will automatically be enrolled in the Medicare Advantage and Prescription Drug Plan.

D. Dependent Eligibility under a Qualified Medical Child Support Order (QMCSO).

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMSCO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan for the purposes of the Plan's coordination of benefits rules.

The Third Party Administrator will notify you if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

2.08 COBRA Continuation Coverage.

A. COBRA Coverage in General.

When you lose coverage because of a Qualifying Event, coverage for you or your eligible Dependents can be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying Events are defined as the death of the Participant, a reduction of the Participant's hours or loss of employment (except due to gross misconduct), the Participant's entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan, and legal separation or divorce from the Participant.

The Plan provides two options for COBRA coverage: (1) medical only; or (2) medical, dental and vision coverage. Both options include Prescription Drugs. COBRA coverage does not include the following benefits: Death, Accidental Dismemberment and Short-Term Disability Benefits.

If you elect COBRA coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA coverage is conditioned on timely and uninterrupted payment of premiums.

If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Third Party Administrator in writing of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the Qualifying Event that triggered COBRA Continuation Coverage.

There may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Third Party Administrator. For information on the Marketplace, please visit www.healthcare.gov.

B. Eligibility.

1. 18-Month COBRA Continuation Coverage.

You are eligible to elect COBRA coverage when you lose eligibility for benefits because of a Qualifying Event. In such event, you and your eligible Dependents may elect up to 18 months of COBRA coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. An eligible beneficiary generally is an individual covered by the Plan on the day before the Qualifying Event occurs. This includes your spouse and your Dependent child. Also, any child born to or placed for adoption with you during the period of COBRA coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage based on when you no longer have sufficient Employer Contributions in your Reserve Dollars Bank to meet the Continued Eligibility Requirements.

2. Disability Extension of 18-Month COBRA Continuation Coverage.

If you or an eligible Dependent is determined by Social Security to be disabled, you and all family members previously covered under COBRA may be entitled to receive an additional 11 months of COBRA coverage. This means that COBRA Continuation Coverage will continue for a total of 29 months if the required premium is paid. Coverage for the additional 11 months may be at a higher cost.

You must notify the Third Party Administrator of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the first 18 months of continued coverage. Otherwise, you will not be eligible for the additional 11 months of coverage.

3. 36-Month COBRA Continuation Coverage.

Certain Qualifying Events allow your eligible Dependents to purchase a total of 36 months of COBRA Continuation Coverage. A total of 36 months is allowed if one of the following events occurs during the initial 18-month continuation period or if coverage ends for any of the following reasons:

a. Your death;

b. Your divorce or legal separation;

c. Your reaching eligibility for Medicare; or

d. Your Dependent child no longer qualifies as a Dependent under the terms of the Plan.

Coverage terminates at the end of the month in which the event occurs. You or your Dependent must notify the Third Party Administrator in writing in the event of a legal separation, divorce or a child losing Dependent status within 60 days of the date coverage terminates. If you do not provide the notice to the Third Party Administrator within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA Continuation Coverage.

C. COBRA Premiums, Payments and Due Dates.

The standard COBRA premium is determined by the Trustees and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan.

COBRA premium payments must be made monthly to the Third Party Administrator. The initial COBRA premium payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month, but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA premium payment is not received by the Third Party Administrator within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the last day of the month in which a timely COBRA premium payment was made. Once this coverage is terminated due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

D. The Notification Responsibilities of the Third Party Administrator.

When the Third Party Administrator is notified of a Qualifying Event, the Third Party Administrator will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Third Party Administrator will send the notice within 14 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

In order to protect your Dependents' rights, you should keep the Third Party Administrator informed of any change in your address or in the addresses of your Dependents.

E. Electing COBRA Continuation Coverage.

You or your Dependents must complete the COBRA Election Form and send it back to the Third Party Administrator in order to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.

2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.

3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any other eligible Dependents who were covered by the Plan on the date of the Qualifying Event.

4. The person electing COBRA Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of COBRA Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.

5. If the COBRA Election Form is not mailed back to the Third Party Administrator within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

F. When the COBRA Coverage Period Begins.

If you properly elect COBRA Continuation Coverage, the period of COBRA coverage (18, 29 or 36 months) begins on the date your eligibility or your Dependents' eligibility for coverage otherwise terminated under the Plan.

G. When COBRA Coverage Ends.

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group health plan. However, coverage will continue if you or an eligible Dependent was covered under another group health plan prior to the COBRA election, or if you or the eligible Dependent has a health problem for which coverage is excluded or limited under the other group health plan;

2. The required premium is not timely paid;

3. The Trustees terminate the Plan;

4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month applicable Continuation Coverage period;

5. Your coverage under the Plan ends and you become entitled to Medicare after you elect COBRA Continuation Coverage. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or

6. Your Dependents become entitled to Medicare after their coverage under the Plan ends.

2.09 Special Enrollment Rights.

If your eligible Dependent declines coverage under this Plan because he or she has other health insurance or group health plan coverage, federal law may allow your Dependent to enroll for coverage under this Plan when:

1. Your Dependent later loses the other health coverage; or

2. You acquire a Dependent through marriage, birth, adoption, or placement for adoption.

If the other health coverage was COBRA Continuation Coverage, a special enrollment is only available after the COBRA Continuation Coverage has been exhausted. If the other coverage is not COBRA Continuation Coverage, a special enrollment is available if your Dependent is no longer eligible for coverage or employer contributions for the other coverage.

To exercise your special enrollment rights, you must notify the Third Party Administrator within 60 days of the loss of other coverage or the date of marriage, adoption, or placement for adoption. To enroll your Dependent, you will need to complete, sign and submit an enrollment form to the Third Party Administrator.

If you are enrolling your Dependent after the other health coverage ends, coverage will become effective on the date your Dependent loses the other health coverage if your Dependent enrolls within 60 days after the date your Dependent loses the other health coverage. If enrollment occurs more than 60 days after the date your Dependent loses the other health coverage, coverage becomes effective on the date the Third Party Administrator receives the completed enrollment form.

Note that you must notify the Third Party Administrator in writing within 60 days of the date you acquire a Dependent due to that Dependent's loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, and within 60 days of the date your Dependent becomes eligible for any state-sponsored premium assistance subsidy program.

SECTION 3: DEATH BENEFIT

UNDER THE OPTIONAL BENEFITS PACKAGE

3.01 Eligibility for Death Benefit.

If you eligible for Active Employee Benefits, you may purchase the Death Benefit under the Optional Benefits Package. You must purchase a complete package of optional benefits. The amounts of the Death Benefit are provided in the Schedule of Benefits.

The Trustees contracted with an insurance carrier to provide this Death Benefit and benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Third Party Administrator.

3.02 Designating Your Beneficiary.

To designate your beneficiary, you must complete a form supplied by the Third Party Administrator and return the form to the Third Party Administrator. You may name more than one beneficiary and indicate the percentage of the Death Benefit you want each beneficiary to receive. If you do not specify the percentage for each beneficiary, your beneficiaries will share the benefit equally. If one of your beneficiaries dies before you, the benefit will be split equally among your remaining beneficiaries. You can change your beneficiary at any time by submitting a new form. Beneficiary designations are effective on the date you sign the form.

If you do not designate a beneficiary or if there is no named beneficiary still surviving at the time of your death, your Death Benefit is divided equally among the living members of the first surviving class listed below:

A. Your spouse;

B. Your children;

C. Your parents;

D. Your brothers and sisters; or

E. Your estate.

3.03 Conversion of Benefit.

If your Death Benefit terminates because your eligibility for this benefit ends or because the group insurance policy terminates, you may be eligible to convert your Death Benefit to an individual policy under the terms of the insurance carrier's policy. For more information regarding conversion, please contact the Third Party Administrator.

SECTION 4: ACCIDENTAL DISMEMBERMENT BENEFIT

UNDER THE OPTIONAL BENEFITS PACKAGE

4.01 Eligibility for Accidental Dismemberment Benefit.

If you are eligible for Active Employee Benefits as a Bargaining Unit Employee, you may purchase the Accidental Dismemberment Benefit under the Optional Benefits Package. You must purchase a complete package of optional benefits. The amounts of the Accidental Dismemberment Benefit are provided in the Schedule of Benefits.

The Trustees contracted with an insurance carrier to provide this Accidental Dismemberment Benefit and benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Third Party Administrator.

This benefit is payable to you if you sustain one of the losses listed in the Schedule of Benefits as the result of an Accident. The loss must occur within 365 days of the Accident. The benefit amounts are shown in the Schedule of Benefits and are in addition to any other benefits you may receive under the Plan. If you die as a result of the Accident, the benefit is paid to your beneficiary.

To qualify as a loss, the severance of a limb must occur above the wrist joint or ankle joint. Loss of sight means the irrecoverable and complete loss of sight. If more than one of the above losses is sustained as the result of the same Accident, benefits are paid only for the loss that pays the greatest amount.

4.02 Limitations on Accidental Dismemberment Benefits.

The benefits described above do not cover any loss that results from:

A. Bodily or mental illness or disease of any kind;

B. Ptomaine or bacterial infections, except infections caused by pyogenic organisms which occur with and through an accidental cut or wound;

C. Suicide or any attempted suicide;

D. Intentional self-inflicted injury;

E. Disease or infection, except pyogenic or septic infection of a visible wound accidentally sustained;

F. Participation in, or the result of participation in, the commission of an assault, felony, riot or a civil commotion;

G. War or act of war, declared or undeclared;

H. Medical or surgical treatment of an illness or disease;

I. Police duty as a member of any military, naval or air organization;

J. Parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activity except as a fare paying passenger on a commercial aircraft;

K. Driving while intoxicated, as defined by applicable state law;

L. Any poison or gas voluntarily taken, administered, absorbed, or inhaled; or

M. Any of the circumstances listed under the General Plan Exclusions in Section 12.

SECTION 5: SHORT-TERM DISABILITY BENEFIT UNDER THE OPTIONAL BENEFITS PACKAGE

5.01 Eligibility for Short-Term Disability Benefits.

If you are eligible for Active Employee Benefits as a Bargaining Unit Employee (Dependents are not eligible), you may purchase Short-Term Disability Benefits under the Optional Benefits Package. You must purchase a complete package of optional benefits.

To be eligible to receive Short-Term Disability Benefits, you must be disabled as a result of a non-occupational Accident or non-occupational Sickness, not receiving wages from any Employer, and you must be covered under the Plan on the date your disability begins.

If you are entitled to any unemployment benefit under any state unemployment laws or entitled to disability benefits under any state workers' compensation law, employers' liability law or similar laws, then you are not entitled to Short-Term Disability Benefits under the Plan.

5.02 Payment of Short-Term Disability Benefits.

The amount of the Short-Term Disability Benefit payable is provided in the Schedule of Benefits. If you are disabled for part of a week, you will receive 1/7 of the weekly benefit for each day of disability. The Plan will withhold your share of FICA tax from each weekly payment made to you and will send it to the government. You must include the weekly benefits you receive in your gross income and pay Federal Income Tax on them at the end of the tax year. If you have questions about how this works, you should consult a competent tax advisor or legal counsel.

Benefits will start on the 1st day of disability due to a non-occupational Accident. For disabilities due to a non-occupational Sickness, benefits will commence on either the first day of Hospital confinement or on the 8th day of disability if you are not confined to a Hospital. This Benefit is payable for up to 26 weeks for any one continuous period of disability. For each week you are paid benefits under this Section, the Fund will credit you with 25% of your monthly premium to continue your Active Employee Benefits under the Plan.

If you have successive periods of disability that are the result from the same or related causes, they will be considered one continuous period of disability.

Alternatively, if the second period of disability is due to a non-occupational Accident or non-occupational Sickness entirely unrelated to the cause of the first disability and the second disability begins after you have returned to work in Covered Employment for at least sixty (60) days or you are available for work with the Union, then the second disability will be considered as a new period of disability and you will be eligible for a new 26-week period of Short-Term Disability Benefits.

5.03 Limitations on Your Short-Term Disability Benefits.

No Short-Term Disability Benefits will be paid (1) for any period for which your disability is not certified by a Physician and you are not under the care of a Physician; or (2) if your loss is caused by any of the items listed in the General Plan Exclusions in Section 12.

SECTION 6: MAJOR MEDICAL BENEFIT

6.01 Eligibility for Major Medical Benefit.

You are eligible for the Major Medical Benefit if you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits.

6.02 Open Enrollment.

Open enrollment is the designated time each year for you to update or confirm your enrollment information, or change your benefit coverage option (if applicable). You must re-enroll every year to verify or update your enrollment information, even if you do not have changes to make. Completing open enrollment every year ensures that you and your eligible Dependents have coverage for the next year beginning on January 1st, so that you can avoid any delayed or unpaid claims.

The open enrollment period is generally offered from November 1 through November 30. You will receive information from the Third Party Administrator that allows you to update or confirm your benefit coverage options. You must return your executed enrollment form to the Third Party Administrator by November 30.

If you timely return your executed enrollment form, your new benefit coverage options shall become effective for services provided on or after January 1. If you do not make an election during the open enrollment period, you will keep the coverage you had the previous year. Please be aware that enrollment into an Optional Benefits Package cannot be revoked until the next open enrollment period.

Generally, Active Employees have three plans from which to choose: (1) Premier Plan; (2) Standard Plan; and (3) Basic Plan. If an Active Employee does not choose a plan when he or she initially becomes eligible for coverage, the Active Employee shall automatically be enrolled in the Standard Plan (i.e., the "Default Plan"). The benefit amounts are shown in the Schedule of Benefits.

Active Non-Bargaining Unit Employees and Flat Rate Employees are only eligible for the Standard Plan, and Pre-Medicare Retirees are only eligible for the Pre-Medicare Retiree Plan. The benefit amounts are shown in the Schedule of Benefits.

6.03 The Deductible.

The Deductible is the amount of Covered Medical Expenses that you and your eligible Dependents pay each calendar year before benefits begin. The amounts of the individual and family Deductibles are shown in the Schedule of Benefits.

The family Deductible may be satisfied through any combination of individual Deductibles. Once you meet the family Deductible, no further Deductible will be applied to any eligible member of your family during the remainder of the calendar year. Additionally, the PPO Deductibles and Non-PPO Deductibles are separate and do not apply towards each other.

In the event that your Deductible is not satisfied in a calendar year, any Covered Medical Expenses incurred and applied toward your Deductible in the last ninety (90) days of a calendar year will also be applied in the same amount toward your Deductible for the following calendar year.

6.04 Percentage of Benefits Payable.

Once you pay the calendar year Deductible, the Fund will pay the percentage of your Covered Medical Expenses listed in the Schedule of Benefits up to the UCR Charges and up to any Plan maximums.

6.05 Out-of-Pocket Maximum.

The maximum amount you pay for Covered Medical Expenses each calendar year is the out-of-pocket maximum listed in the Schedule of Benefits. Once you reach the applicable out-of-pocket maximum, the Plan pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the remainder of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

Amounts that apply towards the Non-PPO out-of-pocket maximums apply towards the PPO out-of-pocket maximums and vice versa. The amounts excluded from the out-of-pocket maximums are provided in the Schedule of Benefits.

6.06 Preferred Provider Organization (PPO).

The Welfare Fund contracts with Preferred Provider Organizations ("PPOs") to help control medical costs. A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower as a result of our participation in the PPO.

To minimize your out-of-pocket costs, contact the plan's Third Party Administrator for information about which Hospitals and providers are in the Plan's PPO network. Although you are not required to use the PPO Hospitals and providers, when you use PPO Hospitals and providers rather than non-PPO Hospitals and providers, you can reduce costs for both you and the Fund. To receive a list of PPO Hospitals and providers free of charge, please contact the Third Party Administrator.

6.07 Pre-Certification, Case Management and Utilization Review.

The Fund has contracted with a provider to perform pre-certification, case management and utilization review.

A. Pre-Certification.

Pre-certification is the process of obtaining approval from the Fund before you have certain procedures performed. Pre-certification is mandatory for all Inpatient Hospital admissions, including observation stays, Inpatient or outpatient surgeries, diagnostic tests, home health care, hospice, skilled nursing care, private duty nursing, MRIs, CAT scans and other outpatient diagnostic testing, physical therapy and medical equipment purchases/rentals. If you are expecting to incur expenses for these types of treatment, you, someone on your behalf, or your Physician must contact the care management organization to obtain pre-certification prior to incurring the expense.

Other selected procedures, medical supplies, and/or therapy also require pre-certification to ensure that the service is Medically Necessary and meets standard guidelines for care. Before you receive treatment recommended by your Physician, you or your Physician should view the pre-certification list of selected procedures, medical supplies, or therapies by contacting the Fund's care management organization. Once you have provided the necessary information, the care management organization will evaluate the proposed services based on your individual treatment needs and the standards of the community.

Please remember that pre-certification does not verify eligibility for benefits or guarantee benefit payments under the Plan. Pre-certification also does not constitute a guarantee or warranty of the quality of treatment you receive.

Additionally, if you fail to contact the care management organization for any services that require pre-certification, all charges incurred will be subject to an additional **$250 penalty** before any payment is made by the Plan. The penalty may not be applied towards any Deductible, Co-payment, co-insurance or out-of-pocket maximum.

B. Case Management and Utilization Review.

Case management is a process in which you as the patient, your family, Physician and/or other health care providers and the Fund work together under the guidance of the Fund's care management organization to coordinate a quality, timely and cost-effective treatment plan that provides Medically Necessary services. Participation in the case management program is voluntary, but the Fund encourages you to explore how this benefit can help you manage your disease or injury.

Utilization review is the evaluation of the necessity, appropriateness and efficiency of medical services, procedures and facilities.

6.08 Centers of Excellence.

The Plan offers an incentive for using "Centers of Excellence" for certain approved procedures because the health care facility you select can have a direct impact on the care you receive and your procedure results. A Center of Excellence is a facility that has been identified as having proven expertise in delivering specialty care and positive outcomes for certain procedures. The Plan recognizes the Blue Cross/Blue Shield "Blue Distinction Centers" as Centers of Excellence.

You may be eligible for the incentive(s) described below with respect to treatment and procedures related to the following services when performed at a Blue Distinction Center:

A. Cardiac Care.

1. Cardiac Surgery (Coronary Artery Bypass Graft – CABG)
2. Percutaneous Coronary Intervention – PCI

B. Treatment for Complex and Rare Cancers.

1. Bladder Cancer
2. Bone Cancer (Primary)
3. Brain Cancer (Primary)
4. Esophageal Cancer
5. Gastric Cancer
6. Head and Neck Cancer
7. Liver Cancer (Primary)
8. Ocular Melanoma

9. Pancreatic Cancer

10. Rectal Cancer

11. Soft Tissue Sarcomas

12. Thyroid Cancer (Medullary or Anaplastic)

13. Acute Leukemia (Inpatient/Non-Surgical)

C. Spine Surgery.

1. Laminectomy Inpatient

2. Spinal Fusion (Anterior) Inpatient

3. Final Fusion (Posterior) Inpatient

D. Transplants.

1. Heart, Liver, Bone Marrow/Stem Cell (Adult and Pediatric)

2. Lung and Pancreas (Adult Only)

E. Bariatric Surgery.

F. Knee and Hip Replacements.

The Plan will reimburse you and/or your eligible Dependents for certain reasonable and customary travel expenses up to $150.00 per day for travel expenses associated with receiving care at a Blue Distinction Center outside of fifty (50) miles from your primary place of residence. Reimbursement of travel expenses shall be subject to a calendar year maximum of $5,000.00. All incentives must be pre-authorized by the Fund. You should contact the Fund prior to your treatment or procedure to determine whether you are eligible to receive the applicable incentive. To receive the incentive, you must provide any documentation and/or claim form as required by the Fund.

6.09 Covered Medical Expenses and Exclusions.

A. Expenses Covered under the Plan.

The Plan covers the Usual, Customary and Reasonable Charges ("UCR Charges"), subject to the Plan maximums and limitations provided in the Schedule of Benefits for the following services and supplies (Covered Medical Expenses) provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:

(a) Room and board fees up to:

i. The Hospital's regular daily semi-private room rate; or

ii. The Hospital's regular daily rate for a private room when required for isolation.

(b) Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services, while hospitalized.

(c) Outpatient Hospital services including fees incurred for the following:

i. Outpatient surgical procedures; and

ii. Emergency treatment for an Accident or Sickness.

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

2. Medical care and treatment (including surgery) that is listed as a covered expense under the Plan and is provided by a legally qualified Physician or other qualified health care professional acting within the scope of their licensure as defined by state law.

3. Physical therapy administered by a provider acting within the scope of his or her license. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiologic principles.

4. Speech therapy and occupational therapy.

5. Services and supplies provided for respiratory therapy.

6. Radiation therapy and chemotherapy.

7. Second surgical opinions.

8. Anesthesia, anesthesia services and professional charges for administration. Benefits are not available when used to perform a non-covered service.

9. Expenses incurred for dialysis treatments of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

10. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It must be expected that the therapy will result in a significant improvement in the level of cardiac functioning.

11. Chiropractic care. Chiropractic treatments are subject to utilization review after twenty-six (26) visits.

12. Treatment of Chemical Dependency/Substance Abuse.

13. Sleep studies and CPAP (continuous position airway pressure) equipment.

14. Diagnostic x-ray and laboratory services, including electrocardiogram (EKG), electroencephalogram (EEG), magnetic resonance imaging (MRI), computed tomography (CT/CAT) scans, and other electronic diagnostic medical procedures.

15. Purchase, fitting, adjustment, repairs and replacement of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissue, or replace all or part of the function of a permanently useless or malfunctioning body part, such as an artificial limb.

    Covered Medical Expenses do not include the following: dental appliances, replacement of cataract lenses, unless needed because of a lens prescription change, garter belts or similar devices, elastic bandages, and orthopedic shoes which are not attached to braces or which are not otherwise deemed Medically Necessary.

16. Whole blood or blood plasma (not replaced or donated) and the cost of its administration.

17. Charges for oxygen and its administration.

18. Purchase and/or rental of Durable Medical Equipment. The Fund reserves the right to purchase the equipment instead of paying for rental if purchase would cost less than the reasonable and customary rental amount.

    Durable Medical Equipment means equipment that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder; (3) generally is not useful in the absence of illness or injury; and (4) is appropriate for use in the home.

    Examples of Durable Medical Equipment include, but are not limited to, the following: wheel chairs, Hospital beds and equipment for giving oxygen.

    Coverage for Durable Medical Equipment is not provided for (1) equipment that serves as a comfort or convenience item or (2) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

    Examples of equipment that are not covered include, but are not limited to, the following: exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, whirlpool tubs, waterbeds and portable Jacuzzi pumps.

19. Home health care services and supplies where:

    (a) The home health care is provided by a qualified Home Health Care Agency in lieu of Hospital confinement or Skilled Nursing Care Facility confinement;

    (b) The home health care services must be prescribed in writing by a Physician as a plan of treatment for a condition; and

    (c) Prior approval is obtained in advanced by the care management organization.

    Covered Medical Expenses for home health care services include charges incurred for the following services and supplies:

    (a) Professional services of a registered or licensed practical nurse;

(b) Treatment by physical means, occupational therapy or speech therapy;

(d) Medical and surgical supplies;

(e) Prescription Drugs;

(f) Oxygen and its administration;

(g) Medical social services, such as the counseling of patients; and

(h) Home health aide visits when you are also receiving covered nursing or therapy services.

Covered Medical Expenses do not include dietitian services, homemaker services, food or home delivered meals, and Custodial Care.

20. Hospice care services and supplies provided in accordance with the following rules and requirements:

(a) The attending Physician must certify that the patient's life expectancy does not exceed six (6) months.

(b) Services must be approved in advance by the care management organization.

(c) The services must be provided by a facility which meets the Plan's definition of Hospice Organization.

Covered expenses include reasonable and necessary services for the care or management of the terminal illness as well as related conditions, including the following:

(a) Continuous home care when at least eight (8) hours of daily care is required during crisis periods in which the covered person elects not to be hospitalized.

(b) Routine home care.

(c) General Inpatient care when continuous care is provided in the Hospital or similar facility and when less intensive care is not provided.

(d) Respite Inpatient care, up to a maximum of five (5) consecutive days, when short term Inpatient care is required in a Hospital, nursing home or free-standing hospice facility in order to relive the family from home care duties. Benefits for respite Inpatient care shall be paid only when the patient does not require intensive care and when general inpatient benefits are not payable.

(e) Physician services.

21. Transportation services provided by a Hospital or a professionally licensed ambulance service where:

(a) The transportation is by a vehicle designed and equipped and used only to transport the sick and injured;

(b) The transportation is from the scene of an Accident or medical Emergency to a Hospital or between Hospitals;

(c) The trip is to the closest facility that can give the appropriate services for the condition; and

(d) Certification by an attending Physician must be received indicating that transportation using ground facilities would not have been appropriate due to the life threatening and Emergency nature of the Accident or illness.

A maximum of two (2) trips per confinement will be provided.

22. Care provided in a Skilled Nursing Care Facility when:

(a) A legally qualified Physician certifies (initially and every two (2) weeks) that the confinement is necessary for your recuperation from an injury or Sickness and that the confinement is not for the purpose of Custodial Care; and

(b) Prior approval is obtained in advanced by the care management organization.

No benefits are payable once a patient can no longer significantly improve from treatment for the current condition as determined by the Plan.

23. Professional services rendered by a Physician.

24. Private duty nursing services. Services must be approved in advance by the care management organization.

25. Allergy testing and treatment.

26. Expenses incurred as a direct result of an accidental injury to the jaw and sound natural teeth, including the initial replacement of these teeth and any necessary dental x-rays. Oral surgical procedures are covered as follows:

(a) Operative and cutting procedures provided for the treatment of diseases and injuries of the mandible and maxilla;

(b) Surgical removal of impacted wisdom teeth, whether partially or completely covered by bone or soft tissue;

(c) Dental root resection (apicoectomy);

(d) Excision of tumors and cysts;

(e) Alveolectomy; and

(f) Gingivectomy.

27. Non-experimental or non-investigative organ and tissue transplants, including patient screening, organ procurement and transportation, and surgery for the patient and a live human donor performed at a Blue Distinction Center for Specialty Care® or a facility approved by the Plan prior to operation.

Covered expenses also include reasonable and necessary transportation and lodging for the covered person and one companion (two companions if the recipient is a Dependent child), up to the current benefit limits set forth in the Internal Revenue Code. Itemized receipts for transportation and lodging expenses must be submitted in a form satisfactory to the Plan. To ensure that you receive the proper payment, please contact the Plan prior to entering an organ transplant program.

Transportation and lodging expenses do not include the following:

(a) Child care;

(b) Mileage within the medical transplant facility city;

(c) Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Plan;

(d) Frequent Flyer miles;

(e) Coupons, vouchers, or travel tickets;

(f) Prepayment or deposits;

(g) Services for a condition that is not directly related to, or a direct result of, the transplant;

(h) Telephone calls;

(i) Laundry;

(j) Postage;

(k) Entertainment;

(l) Interim visits to a medical care facility while waiting for the transplant procedure;

(m) Travel expenses for donor companion/caregiver;

(n) Return visits for the donor for treatment of a condition found during the evaluation; and

(o) Standard meals.

28. Reconstructive surgery to correct conditions resulting from accidental injuries, unless considered to be cosmetic.

29. Medical and surgical benefits for mastectomies as required by federal law under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), including the following, when requested by the patient in consultation with her Physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of all stages of mastectomy including lymphedemas.

30. Treatment for Mental/Nervous Disorders. Treatment also includes family or group therapy where the patient is a covered person and is a participant in the therapy session.

31. Treatment for behavioral problems or learning disabilities.

32. Treatment or surgery for one occurrence of morbid obesity if the covered person:

    (a) Has a documented five (5) year history of morbid obesity (body mass index over 40 kg/m2), or a BMI greater than 35 and a clinically serious condition such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or hypertension;

    (b) Is treated in a surgical program with experience in obesity surgery and which includes a multidisciplinary preoperative and postoperative approach;

    (c) Participates in a six-month treatment plan within the year preceding surgery that includes a multidisciplinary non-surgical program including a low or very low calorie diet, increased physical activity and behavior reinforcement under the direction of the Physician who refers the patient for such surgery;

    (d) Has a documented failure of non-surgical methods of weight reduction;

    (e) Has an absence of significant psychopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations;

    (f) Documents that he or she has received counseling post-operatively regarding cosmetic difficulties and that the patient has agreed to post-operative treatment plans; and

    (g) Is at least eighteen (18) years of age.

    Treatment must be ordered by a Physician and services must be approved in advance by the care management organization. **Additionally, any copayments or coinsurance payments will not apply toward satisfying any out-of-pocket maximum**.

33. One routine colonoscopy per calendar year.

34. One routine gynecological examination and Pap smear per calendar year.

35. One routine bilateral mammogram per calendar year.

36. One routine prostate examination and related prostate-specific antigen (PSA) test per calendar year.

37. One routine physical examination by a Physician for individuals over eighteen (18) years of age per calendar year.

38. Routine immunizations for individuals over eighteen (18) years of age.

39. Routine well newborn and child care, including physical examinations, development assessments, anticipatory guidance and laboratory services and immunizations.

40. Preventive Services in accordance with federal law, including the following:

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided in (d) below;

(b) Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is on the Immunization Schedules of the Centers for Disease Control and Prevention);

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) With respect to women, to the extent not described in paragraph (a) above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The following rules will apply with respect to charging for Physician office visits that include covered Preventive Services:

(a) If a Preventive Service is billed separately (or tracked separately) from an office visit, the Plan will impose the applicable cost-sharing provisions with respect to the office visit;

(b) If a Preventive Service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is the delivery of the Preventive Service, then the Plan will not impose the applicable cost-sharing provisions with respect to the office visit; and

(c) If a Preventive Service is not billed separately (or is not tracked separately) from an office visit, and the primary purpose of the office visit is not the delivery of the Preventive Service, then the Plan will impose the applicable cost-sharing provisions with respect to the office visits.

41. Charges for "routine patient costs" incurred by a "qualified individual" who is participating in an "approved clinical trial." For purposes of this benefit, the following applies:

(a) A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

(b) "Routine patient costs" generally include all items and services that typically would be covered under the Plan for an individual not enrolled in a clinical trial. Routine patient costs do not include the actual device, item or service that is being studied. Also excluded are items and services that are given only to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or a service that is clearly consistent with widely accepted and established standards or care for a particular diagnosis.

(c) An "approved clinical trial" means a Phase I, II, III, or IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening

condition means any disease or condition from which death is likely unless the disease or condition is treated.

42. Injectable medications and specialty medications (and corresponding hypodermic needles and/or syringes for such medications). Where access to certain covered injectable medications and specialty medications is not available under the Major Medical Benefit, the injectable and specialty medications may be obtained under the Prescription Drug Benefit, but shall be paid by the Fund using the Major Medical Benefit payment structure.

43. Hearing aids and examinations up to the maximum benefit specified in the Schedule of Benefits.

44. Diabetes self-management training and education.

45. Telemedicine services.

46. Any expenses related to hypnosis and/or acupuncture.

47. Basic membership to a recognized gym or fitness facility such as the YMCA or Planet Fitness up to the maximum benefit specified in the Schedule of Benefits. Proof of basic membership and paid cost must be submitted to the Third Party Administrator for reimbursement.

48. Any procedures or services covered under the Plan as listed above that are rendered by a qualified Physician or other qualified health professional acting within the scope of his or her licensure as defined by state law.

B. Medical Expenses Not Covered under the Plan.

Certain expenses are excluded from coverage. The Major Medical Benefit does not cover:

1. Services or supplies that are not Medically Necessary, as determined by the Plan Administrator.

2. Services or supplies in excess of any maximum benefit or limitation specified in the Plan.

3. Services or supplies that are not specifically listed as a covered expense under the Major Medical Benefit.

4. Services or supplies received by a person, facility or organization acting outside the scope of the applicable license.

5. Services, supplies, treatments or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational Accident or Sickness, unless specifically identified as being covered under the Plan.

6. Services or supplies for the treatment of autism.

7. Any type of rest cure or Custodial Care (care that is designed primarily to assist a person in meeting the activities of daily living (i.e., milieu therapy) regardless of what the care is called.

8. Private duty nursing services rendered in a Hospital.

9. Any losses, expenses or charges for cosmetic surgical procedures and related expenses, except for conditions resulting from accidental injuries. Examples of cosmetic surgery include, but are not limited to the following:

(a) Reduction mammoplasty (breast reduction surgery);

(b) Augmentation Mammoplasty (breast enlargement surgery), unless part of reconstruction following breast surgery due to a mastectomy;

(c) Rhinoplasty (plastic surgery on the nose), unless the result of an Accident or chronic nasal obstruction;

(d) Otoplasty (plastic surgery on the ears);

(e) Blepharoplasty (repair of drooping eyelids), unless the droop restricts field of vision as verified by an ophthalmologist;

(f) Rhytidectomy (face lift);

(g) Dyschromia (tattoo removal);

(h) Panniculectomy (sometimes called a "tummy tuck"); and

(i) Genioplasty (chin augmentation).

10. Reversal or attempted reversal of vasectomies or other sterilization procedures.

11. Any type of drugs or medications, procedures, tests, examinations, treatments or care provided for or in connection with infertility, including artificial insemination or any related procedure such as in vitro or in vivo fertilization and egg implantation.

12. Any charges in connection with medical services rendered to a surrogate or surrogate fees.

13. Any expenses or charges for chelation therapy.

14. Topical anesthetics or stand-by charge for anesthesia.

15. Any expenses or charges for sex transformation.

16. Any expenses or charges for treatment related to sexual dysfunction, unless the dysfunction is the result of an organic disease.

17. Any expenses or charges for penile implants.

18. Any expenses or charges related to temporomandibular jaw joint (TMJ) disorder.

19. Abortion procedures unless the life of the mother is endangered or the pregnancy is a result of a criminal act.

20. Massage therapy.

21. Travel or transportation except as specifically provided.

22. Charges that are payable by Medicare Part A or Medicare Part B where the claimant is eligible for Medicare.

23. Dietary or nutritional counseling and supplements, except as required under federal law.

24. Non-prescription items, including over-the-counter drugs or supplies, vitamins, and other non-prescription items, except as specifically provided.

25. Services, supplies, treatments or surgical procedures rendered in connection with obesity or an overweight condition except as specifically provided.

26. Air conditioners, air-purification units, humidifiers, dehumidifiers, allergy-free pillows, blankets, mattresses, exercising equipment, electors or elevators or chair lifts, waterbeds, or whirlpools.

27. Special home construction or vehicle modification.

28. Services or supplies that are in the nature of education or vocational testing and training.

29. Education, training, or room and board while a person is confined in an institution which is primarily a school or other institution for training.

30. Homemaking services, such as housekeeping, or meal preparation.

31. Charges for services or supplies which constitute personal comfort or beautification items. Examples of items that are not covered include, but are not limited to, the following: personal hygiene items, hair appointments, magazines, cosmetics, television, or telephone services.

32. Charges for any of the circumstances listed under the General Plan Exclusions in Section 12.

SECTION 7: RETIREE MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN

7.01 Eligibility for Medicare Advantage and Prescription Drug Plan.

You are eligible for the Medicare Advantage and Prescription Drug ("MAPD") Plan if you are eligible for Retiree Benefits and Medicare.

You **MUST** also be enrolled in Medicare Parts A and B and pay your Medicare Part B premium to be eligible for coverage under the MAPD Plan.

7.02 Benefits for Retirees under the MAPD Plan.

The MAPD Plan provides all of the benefits of original Medicare Parts A and B and Medicare Part D prescription drug coverage.

The MAPD Plan provides access to a national network of service providers. The network includes doctors, hospitals and ancillary providers. The MAPD Plan will pay for services provided by any physician, facility or hospital that accepts Medicare assignment and agrees to the MAPD Plan's payment terms and conditions.

Please be aware that the Trustees contracted with an insurance carrier to provide the MAPD Plan and this benefit will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Third Party Administrator.

SECTION 8: PRESCRIPTION DRUG BENEFITS

8.01 Eligibility for Prescription Drug Benefits.

The Prescription Drug Benefit applies to you if you are eligible for Active Employee Benefits, or if you are eligible for Pre-Medicare Retiree Benefits. The benefit amounts are shown in the Schedule of Benefits.

8.02 General Information.

The Prescription Drug Benefit covers Prescription Drugs and is administered by a prescription benefit manager ("PBM"). Accordingly, this benefit is subject to the contractual agreements between the Plan and the PBM.

8.03 The Drug Card Program.

You should have already received a packet of materials regarding the Prescription Drug Card Program and the Mail Order Program. The packet includes a list of participating pharmacies and details about how to use the programs. If you have not received those materials, please contact the Third Party Administrator.

When you or your Dependents need to have a prescription filled or refilled, you should:

A. Go to a participating pharmacy;

B. Show the pharmacist your identification card; and

C. Pay the pharmacist the applicable Co-Payment per prescription.

In some instances, you may be required to have pre-authorization or to submit additional information prior to payment being made by the Plan. When this occurs, contact the PBM at the number listed on your identification card for more information. In the event that you are required to pay the full cost of the Prescription Drug which is covered by this Plan, you need to submit a claim form to receive reimbursement.

8.04 The Mail Order Program.

You may use the Mail Order Program to order up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. You are encouraged to use this service for maintenance medications. Maintenance medications are medications you or your Dependents take for long periods of time for chronic conditions such as high blood pressure, heart conditions, diabetes, asthma, and arthritis.

If your Physician prescribes a long-term medication that you need right away, you may want to ask the Physician to write two prescriptions – one prescription to be filled at a participating pharmacy using the Drug Card Program, and one prescription for the remainder of the medication to be submitted to the Mail Order Program.

For more information on the Mail Order Program, please contact the Third Party Administrator or PBM.

8.05 Covered Prescription Drugs.

Unless otherwise excluded, the Prescription Drug Benefit covers Medically Necessary prescriptions by a Physician. For a complete list of covered Prescription Drugs, you may contact the PBM. The following are examples of covered Prescription Drugs:

A. All federal legend drugs;

B. State restricted drugs;

C. Compound medications; and

D. Contraceptives as required under federal law.

8.06 Excluded Drugs.

The following list provides examples of medications that are not covered under the Plan:

A. Drugs you can purchase without a prescription;

B. Over-the-counter medication or medical supplies other than diabetic supplies;

C. Fees for administering or injecting Prescription Drugs;

D. Charges for more than a 90-day supply of Prescription Drugs;

E. Any refill of a Prescription Drug, dispensed after one (1) year from the date of the original prescription order;

F. Prescription Drugs consumed or administered at the location where the prescription order is issued;

G. Replacement prescriptions (lost, stolen or broken);

H. Experimental, Investigational or unproven drugs;

I. Infertility medications;

J. Therapeutic devices;

K. Artificial appliances;

L. Hypodermic needles, syringes, or comparable medical supplies, devices or appliances;

M. Durable medical equipment;

N. Allergy serums;

O. Drugs intended for cosmetic purposes only;

P. Weight loss medications;

Q. Vaccines (unless required under federal law), immunization agents or biological sera.

8.07 Preferred Drugs, Non-Preferred Drugs and the Specialty Drug Program.

A. Preferred and Non-Preferred Drugs.

The amount of your Prescription Drug Co-Payment will depend on whether the drug is Preferred or Non-Preferred as listed in the Schedule of Benefits. Preferred Drugs are brand drugs which are considered formulary. Non-Preferred Drugs are brand drugs which are considered non-formulary.

Please note that Prescription Drugs may change from Preferred and Non-Preferred (and vice versa) over time. For more information about which drugs are Preferred or Non-Preferred, please contact the PBM at the telephone number provided on your identification card.

B. Specialty Drug Program.

Specialty drugs include oral, injectable, infused or inhaled medications that are either self-administered or administered by a healthcare provider, and used or obtained in either an outpatient or home setting.

Generally, the Plan covers specialty drugs under the Major Medical Benefit. However, the Plan does cover specialty drugs under the Prescription Drug Benefit when access is not available under the Major Medical Benefit. Specialty drugs provided under the Prescription Drug Benefit will be covered under the Major Medical Benefit payment structure.

8.08 Mandatory Generic Drug Program.

If you have a prescription filled with a brand drug when a generic is available, you will pay the applicable brand drug Co-Payment (Preferred or Non-Preferred) as well as the difference between the cost of the generic and the brand drug, unless your Physician checks "Dispense as Written" (DAW).

The generic name of a drug is its chemical name and the brand name is the trade name under which the drug is advertised and sold. Both generic and brand name drugs must meet the same federal requirements for safety, purity and strength.

If your Physician prescribes a brand name drug with a generic equivalent, ask if you can use the generic version instead. If you are unsure if there is a generic equivalent for a brand drug, please contact your Physician, pharmacist or the PBM.

8.09 Out-of-Pocket Maximum.

The maximum amount you pay for expenses under the Prescription Drug Benefit each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Plan pays 100% of all covered Prescription Drug Benefit expenses for the rest of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

SECTION 9: DENTAL BENEFIT UNDER THE OPTIONAL BENEFITS PACKAGE

9.01 Eligibility for Dental Benefit.

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, you may purchase the Dental Benefit under the Optional Benefits Package. You must purchase a complete package of optional benefits. Medicare Retirees are not eligible to purchase the Dental Benefit.

9.02 Payment of Dental Expenses.

The Dental Benefit pays the percentage listed in the Schedule of Benefits. Covered dental expenses are considered to have been incurred on the day the service is rendered. When the complete service is not performed in one day, only the expense for that portion of the completed service will be considered incurred.

9.03 Covered Dental Expenses.

The following list provides examples of covered dental expenses, including services and supplies provided by a Dentist or provided under a Dentist's supervision.

A. Diagnostic and Preventive Expenses.

1. Oral examinations and prophylaxis cleanings;
2. Fluoride treatments;
3. Dental sealants;
4. Space maintainers;
5. Emergency palliative treatment for pain relief; and
6. Dental x-rays, including full mount x-rays, supplementary bitewing x-rays, and other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

B. Other Covered Dental Expenses.

1. Amalgam, synthetic porcelain, and plastic fillings;
2. Treatment of gums and other supporting structures of the teeth;
3. Endodontic treatment, including root canal therapy;
4. Repair of fillings, bridges, dentures, inlays, or crowns; and
5. Simple extractions.

9.04 Exclusions and Limitations.

Benefits shall not be paid by this Plan for any of the following services or supplies:

A. Dental services or supplies which are covered under the Major Medical Benefit;

B. Treatment by persons other than a licensed Dentist, except that cleaning and scaling of teeth and topical applications of fluoride may be performed by a licensed dental hygienist under the supervision and direction of a Dentist;

C. Services rendered by a Dentist and/or oral surgeon beyond the scope of his or her license;

D. Charges for the replacement of lost, stolen or missing dental appliances;

E. Any services payable under workers' compensation or employer's liability laws;

F. Services rendered prior to the date you became eligible for benefits;

G. Services rendered after your eligibility ends;

H. Charges for failure to keep scheduled appointments or charges for completion of claim forms; and

I. Any of the items listed in the General Plan Exclusions in Section 12.

SECTION 10: VISION BENEFIT UNDER THE OPTIONAL BENEFITS PACKAGE

10.01 Eligibility for Vision Benefit.

If you are eligible for Active Employee Benefits or Pre-Medicare Retiree Benefits, you may purchase the Vision Benefit under the Optional Benefits Package. You must purchase a complete package of optional benefits.

10.02 Covered Expenses.

The following list provides examples of covered vision expenses under the Plan, subject to the Schedule of Benefits:

A. Professional examinations by an ophthalmologist or optometrist;

B. Lenses prescribed by either an ophthalmologist or optometrist for corrected vision;

C. Frames;

D. Contact lenses; and

E. Refractive surgery, which includes but is not limited to, LASIK, photorefractive keratectomy (PRK), radial keratotomy, astigmatic keratotomy (AK), lamellar keratoplasty (LK), INTACS, and non-cataract lens implementation.

10.03 Exclusions and Limitations.

Benefits shall not be paid by this Plan for any of the following:

A. Services rendered prior to the date you became eligible for benefits;

B. Services rendered after your eligibility ends;

C. Any services payable under workers' compensation or employer's liability laws;

D. Charges for failure to keep scheduled appointments or charges for completion of claim forms; and

E. Any of the items listed in the General Plan Exclusions in Section 12.

10.04 Discount Vision Program.

If you are eligible for Active Employee Benefits or Retiree Benefits, you have access to the VSP Vision Savings Pass. You do not have to purchase the Vision Benefit under the Optional Benefits Package to have access to the program. The VSP Vision Savings Pass provides discounts on eye exams, contact lenses and frames. For more information regarding the program, please contact the Third Party Administrator.

SECTION 11: HEALTH REIMBURSEMENT ARRANGEMENT

11.01 General Provisions and Eligibility.

The Plan provides for a Health Reimbursement Arrangement (HRA) as approved in Treasury Department Notice 2002-45 and Revenue Ruling 2002-41. The HRA is designed to reimburse you for qualified medical expenses under Section 213 of the Internal Revenue Code that are incurred by you or your Dependents on a tax free basis.

A. HRA Component of Reserve Dollars Bank.

Eligible Active Bargaining Unit Employees and Retirees can withdraw amounts from the HRA component of their Reserve Dollars Bank to cover specified expenses that are related to, but not payable under the regular provisions of the Plan. You must have more than $10,000.00 in your Reserve Dollars Bank to request reimbursement.

B. Supplemental HRA.

Eligible Active Bargaining Unit Employees and Retirees can withdraw amounts from their Supplemental HRA to cover specified expenses that are related to, but not payable under the regular provisions of the Plan. Your Supplemental HRA balance is equal to the dollar value transferred to your Supplemental HRA from the Sheet Metal Workers Local No. 33 Retiree Health Fund on June 1, 2010, less any disbursements made.

11.02 Description of HRA.

The Fund keeps track of your HRA as a bookkeeping entry. HRAs are not funded or vested and no interest is credited. The HRA and the amounts in the HRA accounts are subject to amendment or termination at the Board's discretion.

If the Fund issues a reimbursement check to you for an HRA covered expense, your account balance will be reduced by the amount of such reimbursement. Your account balance will be carried over from year to year, except as specified below. Neither the Contributions to your account nor the reimbursements paid from it will be considered taxable income to you.

11.03 Your HRA is Not a Vested Benefit.

You and your Dependents are not vested in your HRA balances. Amounts accumulated in your HRA can only be used for HRA Covered Expenses, subject to the rules and provisions set forth in this Section.

Benefits payable under the HRA shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

11.04 HRA Reimbursements.

Your entitlement to reimbursement and the amount of any such reimbursement made by the Third Party Administrator will be based on your HRA balance at the time the reimbursement check is requested. You may receive reimbursement from your HRA for the types of expenses specified below.

A. Covered Expenses.

Covered expenses are "qualified medical expenses" under Section 213 of the Internal Revenue Code ("IRC"). Examples of such reimbursable expenses include the following:

1. Deductibles and Co-Payments under the Plan;

2. Medical expenses not covered by or in excess of the benefits provided under the Major Medical Benefit;

3. Guide dogs for visually impaired or hearing impaired persons;

4. Certain travel expenses when necessary to receive essential medical care, and the travel and lodging expenses of another family member whose presence is necessary for the treatment. The patient's Physician must certify that the family member's presence is necessary for the treatment;

5. Special telephone and television equipment for hearing impaired persons;

6. Smoking cessation programs;

7. Expenses for dental treatment, including orthodontia;

8. Vision expenses, including surgery or laser treatments to correct vision;

9. Hearing aids and examinations;

10. Schooling for the mentally impaired or physically disabled;

11. Acupuncture;

12. Prescriptions and over-the-counter medications, provided that such items are accompanied by a written prescription and generally accepted as medicine and drugs. Such items shall not include toiletries, sundries or cosmetics; and

13. Weight loss programs to treat a specific disease diagnosed by a Physician, but not food or dietary supplements.

B. Exclusions.

No reimbursement will be made from your HRA for expenses that are not listed as "qualified medical expenses" in Section 213(d) of the IRC. Examples of expenses that are not covered include the following:

1. Cosmetic surgery and treatment;

2. Child and elder care;

3. Funeral expenses;

4. Household help;

5. Health club memberships and expenses;

6. Maternity clothes;

7. Premiums for coverage through a state or federal Health Insurance Marketplace ; and

8. Expenses for which reimbursement can be made by some other source, including, but not limited to, benefits provided by another benefit or insurance plan.

11.05 Submitting Reimbursement Requests.

Reimbursements from your HRA are subject to the following provisions:

A. The Plan will not issue a reimbursement that will cause your Reserve Dollars Bank balance to be less than $10,000.00 at the time the reimbursement request is processed.

B. Reimbursement requests may be submitted at any time.

C. You must submit your claim request in writing to the Third Party Administrator. Copies of itemized bills and/or proof of payment suitable to the Trustees must also be submitted. Claims must include a copy of the explanation of benefits (EOB) provided by any other plan covering the claimant, if any.

D. Reimbursement requests must be submitted no more one (1) year following the end of the calendar year in which the services were rendered.

E. The Plan will not reimburse you for any expense that is payable by another source, including, but not limited to, another insurance plan or government program. The total combined reimbursement from all benefit/insurance plans when added to the amount of the requested reimbursement cannot exceed 100% of the billed amount.

F. Reimbursements will not be made for any expenses not specifically listed above.

11.06 Reimbursements.

Upon receipt of a reimbursement request for an HRA Covered Expense that has been submitted in accordance with the provisions of this Section, the Third Party Administrator will issue you a reimbursement check. This check will generally be issued within 30 days of your request for the amount of the Covered Expense, up to, but not to exceed the amount of your account balance. Once the check has been issued, the Third Party Administrator will deduct the amount of such reimbursement from your HRA.

11.07 Your Right to Opt-Out.

You may choose to permanently opt-out of the HRA component of your Reserve Dollars Bank or your Supplemental HRA and forfeit your right to reimbursement at any time by notifying the Third Party Administrator in writing. Any balance in your account as of the date the Third Party Administrator receives notice of such opt-out will be permanently forfeited.

11.08 Forfeiture of HRA Balance.

The HRA component of your Reserve Dollars Bank will be forfeited in the following situations:

A. You opt-out of the HRA component of your Reserve Dollars Bank in writing at any time.

B. Your Reserve Dollars Bank is forfeited under Section 2.01(D)(2).

Your Supplemental HRA will be forfeited in the following situations:

A. You opt-out of your Supplemental HRA in writing at any time.

B. Your Reserve Dollars Bank is or would be forfeited under Section 2.01(D)(2).

C. Your Supplemental HRA is inactive for a period of three (3) calendar years.

11.09 Payments of Benefits Upon Your Death.

If you die and your Reserve Dollars Bank has a balance of more than $10,000.00, your surviving Dependents may use your Reserve Dollars Bank by submitting claims to the Third Party Administrator for reimbursement of Covered Expenses. Your surviving Dependents may continue to be reimbursed until your Reserve Dollars Bank reaches a balance of less than $10,000.00.

If there is a balance in your Supplemental HRA on the date of your death, your surviving Dependents may use any remaining balance by submitting claims to the Third Party Administrator for reimbursement of Covered Expenses. Any remaining balance not reimbursed to your surviving Dependents will be forfeited if your Supplemental HRA is inactive for a period of three (3) calendar years.

If you die and you do not have any surviving Dependents, any balance in your HRA will be forfeited.

SECTION 12: GENERAL PLAN EXCLUSIONS

12.01 Exclusions.

The following list of specific exclusions is not an all-inclusive listing of the Plan's limitations and excluded procedures, services, supplies and types of treatment. It is only representative of the types of services and supplies for which charges may be incurred which are not payable by the Plan.

A. Accidents, Sicknesses, or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law. However, this exclusion does not apply to the Death or Accidental Dismemberment Benefits.

B. Care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan.

C. Any expenses or charges for services or supplies that are provided by Hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.

D. Any expenses or charges for which you do not have to pay.

E. Any expenses or charges caused by your voluntary participation in a riot.

F. Any expenses or charges caused by war or any act of war, whether declared or undeclared.

G. Any expenses or charges incurred during the commission of a felony.

H. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA.

I. Any expenses or charges for care, treatment, services or supplies:

   1. Not provided in accord with generally accepted professional medical standards;
   2. Not Medically Necessary; or
   3. For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.

J. Any expense or charge for Experimental or Investigative Treatments and Procedures.

K. Any expenses or charges for services and supplies that exceed the UCR Charges.

L. Any expenses for the care of conditions that state or local law require to be treated in a public facility.

M. Any expenses rendered or billed for by a school or halfway house or a member of its staff.

N. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.

O. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).

P. Any expenses or charges for third party ordered care, such as a pre-employment physical.

Q. Any expenses or charges for (1) failure to keep scheduled visits; (2) completion of claim forms; or (3) reports or medical requests not requested by the Fund.

R. Charges that would not have been made if this Plan did not exist.

SECTION 13: COORDINATION OF BENEFITS

13.01 Benefits Are Coordinated.

Under the Plan, your medical benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits are coordinated so that no more than 100% of your expenses are paid through the combined coverage of the plans.

The coordination of benefits applies only to Medical, Prescription, Vision and Dental Benefits provided under this Plan. It does not apply to Death, Accidental Dismemberment or Short-Term Disability Benefits.

13.02 Another Group Plan Defined.

Another group plan or source refers to any plan providing benefits or services and includes:

A. Group blanket or franchise insurance coverage (such as coverage provided to college students);

B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;

C. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;

D. Any coverage under governmental programs;

E. Any coverage required or provided by statute; and

F. This Plan when you are covered as:

1. An Employee and as a Dependent; or

2. A Dependent child of more than one Employee.

13.03 How Benefits are Paid.

Benefits coordination insures that you receive maximum benefits, and that benefits are not paid for more than 100% of the actual charges incurred.

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When this Plan is secondary, it will pay the difference between your Allowable Expenses under this Plan (as though there was no other coverage) and what your primary plan paid.

This Plan defines Allowable Expenses as any necessary, reasonable and customary item of expense for medical care or treatment that is covered under at least one of the plans by which you are covered. If the Plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. Allowable Expenses do not include any portion of a charge that is not considered a Covered Medical Expense under this Plan.

The combined payments of both plans will not be more than the primary plan's contract calls for if the primary plan has a contract with the provider through an HMO or PPO arrangement. Moreover, if this Plan and the other

plan have a contract with the same provider, the Allowable Expense will be the lower of the two contracted or negotiated fees.

If you or a Dependent is covered by another group plan or source in addition to this Plan, the order of benefit payment will be determined according to the Plan's coordination of benefits rules.

13.04 Order of Benefit Payment.

For coordination with other plans the following rules apply:

A. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.

B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent. Additionally, a plan that covers a person as a Dependent spouse is primary and pays benefits before a plan that covers the person as a Dependent child.

C. The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree and an Employee. However, coverage provided to an individual as a retired worker and as a Dependent of an actively working spouse will be determined under B above.

D. For claims on behalf of Dependent children whose parents are not divorced or separated, or for claims on behalf of Dependent children whose parents share custody or shared custody prior to the child attaining age of majority, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.

E. For claims on behalf of Dependent children whose parents are divorced or separated, whether or not they have ever been married, the following rules apply:

    1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility or had financial responsibility prior to the child attaining the age of majority will be primary.

    2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary. The plan who covers the parent who had custody at the time the child reached age of majority will be primary.

    3. If there is no such court decree and the parent with custody (or who had custody at the time the child reached the age of majority) has remarried, the order of benefit coordination will be as follows:

        (a) The plan of the parent with custody is primary and pays benefits first;

        (b) The plan of the step-parent with custody pays benefits second;

        (c) The plan of the parent without custody pays benefits third; and

        (d) The plan of the step-parent without custody, if any, pays benefits fourth.

F. A plan that covers you an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

G. A plan that covers you as a current full-time employee or as a Dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.

H. If a person is covered under the Plan as both an Employee and a Dependent spouse, the Plan will coordinate benefits and will pay primary employee benefits and secondary Dependent benefits, up to the maximums provided in the Schedule of Benefits.

I. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, retiree or dependent, the COBRA Continuation Coverage is secondary.

J. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

K. If a Retiree or Dependent is covered under any other group health plan or other type of medical insurance coverage or Medicare, the Plan will always pay its benefits after all other plans and insurance coverage and Medicare have paid their benefits.

13.05 Coordination of Benefits Implementation Rules.

The Trustees, without the consent of any person, have the following rights to implement the coordination of benefits rules:

A. Release or obtain information considered necessary;

B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and

C. Recover payments in excess of the amount that should have been paid by this Plan.

13.06 Coordination of Benefits with Medicare.

A. When You are an Active Employee.

If you are an Active Employee, this Plan will be primary and pay benefits first. If you are an Active Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

B. When You are a Retired Employee.

If you retire and are eligible for Retiree Benefits, you will automatically be enrolled in the Medicare Advantage and Prescription Drug Plan when you become eligible for Medicare.

C. End Stage Renal Disease (ESRD).

There are special rules that apply to the first 30 months of an ESRD (the initial 30-month period). The primary/secondary rules depend on whether the covered individual is eligible for Medicare due to age or disability as of the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary.

1. Eligibility because of the Employee's active status.

If you are eligible for benefits under the Plan because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second. After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

If during the initial 30-month period the Employee becomes eligible for Retiree Benefits, the Plan will continue to pay as the primary plan during the balance of the 30-month period. After the initial 30-month period, you will be enrolled in the Medicare Advantage and Prescription Drug Plan.

2. Eligibility because of the Employee's retired status.

If you are retired and not otherwise eligible for Medicare at the time you become entitled to Medicare ESRD benefits, the Plan will have primary responsibility for ESRD during the initial 30-month period and Medicare will pay second. After the initial 30-month period, you will be enrolled in the Medicare Advantage and Prescription Drug Plan.

If you are retired and already eligible for Medicare at the time you become entitled to Medicare ESRD benefits, the Medicare Advantage and Prescription Drug Plan will have primary responsibility for ESRD during the initial 30-month period and this Plan will pay second. After the initial 30-month period, the Medicare Advantage and Prescription Drug Plan continues to pay primary.

SECTION 14: SUBROGATION OR REIMBURSEMENT

14.01 Reimbursement to the Plan.

The Fund's right of subrogation and reimbursement arises when benefits are paid on behalf of you or your Dependent as a result of an injury or illness for which another party may be responsible. If the Fund pays any benefits that arise out of the injury or illness which results or could result in a claim against a Third Party, acceptance of these benefits under the Plan means you agree to reimburse the Fund for all expenses paid on your or your Dependent's behalf.

14.02 Third Parties Defined.

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

A. Any person or entity legally responsible for your injury;

B. Other benefit plans;

C. An insurance company, including but not limited to the party at fault's insurance;

D. Workers' compensation; or

E. Any other person or entity that is obligated to make payments, which the Fund would otherwise be obligated to make.

14.03 Your Responsibilities.

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

A. You and/or your Dependent must immediately notify the Third Party Administrator whenever a claim against a Third Party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.

B. You and/or your Dependent must cooperate with the Fund by providing, among other things, information requested by the Fund concerning subrogation or reimbursement. You must provide the Third Party Administrator with:

1. A signed Subrogation and Reimbursement Agreement;

2. The names and addresses of all potential third parties and their insurer, adjusters and claim numbers;

3. Accident reports; and

4. Any other information the Fund requests.

C. If you fail to meet your responsibilities, the Fund may withhold future benefit payments until you comply with these requirements.

D. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Fund the right to prosecute your claim and maintain an action against the third party on your behalf (subrogation).

14.04 If You Are Reimbursed by a Third Party.

The Fund is entitled to 100% reimbursement of all medical and short term disability claims paid on your and/or your Dependent's behalf, related to the injury or illness, from all Third Party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

A. First, the Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the Injury or Illness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA); then

B. Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above, even if you and/or your Dependent are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all third parties.

You and/or your Dependents (if applicable) shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover 100% of the benefits paid. Such action includes, but is not limited to:

A. Initiating a claim to compel compliance with these terms or the terms of the Subrogation and Reimbursement Agreement;

B. Withholding benefits payable to you or your Dependents until you or your Dependents comply; or

C. Initiating such other equitable or legal action it deems appropriate (the Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recovery payment).

14.05 Attorney Common Fund Doctrine Claims against the Fund.

If you and/or your Dependents retain your own attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain the Third Party recovery. If the attorney(s) that you and/or your Dependents retain in relation to an injury or illness brings a separate claim or lawsuit against the Fund to recover his/her attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependents are required to reimburse the Fund from the money you and/or your Dependents recover from any Third Party for (i) any money judgment entered against the Fund in the lawsuit brought by the attorney and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your Dependents shall fully indemnify, hold harmless and defend the Fund and its Trustees, employees and agents from and against any such claims or lawsuits. The Fund shall have the right to appoint counsel.

To the extent the Fund is required to initiate a formal proceeding against you and/or your Dependents to enforce its reimbursement rights, you and/or your Dependents shall also be responsible for the Fund's attorney's fees and costs incurred. In addition, to the extent the expenses, including but not limited to attorney's fees and costs, incurred by the Fund exceed the amount you and/or your Dependents recover from any Third Party or you and/or your Dependents refuse or fail to reimburse the Fund from any Third Party recovery, the Fund shall have the right to withhold benefits to you and/or your Dependents until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

14.06 Lien on Third Party Recoveries.

You and/or your Dependents grant the Fund a lien on the monies recovered from any Third Party in the amount of (i) all medical and short term disability claims paid on your and/or your Dependents' behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

SECTION 15: CLAIMS AND APPEALS

15.01 General Information.

A. Exhaustion of Remedies.

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action.

If you institute legal action after the denial of your internal appeal or after the denial of your external review, your lawsuit must be filed within four months of the date of such denial.

B. Discretionary Decision Making Authority of the Trustees.

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits, and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan.

No determinations involved in or arising under the Trust Agreement or this Summary Plan Description/Plan Document will be subject to the grievance or arbitration procedure established in any Collective Bargaining Agreement between an Employer and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such Collective Bargaining Agreements.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

15.02 Filing Your Initial Claim for Benefits.

A. What is a Claim?

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures.

If you make an inquiry about the Plan's provisions without a claim form, the Fund will not treat the inquiry as a claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, it will not be treated as a claim for benefits. A claim may fall into one of the following categories:

1. Post-service claim – a claim for payment is requested for a treatment or supply that has already been received;

2. Disability claim – a claim for Short-Term Disability Benefits;

3. Pre-service claim – a claim for pre-certification for a treatment or supply that requires approval in advance of obtaining care;

4. Urgent care claim – a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

5. Concurrent care claim – a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved. When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim.

To file a claim for benefits offered under this Plan, you must generally submit a completed claim form within 365 days from the date that the service for the charge is rendered.

You may obtain a claim form by calling the Third Party Administrator. A claim may be filed by a Participant, covered Dependent, an authorized representative or by a network provider. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. If a claim is filed by a provider, the provider will not automatically be considered a claimant's authorized representative.

1. Hospital, Physician and Medical Claims for Active Employees and Pre-Medicare Retirees

   The following information must be completed by you and the provider in order for your request for medical benefits to be a claim and for the Third Party Administrator to be able to decide your claim:

   (a) Employee's name;

   (b) Patient's name;

   (c) Patient's date of birth;

   (d) Social Security number of Employee or Retiree;

   (e) Date of service;

   (f) CPT-2017 (the code for Physician services and other health care services found in the *Current Procedural Terminology*, as maintained and distributed by the American Medical Association);

   (g) The appropriate ICD (the diagnosis code found in the *International Classification of Diseases, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);

   (h) Billed charge;

   (i) Number of units (for anesthesia and certain other claims);

(j) National Provider Identifier (NPI) of the provider; and

(k) Billing name and address.

2. Prescription Drug Claims for Active Employees and Pre-Medicare Retirees

You can avoid the need for filing for direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the PBM Claims Department as identified on your identification card.

3. Hospital, Physician, and Medical Claims for Medicare Retirees

Hospital, Physician and Medical Claims are generally filled by providers. If your claim is not submitted directly by your provider, please contact the Medicare Advantage and Prescription Drug Plan as identified on your identification card for further information about how to file a claim form.

4. Prescription Drug Claims for Medicare Retirees

You can avoid the need for filing for direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the Medicare Advantage and Prescription Drug Plan as identified on your identification card.

5. All Other Benefits

You should contact the Third Party Administrator about how to file a claim for all other benefits provided under the Plan.

D. Where to File a Claim.

1. Hospital, Physician and Medical Claims for Active Employees and Pre-Medicare Retirees

All Hospital, Physician and medical claims in general (both PPO and non-PPO providers) should be filed electronically with Anthem Blue Cross Blue Shield ("Anthem"). The Fund will consider your claim to have been filed as soon as it is received by the Third Party Administrator. Both PPO and non-PPO providers should complete the claim form for you and send it electronically to Anthem.

2. Prescription Drugs for Active Employees and Pre-Medicare Retirees

For more information on where to file a Prescription Drug claim, please contact the PBM at the number located on the back of your identification card.

3. Hospital, Physician, Medical and Prescription Drug Claims for Medicare Retirees

For more information about where to file a medical or prescription drug claim, please contact the Medicare Advantage and Prescription Drug Plan at the number located on the back of your identification card.

4. All Other Claims

   All other claims should be sent to the Third Party Administrator.

15.03 Initial Claim Determination Timeframes.

A. Claim Filing Deadline.

You must file your claim for benefits as soon as possible following the date you incurred the charges. A claim is considered to have been filed on the day it is received by the correct claims office, even if it is incomplete.

If you fail to file your claim as soon as possible, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, you must submit your claim no later than 12 months from the date you incurred the charges unless you can show good cause for filing a claim beyond the 12-month deadline. The Board of Trustees will determine whether you have shown good cause.

B. Claim Processing Timeframes.

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Plan's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim.

The amount of time the Plan can take to process a claim depends on the type of claim.

1. Post-service Claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 30 days from the Plan's receipt of the claim.

   (b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

   (c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at that time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal time period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

2. Short-Term Disability Claims

   (a) The Plan will make a decision on your Short-Term Disability claim and notify you of the decision within 45 days.

(b) If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Plan will make its decision within 30 days of the time the Plan notifies you of the delay.

The Plan may delay the period for making a decision for an additional 30 days, provided the Plan Administrator notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, before the expiration of the first 30-day extension period.

(c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information or at the expiration of the 45 days if you do not respond, the Plan will make its decision on the claim and notify you within 30 days.

3. Pre-Service Claims

(a) Ordinarily, the Plan will notify you of the decision on your claim within 15 days from the Plan's receipt of the claim.

(b) The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(c) If an extension is needed because the Plan needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision and notify you of the determination.

4. Urgent Care Claims

(a) Ordinarily, the Plan will notify you of the decision on your claim within 72 hours from the Plan's receipt of the claim.

(b) If an extension is needed because the Plan needs additional information from you to process your claim, the Plan will notify you of such extension within 24 hours. In that case you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis

of the information that the Plan has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or until you respond to the request (whichever is earlier). The Plan then has 48 hours to make a decision and notify you of the determination.

5. Concurrent Care Claims

   (a) If the concurrent care claim is urgent and made 24 hours prior to the end of the already authorized treatment, the Plan will notify you of its decision within 24 hours.

   (b) If the concurrent care claim is not an urgent claim, then the pre-service limits apply.

6. Death and Accidental Dismemberment Claims

   (a) Ordinarily, the Plan will notify you of the decision on your claim within 90 days from the Plan's receipt of the claim.

   (b) The Plan may extend this period one time for up to 90 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Plan will notify you before the end of the initial 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

15.04 Notice of Initial Decision.

You must be provided with a notice of the initial determination about your claim within certain timeframes after your claim is received. The notice must provide the following information:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the denial of benefits or other Adverse Benefit Determination;

C. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;

D. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

E. A copy of the review procedures and time periods to appeal your claim, a statement of your right to bring a civil action under ERISA following an Adverse Benefit Determination on review;

F. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to you at no cost upon request; and

G. If your health or Short-Term Disability claim was denied on the basis of medical necessity, Experimental or Investigative Treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request.

15.05 Internal Appeal Procedures.

A. Internal Appeal Filing Deadline.

You have the right to a full and fair review if your claim for benefits is denied by the Plan. You must file your appeal in writing, unless your appeal is an urgent care claim, which may be submitted orally by telephone. You must make your request to the Third Party Administrator within 180 days after receiving notice of denial, except with respect to Death and Accidental Dismemberment claims. You must file a request for an appeal of the denial of a Death or Accidental Dismemberment claim within 60 days after receiving notice of the denial. Your appeal application must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written statement.

B. Internal Appeal Process.

The appeal process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

   (a) it was relied upon by the Plan in making the decision;

   (b) it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

   (c) it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or

   (d) it constitutes a statement of Plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

3. Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

4. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and testimony as part of your appeal. The decision will be made on the basis of a full and fair review of the record, including such additional evidence and testimony that you may submit.

5. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental or Investigational Treatment), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Internal Appeal.

1. Urgent Care Claims

   If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

2. All Non-Urgent Pre-Service Care Claims

   If the appeal is for a non-urgent pre-service claim, you will be notified no later than 30 days after receipt of the request for appeal.

3. Short-Term Disability Claims and Post-Service Care Claims

   Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. The Plan will advise you in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

4. Death and Accidental Dismemberment Claims

   The Plan will send you a notice of the Board of Trustees' decision on appeal within 60 days of the receipt of the appeal by the Third Party Administrator.

15.06 Notice of Decision on Internal Appeal.

The Plan will provide you with a written decision, in a culturally and linguistically appropriate manner, on any internal appeal of your claim. However, if your claim is an urgent care claim, the Plan may notify you of the decision in writing, via fax or orally via telephone. The notice of a denial of a claim on appeal will state:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason(s) for the determination;

C. Reference to the specific Plan provision(s) on which the determination is based;

D. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

E. A statement of your external appeal rights, an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal;

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes; and

G. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity or because the treatment was Experimental or Investigational Treatment or other similar exclusion, the Plan will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

15.07 External Review Procedures.

A. External Review Filing Deadline.

If your health care claim involving medical judgment or a rescission of coverage was denied, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. External Review Process.

The external review process works as follows:

1. Request for External Review

   Within five days of the Plan's receipt of the written request for external review, the Plan must determine whether:

   (a) You are or were covered under the Plan at the time of service or requested service;

   (b) The Adverse Benefit Determination relates to a medical judgment determination or rescission of coverage;

   (c) You exhausted or are deemed to have exhausted the Plan's internal appeal process; and

   (d) You have provided all information and forms required to process an external review.

2. Determination of Eligibility for External Review

   Within one business day after the completion of this review, the Plan must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Plan must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

3. Referral to an Independent Review Organization (IRO)

   If your request is eligible for review, the Plan will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:

   (a) The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

   (b) The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO must send notice of such to you and the Plan within one business day.

   (c) The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.

   (d) The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

      (1) The claimant's medical records;

      (2) The attending health care professional's recommendation;

      (3) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

      (4) The terms of the Plan;

      (5) Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

      (6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

      (7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

4. Request for an Expedited External Review

   You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care

item or service for which the claimant received Emergency services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant notice of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. Timing of Notice of Decision on External Review.

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. Content of Notice of Decision on External Review.

The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all of the following:

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

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act section 2793.

15.08 Physical Examination.

The Trustees have the right and opportunity, at the Plan's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while your claim for Plan benefits is pending.

15.09 Payment of Claims.

The Plan will make payments due immediately upon receipt by the Third Party Administrator of proper written proof of loss. The Plan may pay all or a portion of any benefits provided for health care services to

the provider, unless you direct otherwise in writing at the time you file your claim. The Plan does not require that the services be rendered by a particular provider.

Upon your death, benefits accrued on your behalf will be paid at the Plan's option to the first surviving class of the following:

A. Your spouse;

B. Your Dependent children, including legally adopted children;

C. Your parents;

D. Your brothers and sisters; or

E. Any person the Trustees determine is entitled to payment.

The Fund will rely upon an affidavit to determine benefit payments, unless it receives written notice of a valid claim before payment is made. The affidavit will release the Fund from further liability.

Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

15.10 Authorized Representatives.

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete it yourself and have previously designated the authorized representative to act on your behalf. You may obtain a form from the Third Party Administrator to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

15.11 Benefit Payment to an Incompetent Person.

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent or to a person who in the opinion of the Trustees is unable to administer such payments properly because of mental or physical disability. The Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose(s) for which paid if they are paid:

A. Directly to such person;

B. To the legally appointed guardian or conservator of such person;

C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or

D. By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

15.12 Misrepresentation or Falsification by Plan Participant.

If you make an intentional misrepresentation or falsification of any information or a matter in connection with a claim for Plan benefits, the Trustees or their representative(s) may deny all or part of the benefits that might otherwise be due.

15.13 Prohibition on Rescission.

The Plan cannot rescind coverage except in the case of fraud or intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

SECTION 16: DEFINITIONS

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.

B. **Active Bargaining Unit Employee** means a person who is a member of the collective bargaining unit represented by the Union on whose account the Contributing Employer is required or has been required to make Contributions into the Fund and who is eligible to participate and receive benefits in accordance with this Plan. Active Bargaining Unit Employees include Hourly Rate Employees and Flat Rate Employees.

C. **Active Employee** means a person who is working for a Contributing Employer who is required under a Collective Bargaining Agreement or other written agreement to make Contributions to the Fund on his or her behalf.

D. **Active Non-Bargaining Unit Employee** means a person who is not a member of the collective bargaining unit represented by the Union on whose account the Contributing Employer is required or has been required to make Contributions to the Fund pursuant to a written agreement.

E. **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

1. A determination of an individual's eligibility to participate in the Plan;

2. A determination that a benefit is not a covered benefit;

3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or

4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

F. **Board of Trustees and/or Trustees** means the Trustees and Board of Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Tri-County Building Trades Health Plan. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.

G. **Chemical Dependency/Substance Abuse** means any abuse of, addiction to or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).

H. **Collective Bargaining Agreement** is any applicable collective bargaining agreement now existing or executed in the future between the Union and an Employer which provides for Contributions to the Trust Fund, as well as any extensions, amendments, or renewals thereof.

I. **Contributions** are payments made by Contributing Employers to the Trust Fund on behalf of their Active Bargaining Unit and/or Non-Bargaining Unit Employees.

J. **Contributing Employer or Employer** means any person, firm, association, partnership or corporation which is signatory to a Collective Bargaining Agreement which requires Contributions to this Fund. Contributing Employer also means the Union and any other entity that has entered into a participation agreement with the consent of the Trustees and which does in fact make Contributions to this Fund as provided for in the Fund's Trust Agreement and has agreed in writing to be bound by such Trust Agreement.

K. **Co-Payment** means the fixed dollar amount you are required to pay for services at the time you receive services.

L. **Covered Employment** means employment of an Active Bargaining Unit Employee by a Contributing Employer for which Contributions to this Fund are required.

M. **Covered Medical Expenses** means the UCR Charges for expenses ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-occupational Accident or Sickness.

N. **Custodial Care** means care designed to help a disabled person with daily living activities when:

1. There is no plan of active medical treatment to reduce the disability; or

2. The plan of active medical treatment cannot be reasonably expected to reduce the disability.

O. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular dental service rendered.

P. **Dependent** means any one of the following individuals:

1. A Participant's spouse (marriage license and birth certificate required).

2. Each child of a Participant from the date he or she first becomes a child of the Participant to the end of the month in which such child attains age 26 (birth certificate required).

3. A child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

   (a) Such incapacity began before the end of the month such child attains age 26;

   (b) Such child is chiefly dependent upon the Employee for financial support and maintenance; and

   (c) Proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.

4. A Participant's children include natural and legally adopted children, children placed in the Employee's home for adoption, foster children and step children. A Dependent child will also include a child of an eligible Participant who has been appointed legal guardian by a court of competent jurisdiction. Proof of such guardianship may be required.

Q. **Emergency** is the sudden and unexpected onset of a medical condition requiring immediate medical attention. A condition will be an Emergency only if:

1. Severe symptoms occur suddenly and unexpectedly;

2. Immediate care is secured; and

3. The Sickness or condition is finally diagnosed as one that would normally require immediate medical care.

R. **Experimental or Investigative Treatments and Procedures** applies to a service, procedure, drug, device, or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria:

1. Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body;

2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis;

3. Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval;

4. Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials, or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

5. Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Note: The Trustees have the authority to determine whether a service, procedure, drug, device, or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device, or treatment does not, in itself, make it eligible for payment.

S. **Fund and/or Welfare Fund** means the Tri-County Building Trades Health Fund.

T. **Plan Administrator** means the Board of Trustees of the Tri-County Building Trades Health Fund.

U. **Hospice Organization** means a public or private agency or organization primarily engaged in providing a coordinated set of services at home or in an outpatient or institutional setting to persons suffering from a terminal or medical condition. The agency or organization must:

1. Be eligible to participate in Medicare;

2. Have an interdisciplinary group of personnel that includes the services of at least one Physician and one registered nurse (R.N.);

3. Maintain clerical records on all of its patients;

4. Meet the standard of the National Hospice Organization; and

5. Provide either directly or indirectly or by another arrangement, the "core service" listed as Covered Expenses.

V. **Hospital** means a lawfully operating institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses, and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a Hospital operated by the United States Government, unless the claimant is required to pay such expense.

W. **Inpatient** means a person receiving room and board while undergoing treatment in a Hospital or other healthcare facility.

X. **Medically Necessary** means a service or supply that:

1. Is consistent with the symptoms of diagnosis and treatment of the person's injury or Sickness;

2. Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and

3. Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Y. **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

Z. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

AA. **Mental or Nervous Disorder** means (1) a Mental Illness or (2) a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.

BB. **Participant** means an Active Bargaining Unit Employee, Active Non-Bargaining Unit Employee and/or Retiree who is eligible and covered under the Plan.

CC. **Physician** means a person licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license.

DD. **Plan and/or Welfare Plan** means this document as adopted by the Trustees and as amended by the Trustees.

EE. **Prescription Drugs** means legal drugs and medicine approved by the United States Food and Drug Administration ("FDA"), dispensed by a pharmacist pursuant to the written prescription of a Physician.

FF. **Retiree** is a person who meets the applicable eligibility requirements for Retiree Benefits.

GG. **Self-Payments** are any payments made by Active Employees, Dependents or Retirees for the purpose of maintaining coverage under the Plan.

HH. **Sickness** includes pregnancy, childbirth, abortion, and related medical conditions among other illnesses.

II. **Skilled Nursing Care Facility** means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or injury which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or Surgeon or a registered nurse (R.N.).

JJ. **Third Party Administrator** means the office of BeneSys, Inc., the contracted third party administration organization.

KK. **Usual, Customary and Reasonable Fee or Charges** means the following:

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as payment in full under its contract with a Plan PPO or similar organization.

2. For service or supply where the fee is not determined under (1) above, the amount the Fund would have paid if the item had been covered under any such Plan PPO contract as represented to the Fund by the network administrator. However, for Emergency services from a non-network provider, the fee will be the greater of the following amounts: (a) the median of the amount negotiated with each PPO provider; (b) the amount the Plan generally uses to determine payments for non-network services; or (c) the Medicare rate.

3. For service or supply where the fee cannot be determined under (1) or (2) above, the fee shall be based on 125% of the amount that would be allowed by Medicare, except as described in (4) below.

4. For outpatient facility charges and ambulatory surgical center charges where the fee cannot be determined under (1) or (2) above, the fee shall be based on 150% of the Medicare grouper rate.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under the subsections listed above.

LL. **Union** means the International Association of Sheet Metal, Air, Rail and Transportation Workers Local Union No. 33.

MM. **Other Terms**

Additional terms are defined in other Sections of this Plan as follows:

SECTION 17: ADDITIONAL PLAN INFORMATION

17.01 Plan Name.

Tri-County Building Trades Health Fund.

17.02 Board of Trustees.

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union which have entered into Collective Bargaining Agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the address below.

As of the date of this Plan Restatement, the Trustees of this Plan are:

Union Trustees	Management Trustees
Mr. Jerry Durieux Sheet Metal Workers Local 33 1890 Venture Circle S.E. Massillon, OH 44646	Mr. Matt Fox Metal Masters 125 Williams Drive NW Dover, OH 44622
Mr. Dave Larson Sheet Metal Workers Local 33 637 Perry St. Vermillion, OH 44089	Mr. Aaron Hall SMACNA, East Central Ohio 2181 Akron-Peninsula Rd. Akron, OH 44313
Mr. Scott Mazzulli Sheet Metal Workers Local 33 20 North 5th Street Martins Ferry, OH 43965	Mr. John Trifonoff East Coast Metal Systems P.O. Box 217 Bellaire, OH 43906
Mr. Josh Tullius, Alternate Sheet Metal Workers Local 33 4601-A Camden Avenue Parkersburg, WV 26101	Mr. Seth Abraham, Alternate Kalkreuth Roofing & Sheet Metal 53 14th Street, Suite 100 Wheeling, WV 26003

17.03 Plan Sponsor and Administrator.

The Board of Trustees is the Plan Sponsor and Plan Administrator. The Board has contracted with BeneSys, Inc. to provide administrative services, including the processing of claims as the Third Party Administrator. BeneSys, Inc. may be contacted at 700 Tower Drive, Suite 300, Troy, Michigan 48098. The telephone number is (248) 641-4902 and the fax number is (248) 813-9898.

17.04 Plan Numbers.

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 34-0751987.

17.05 Agent for Service of Legal Process.

BeneSys, Inc.
Third Party Administrator
12515 Corporate Drive
Parma, Ohio 44130

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the addressed provided in Section 17.02.

17.06 Source of Contributions.

The benefits described in this Welfare Fund booklet are provided through Contributions and Self-Payments. The amount of Employer Contributions and the employees on whose behalf Contributions are made are determined by the provisions of the Collective Bargaining Agreements. The amount of Self-Payments is determined by the Trustees.

17.07 Collective Bargaining Agreement.

The Plan is maintained pursuant to various Collective Bargaining Agreements between the International Association of Sheet Metal, Air, Rail and Transportation Workers Local Union No. 33 and the Employers. Other agreements may be in effect from time to time. The agreements specify the Contributions required.

The Third Party Administrator will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of Participants working under a Collective Bargaining Agreement or a list of participating Employers.

17.08 Trust Fund.

All assets are held in Trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis, except for Accidental Dismemberment, Death and certain Medicare Retiree Benefits, which are insured.

The Plan has contracted with a stop-loss insurance carrier to cover its exposure in the event of large health claims. Please contact the Third Party Administrator with all questions regarding the stop-loss insurance policy and its administration.

The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

17.09 Plan Year.

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on May 1 and ends on April 30.

17.10 Type of Plan.

This Plan is maintained for the purpose of providing death, accidental dismemberment, disability, medical, dental, vision, and Prescription Drug benefits to Participants in the event of death, Sickness or Accident. The Plan benefits are shown in the applicable Schedules of Benefits in Section 1 of this booklet.

17.11 Gender.

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

17.12 Assignment.

Generally, benefits from the Plan belong to you. You may not sell, assign, transfer or garnish these benefits.

17.13 Amendment and Termination.

You do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

17.14 Discretionary Authority.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

17.15 Severability Clause.

If a provision of the Trust Agreement or the Plan or any amendment made to the Trust Agreement or to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or the Plan.

17.16 Worker's Compensation Not Affected.

The Plan is not in lieu or and does not affect any requirements for coverage by the applicable workers' compensation laws or occupational disease laws of any state.

17.17 Recovery of Benefits Paid in Error.

If for any reason, any benefit paid to a covered person under this Plan is determined to have been in error, or wholly or partially in excess of the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide.

17.18 Privacy Policy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Third Party Administrator.

This Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Third Party Administrator if:

A. You need a copy of the Privacy Notice;

B. You have questions about the privacy of your health information; or

C. You wish to file a complaint under HIPAA.

17.19 The Plan's Use and Disclosure of Your Protected Health Information (PHI).

A. How the Plan Uses and Discloses Your Protected Health Information.

The Plan will use your protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to the Retirement Fund, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment.

Payment includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (e.g. cost of a benefit, Plan maximums and Co-Payments as determined for an individual's claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Subrogation of health benefit claims;

5. Establishing Employee Contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives) inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

C. Definition of Health Care Operations.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

7. Business management and general administrative activities of the entity, including, but not limited to:

    a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

    b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

    c. resolution of internal grievances; and

    d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or following completion of the sale or transfer, will become a covered entity.

D. The Plan's Disclosure of Protected Health Information to the Board of Trustees.

For purposes of this section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by the individual;

5. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make the information available that is required to provide an accounting of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA; and

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

1. The Plan Administrator; and

2. Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

17.20 Statement of ERISA Rights.

As a Participant in the Tri-County Building Trades Health Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

A. Receive Information about Your Plan and Benefits.

You have the right to:

1. Examine, without charge, at the Third Party Administrator's office, all documents governing the Plan. These include insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. 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.

B. Continue Group Health Plan Coverage.

You also have the right to 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.

C. Prudent Actions by Plan Fiduciaries.

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

D. 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a 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 a lawsuit in court. You must exhaust all of the Plan's claims and appeals procedures before filing a lawsuit. 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 a lawsuit. 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.

E. Receive Assistance with Your Questions.

If you have any questions about your Plan, you should contact the Third Party Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Third Party Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

1. By calling (866) 444-3272;

2. Sending electronic inquires to www.askebsa.dol.gov; or

3. Visiting the EBSA web site at www.dol.gov/ebsa.