Sheet Metal Workers Local No. 265 Health and Welfare Plan

2013 SUMMARY PLAN DESCRIPTION

Sheet Metal Workers Local No. 265
Health and Welfare Plan

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This booklet, which supersedes and replaces any prior materials, has been prepared for Sheet Metal Workers Union Local 265 Eligible Participants and serves as the Plan's Summary Plan Description (SPD) booklet and legal Plan Document as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SPD/Plan Document booklet and supplemental documents such as the Plan's HIPAA Privacy Policies and Procedures and COBRA notices serve as the Plan's controlling legal documents. These documents are used by the Plan's Trustees to determine eligibility for benefits and to prescribe the amount, extent, conditions, and methods of payment of such benefits.

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Introduction

This booklet describes the benefits available to several different classes of Sheet Metal Workers Local No. 265 Health and Welfare Plan Eligible Participants, effective as of January 1, 2013, including:

- **Class A:** Employees and their Eligible Dependents;
- **Class B:** Non-Medicare-eligible retired Employees and Non-Medicare-eligible Dependents of retired Employees;
- **Class C:** Medicare-eligible retired Employees and Medicare-eligible Dependents of retired Employees;
- **Class D:** Medicare-eligible retired Employees under age 65 and Medicare-eligible Dependent Spouses under age 65 of retired Employees;
- **Class E:** Employees and their Eligible Dependents;
- **Class G:** Employees and their Eligible Dependents;
- **Class H:** Employees and their Eligible Dependents; and
- **Class I:** Employees and their Eligible Dependents.

If you are an Employee, your collective bargaining agreement determines your Class eligibility. To find out what Class you are in, contact the Fund Office.

Depending on your Class, you may qualify for a wide range of benefits including:

- Medical;
- Prescription drug;
- Hearing;
- Dental;
- Vision;
- Weekly Loss of Time;
- Death; and
- Accidental Death and Dismemberment (AD&D).

This booklet explains these benefits. Please read the booklet and if you are married, share it with your spouse. Keep this booklet with your important papers so you can refer to it when needed.

Within this booklet, we have described your benefits as completely as possible and in everyday language. We have also organized the book in a way that will be useful to you. This booklet includes:

- A summary of the coverage provided by the Plan;
- A list of important phone numbers;
- A Life Events section designed to show you how your benefits work and how they fit into the different stages of your life;
- Information about when you and your Eligible Dependents can participate in the Plan;
- An explanation about your coverage under each benefit program;
- Information about how to file claims;
- General Plan administrative information; and
- A Glossary of important definitions.

Defined Terms
Defined terms are capitalized throughout this booklet. The booklet's Glossary, which begins on page 75, provides the definitions.

Important Things to Remember

Be Wise Health Care Consumers

Our Plan is self-funded; it is not insured. This means that the Plan pays for all claims out of its assets. In an insured arrangement, the Plan would pay premiums to an insurance company that would be responsible for paying claims.

In some instances, the Plan's Board of Trustees has delegated administrative responsibilities to other organizations. These organizations assist the Plan by performing administrative duties, but all benefits are paid from the Plan's assets.

To help the Plan remain financially stable and to reduce some of your expenses, you are encouraged to be wise health care consumers. You can do so by taking advantage of cost-saving features built into the Plan. Whenever possible:

- **Use network providers.** Hospitals, Physicians, pharmacists, dentists, and other health care providers that participate in a network have agreed to accept negotiated rates that are generally less than what other providers charge.
- **Get regular physical exams.** Getting regular physicals can help you be healthier by identifying potential health risks earlier, which could mean fewer health care problems overall.
- **Get precertification for services when required**, such as for home health care services, hospitalization, surgery, Durable Medical Equipment, obesity treatment, and mental health and substance abuse treatment. This will help you get reimbursed properly and in a timely manner. Of course, if it is an emergency, get medical help quickly and then notify the Plan's utilization management provider if you are admitted to a Hospital.
- **Request generic equivalents.** The cost of a generic medication can be significantly less than the cost of a brand name medication and, by law, they are required to be equivalent.
- **Use the mail order prescription drug program.** Not only is it convenient but prescription medications are available at discounted prices.
- **Review your medical bills to ensure that they are accurate.** If something does not seem right, or if you are charged for a procedure or supply you never received, question the bill. Sometimes bills and payments cross in the mail, so also make sure you do not pay a bill twice.

Important Contact Information

The Board of Trustees has delegated some administrative responsibilities to other individuals or organizations, as follows:

- **Med-Care Management, Inc.** is responsible for pre-certification of Hospital admissions, surgery, mental health and substance abuse treatment, home health care and Durable Medical Equipment;
- **Employee Resource Systems (ERS), Inc.** administers the Member Assistance Program and provides confidential mental health care services for Eligible Participants; and
- **Envision/Rx Options** is responsible for paying prescription drug claims.

The chart below lists the contact information for the organizations that provide services under the Plan.

If You Have a Question or Need Information About:	Contact:	Telephone Number/ Website:
Eligibility	Fund Office	630-668-7260 www.smw265funds.org
Medical, Dental, Hearing, Vision, Weekly Loss of Time, Death, and AD&D Benefits	Fund Office	630-668-7260 www.smw265funds.org
Pre-Certification (Hospital admission or Outpatient surgery)	Med-Care Management, Inc.	800-375-9173
Medical PPO Network Providers	BlueCross BlueShield of Illinois	800-571-1043 for providers in Illinois 800-810-2583 for providers outside Illinois www.bcbsil.com
MRI, CT Scan, and PET Scan Network Providers	DBM Diagnostics	800-331-5720
Member Assistance Program	Employee Resource Systems, Inc.	800-292-2780 www.ers-eap.com
Prescription Drug Benefits	Envision/Rx Options	800-361-4542 www.envisionrx.com
Hearing Network Providers	Hear USA	800-333-3389 www.hearusa.com
Dental Network Providers	Dental Network of America	866-522-6758 www.dnoa.com
Vision Network Providers	EyeMed Vision Care	866-723-0514 www.eyemedvisioncare.com

Eligibility for Benefits

Active Plan Benefits

Generally, you are eligible for benefits from the Plan if you work for an Employer that contributes on your behalf. Your eligibility (initial and continued) for coverage is based on a quarter system and is determined as described in the following information.

Coverage is automatic for you and your Eligible Dependents when you meet the eligibility requirements. However, when you are initially eligible for benefits, you will need to complete an enrollment card for yourself and your Eligible Dependents. You will also be asked to provide appropriate documentation, such as a marriage certificate, birth certificate, or divorce decree, as appropriate.

As an Employee, the Class for which you are eligible is determined by your collective bargaining, participation, or other written agreement. For more information on your Class and the eligibility requirements, contact the Fund Office.

Initial Eligibility

You will be initially eligible for coverage under the Plan once you have been employed by a Contributing Employer(s) and your Employer is required to contribute to the Plan on your behalf for at least 500 hours worked within a 12-consecutive month period. Your coverage will begin on the first day of the month following the month in which you work 500 hours within a 12-consecutive month period.

Once you are initially eligible, your coverage continues for the remainder of the Benefit Quarter (refer to next section for information on Benefit Quarters). If your initial eligibility period is less than two months of the Benefit Quarter, then eligibility will continue for the next following Benefit Quarter.

Continuing Eligibility

Your eligibility for coverage continues on a quarter-by-quarter basis. As long as sufficient Employer Contributions are made on your behalf to continue coverage, your coverage will continue. Continuing eligibility is based on Contribution and Benefit Quarters, as follows:

Contribution Quarters: Work performed during:	Benefit Quarters: Determines your eligibility for:
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

Contribution Quarter
A three-month period during which Employer Contributions are made to the Plan on your behalf for the hours you worked in that quarter.

Benefit Quarter
A three-month period during which you are eligible for benefits based on the Employer Contributions made on your behalf during the corresponding Contribution Quarter.

For your coverage to continue for the next benefit quarter, you must continue to work for a Contributing Employer and your Employer must contribute to the Plan on your behalf for at least:

- 350 hours in the corresponding Contribution Quarter;
- 600 hours in the corresponding Contribution Quarter and the prior Contribution Quarter combined; or
- 1,400 hours in the corresponding Contribution Quarter and the prior three Contribution Quarters combined.

CONTINUING ELIGIBILITY EXAMPLE

By working a total of 500 hours during January, February and March, Scott continues his eligibility for coverage in June, July, and August.

In April, May and June, Scott only works 200 hours. Scott's eligibility will continue for September, October, and November since he has 700 hours in two Contribution Quarters (500 in January, February and March plus 200 in April, May, and June).

In the event that you do not have sufficient Employer Contributions made on your behalf to continue to be eligible for coverage, you may make self-payments to continue your coverage, refer to page 14.

Retiree Plan Benefits

All benefits under the retiree program will be coordinated with any other group insurance program (including Medicare) for which you are eligible. If you are eligible for Medicare coverage, Medicare will pay benefits first, before this Plan (unless you are still working, in which case, this Plan will pay benefits first).

If you are eligible for coverage as a retired Employee, when you initially retire you will have a choice of electing retiree benefits or continuing active coverage through COBRA Continuation Coverage (refer to page 15).

To be eligible for coverage as a retired Employee, you must:

- Have worked under a collective bargaining, participation, or other written agreement that provides for retiree coverage under the Plan;
- Be at least 55 years old or Totally Disabled;
- Have been eligible for active coverage at the time of retirement, and:
  - Have been covered under the active Plan for at least 18 of your last 20 Benefit Quarters immediately before your retirement; *or*
  - Have been covered under the active Plan for the last 10 Benefit Quarters, plus have at least 10 years of prior service in the jurisdiction of Sheet Metal Workers Local No. 265;
- Be receiving a pension from the Sheet Metal Workers Local No. 265 Pension Plan, the Fox Valley & Vicinity Construction Workers Pension Plan, or the Sheet Metal Workers' National Pension Fund; and
- Submit satisfactory evidence of your retirement to the Board of Trustees within 30 days of your retirement date, or of the date your retirement is approved by the Trustees, whichever is later.

Your retiree coverage must begin immediately after your coverage under the active program would otherwise end, including any extension available because of self-payments. To ensure that your coverage continues, you must apply for retiree coverage before your coverage under the active program ends. If you do not elect retiree coverage immediately upon retirement, you may not elect to participate later.

If you return to employment and earn eligibility under the active program, your retiree coverage will end. However, you will have the opportunity to reinstate your retiree coverage, in accordance with the prior rules, upon the subsequent loss of your eligibility under the active program.

Retiree Classes

To be eligible to participate in the retiree program, you may be covered under one of three benefit classes, depending on whether or not you are eligible for Medicare as follows:

- **Class B.** Coverage for retired Employees and Eligible Dependents of retired Employees who are not eligible for Medicare.

- **Class C.** Coverage for retired Employees and Eligible Dependents of retired Employees who are eligible for Medicare.
- **Class D.** Coverage for Medicare-eligible retired Employees and Medicare-eligible Dependent Spouses of retired Employees who are under age 65.

The benefits available under the different classes are specified in the *Summaries of Benefits* in the *Appendix*. In the event that you are retired and eligible for Medicare, the Plan will coordinate your coverage with Medicare, with Medicare paying first.

Self-Payments for Retiree Coverage

To continue coverage under the retiree program, you may be required to make self-payments for coverage. What you pay for coverage depends on the Class of coverage for which you are eligible. The quarterly cost is determined by the Trustees; the Fund Office will inform you of the quarterly self-payment amount when you apply for retiree coverage.

The cost of providing health coverage for Medicare eligible participants is less than for non-Medicare eligible participants.

Since the Plan coordinates coverage with Medicare, the quarterly cost of providing coverage for Medicare eligible participants is less than providing coverage for non-Medicare eligible participants.

If you or your Eligible Dependent is eligible to continue health coverage by making self-payments, self-payments must be received in the Fund Office within 30 days of the due date. Self-payments are made on a quarterly basis. The Trustees have the right to adjust the self-payment amount from time to time. The Trustees also have the right to terminate this program by giving advance notice to those individuals covered under the program.

Dependent Eligibility

In general, your Eligible Dependents include your spouse and your Eligible Dependent children under age 26.

Your Eligible Dependents become eligible for coverage on the same date you become eligible, or if later, on the date you acquire an Eligible Dependent. Whenever you acquire a new Eligible Dependent, you should contact the Fund Office to update your personal information on file. In addition, you should notify the Fund Office of any change in your address.

Your Eligible Dependents are eligible for the same coverage you are, except for Weekly Loss of Time Benefits. However, in certain circumstances, the level of coverage may differ. Your Eligible Dependents are your spouse and children who meet the Plan's definition of Eligible Dependent described beginning on page 76. Certain documentation may be required to verify that your spouse and/or children are eligible for Plan coverage.

In general, benefits for your Eligible Dependent children are available provided your child is:

- Less than 26 years old;
- Covered under a Qualified Medical Child Support Order (QMCSO); or
- Is age 26 or older, was totally disabled before reaching age 26, and satisfies the conditions of the Plan's definition of a totally disabled Dependent.

Refer to page 76 for more information.

Special Enrollment Rights

If you are an Employee and you decline coverage for yourself or an Eligible Dependent because of other group health plan coverage, you may, in the future, be able to enroll yourself and your Eligible Dependent in this Plan, provided that you request enrollment within 30 days after the other coverage ends. If that other coverage was COBRA coverage, a special enrollment is only available after the COBRA Continuation Coverage has been exhausted. If that other coverage was coverage under Medicaid or the State Child Health Insurance Program (SCHIP) or you became eligible to participate in a financial assistance program through Medicaid or SCHIP for coverage under the Plan, you must request special enrollment within 60 days after that other coverage ended.

If you acquire a new Eligible Dependent because of marriage, birth, adoption, or placement of a child for adoption, you may enroll yourself and your Eligible Dependents, provided you enroll within 30 days of the marriage, birth, adoption, or placement for adoption.

When Coverage Ends

When your coverage or your Eligible Dependent's coverage ends, you or they may be eligible to continue coverage by making monthly payments for COBRA Continuation Coverage. Refer to page 15 for more information.

Certificate of Coverage

When your coverage ends, you will be provided with certification of your length of coverage under this Plan. This Certificate of Coverage may help reduce or eliminate any pre-existing limitation under a new group medical plan.

Employees

Your eligibility for coverage under the Plan will end on the last day of the Benefit Quarter following the earliest of the date:

When coverage ends, you or your Eligible Dependents may be able to continue coverage by making monthly payments for COBRA Continuation Coverage. In addition, you will be provided with certification of your length of coverage under this Plan.

- You do not meet the continuing eligibility requirements described in this section;
- Your participant Class is no longer covered under the Plan;
- You enter military service, subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA), as described on page 12;
- You become eligible for coverage under another employment-related group health plan, unless otherwise eligible for continued coverage;
- You become employed in the occupational and geographical jurisdiction of the Sheet Metal Workers Local No. 265 for an Employer who is not signatory to a collective bargaining agreement that requires contributions to the Plan, unless authorized by the Sheet Metal Workers Local No. 265 Union; or
- The date you leave the geographical jurisdiction of the Sheet Metal Workers Local No. 265.

In addition to the above, your coverage would end on the date this Plan ends.

Retired Employees

Your eligibility for retiree coverage under the Plan will end on the last day of the Benefit Quarter for which the required self-payment to continue coverage is made. However, eligibility may end earlier, as of the last day of the month:

- You do not make the required self-payment to continue coverage;
- When the Plan no longer provides retiree or any Plan coverage; or
- In which your death occurs.

Eligible Dependents

Your Eligible Dependent's eligibility for coverage will end on the earlier of the:

- Date the Plan ends;
- First day of the month following the date your Eligible Dependent no longer meets the Plan's definition of an Eligible Dependent;
- Date you lose your eligibility or your participant Class is no longer covered;
- Date your Eligible Dependent's qualifying disability ends; or
- Date specified under the terms of a Qualified Medical Child Support Order (QMCSO).

Reinstating Eligibility

Employees

If you were once eligible for Plan coverage, lose eligibility, and want to reinstate coverage within 12 months of when you lost eligibility, your coverage may be reinstated by meeting the Plan's continuing eligibility provisions described on page 4). If you do not return to reinstate coverage within 12 months of when you lost eligibility, you must meet the Plan's initial eligibility requirements to reinstate coverage.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

Life Events

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when different events occur.

Life events such as those below can affect your benefits:

- Marriage;
- Birth or adoption of a child;
- Divorce;
- Leave of absence;
- Death;
- Medical leave;
- Military duty; or
- Retirement.

Getting Married

When you get married, you may want to consider updating your beneficiary information for your Death and AD&D Benefits, if you are eligible for such benefits. You are automatically the beneficiary for any Dependent Death Benefits, if eligible.

If your spouse is covered under this Plan and another group medical plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage. This Plan's benefits will be paid after and reduced by the amount of any benefits payable from your spouse's plan.

- **Employees.** When you get married, your spouse is eligible for benefits as of the date of your marriage provided you are eligible for benefits. To ensure your spouse is covered, you must provide all requested information.
- **Class B and D Retired Employees.** When you get married, your spouse is eligible for benefits as of the date of your marriage. However, you will be required to make self-payments for such coverage. To ensure your spouse is covered, you must provide all requested information and make the appropriate self-payment.
- **Class C Retired Employees.** If you are receiving coverage under the Plan as a Class C retired Employee and you subsequently marry, your spouse is eligible for coverage under the Plan.

Adding a Child

Your and your spouse's newborn child will be eligible for coverage on the date of birth (please note that Dependent Children cannot be added to Class C). If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of an Eligible Dependent child. Stepchildren and children for whom you have legal guardianship may be covered under the Plan as well. Refer to page 6 for more information.

To ensure that your Eligible Dependent's coverage begins as it should, you must provide any required information. Refer to the definition of Eligible Dependent on page 76 for the requirements for children.

Getting Divorced

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as an Eligible Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your Death and AD&D Benefits.

In the event of a divorce, be sure to notify the Fund Office.

Qualified Medical Child Support Orders (QMCSO)

The Plan recognizes Qualified Medical Child Support Orders (QMCSO) in accordance with the requirements of the Omnibus Budget Reconciliation Act of 1993. The QMCSO must be in the form of a judgment, decree, or order issued by a court. The QMCSO cannot require any type or form of benefit or any option not otherwise provided under the Plan.

Please notify the Fund Office if your situation involves a Qualified Medical Child Support Order (QMCSO). Contact the Fund Office for more information about how QMCSOs are handled or for a free copy of the Plan's QMCSO procedures.

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he or she reaches age 26. You should notify the Fund Office at least 60 days before the date your Eligible Dependent reaches age 26.

Your child may elect COBRA Continuation Coverage for up to 36 months after losing eligibility as an Eligible Dependent. You or your child must notify the Fund Office and make any necessary payments within 60 days after your child no longer meets the eligibility requirements to obtain COBRA Continuation Coverage.

If your child is not capable of self-supporting employment due to a qualified physical or mental handicap, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for more than 50% of his or her financial support and maintenance. To qualify, your child's disability must begin before his or her coverage would otherwise end in the absence of the disability, and your child must meet the other required qualifications of a disabled dependent child. Refer to page 77 for more information.

When You Are Out of Work Due to a Disability

Employees

If you do not work due to a work-related disability, you may be eligible for workers' compensation benefits. This Plan is not a substitute for nor does it affect any requirements for workers' compensation.

If you do not work due to a non-work related disability, you may be eligible for Weekly Loss of Time Benefits. Benefits continue until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first (refer to page 11).

If you are eligible and receiving either Weekly Loss of Time Benefits or workers' compensation benefits as the result of a disability, you are entitled to hours of disability credit each week toward continuing your eligibility for coverage under the Plan, up to the maximum number of hours of disability credit for your Class for any single period of disability. The weekly hours of disability credit and maximum per period of disability as specified in your collective bargaining, participation, or other written agreement. I**f you remain Totally Disabled and unable to return to work** at your regular occupation after receiving the maximum hours of disability credit, you may continue your coverage under the Plan for up to five eligibility quarters by making self-payments for coverage. However, you will only be eligible to continue coverage if you remain Totally Disabled during this period.

All disability absences will be considered as occurring during a single period of disability unless evidence provides that the cause of the latest disability absence is:

- Not connected with the cause of any prior disability absence and the latest disability absence occurs after your return to active work for at least one day; or

- Connected with the cause of a prior disability but the two were separated by your return to work for at least two full, consecutive weeks.

You must provide initial proof of disability as well as possible subsequent proof of continued disability.

Returning to Work After Disability

If you return to work immediately from a continuation of eligibility due to disability for which you received Weekly Loss of Time Benefits or workers' compensation, your eligibility will continue under these provisions for a limited time while you work the 350 hours necessary for reinstatement as an Employee. This limited time includes the remainder of the Contribution Quarter in which you return to work plus the next Contribution Quarter.

If you do not work the necessary hours during this time, you must meet the Plan's initial eligibility requirements before you are once again eligible for coverage under the Plan.

Continuation of Coverage During Total Disability

If you become Totally Disabled and unable to perform any sheet metal work due to that Total Disability, you may continue coverage under the Plan by making self-payments for up to 36 months. To be eligible, you must have been eligible for coverage for at least 18 of the last 20 Benefit Quarters immediately before your disability.

You and your Eligible Dependents may continue the same coverage you were eligible for before your Total Disability, except Weekly Loss of Time Benefits for you and Vision Benefits for you and your Eligible Dependents. Provided the required self-payments are made, coverage will continue until the earlier of:

- For you, the date you:
  - Are no longer Totally Disabled; or
  - Become eligible for Medicare; and
- For your Eligible Dependents, the date your Eligible Dependent:
  - No longer meets the Plan's definition of an Eligible Dependent; or
  - Becomes eligible for Medicare.

In no event will benefits continue during disability for more than 36 months. This coverage is separate from and is not considered COBRA Continuation Coverage.

Taking a Family and Medical Leave of Absence

The Family and Medical Leave Act (FMLA) allows eligible Employees of Contributing Employers who are obligated to comply with the FMLA to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child or placement of a child with you for foster care or adoption;
- The care of a seriously ill spouse, parent or child; or
- Your serious Illness.

FMLA applies to Employers who have 50 or more Employees, within a 75-mile radius, working at least 20 workweeks in the current or preceding calendar year, including part-time, temporary, and seasonal Employees.

In addition, the FMLA allows eligible Employees of Contributing Employers who are obligated to comply with the FMLA to take up to a total of 26 workweeks of unpaid leave during any 12-month period to care for a service member who must be:

- The son, daughter, parent, or next of kin of the Employee;
- Undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed services; and
- An outpatient or on the temporary disability retired list of the armed services.

If you are eligible and comply with the provisions of the FMLA to take a leave, you may continue your medical benefits under the Plan. To continue such coverage, your Employer must:

- Notify the Fund Office when such leave is granted;
- Demonstrate eligibility for the FMLA leave in a manner that is satisfactory to the Plan; and
- Make the required payments on a timely basis.

If you do not return to work within 12 weeks, or 26 weeks, if applicable, you will be eligible for COBRA Continuation Coverage as described on page 15.

Contact your Employer for more information regarding an FMLA leave.

Taking a Military Leave

If you are in active service for up to 31 days, your coverage during that leave will be continued as long as you make the required self-payments. If you are in active service for more than 31 days, you may continue your coverage for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Self-payments for this coverage include your Employer's share of the payments as well as any retroactive payments.

Following your discharge from service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your Employer.

Your coverage will continue to the earliest of the following:

- The date your former Employer no longer provides coverage to any Employee;
- The date you or your Eligible Dependents do not make the required self-payments;
- The date you lose your rights under USERRA, such as for a dishonorable discharge;
- The date you reinstate your eligibility for coverage under the Plan; or
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA.

Continuation coverage under USERRA will be administered in the same manner as COBRA Continuation Coverage, except that coverage may only be continued for up to 24 months under USERRA, and only the Employee may elect continuation coverage under USERRA for himself or herself, and his or her Eligible Dependents. Premiums for continuation coverage under USERRA will be the same amount as premium payments for COBRA Continuation Coverage.

You need to notify the Fund Office in writing when you enter the military, unless you are prevented from doing so because of military necessity. For more information about continuing coverage under USERRA, contact the Fund Office.

Once you are discharged from such service, you may be eligible to apply for reemployment with your former Employer in accordance with the provisions of USERRA; this includes your right to elect reinstatement in any coverage currently provided by your Employer.

When You Do Not Continue Coverage Under USERRA

When you enter military service, if you do not continue your coverage under USERRA, your coverage and that of your Eligible Dependents will end on the last day of the Benefit Quarter in which your induction occurs. You and your Eligible Dependents will have the opportunity to elect COBRA Continuation Coverage.

When you enter into the Armed Forces, any accumulated eligibility will be kept on the records of the Plan. You have the choice of using that accumulated eligibility toward coverage under USERRA and then making self-payments for coverage upon your return from service, or of saving that accumulated eligibility to apply to your coverage upon your return from service.

When you are discharged from military service, you have up to the USERRA specified time limit (based on your term of service) to return to covered employment. When you return to covered employment during this time limit, your coverage and that of your Eligible Dependents will be reinstated on the first day of the month after you are discharged and return to covered employment, provided you were eligible for coverage when you left for service.

If after your discharge from active military service, you are seeking work in covered employment but are unable to find any, any accumulated eligibility will be made available to you and you may be eligible to make self-payments for coverage (refer to page 14).

If covered employment is available and you are physically fit, you must return to work for a Contributing Employer within the USERRA specified time limit (based on your term of service) to retain your right to your eligibility. If you do not return to work in covered employment within this time limit, you must meet the Plan's initial eligibility requirements (refer to page 4) before you are again eligible for coverage under the Plan.

In the Event of Death

In the event of your death while eligible for coverage under the Plan, your beneficiary will receive a Death Benefit (and an AD&D Benefit if your death is caused by an Accident). Refer to *Claims Information* beginning on page 49 for information on how to file a Death Benefit claim.

In the event of your Eligible Dependent's death, you should notify the Fund Office as soon as possible after the death to file a claim for Dependent Death Benefits, if eligible. Refer to *Claims Information* beginning on page 49 for information on how to file a Dependent Death Benefit claim.

You'll also want to review your beneficiary designation and determine whether any changes are necessary.

Continuation of Dependent Coverage After Your Death

Provided your Eligible Dependents continue to meet the Plan's definition of an Eligible Dependent, your spouse's, and child(ren)'s coverage will continue, without self-payments, until the later of:

- The date your eligibility would have ended, based on your employment records, had you not died; or
- The last day of the third month following the month in which you die.

Your Eligible Dependents may continue coverage under the Plan beyond that time by making self-payments for coverage. For your Eligible Dependents to be eligible to continue coverage by making self-payments, you must have been eligible under this Plan:

- To make self-payments at the time of your death; and
- For 18 of the last 20 Contribution Quarters immediately preceding your death.

This coverage is separate from and is not considered COBRA Continuation Coverage; however, this coverage runs concurrently with any applicable COBRA Continuation Coverage period.

Your Eligible Dependents' coverage will be the same as the coverage for which you were eligible before your death, except that the following benefits are **not** covered:

- For surviving spouses:
  - Weekly Loss of Time and Vision Benefits.
- For surviving Eligible Dependent children:
  - Maternity Benefits;
  - Vision Benefits; and
  - Weekly Loss of Time Benefits.

When Your Dependent's Survivor Coverage Ends

Each Eligible Dependent may continue to make self-payments to continue his or her survivor coverage until the earlier of the date that relates to that individual:

- For your spouse, the date your spouse remarries or ending 60 months after survivor coverage began by making self-payments, unless your death occurred after your spouse reached age 55;
- For your child, the date he or she no longer meets the definition of an Eligible Dependent; or
- For your Eligible Dependent, when he or she becomes eligible for Medicare, becomes eligible under any other group health care program, or relocates outside of the United States.

If your eligible spouse continues his or her eligibility until he or she becomes eligible for Medicare, your Eligible Dependent may continue Class C coverage.

Continuing Coverage

Self-Payments

If you would otherwise lose eligibility due to a lack of sufficient Employer contributions made on your behalf, you may continue coverage for yourself and your Eligible Dependents (not including coverage provided through SASMI contributions) for up to 10 successive Benefit Quarters by making self-payments to the Plan. To be eligible to make self-payments, you must be available for work in covered employment.

Self-payment continuation coverage is separate from and is not considered COBRA Continuation Coverage; however, this coverage runs concurrently with any applicable COBRA Continuation Coverage period.

The amount of the payment is equal to 350 hours times the hourly rate in effect for Contributing Employers. The self-payment hours requirement amount is reduced by any hours you worked in the most recent Contribution Quarter.

Self-payments must be received at the Fund Office within thirty days of the due date to continue coverage. If you do not make the necessary self-payments, your eligibility will end on the last day of the Benefit Quarter for which coverage was paid.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your Eligible Dependents may continue health care coverage past the date coverage would normally end. Under certain circumstances, by making self-payments, you and/or your Eligible Dependents may continue medical, prescription drug, hearing, dental, and vision benefits (provided you were eligible for this coverage before your coverage ended).

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan, except you will not be eligible to continue coverage for Weekly Loss of Time, Death, Accidental Death and Dismemberment (AD&D) or Dependent Death Benefits.

To be eligible for COBRA Continuation Coverage as Qualified Beneficiaries, you must have been covered under the Plan on the day before the date that coverage was lost. However, if you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add such child to your coverage and such child will be treated as a Qualified Beneficiary. You must notify the Fund Office, in writing, of the birth, adoption, or placement of a child with you for adoption to have this child added to your coverage.

Children born, adopted, or placed for adoption as described above, have the same COBRA Continuation Coverage rights as a spouse or Eligible Dependents who were covered by the Plan on the day before the date of the event that triggered COBRA Continuation Coverage. Like all Qualified Beneficiaries with COBRA Continuation Coverage, these children's continued coverage depends on timely and uninterrupted self-payments on their behalf.

COBRA Continuation Coverage Qualifying Events

You do not have to show that you are insurable for COBRA Continuation Coverage. It is offered if you or your Eligible Dependents lose coverage because of a qualifying event. Qualifying events include:

- Termination of your employment (for a reason other than gross misconduct);
- Reduction in your hours;
- Your death;
- Your entitlement to Medicare coverage;
- Your divorce or legal separation; and
- Your child's loss of Eligible Dependent status under the Plan.

It's important to notify the Fund Office of a qualifying event to maintain your COBRA Continuation Coverage rights.

Notifying the Fund Office

You or your Eligible Dependent must inform the Fund Office of your divorce, legal separation, or Eligible Dependent child no longer qualifying as an Eligible Dependent within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such an event, you will lose your right to elect COBRA Continuation Coverage.

Your Employer will notify the Fund Office of your termination of employment, reduction in hours, death, or entitlement to Medicare coverage. However, because Employers contributing to multiemployer funds may not be aware of these events, the Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of qualifying events as soon as they occur.

When the Fund Office is notified that one of these events has occurred, you and your Eligible Dependents will be notified of the right to elect COBRA Continuation Coverage. Once you receive a COBRA notice, you have 60 days to respond if you wish to elect COBRA Continuation Coverage. If you do not elect coverage, your Eligible Dependents will be given the opportunity to elect coverage independently from you. If your Eligible Dependent is a minor or otherwise incapable of electing coverage, the Eligible Dependent's parent or legal guardian should contact the Fund Office for more information.

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Eligible Dependents' coverage under the Plan terminated as well as for the current month. This first payment is due no later than 45 days after the date you or your Eligible Dependents return the election form to the Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a payment later than the first day of the month for the period to which it applies, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

It is your responsibility to ensure that the Fund Office receives payment by the due date.

If payment is not received by the due date, all benefits will terminate immediately. Once your COBRA Continuation Coverage is terminated, it cannot be reinstated.

Period of Coverage

- **Coverage Continues for 18 Months.** You may elect to make self-payments for COBRA Continuation Coverage for yourself and your Eligible Dependents for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.
- **Coverage Continues for 29 Months.** If your employment ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your Eligible Dependents is Totally Disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office of your determination of Total Disability by the Social Security Administration. The self-payment for the additional 11 months will be 150% of the self-payment for the first 18 months.
- **Coverage Continues for 36 Months.** Your Eligible Dependents may elect to continue coverage for up to 36 months if coverage ends because:
  - You die;
  - You become entitled to health care coverage under Medicare;
  - You and your spouse divorce or legally separate; or
  - Your Eligible Dependent child no longer qualifies for coverage under the Plan.

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any pre-existing limitation under a new group medical plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for you or your Eligible Dependents may be cut short if:

- You or your Eligible Dependents do not make the required self-payments within 30 days of the due date;
- The Plan ceases to provide any group health benefits;
- You or your Eligible Dependents first become covered under any other group health care plan after election of COBRA Continuation Coverage (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions);
- You or your eligible spouse become entitled to Medicare; or
- Your Employer withdraws from the Plan.

Trade Act COBRA Provisions

This provision applies primarily if your employment is adversely affected by international trade. If the U.S. Department of Labor (DOL) certifies that you are eligible for benefits under the Trade Act of 2002, you may be eligible for both a new opportunity to choose COBRA Continuation Coverage and an individual Health Insurance Tax Credit. If you did not choose COBRA during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event will this benefit allow you to choose COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act you can either take a tax credit or get advance payment of 65 % of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. You can find more information about the Trade Act at **www.doleta.gov/tradeact**. The Plan Administrator may also be able to assist you with your questions.

Medical Benefits

All Eligible Participants

How the Medical Program Works

The medical program pays benefits for a wide range of services and supplies that are Medically Necessary to treat Illness and/or Injury, including Physicians' charges, diagnostic testing, Hospital charges, and surgery. For most covered expenses, once you meet your deductible, the Plan pays:

- 90% of the Preferred Provider Organization (PPO) Allowable Charges; and
- 80% of the non-PPO Reasonable and Customary Charges.

Certain covered expenses may be paid at a different rate. Refer to the Summaries of Benefits in the Appendix *for your coverage amounts.*

In general, once your covered expenses (excluding your deductible) reach the out-of-pocket maximum (subject to applicable Plan provisions), the Plan will pay 100% of the covered expenses you incur for the remainder of that calendar year, subject to any Plan limits. Refer to the *Summaries of Benefits* in the *Appendix*.

It is important to remember that the medical program is not designed to cover every health care expense. The Plan pays charges for eligible expenses, up to the limits and under the conditions established under the Plan's rules. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

When you need to see a Physician:

- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you're taking. Be sure to note how often you take the medications.

When you go to a PPO provider, the provider will file the claim for you. Be sure to show your ID card so your provider knows where to submit your claim.

When you go to a non-PPO provider, it is your responsibility to submit the claim. Refer to *Filing Claims* on page 50.

Deductible

The deductible is the amount of covered expenses that you pay before the Plan begins to pay for certain benefits. You must pay the deductible amount each calendar year before the Plan begins to pay for benefits. The deductible applies to each covered person each year. Certain benefits may not be subject to the deductible. Refer to the *Summaries of Benefits* in the *Appendix*.

Expenses incurred during the last three months of the calendar year that are applied against the individual deductible will also count toward next year's deductible.

The Plan generally pays a percentage of covered charges after you meet the deductible. In most instances, if you reach the out-of-pocket maximum, the Plan pays 100% for the rest of the calendar year.

Coinsurance or Copayments

Coinsurance and copayments are the charges you are responsible for paying for certain covered health services. Coinsurance, generally expressed as a percentage, is the amount you pay for covered services after you meet the deductible, if applicable. Copayments are usually expressed as flat dollar amounts.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay out of your pocket in a calendar year for covered medical expenses. Once you meet the out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year, subject to any Plan limits.

Certain expenses do not apply toward your out-of-pocket maximum. They include:

- The deductible;
- Charges for chiropractic treatment and diagnostic x-rays and laboratory tests;
- Charges for infertility treatment;
- Charges for organ transplant benefits;
- Charges for non-medical speech therapy;
- Expenses not considered covered medical expenses;
- Charges for any cutting of the mouth, gums or bone in connection with extraction, repair or replacement of teeth or disorders of the gums;
- Hospital charges determined to be Medically Necessary that are required due to covered Dental services.
- Charges for out-of-network Preventive Services Benefits, including newborn and well-child care;
- Charges for treatment of developmental disorders;
- Charges for disease awareness and educational services;
- Charges for Sjogren's syndrome; and
- Charges for hearing aids.

Annual Maximum

The annual maximum amount of benefits payable under the Plan is specified in the *Summaries of Benefits* in the *Appendix*.

Allowable Charges and Reasonable and Customary Charges

In general, negotiated amounts charged by PPO providers are considered to be Allowable Charges. For non-PPO providers, the Trustees determine Reasonable and Customary Charges. For a definition of Reasonable and Customary Charges, refer to page 80.

Maximizing Your Medical Benefits

The Plan has two cost management programs designed to help manage certain health care costs:

- A Preferred Provider Organization (PPO); and
- A Utilization Management (UM) program.

Preferred Provider Organization (PPO)

The Board of Trustees has contracted with a Preferred Provider Organization (PPO). Participating providers in the PPO network have agreed to negotiated, reduced fees. When you go to a PPO provider, you save money for yourself and the Plan because the provider has agreed to accept a reduced amount for its services.

For help locating a PPO network provider, call the toll-free phone number listed on page 3.

It's your decision whether to go to a PPO or a non-PPO provider. You always have the final say about the providers you and your family use. However, remember that when you use a non-PPO network provider, you pay a higher percentage of covered charges.

Utilization Management (UM) Program

The Plan also provides a Utilization Management Program to help ensure that you receive quality care by using the Plan's valuable health care resources as wisely as possible. To make it work, we need you to become involved in the decisions regarding your health care.

It is very important to call for pre-certification if your Physician recommends hospitalization or surgery. If you do not call for pre-certification, you'll pay $100 more in covered expenses.

In addition, if you do not have your treatment for inpatient mental health or inpatient substance abuse, your home health care, or your Durable Medical Equipment pre-certified, the percentage payable by the Plan will be reduced.

If your Physician recommends hospitalization or surgery, you should call the UM program to have your care pre-certified. If you don't call for pre-certification, you pay $100 more in covered expenses.

If you receive services for an Emergency Medical Condition/ hospitalization, you or a family member must call to notify the UM program within 48 hours after the Hospital admission.

The Plan's UM program provides the following services:

- Preadmission review and certification;
- Emergency admission review for an Emergency Medical Condition;
- Inpatient/Outpatient surgery review;
- Inpatient treatment review;
- Discharge planning and home health care coordination;
- Obesity treatment (no benefits will be paid if treatment is not pre-certified);
- Inpatient and outpatient mental health treatment review;
- Inpatient and outpatient substance abuse treatment review;
- Major case management;
- Coordination of Durable Medical Equipment and supplies for home use; and
- Referrals to appropriate providers.

Covered Medical Benefits

The Plan covers charges for Medically Necessary medical benefits, up to the limits specified in the *Summaries of Benefits* in the *Appendix*.

Covered Charges
Contracted Allowable Charges of PPO network providers, or Reasonable and Customary charges of non-PPO network providers that are typically billed for the same types of services and supplies received in the geographic area, as determined by the Trustees.

Class A, B, D, E, and I Eligible Participants

The following benefits are paid up to any limits specified in the *Summaries of Benefits* in the *Appendix*.

Hospital Expenses

Inpatient Hospital benefits include:

- Daily Hospital room and board up to the semi-private room rate, including any Hospital length of stay in connection with childbirth for the mother or newborn child up to 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- The average room rate of the Hospital, if the Hospital has only private rooms.
- General nursing services.
- Coverage if, when undergoing Inpatient treatment for mental or nervous conditions, the individual is temporarily released for up to two consecutive days for therapeutic reasons, with an aggregate maximum of six such days per period of disability.
- Daily Hospital charges for coronary or Intensive Care Unit treatment.
- Medically Necessary services and supplies furnished by the Hospital.
- Hospital-miscellaneous charges for all other Medically Necessary services and supplies furnished in a Hospital that are not included in the daily room and board charge.
- Outpatient surgical Hospital or Ambulatory Surgical Center expenses.
- Crib care benefits including care of a newborn Eligible Dependent child payable during the period the mother of the child is Hospital-confined because of giving birth to the child.
- Charges related to Hospital confinement that are not billed by the Hospital but are related to Hospital treatment eligible under the Plan, including charges:
  - For professional local ambulance services to or from the Hospital (or between Hospitals if necessary for more highly specialized care);
  - Made by a Physician, other than the operating Physician or his assistant, for the administration of anesthesia by other than local infiltration and for inpatient visits;
  - For services of a Certified Registered Nurse Anesthetist (CRNA) and an anesthesiologist (MD); and
  - Made by a radiologist or pathologist;
- Medical examination and care of a newborn Eligible Dependent by a Physician specializing in pediatrics, while Hospital-confined on the day of birth and the following day.
- Skilled Nursing Care Facility expenses.
- Services received in a U.S. Department of Veteran Affairs Hospital or Facility for any condition that is not a military service-related Illness or Injury up to the extent those services are Medically Necessary and the charges are Reasonable and Customary.

Surgical Expenses

Surgical benefits include charges of a Physician for a covered surgical procedure not to exceed any maximums specified by the Plan. Charges by an assistant Surgeon are a covered expense provided they are Medically Necessary. The Plan will pay up to 20% of the Reasonable and Customary Charges of the

surgical procedure for the services of an assistant Surgeon. The Plan covers services of a certified surgical assistant at the rate of 10% of the PPO allowance for Physicians or in the absence of a PPO Physician, at the rate of 10% of the Reasonable and Customary surgical allowance. In addition, the Plan covers services of a certified registered nurse anesthetist (CRNA). However, benefits paid for anesthesia will be considered either for the services provided by an anesthesiologist (MD) or a CRNA, but not both.

- Charges for Surgical Procedures performed in a Hospital, Ambulatory Surgical Center or approved surgical facility due to non-occupational Accident or Illness, including pre- and post-operative care and any anesthetic customarily administered by the Surgeon or an approved surgical facility.
- Benefits for circumcision of a newborn Eligible Dependent male child by a Physician.
- Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This coverage, which is subject to the Plan deductibles and coinsurance provisions includes:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery on the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- Sterilization charges for you and your spouse only.
- Surgical Procedures, including pre- and post-operative care, for jaw joint problems, gnathic surgery of maxilla and/or mandible, temporomandibular joint (TMJ) dysfunction, disorder or syndrome disorders, and any other craniomandibular disorders or conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues.
- Podiatric surgery, if performed in a podiatrist's office or a podiatric surgical center, and non-surgical podiatry treatment, up to the per person per calendar year limit specified in the *Summaries of Benefits* in the *Appendix*.
- Podiatric surgical treatments performed in a Hospital or an Ambulatory Surgical Center, up to the per person per calendar year limit specified in the *Summaries of Benefits* in the *Appendix*.
- Surgery needed to correct the effects of a congenital disease or gross developmental anomaly for an Eligible Dependent child causing a functional defect such as a cleft palate and lip that limits that child's ability to eat and drink.

Medical Services and Supplies

- Services of a legally qualified Physician, including a Physician Assistant (PA) under the direction of a Physician.
- Services of a legally qualified Nurse Practitioner.
- Diagnostic laboratory and x-ray examinations, x-ray, or radium therapy treatment.
- Casts, splints, trusses, braces, crutches and artificial limbs and eyes replacing limbs or eyes that are lost while eligible for benefits.
- Whole blood or blood plasma, including the cost of administration, other than those charges for "elective" testing and donation. Autologous transfusion procedures will be considered if Medically Necessary due to surgery and only those pints used (because of the surgery) will be considered an eligible expense.
- Anesthetics and oxygen, including administration or rental of equipment.
- Durable Medical Equipment, when ordered by a Physician, including:

  - Rental, up to the allowed purchase price of the device, based on at least two purchase estimates for such equipment;
  - Purchase of standard models at the option of the Plan;
  - Medically Necessary repair, adjustment or servicing of the device; and
  - Medically Necessary replacement of the device due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired, but not more than once every 60 months from the last purchase, if related to a loss that occurred or to a purchase made after becoming eligible.
- Speech therapy for treatment of developmental disorders, up to the number of visits per calendar year per person as specified in the Summaries of Benefits in the *Appendix*.
- Home health care services for part-time intermediate skilled nursing by a graduate registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) provided those services are not rendered by someone who ordinarily resides in your home or who is a member of your or your spouse's family. Home Health Care must:
  - Replace a needed Hospital stay;
  - Be for the care or treatment of a sick or injured person;
  - Be furnished by a facility, organization or association that meets the Plan's definition of a Home Health Care Agency; and
  - Be pre-certified before services are obtained.
- Respiratory and physiotherapist treatment when required due to physical impairment caused by Illness or Injury.
- Cardiac rehabilitation (not to exceed six weeks unless Medically Necessary) following a heart attack or surgery.
- Hospice care services (of an approved hospice program) provided to a terminally ill individual if the medical prognosis indicates a life expectancy of six months or less. Benefits for hospice care are provided for the period beginning on the date the attending Physician certifies that the Eligible Person is terminally ill, and ends six months after it began or on the date of the individual's death, whichever is sooner. Benefits may be extended to a maximum of 12 months (from the date care began) if the Physician certifies that the individual is still terminally ill.
- Organ, bone marrow and stem cell transplants (including organ shipping, procurement, donor charges, and other related expenses). Organ transplants include only those transplants approved by Medicare. The Plan will cover charges incurred by a donor in an organ transplant procedure whether or not the donor is eligible under the Plan. Such coverage is included as part of the overall annual maximum and will be coordinated with any other coverage the donor may have, with the donor's coverage paying first and this Plan's coverage paying secondary.
- Chiropractic treatments for covered participants age six or older, which include office visits, manipulation (limited to one treatment per day), electrical stimulation, modalities, acupuncture and ultrasound treatments. This does not include:
  - Diet or hair analysis;
  - Nutritional or food supplements and/or vitamins;
  - Pillows, supports or similar devices;
  - More than one chiropractic treatment per day;
  - Booklets; and
  - Items such as orthotics or braces when furnished or prescribed by a chiropractor.

- Chiropractic x-rays and laboratory service ordered and/or performed by a chiropractor, up to Plan limits.
- For Class A, E, G, H, and I Eligible Employees and Dependent Spouses only, infertility treatment, up to the Plan's limits, for office visits, x-ray and lab, prescription drugs, drug/hormone therapy and Surgical Procedures for infertility.
- Services rendered by a certified, registered psychologist (Ph.D. or PsyD) or, when referred by a Physician, a Licensed Mental Health Counselor, Certified Addiction Professional (CAP), Certified Addiction Drug Counselor (CADC), Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC).
- Eyeglasses prescribed after cataract surgery.
- Treatments or Surgical Procedures provided in connection with an overweight condition or condition of obesity only if:
  - The person is 100 or more pounds over the medically desirable weight; and
  - The obesity is a threat to the individual's life due to other complicating health factors such as diabetes, heart trouble or hypertension;
  - The individual has a history of unsuccessful attempts to reduce weight by more conservative measures; and
  - Before the person receives any treatment for obesity, the Utilization Management program is contacted for a review of the treatment plan and treatment is authorized as Medically Necessary (if treatment is not precertified, it will not be covered by the Plan);
- Developmental disorder treatment, regardless of the cause, are covered up to the maximum amount per person per calendar year specified in the *Summaries of Benefits* in the *Appendix*, provided the Eligible Participant uses available government-mandated programs. The calendar year maximum does not include Expenses Incurred for speech therapy; speech therapy is covered as a separate benefit subject to a separate maximum.
- Dental expenses for treatment of sound, natural teeth damaged as the result of an Accident, provided treatment is received within 24 months of the Accident.
- Aural Rehabilitation/Habilitation Services provided by a licensed audiologist and/or a certified auditory/verbal therapist based on Medical Necessity, up to the maximum amount per person per calendar year specified in the *Summaries of Benefits* in the *Appendix*, for individuals with hearing aids or cochlear implants. Up to 10 sessions of auditory rehabilitation required to train the recipient about cochlear implants (which are covered prosthetic devises under the Plan) and proper use are covered; additional sessions may be covered if pre-certified as Medically Necessary.
- Physical, occupational and rehabilitation therapy ordered by a Physician and provided by a licensed physical therapist or a licensed physical therapist assistant working in collaboration with a Physician and/or licensed physical therapist, up to 25 visits per person per calendar year, as specified in the *Summaries of Benefits* in the *Appendix*. More than 25 visits per person per year would require referral to the Plan's Utilization Management (UM) Provider for prior approval. The maximum would not apply for therapy while Hospital-confined.
- Podiatry, physical, occupational, and rehabilitation therapy would be limited to the podiatry maximum allowed under the Plan and any covered therapy by a chiropractor is limited to the maximum allowed under the Chiropractic Benefit. Therapy ordered by a chiropractor is not a covered expense under the Plan.
- Four prosthetic bras per calendar year.
- Custom fitted Medically Necessary foot orthotic devices prescribed by a Physician, Up to two pairs in any three-year period, unless under age two and prescribed by a Physician. If ordered by or supplied by a podiatrist, benefit limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year.

- Disease awareness/education services, only if rendered by a licensed provider acting under a Physician's order, excluding chiropractors, up to the maximum amount specified in the *Summaries of Benefits* in the *Appendix*.
- The services of a legally qualified Optometrist for the treatment of Illness or Injury only.
- Replacement of prosthetic medical devices whenever such replacement is Medically Necessary.
- Coverage for dental services that are caused by medical conditions, such as Sjogren's Syndrome, up to the maximum amount per person per year (in addition to the limits provided under the Plan's Dental Benefits) specified in the *Summaries of Benefits* in the *Appendix*. Tooth replacement because of these medical conditions is only covered under the Plan's Dental Benefits.

Behavioral Health Benefits

The Plan covers behavioral health (mental health and alcohol and substance abuse) treatment as follows:

- Mental health benefits including treatment of mental and nervous disorders, up to Plan limits, including treatment of Attention Deficit Disorders (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and autism; Mental health benefits when provided in a Partial Hospital Program (PHP) or Intensive Outpatient Program (IOP) are covered the same as Inpatient Hospital treatment.

  PHP or IOP mental health treatment is covered in the same way as Inpatient Hospital care and is subject to the Inpatient deductible and coinsurance specified in the *Summaries of Benefits* in the *Appendix*.

For more information relating to Behavioral Health Benefits, refer to page 30, which provides information about the Plan's Member Assistance Program (MAP).

- Alcoholism and substance abuse treatment, up to Plan limits, are covered as specified in the *Summaries of Benefits* in the *Appendix*. PHP or IOP alcoholism and substance abuse treatment is covered the same as Inpatient Hospital care and is subject to the Inpatient deductible and coinsurance specified in the *Summaries of Benefits* in the *Appendix*.

Preventive Services Benefits

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (PPACA). Coverage is available for the following services only when provided by a PPO network provider:

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

PPO network provider preventive services that are identified by the Plan as part of the PPACA guidelines will be covered with no cost-sharing by you or your Eligible Dependents. This means that the service will be covered at 100% of the Plan's Allowable Charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-PPO network provider, they will not be eligible for coverage under this Preventive Services Benefit. However, in some cases, federal guidelines are unclear about which preventive benefits must be covered under the PPACA. Therefore, the Trustees will determine whether a particular benefit is covered under this Preventive Services Benefit. In that respect, the Plan provides 100% reimbursement for annual flu shots for you and your covered Eligible Dependents, regardless of whether they are received from a PPO network provider, or a non-PPO network provider. You can submit your receipt for the flu shot and be reimbursed by the Fund Office or have your physician submit a claim through the PPO.

Annual Physical Examination and OB/GYN Visit Coverage: All Employees, Retired Employees, and Eligible Dependent Spouses Except Class C Eligible Participants

The Plan will cover the expense related to a routine annual physical examination (including routine OB/GYN examinations) by a Physician at 100% without cost sharing. This benefit is limited to one examination (plus one OB/GYN visit for females) per year for you and each of your covered Eligible Dependents and must be provided by a PPO network provider.

Eligible expenses include the Physician's professional fees and diagnostic x-ray or laboratory charges. The examination may be performed in a Physician's office, clinic, or Hospital Outpatient department. A chiropractor is not considered a Physician for Routine Physical Examination benefits.

In addition to any limitations or exclusions listed in the *General Plan Exclusions and Limitations* section beginning on page 45, this benefit does not cover:

- Testing or examination related to Accidental Bodily Injury, Illness, or Pregnancy (including resulting child birth or complications);
- Testing or examination related to or as a condition of employment or to the issuance of any insurance policy; or
- Expenses incurred by a Dependent other than the Employee's spouse, except that the Plan will comply with all provisions of the PPACA with regard to preventive services that are required to be provided to Dependent children.

If you use the services of a non-PPO network provider for your routine annual physical examination or OB/GYN examination, the Plan will pay for that examination as it would for any other service, so that it will be subject to coinsurance and the deductible specified in the *Summaries of Benefits* in the *Appendix*.

Newborn and Well-Child Care Coverage

The Plan will cover expenses related to newborn and well-child care recommended in the Bright Futures Recommendations at 100% without cost sharing. This includes well-child physical exams. This benefit is limited to services provided by PPO network providers.

If you use the services of a non-PPO network provider for your newborn and well-child care, the Plan will pay for that examination as it would for any other service, so that it will be subject to coinsurance and the deductible specified in the *Summaries of Benefits* in the *Appendix*.

In addition to any limitations or exclusions listed in the *General Plan Exclusions and Limitations* section beginning on page 45, this benefit does not cover:

- Testing or examination related to Accidental Bodily Injury, Illness, or Pregnancy (including resulting child birth or complications); or
- Testing or examination related to or as a condition of employment or to the issuance of any insurance policy.

Preventive Services Benefit Overview

Preventive Services covered with no cost sharing. PPO network Preventive Services Benefits are available under the Fund's Preventive Services Benefit with no cost sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit (that is not the routine annual physical examination or annual OB/GYN examination) is payable under the Preventive Services Benefit. The following conditions apply to payment for PPO network provider office visits under the Preventive Services Benefit. Non-PPO network provider office visits are not covered under the Preventive Services Benefit under any condition, but are subject to the Plan's medical deductible and coinsurance provisions for out-of-network medical services.

- If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit:
  - Is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit; or
  - Is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

    For example, if a person has a cholesterol screening test during an office visit, and the Physician bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge coinsurance for the office visit as specified in the *Summaries of Benefits* in the *Appendix*, but not for the lab work. If a person sees a Physician to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge coinsurance for the office visit because the blood pressure check was not the primary purpose of the office visit.

Preventive Services Coverage Limitations and Exclusions

- Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services Benefit. A service is covered for diagnostic reasons if you or your Eligible Dependent had symptoms requiring further diagnosis or had abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
- Services covered under the Preventive Services Benefit are not also payable under other portions of the Plan.
- The Plan will use reasonable medical management techniques to control costs of the Preventive Services Benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services Benefit.
- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.
- Examinations, screenings, tests, items or services are not covered when they are Investigational or

Experimental, as determined by the Plan.

- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  - When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
  - When related to judicial or administrative proceedings;
  - When related to medical research or trials; or
  - When required to maintain employment or a license of any kind.
- Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services Benefit. For example, the following drugs, medicines, vitamins, and supplements are not covered:
  - Aspirin for any reason, including for prevention;
  - Chemoprevention for any indication, including but not limited to breast cancer;
  - Supplements, including but not limited to oral fluoride supplements and folic acid supplements; and
  - Tobacco cessation products, drugs, or medicine, except as provided under the following Smoking Cessation Benefits.

Smoking Cessation Benefits: All Employees, Retired Employees, and Eligible Dependents Spouses Except Class C Eligible Participants

If you or your Eligible Dependent spouse incurs expenses for a smoking cessation program, the Plan will pay covered expenses up to the maximum specified in the *Summaries of Benefits* in the *Appendix*. Services must be performed by a covered provider under the Plan. Smoking cessation medications are only payable when prescribed by a Physician (a written prescription is required).

Medical Expenses Not Covered

In addition to any limitations or exclusions listed in the *General Plan Limitations and Exclusions* section beginning on page 45, the following expenses are not covered under the Plan's Medical Benefits:

- Eyeglasses or hearing aids, including related examinations or fittings, except as otherwise covered under the Plan's Hearing or Vision Benefits or as covered after cataract surgery;
- Dental care or treatment, except as specifically listed as covered; and
- Testing or examination not recommended as Medically Necessary to diagnose Illness or Accident (e.g., pre-marital or employment examination, issuance of any insurance policy or research studies).

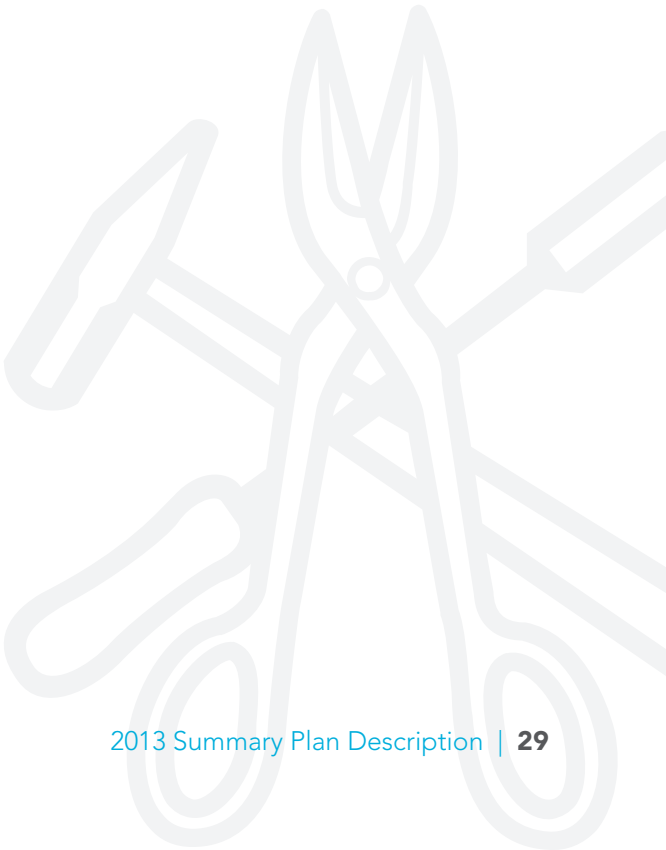
If you incur a non-PPO charge for a medical service or supply that is in excess of what the Trustees consider Reasonable and Customary, you will be responsible for payment of the excess amount.

Health Reimbursement Arrangement

The Trustees have established a Health Reimbursement Arrangement (also called the "HRA Plan") to permit Class C Medicare-eligible retired employees and their Medicare-eligible spouses to obtain reimbursement for certain qualified medical care expenses on a non-taxable basis.

The HRA Plan is intended to qualify as an employer-provided medical reimbursement plan under the Internal Revenue Code (IRC) of 1986 (the "Code"), as amended, Code §105 and §106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45.

Refer to the supplement to this Summary Plan Description/Plan Document for detailed information about the HRA Plan.



Member Assistance Program

All Eligible Participants

The Plan provides a Member Assistance Program (MAP) through Employee Resource Systems (ERS), Inc. The MAP provides confidential mental health care services to help you and your family cope with personal difficulties. The MAP can assist you with a variety of problems that can affect your lives both at home and at work, including:

- Alcohol and drug abuse;
- Stress, anxiety, and depression;
- Marital, family, and relationship friction;
- Child and adolescent behavioral problems;
- Domestic violence;
- Child and elder care;
- Financial and legal concerns; and
- Educational and career-related problems.

Calling the MAP can be a first step toward resolution of personal difficulties. The MAP provides up to six free counseling sessions per problem, situation or issue; these sessions are provided at no cost to you. Services may include a comprehensive evaluation, brief counseling, and a referral if necessary. The MAP may cover some services that are not covered by the Plan.

All contact with the MAP is confidential; the MAP counselor will not speak with any supervisor, coworker, or family member without permission of the individual seeking assistance. However, in the event of a life-threatening situation (such as suicide or homicide risk, stalking, or child abuse), confidentiality may need to be compromised.

MAP services are available by calling 800-292-2780 from anywhere in the United States. Calls are always answered by clinical professionals who provide immediate services, even after standard business hours. ERS standard business hours are Monday through Friday from 8:30 a.m. to 5:30 p.m. CST; however, Emergency Services are available 24-hours-a-day, 7-days-a-week.

Prescription Drug Benefits

All Eligible Participants, Except Class C

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with a prescription drug network provider, which provides a network of participating pharmacies and a mail order prescription drug program. When you have your prescriptions filled at a participating pharmacy or through the mail order prescription drug program, you save money for yourself and the Plan.

When you need a medication for a short time—an antibiotic or cold remedy for example—it's best to choose the retail pharmacy program. If you are taking a medication on a long-term basis, it's usually best to have it filled through the mail order prescription drug program.

Generic Versus Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. Both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can save about half the cost of the brand name medications. For some medications, this savings can be a significant source of savings for you and the Plan. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

To encourage you to use generic medications whenever possible, you pay a smaller copayment when you use generic medications.

You may want to ask your Physician or pharmacist if a generic equivalent is available for the prescriptions you need filled.

Retail Pharmacy Program

Retail pharmacy benefits are provided through a retail pharmacy network. The network includes participating pharmacies throughout the United States, including most national and regional chains and most independent pharmacies. The program offers you preferred prices on your prescriptions when you go to a participating pharmacy and present your prescription drug ID card. You simply pay your copayment amount when you pick up your prescription for up to a 30-day supply; there are no claim forms to submit.

If you go to a non-participating pharmacy, you will have to pay the full cost of the prescription when you pick it up. You will then need to submit a claim for reimbursement. The prescription drug network provider will reimburse you based on the medication's discounted cost, minus your copayment amount.

Step therapy programs are designed to control utilization of expensive medications by requiring the use of less expensive medications as first-line therapies. Medication classes that are targeted by step therapy programs typically contain multiple therapeutic alternatives. The goal of step therapy programs is to use a series of steps designed by using nationally accepted clinical guidelines to guide patients through the most cost-effective treatment sequence.

When you need to order medication through the mail order prescription drug program:

- Ask your Physician to prescribe a 90-day supply with refills, if appropriate.
- Mail the original prescription along with the appropriate form to the mail order prescription drug program. You can obtain a form from the Fund Office.

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply that you can have filled right away at a participating retail pharmacy; and
- A 90-day, refillable supply that you can have filled through the mail order prescription drug program.

Mail Order Prescription Drug Program

Use the mail order prescription drug program when you have prescriptions filled for maintenance drugs. Maintenance medications are prescription drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic Illnesses such as:

- Arthritis;
- Diabetes;
- Heart disorders;
- High blood pressure; and
- Ulcers.

When you order by mail, you can get a larger quantity of medication at one time – up to a 90-day supply. The Plan pays 100% of the costs after you pay your copayment. You save money by using the mail order prescription drug program.

You may want to ask your Physician if a generic equivalent is available for the prescriptions you need filled.

Specialty Drug Program

The Plan covers specialty medications that are used to treat certain complex chronic health conditions, in accordance with the specifications in the *Summaries of Benefits* in the *Appendix*.

Specialty medications are prescription drugs that require special handling and close monitoring. They are often considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed:

- Specialty drugs require preauthorization by the prescription drug network provider;
- Specialty drugs are primarily self-injectable medications requiring patient training and education; and
- Their unique manufacturing and distribution process limits the number of pharmacies that are capable of effectively purchasing, storing, and distributing the medications.

Before attempting to have your prescription for a specialty medication filled, you or your Physician **must** call the prescription drug network provider. A specialty pharmacy representative will go through the approval process with you or your Physician. Coordination will take place so that your medication can be sent directly to you or your Physician's office, whichever you prefer.

If you need information regarding a specialty medication or need help locating a specialty pharmacy, you can contact the prescription drug network provider. Refer to page 3 for contact information.

Covered Prescription Drug Expenses

The Plan pays for covered medications that require a written prescription from a Physician or Dentist. A licensed pharmacist must dispense these prescriptions. Covered federal legend prescription medications include:

- Accutane for Eligible Participants 18 and younger;
- ADD/ADHD medications;
- Allergens/allergy injections;
- Class V medications;

- Compound medications;
- Contraceptive pills/birth control pills, for any reason and contraceptive/birth control devices;
- Epipen and Ana-guard;
- Immunosuppressive medications;
- Injectable medications;
- Migraine medications (such as Imitrex and Relpax);
- Pre-natal vitamins;
- Retin-A for Eligible Participants 18 and younger; and
- Diabetic supplies (including over-the-counter supplies), such as blood sugar diagnostic strips, insulin, insulin syringes, lancets, and urine test strips.

The following prescriptions require pre-certification before they are covered by the Plan:

- Retail pharmacy prescriptions for a 30-day supply costing $500 or more;
- Mail order prescriptions for a 90-day supply costing $1,000 or more; and
- Injectable medications.

Prescription Drug Expenses Not Covered

In addition to any limitations or exclusions listed in the *General Plan Limitations and Exclusions* section beginning on page 45, the Plan does not cover:

- Non-FDA approved medications;
- Medications and devices that are not prescribed, including over-the counter medications (unless specified otherwise), such as blood sugar diagnostic meters and Prilosec OTC;
- Blood and blood plasma;
- Cosmetic medications;
- Fertility medications;
- Fluoride preparations;
- Growth hormones;
- Nutrients;
- Smoking deterrents, except as covered under the Plan's Smoking Cessation Benefit;
- Sexual dysfunction medications;
- Vitamins; and
- Weight loss medications.

Medicare Eligibility of Retirees and Their Dependents

Retiree prescription drug coverage ends for you and/or your dependent when you and/or your dependent attain age 65 and become eligible for Medicare. HRA benefits will continue; however, you should sign up for Medicare Prescription Drug Coverage to continue coverage for prescription drug benefits.

NOTE TO MEDICARE-ELIGIBLE INDIVIDUALS: If you drop or lose your prescription drug coverage under the Health and Welfare Fund and do not enroll for Medicare Part D Prescription Drug Coverage after your current prescription drug coverage ends, you may pay more for Medicare Prescription Drug Coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Part D Prescription Drug Coverage, your monthly premium for Medicare Part D Prescription Drug Coverage will increase. The increase will be at least 1% per month for every month after you are eligible for but did not have Medicare coverage. For example, if you go 19 months without coverage, your monthly premium will always be at least 19% higher than what most other people pay. You will have to pay the higher premium penalty as long as you have Medicare Part D Prescription Drug Coverage. In addition, you may have to wait until the next open enrollment period (October 15 to December 7 each year) to enroll.

For More Information About Medicare Prescription Drug Coverage

To get more information:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number will be included in the *Medicare & You* handbook).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and assets, extra help paying for Medicare Prescription Drug Coverage is available. Additional information is available from the Social Security Administration by:

- Visiting **www.socialsecurity.gov**.
- Calling 1-800-772-1213 (TTY users should call 1-800-325-0778).

Dental Benefits

Class A, B, D, E, G, and I Eligible Participants

To help you meet the cost of routine and unexpected dental care, the Plan provides Dental Benefits to all Class A, B, D, E, G, and I Eligible Participants.

How the Dental Program Works

The Plan pays dental, orthodontia, and TMJ expenses, according to the percentages specified in the *Summaries of Benefits* in the *Appendix*, up to the maximum listed per covered person each year.

When you need dental care:

- Schedule your dental appointment.
- Submit a claim form completed by you and your Dentist to the Fund Office. The Fund Office pays claims for PPO and non-PPO providers.

Preferred Provider Organization (PPO)

The Board of Trustees has contracted with a dental Preferred Provider Organization (PPO). Participating providers in the PPO network have agreed to negotiated, reduced fees. When you go to a PPO provider, you save money for yourself and the Plan because the provider has agreed to accept a reduced amount for his/her services.

EXAMPLE: HOW USING PPO DENTISTS SAVES MONEY

Let's assume you go to the Dentist and need a crown. The Plan pays 80% of the cost of this service. When you go to a PPO Dentist, you pay a percentage of a lower amount and this saves you money as shown below.

	PPO Dentist	Non-PPO Dentist
Cost of dental services	$665	$850
Amount Plan pays	$665 x 80% = $532	$850 x 80% = $680
You pay	$665 - $532 = **$133**	$850 - $680 = **$170**

In this example, you would save $37 by using a PPO Dentist.

Contact the PPO network for information about participating providers. Refer to page 3 for contact information.

Show Your ID Card
When receiving dental care, show your ID card to ensure you receive any available discounts.

The Plan pays benefits for non-PPO providers only to the extent that they are Reasonable and Customary. This is the amount a provider in the same geographic area most frequently charges for the same or similar service or procedure.

Predetermination of Dental Benefits

To determine whether a course of treatment or dental procedure is covered and how much the Plan will pay, you or your Dentist may request a predetermination of benefits before treatment begins. Before receiving major dental procedures, it's usually a good idea to have benefits predetermined. You or your Dentist need to submit the request for a predetermination of dental benefits to the Fund Office before treatment begins. The Fund Office will then let you know what is covered and up to how much. If necessary, you and your Dentist can discuss treatment alternatives.

Covered Dental Expenses

The Plan covers four classes of dental services: preventative and diagnostic, restorative and prosthodontic, orthodontic, and TMJ and related disorders. Expenses covered under each of these classes are highlighted in the following sections.

Preventative and Diagnostic Dental

Preventative and diagnostic dental expenses covered under the Plan include charges for the following:

- Oral examinations;
- X-rays, including up to:
  - Two bitewing x-rays in a calendar year; and
  - One set of full mouth or panoramic x-rays in a 36-consecutive month period;
- Preventative treatment, including:
  - Oral prophylaxis (cleaning and scaling of teeth); and
  - Topical sodium and stannous fluoride treatment or sealant once in any calendar year;
- Space maintainers for Eligible Dependent children up to age 19.

Reasonable and Customary Charges for Non-PPO Network Providers

Reasonable and Customary Charges are comparable with those usually made for dental services and supplies in your geographic area, as determined by the Trustees.

You will be responsible for payment of any charges in excess of Reasonable and Customary Charges.

Restorative and Prosthodontic Dental

Restorative and prosthodontic dental expenses covered under the Plan include charges for the following:

- Extractions not related to orthodontics;
- Medically Necessary administration of local or general anesthetics;
- Fillings, other than gold (except as otherwise provided);
- Periodontal treatment (diseases of gums);
- Endodontic treatment (pulp infection and root canal therapy);
- Injections of antibiotic drugs;
- Initial installation of complete or partial bridgework fixed or removable;
- Initial installation of gold fillings or crowns, provided that amalgam, silicate, plastic or other materials will not adequately restore the teeth;
- Replacement of previously existing gold restorations provided:
  - Amalgam, silicate, plastic or other materials will not adequately restore the tooth; and
  - The previous restoration was installed three or more years before its replacement;
- Replacement of previously existing complete or partial removable dentures or fixed bridgework provided:
  - Replacement is required due to the extraction of one or more natural teeth; or
  - The previous denture or bridgework was installed three or more years before its replacement unless the result of an Accidental Bodily Injury;
- Repair or recementing or rebasing of bridgework, dentures, crowns and inlays;
- Occlusal mouth guards up to $300 once in any five-year period; and
- Dental implants.

Orthodontia (Eligible Dependent Children Up to Age 19 Only)

The Plan covers charges for orthodontia expenses. Covered services include:

- Diagnostic procedures, including cephalometric x-rays;
- Appliance therapy (braces), including related periodic oral exams, surgery and extractions;
- Orthodontics (teeth alignment) is covered only if required by cross-bite or special severity of malposition.

TMJ and Other Jaw-Related Disorders

The Plan covers charges for non-surgical treatment of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome, and any other craniomandibular disorders or conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

Dental Expenses Not Covered

The following dental expenses are not covered under the Plan's Dental Benefits:

- Any services rendered, supplies provided or treatment that occurred before coverage under this Plan became effective;
- Treatment other than by a licensed Dentist or licensed Physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist;
- Services or supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures; for purposes of this Plan, facings on crowns or pontics posterior to the second bicuspid are considered cosmetic;
- Replacement of a lost, missing, damaged, or stolen prosthetic device;
- Replacement or repair of an orthodontic appliance;
- Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer;
- Services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are Experimental in nature;
- Any duplicate appliance or prosthetic device;
- A plaque control program;
- Periodontal splinting;
- Services that are provided under other portions of this Plan;
- Myofunction therapy (correction of harmful habits including but not limited to bruxism);
- Expenses for services other than those specifically indicated as covered;
- Veneers;
- Athletic mouth guards; and
- Replacement of any prosthetic appliance, crown, inlay, onlay, restoration, or fixed bridge within three years of the date of the last placement of such item.

Extension of Dental Benefits

In general, all dental treatment must be performed while you or your Eligible Dependents are eligible for benefits. However, benefits for the following dental services are extended for up to two months after your or an Eligible Dependent's eligibility would otherwise end, if the service involves:

- A prosthetic device (such as full or partial dentures) if impressions were taken and abutment teeth were prepared while covered under the Plan;
- A crown, inlay, or onlay if the tooth was prepared for the crown while covered under the Plan; or
- Root canal therapy if the tooth was opened while covered under the Plan.

Hearing Benefits

All Eligible Participants, Except Class C

How well you hear may affect life in many ways. Recognizing this, the Plan provides Hearing Benefits for all Employees, retired Employees, and their Eligible Dependents. If you or one of your Eligible Dependents notices a change in hearing, you should contact an ear specialist (otologist or otolaryngologist).

Managed Care Versus Non-Managed Care

The Plan has contracted with a managed care network. Physicians and audiologists that participate in the managed care network (network providers) have agreed to charge negotiated rates, usually less than what they normally charge. When you or your family goes to a network provider, your out-of-pocket costs are generally less.

You may use non-network providers. When you go to a non-network provider, benefits are still payable under the Plan, but certain services may be covered at a lower level.

It's your decision whether to use a network or non-network provider. You always have the final say about the providers you and your family use. Benefits are limited as specified in the *Summaries of Benefits* in the *Appendix*.

Covered Hearing Benefit Expenses

The Plan covers hearing care up to the maximums specified in the *Summaries of Benefits* in the *Appendix*. Covered benefits include:

- Hearing examination by a Physician;
- Hearing test by a Physician or a licensed audiologist;
- Purchase of a hearing aid, if required, including:
  - Manufacture of ear molds by a Physician or a licensed audiologist; and
  - Purchase of a hearing aid, including hearing aid rental and licensed audiologist consultation fees during an evaluation period whether or not a hearing aid is found to be satisfactory and is purchased.

Hearing Benefit Expenses Not Covered

The following items are not covered under the Plan's Hearing Benefits:

- Examination and testing by other than a Physician or a licensed audiologist;
- Charges for hygienic cleaning of the hearing aid;
- Batteries and their installation; and
- Any items listed in the *General Plan Exclusions and Limitations* section beginning on page 45.

Vision Benefits

Class A, E, G and I Eligible Participants

Eye care can often be overlooked but it is an important part of your overall health care benefits. The Trustees recognize this and, as a result, provide Vision Benefits for Class A, E, G and I Eligible Participants.

Managed Care Versus Non-Managed Care

The Plan has contracted with a managed care network. Opticians, Optometrists, or ophthalmologists that participate in the managed care network (network providers) have agreed to charge negotiated rates, usually less than what they normally charge. When you or your family goes to a network provider, your out-of-pocket costs are generally less.

You may use non-network providers. When you go to a non-network provider, benefits are still payable under the Plan, but your out-of-pocket expenses may be higher than if you go to a network provider.

It's your decision whether to use a network or non-network provider. You always have the final say about the providers you and your family use. Each year, benefits are limited to either the network or non-network benefits specified in the *Summaries of Benefits* in the *Appendix*; but not both.

When you need vision care:

- Schedule an appointment with an Optician, Optometrist, or ophthalmologist.
- If you go to a network provider, the provider will file your claim for you.
- If you go to a non-network provider, you must file a completed claim form with the Fund Office.

Covered Vision Expenses

You and each of your covered Eligible Dependent can receive the vision benefits listed in this section, up to the maximums specified in the *Summaries of Benefits* in the *Appendix*.

Vision Examination

The Plan covers up to one complete vision examination each calendar year for you and each of your Eligible Dependents, including vision screening and vision analysis. A vision screening includes:

- A check of principal vision functions; and
- Determination of vision ability and condition.

Vision Analysis

When a vision screening indicates it is necessary, a vision analysis may be performed. Vision analysis includes:

- Complete case history;
- Measuring and recording of visual acuity, corrected and uncorrected;
- Examination of fundus, media, crystalline lens, optic disc and pupil reflex for pathology, anomalies or Injury;
- Corneal curvature measurements;
- Retinoscopy;
- Fusion determination, distance and near;
- Subjective determination, distance and near;

- Stereopsis determination, distance and near;
- Color discrimination;
- Amplitude or accommodation;
- Analysis of findings;
- Lens prescription (if needed); and
- Measuring and recording of visual acuity, distance and near, with new prescription if required.

Lenses and Frames

When the vision analysis indicates that lenses are required, the Plan covers one set of lenses and frames. Related services and supplies include:

- Professional advice on frame selection;
- Facial measurements and preparation of specifications for optical laboratory;
- Verifying and fitting of prescription glasses;
- Re-evaluation and progress report after fitting new prescription; and
- Subsequent servicing.

Vision Expenses Not Covered

The following items are not covered under the Plan's Vision Benefits:

- Examinations or materials provided more frequently than once a year;
- Lost or broken lenses, frames, or contact lenses, except at the normal intervals when benefits are available;
- Safety lenses or goggles;
- Special procedures such as orthoptics, vision training, or aniseikonia;
- Non-prescription sunglasses;
- Services, treatment, or supplies related to medical or surgical treatment of the eyes; and
- Services, treatment, or supplies rendered or furnished before the date a person becomes initially eligible or after the date a person's eligibility terminates.

Weekly Loss of Time Benefits

Employees Only

The Plan provides a Weekly Loss of Time Benefit in the event you cannot work because of a non-occupational disability. The amount of the benefit is specified in the *Summaries of Benefits* in the *Appendix*.

If you are unable to work at your occupation due to an Injury or Illness and you are under the care of a Physician, benefits begin immediately if you are eligible due to an Accident, Outpatient surgery, or Illness where you are confined in a Hospital. In the event of an Illness where you are not confined in a Hospital, benefits begin after seven days of disability.

The Plan requires that you be under the care and attendance of an M.D. or D.O. A chiropractor is not considered a Physician for this purpose. However, in the event that you have surgery performed by a podiatrist, a podiatrist is considered a Physician for this purpose.

The amount of the weekly benefit is 90% of your base wage rate times 40 hours, up to the maximum specified in the *Summaries of Benefits* in the *Appendix*. However, only 50% is paid for a second period of disability that is due to substance abuse treatment. In addition, after two courses of substance abuse treatment, no Weekly Loss of Time Benefits will be paid.

If you can't work because of an Injury or Illness:

- Call your Employer and the Fund Office.
- See a Physician as soon as possible.
- File a claim with the Fund Office.

For purposes of the Weekly Loss of Time Benefit, a non-occupational Injury or Illness is an Injury or Illness that does not occur in the course of any employment for wage or profit.

How Long Benefits Are Paid

Benefits continue until you recover or receive 39 weeks (13 weeks for Class I Employees) of benefits for one period of disability, whichever occurs first.

All disability absences will be considered as occurring during a single period of disability unless evidence provides that the cause of the latest disability absence:

- Cannot be connected with the cause of any prior disability absence and the latest disability absence occurs after your return to active work for at least one day; or
- Can be connected with the cause of a prior disability but the two were separated by your return to work for at least two full, consecutive weeks.

For all Employees except Class I Employees, if you were released for full duties and no work was available, you could be eligible for an additional period of disability of up to 13 weeks if you again become Totally Disabled provided that you:

- Are eligible under the Plan at the time you again become Totally Disabled;
- Requested your name to be placed on the Union's out of work listing; and
- Submitted confirmation from at least one contractor advising that no work was available.

One day must have elapsed since the date you were released to return to work and again became Totally Disabled if the disability is not due to the same cause as the previous disability and at least two weeks have elapsed if the disability is for the same cause as the previous disability.

No disability will be considered to begin before your first visit to a Physician. In addition, no benefits are payable for days during which you perform work at your occupation. Weekly Loss of Time Benefits end when you retire.

Death Benefits

Death Benefit

Employees and Retired Employees

The Death Benefit is designed to help your family pay its expenses in the event of your death. The amount of the Death Benefit is specified in the *Summaries of Benefits* in the *Appendix*.

Benefit Payment

Generally, the Death Benefit is paid in a lump sum. In the event of your death, your beneficiary must contact the Fund Office. The Fund Office will provide a claim form for your beneficiary to complete and return along with any required documentation.

Designating Your Beneficiary

Initially, you choose your beneficiary when you become eligible under the Plan. You may choose one or more beneficiaries and you can change your beneficiary(ies) at any time by submitting a completed, signed form to the Fund Office. The change must be received by the Fund Office to be effective as of the date you signed the form.

If you designate more than one beneficiary, your benefit will be divided as you designate. If you do not designate any shares, then your benefit will be paid in equal shares to your designated beneficiaries. If you do not name a beneficiary or if none of your designated beneficiaries is living at the time of your death, your benefit will be paid to your:

If you need a beneficiary form, contact the Fund Office.

- Spouse, or if none;
- Children (including adopted children) in equal shares, or if none;
- Parents in equal shares, or if none;
- Brothers and sisters in equal shares, or if none;
- Executor or administrator of your estate.

Dependent Death Benefit

Class A, E, G, H, and I Eligible Dependents

If you are a Class A, E, G, H, or I Employee, the Dependent Death Benefit pays a benefit if your spouse or Eligible Dependent child dies while covered by the Plan. Refer to *Eligibility for Benefits* on page 4 for information about who is considered an Eligible Dependent under the Plan. You are the beneficiary for the Dependent Death Benefit.

Accidental Death and Dismemberment (AD&D) Benefit

Class A, E, G, H, and I Employees

In addition to the Death Benefit, the Plan also provides an Accidental Death and Dismemberment (AD&D) Benefit. This benefit is payable if you lose your life, limb(s) or entire sight in one or both eyes. This benefit is not available to Dependents.

Benefit Amount

The amount of the AD&D Benefit is specified in the applicable *Summaries of Benefits* in the *Appendix* and is based on the type of loss incurred as follows:

Type of Loss	Amount Payable
Life	Full Amount
Both hands, both feet, or sight in both eyes	Full Amount
One hand and one foot, one hand and sight of one eye, or one foot and sight of one eye	Full Amount
One hand, one foot, or sight of one eye	Half of Full Amount

Benefits are payable only if a death or Injury is the direct result of an Accidental Bodily Injury sustained (work-related or non-work-related) while you are covered by the Plan. The loss must occur within 180 days after the date of the Accident. If more than one loss occurs, only one benefit, the larger, is payable.

Benefits are paid directly to you for an Injury or to your beneficiary in the event of your death. AD&D Benefits are in addition to any Death Benefits that may be paid.

When AD&D Benefits Are Not Paid

Benefits are not paid for losses contributed to or caused by:

- Bodily disease or mental infirmity;
- Ptomaine or bacterial infections, except septic infections on and through a visible wound accidentally sustained;
- Alcohol, drug, or substance abuse;
- War, act of war, riot or duty in the armed forces;
- Medical or surgical treatment not made necessary by Injury covered under the Plan;
- Commission of an assault or a felony;
- Self-destruction or Injury and/or attempted self-destruction or Injury, unless due to an underlying physical or mental condition;
- Medical or surgical treatment not made necessary by Injury covered under the Plan;
- Travel or flight in or descent from any species of aircraft if you are a student pilot or member of the crew or if you are a passenger on any:
  - Civilian aircraft not having a current and valid air worthiness certificate or piloted by a person who does not then hold a valid and current certificate of competency of a rating authorizing him to pilot such aircraft; or
  - Type of aircraft operated by any military authority of the United States or by any duly constituted governmental authority of any country recognized by the United States Government while in the course of any training maneuvers of any armed forces; and
- Riding, driving, or testing of a vehicle used in a speed contest or participation in the sport of parachute or bungee jumping.

General Plan Exclusions and Limitations

In addition to any exclusions or limitations specified elsewhere in this booklet, the following expenses are not covered under the Plan:

This is not a complete list of exclusions and limitations. The fact that a service, supply, or treatment is not listed as an exclusion or limitation does not mean that it is covered under the Plan.

1. Routine care, except as specifically provided otherwise;
2. Diet medication or supplements;
3. Treatments to improve sexual dysfunction or inadequacy, including, but not limited to, Viagra;
4. Services or supplies that are not Medically Necessary, except as specifically provided otherwise;
5. Non-Emergency Hospital admission and confinement over a weekend;
6. Hospital admission for surgery that is generally performed on an Outpatient basis unless such admission is deemed Medically Necessary;
7. Services or supplies for work-related Illnesses or Injuries;
8. Self-inflicted Injury or Illness, unless due to an underlying physical or mental condition;
9. Charges that exceed Reasonable and Customary Charges as defined by the Plan;
10. Expenses Incurred while confined in a Hospital owned or operated by the federal government or other government unit for services or supplies to treat Illness or Injury resulting from military service;
11. Treatment by a Physician employed by the federal government or other government unit for services or supplies to treat Illness or Injury resulting from military service;
12. Services for which the patient would not legally have to pay if there were no coverage;
13. Injury or Illness arising out of the commission of a felony, except that Injury or Illness arising out of acts of domestic violence will be covered;
14. Confinement in any Hospital or treatment by any provider otherwise eligible under this Plan when such treatment is ordered as a part of any litigation, court ordered judgment or penalty (including, but not limited to psychiatric evaluation or counseling and confinement, evaluation or other treatment related to alcoholism or substance abuse);
15. Alcoholism or substance abuse treatment programs not conducted by a state licensed provider or facility or that exceeds the Reasonable and Customary charge;
16. Declared or undeclared war, or any act thereof, or military or naval services of any country;
17. Services, treatment, or supplies received from a dental or medical department maintained by a mutual benefit association of this or another employee benefit plan or labor Union;
18. Services, treatment, or supplies that are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees have, directly or indirectly, paid for all or a portion of the cost;
19. Services, treatment or supplies rendered or furnished:
    a. Before the individual concerned became eligible; or
    b. Without the recommendation and approval of a legally qualified Physician.
20. Services related to obesity, diet or weight control, including but not limited to exercise programs, special diet or diet supplements, amphetamines, or any form of diet medication whether or not recommended or supervised by a Physician, including dietary or nutritional counseling, books, pamphlets or classes, except as specifically provided otherwise;

21. Diet or hair analysis;
22. Custom fitted shoe inserts unless prescribed by a Physician (and then only up to two pairs in any three-year period) and shoes unless under age two and prescribed by a Physician;
23. Any deductible or copayment required under Medical Benefits;
24. Nutrition or food supplements and/or vitamins;
25. Pillows, supports, or similar devices;
26. Services rendered by a naprapath;
27. Phone consultation charges;
28. Elective abortions, unless the life of the mother is threatened; however, the Plan covers complications of abortion;
29. Mental counseling, physical therapy, supplies or prosthesis for sexual dysfunction or inadequacies;
30. Except as otherwise covered under the Plan's Member Assistance Program (MAP), behavior disorder counseling and other counseling such as, but not limited to:
    a. Adoption counseling;
    b. Court-ordered counseling;
    c. Custody counseling;
    d. Developmental disabilities;
    e. Dyslexia;
    f. Family planning counseling;
    g. Learning disorders;
    h. Marriage, couples and/or sex counseling;
    i. Pregnancy counseling;
    j. Transsexual counseling;
    k. Vocational disabilities; and
    l. Conduct disorders.
31. Implantation within the human body of artificial mechanical devices designed to replace human organs other than pacemakers or similar devices that merely assist rather than replace the function of the organ;
32. Ambulance service or transportation between cities or states (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening Illness or Injury;
33. Growth hormones;
34. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;
35. Special home construction to accommodate a person;
36. Education, special education, job training or work hardening whether or not given in a facility that also provides medical or psychiatric treatment. This includes special education or like services, regardless of the type of education, the purpose of the education, the recommendation of the attending Physician or the qualification of the individual rendering the educational services;

37. Consultations or sessions with family members that are primarily in connection with the treatment of another family member;

38. Rest cures, Custodial Care, and/or residential treatment programs;

39. Supplies or equipment for personal hygiene, grooming, comfort, or convenience, including such supplies or equipment provided while confined in a Hospital, such as guest tray meals, television rental, barber or beautician services, or admission kits;

40. Hospital confinement that is not Medically Necessary, including early admission or late discharge and confinement related to elective Surgical Procedures such as cosmetic surgery;

41. Treatment on any day of Hospital confinement for which Hospital benefits are not payable;

42. Services, treatment, or care rendered by a member of the eligible family member's family;

43. Treatment or services for or in connection with marriage, family, parental, child, career, social adjustment, pastoral or financial counseling or counseling services for other anti-social actions, except as otherwise covered under the Plan's Member Assistance Program;

44. Treatment or services for primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetics therapy, vision perception training, or carbon dioxide therapy;

45. Hearing aids, except as specifically provided;

46. Cosmetic or reconstructive surgery (such as rhinoplasty or breast augmentation) and all related charges, except as specifically listed as covered, unless such surgery is:
    a. Necessary for the prompt repair of Accidental Bodily Injury, Illness, or disease; and
    b. Performed within two years from the date of a covered loss.

    Breast reduction (reduction mammoplasty) may be considered an eligible medical expense in certain cases when determined to be Medically Necessary. Examples of Medical Necessity include: severe skin disorder (such as rash or ulceration under the breast) and/or severe musculoskeletal symptoms (such as back pain or shoulder disfiguration) that generally require no less than 550 grams of tissue be removed from each breast.

47. Elective procedures, services, or supplies;

48. Experimental or Investigational procedures;

49. Pregnancy-related expenses incurred by an Eligible Dependent child;

50. Organ transplants not approved by Medicare and treatment employing Experimental or Investigative medical or Surgical Procedures;

51. Vision improvement procedures such as, but not limited to:
    a. Radial Keratotomy (RK);
    b. Automated Lamellar Keratoplasty (ALK);
    c. Astigmatic Keratotomy (AK);
    d. Photorefractive Keratotomy (PRK); and
    e. LASIK surgery.

52. Services rendered in a U.S. Department of Veterans Affairs Hospital or facility because of a military service-related Illness or Injury;

53. Charges incurred for treatment provided to a covered individual beyond a period of three weeks from the date of leaving the United States. However, in the event of requiring emergency treatment provided as a result of an Emergency Medical Condition or life threatening condition, such treatment covered up to a maximum benefit of $250. Eligible Dependents who are full-time students studying outside the United States are not subject to this limitation and will be covered by this Plan secondary to any insurance provided by the enrolling Educational Institution, provided they have lived with the Employee in a regular parent-child relationship within the prior 12-month period;

54. Medications that can be obtained without a prescription;

55. Charges for prevention of Illness. Benefits for routine or wellness care are payable only to the maximums specified in the Plan;

56. Charges to fill out forms;

57. Charges for ear plugs. This also applies if a Physician recommends ear plugs for a dependent child with ear tubes;

58. Hair loss treatment (treatment with medication with or without a prescription);

59. Administrative charges for the completion of claim forms or any type of administrative expenses incurred in regard to health care are excluded from coverage under the Plan;

60. Shipping, handling, and/or taxes;

61. Any medical treatment or prescription drug usage that extends beyond a period considered as prudent care and evaluated as not an appropriate course of treatment (after review and determination by the Board of Trustees);

62. Charges by a non-licensed facility or provider;

63. Travel expenses; and

64. Charges for services when patient is not present.

Claims and Appeals

Claims Information

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your claim reviewed by the Trustees.

If you or an Eligible Dependent has coverage under more than one health care plan, benefits are coordinated as explained, beginning on page 60.

If you are eligible for Plan coverage under Class C, you may be eligible to obtain reimbursement for certain qualified medical care expenses on a non-taxable basis through the employer-funded Health Reimbursement Arrangement (HRA) Plan. Refer to the supplement to this SPD/Plan Document for information about the HRA Plan.

Claim Types

There are three basic types of claims under the Plan:

- **Health Care Claims**, which include:
  - *Medical claims:* When you go to a PPO provider, the provider will file the claim for you. Be sure to show your ID card so your provider knows where to submit your claim. If you choose to go to a non-PPO provider, it is your responsibility to submit the claim. Refer to *Filing Claims* on page 50 for more information.
  - *Prescription drug claims:* In general, if you go to a participating pharmacy or use the mail order prescription drug program, you simply pay your copayment and the Plan pays the rest, so there are no claim forms to file. If you go to a non-participating pharmacy, you will have to pay the full cost of the prescription when you pick it up. You will then need to submit a claim for reimbursement to the prescription drug program provider. Contact the Prescription Drug Benefits Manager at the toll-free phone number listed on page 3 for a claim form.
  - *Dental claims:* It is your responsibility to submit a claim for dental benefits. Refer to *Filing Claims* on page 50 for more information.
  - *Vision claims:* When you go to a managed care network provider, the provider will file the claim for you. Be sure to show your ID card so your provider knows where to submit your claim. If you choose to go to a non-network provider, it is your responsibility to submit the claim. Refer to *Filing Claims* on page 50 for more information.
  - *Hearing claims:* When you go to a managed care network provider, the provider will file the claim for you. If you choose to go to a non-network provider, it is your responsibility to submit the claim. Refer to *Filing Claims* on page 50 for more information.
- **Disability claims**, which includes claims for Weekly Loss of Time Benefits: Be sure to notify your Employer and the Fund Office if you are Sick or Injured and are unable to work. The Fund Office will send you a claim form. You and your Physician must complete the form. Then send the completed form to the Fund Office as soon as possible (but no later than 12 months after the Illness or Injury starts). Benefits paid are generally considered as income and are subject to federal income tax. If you would like to have federal income taxes withheld from your benefit payment, you should contact the Fund Office to obtain a W-4 form. Complete and return this form to the Fund Office.
- **Other claims**, which include Death, Dependent Death, and AD&D Benefit Claims: In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. If you have an Injury covered under the AD&D program or if an Eligible Dependent dies, you should file the claim.

The Plan requires proof of death or loss-usually in the form of a death certificate or Physician's statement. In some situations, the Plan has the right to request a physical exam by a Physician of its choice or an autopsy. Proof of death or loss should be submitted as soon as possible, but no later than 12 months after the death or loss.

Health Care Claims

Health care claims are further divided into four categories of claims:

- **Urgent care**, which is a claim for care or treatment, as determined by the Plan, that would:
  - Seriously jeopardize your life, health, or ability to regain maximum function if normal pre-service standards were applied; or
  - Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- **Pre-service**, which is a claim for benefits where pre-certification is required before you obtain care (such as for Hospital admissions, surgery, mental health and substance abuse inpatient treatment, home health care and Durable Medical Equipment). However, the Plan will not deny benefits for these benefits if it is not possible for you to obtain pre-certification or if the process would jeopardize your life or health.
- **Concurrent care**, which is a claim that is reconsidered after it is initially approved (such as re-certification of the number of days of a Hospital stay) and the reconsideration results in reduced benefits or a termination of benefits.
- **Post-service**, which is a claim for benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services for which the claim is being submitted.

Filing Claims

All claims should be submitted as soon as possible, usually within 90 days (but no later than 12 months) from the date of service. To assist the Fund Office in processing claims as quickly as possible, please follow the steps listed below.

You must follow the Plan's claims and appeals procedures completely before you bring any legal action to obtain benefits. The Trustees, or their designated representative, have sole, discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees.

Step 1: Obtain the appropriate claim form from the Fund Office.

Step 2: Complete the form by filling in all information requested.

- Be sure to include your unique identification number and sign your form. If the claim is for an Eligible Dependent, provide the name of the Eligible Dependent.
- If you or an Eligible Dependent has coverage under more than one health plan, be sure to include the name of the other health plan(s).
- If the claim is the result of an Accident, be sure to complete the Accident portion of the benefit claim form.

Step 3: Have your Physician or Dentist complete the appropriate portion of the claim form, including the Diagnosis.

Step 4: Attach all bills or receipts relating to the service provided.

- Make sure each bill clearly identifies the Diagnosis, the service or supply, the fee, the date each charge was incurred, the patient's name and the date of service.
- If you are also covered by any other coverage, including Medicare, attach a copy of the itemized bill relating to the health service provided and a copy of the other coverage's and/or Medicare's explanation of benefits. Both the bill and explanation of benefits must be submitted.

Step 5: Forward the completed form and all related bills as directed on the claim form. If the claim is to be submitted to the Fund Office, it should be sent to:

Sheet Metal Workers Local No. 265
Health and Welfare Plan
205 Alexandra Way
Carol Stream, Illinois 60188

For your claim to be considered, you must provide all the information needed for the Fund Office to make a determination on your claim. Generally, the information that is needed is listed on the Plan's claim form. If you need a claim form, you may obtain one online at www.smw265funds.org or by calling the Fund Office.

Payments generally are made directly to you, unless you assign benefits to the provider.

Because of federal guidelines and the Plan's PPO network's required procedures, the Fund Office will send out only one notice to you when your claim does not contain all of the necessary information. If the Fund Office does not have all of the information necessary to make a determination on the date the claim is initially filed, the claim will be denied. You may then either resubmit the claim with all required information within 24 months of the date of service or you may appeal the claim. Refer to page 54 for information on appealing a denied claim.

To be considered a properly completed claim form, and for the Fund Office to be able to decide the claim, the form should include the following information:

- Employee's name;
- Patient's name;
- Patient's date of birth;
- Identification number of Employee or retired Employee;
- Date of service;
- CPT-4 (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- ICD-9 (the Diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to an Accident, details of the Accident.

Class C Participants covered by Medicare must submit a completed retiree claim form, along with the following information, as applicable:

- For Medicare supplement plan reimbursements, documentation of participation in the Medicare supplement program, including the monthly cost;
- For Medicare Part D premium reimbursements, documentation of participation in the Medicare Part D program, including the monthly cost;
- For reimbursements of deductibles and coinsurance payments for Physician and Hospital charges, a copy of the Medicare explanation of benefits and the Medicare supplement's plan explanation of benefits, if applicable;

- For reimbursements of covered prescription drug expenses, a copy of the pharmacy receipt or an itemized list from the pharmacy showing the amount the Eligible Person was required to pay; and
- For vision, dental or hearing reimbursements, an itemized receipt that includes the name of the patient and date of service.

Claim Decisions

When you submit a claim for benefits, the Plan will determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly, when complete claim information is received. The Plan will make an initial determination within certain timeframes, as follows:

- **Health care claims:** Generally, health care determinations will be made as soon as administratively possible, as follows:
  - *Urgent care claims:* The Plan will notify you of its determination as soon as possible but no later than 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified as soon as possible but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. The Plan will notify you of its determination as soon as possible but no later than 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.
  - *Pre-service claims:* The Plan will notify you of its initial determination within 15 days from receipt of your claim. If the Plan needs additional information to decide your claim, the Plan will request the information. The initial 15-day decision period is suspended while the Plan is awaiting the additional information from you. You have 45 days to provide the information. The Plan will make a decision on your claim at the end of the time you are given to provide the additional information or when it receives the additional information, if sooner. In addition, the Fund Office may determine that an extension of time is necessary to make a decision on your claim because of matters beyond the Plan's control. In this instance, the Plan is allowed one 15-day extension.
  - *Concurrent care claims:* The Plan will notify you as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the expiration of the previously approved time period or number of treatments, the Plan will respond according to the type of claim involved.

    If a claim for post-service or concurrent care is approved, payment will be made and the payment may be considered notice that the claim was approved.

  - *Post-service claims:* The Plan will notify you of its initial determination within 30 days from receipt of your claim. If the Plan needs additional information to decide your claim, the Plan will request the information. The initial 30-day decision period is suspended while the Plan is awaiting the additional information from you. You have 45 days to provide the information. The Plan will make a decision on your claim at the end of the time you are given to provide the additional information or when it receives the additional information, if sooner. In addition, the Fund Office may determine that an extension of time is necessary to make a decision on your claim because of matters beyond the Plan's control. In this instance, the Plan is allowed one 15-day extension. Refer to page 54 for information on appealing a denied claim.

- **Disability claims:** Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If the Plan needs additional information to decide your claim, the Plan will request the information. The initial 45-day decision period is suspended while the Plan is awaiting the additional information from you. You have 45 days to provide the information. The Plan will make a decision on your claim at the end of the time you are given to provide the additional information or when it receives the additional information, if sooner. In addition, the Fund Office may determine that an extension of time is necessary to make a decision on your claim because of matters beyond the Plan's control. In this instance, the Plan is allowed two 30-day extensions. The Plan will notify you by the end of the initial 45-day period if an extension is needed and will notify you by the end of the first extension period if an additional extension is needed. The notice will state the special circumstances and the date the Plan expects to make a decision.
- **Other claims:** Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this 90-day deadline. The Plan may extend this 90-day period up to a maximum of an additional 90 days.

If circumstances require an extension of time for making a determination on your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

Claim Decision Notice

The Plan will:

- Notify you of its initial determination of your claim within certain timeframes (as described above), which will be either approval and payment of your claim, or an adverse benefit determination;
- Provide you with certain information about your claim; and
- Provide you with written notice of the decision on your claim.

A claim denial, or adverse benefit determination, for the purpose of the initial and appeal claims processes for health care claims, is defined as:

- A denial, reduction, termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of a beneficiary's or an individual's eligibility to participate in this Plan, or a determination that a benefit is not a covered benefit; and
- A reduction in a benefit resulting from the application of any utilization review decision, pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

When the Plan notifies you of the initial decision on your claim, the notice will:

- Identify the claim involved, date of service, health care provider, and claim amount, if applicable;
- State that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- Give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any standards used in denying the claim;

- Reference the specific Plan provision(s) on which the determination is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol, or similar criterion, a statement will be provided that such rule, guideline, protocol or criterion that was relied upon will be provided free of charge to you, upon request;
- If the denial was based on medical necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow and completely exhaust the Plan's appeals procedure (including time limits) before you request an external review of your claim or file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

In general, you should send your written request for an appeal to the Board of Trustees at the Fund Office as soon as possible. For urgent care claims, your appeal may be made orally. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days from the date of a decision for health care or disability claims; or
- 60 days from the date of a decision for other claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative and comply with the Plan's procedures. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on Medical Necessity, Experimental treatment or similar exclusion or limit.

Appeal Decisions

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the decision maker will not defer to the initial decision. An appropriate fiduciary of the Plan, such as the Board of Trustees, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within the required deadline for the particular type of claim. However, the Plan may provide oral notice of a determination on your urgent care claim within the required deadline to be followed up with a written determination.

Appeal Decision Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as follows:

- **Health Care Claims:**
  - *Urgent care claims:* The Plan will notify you of its determination as soon as possible and not later than 72 hours from receipt of your appeal.
  - *Pre-service claims:* The Plan will notify you of its determination within 30 days of receipt of your appeal.
  - *Concurrent care claims:* The Plan will notify you of its determination before termination of your benefit.
  - *Post-service claims.* A determination will be made at the Trustees' next regularly scheduled quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal. You will be notified of the Trustees' decision in writing within 5 days of the date of the meeting at which the decision is made.

You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision.

- **Disability and Other Claims:** A determination will be made at the Trustees' next quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second quarterly meeting following receipt of your appeal. If special circumstances require an extension of time, you will be notified and a determination will be made no later than the third quarterly meeting following receipt of the appeal. You will be notified of the Trustees' decision in writing within 5 days of the date of the meeting at which the decision is made.

Appeal Decision Notice

The Plan will:

- Notify you of its determination of your appeal within certain timeframes (as described above); and
- Provide you with written notice of the decision on your claim.

When the Plan notifies you of the decision on your appeal, the notice will include:

- Information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for external review of your claim;

- The specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the Plan's external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- If the denial was based on medical necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- The statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

Medical Judgments

A medical judgment includes denial of your claim on the basis that it is:

- Experimental;
- Investigational;
- Not Medically Necessary; or
- Appropriately excluded from medical coverage.

If your claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the original denial of your claim.

You have the right to be advised, upon request, of the identity of any medical experts consulted in making a determination of your appeal.

External Review of Claims

This External Review process is intended to comply with the external review requirements of the Patient Protection and Affordable Care Act (PPACA). For purposes of this section, references to "you" or "your" include you, your covered Eligible Dependent(s), and you and your covered Eligible Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further, external review by an Independent Review Organization ("IRO"), if your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim (including a claim under the HRA Plan), is denied and it fits within the following parameters:

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

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this external review process does not pertain to claims for Weekly Loss of Time, Death Benefits, or Accidental Death and Dismemberment insurance, or to the Plan's Health Reimbursement Arrangement (HRA).

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. External Review of Standard (Non-Urgent) Claims.

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an Initial Claim Benefit Determination or adverse Appeal Claim Benefit Determination. For convenience, these Determinations are referred to below as adverse benefit determinations, unless it is necessary to address them separately.

A. Preliminary Review of Standard Claims.

1. Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:
   a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   b. The adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
   c. You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
   d. You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

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

B. Review of Standard Claims by an Independent Review Organization (IRO).

1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
   a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days);
   b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its adverse benefit determination;
   c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its adverse benefit determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review;
   d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; and

      In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
   e. The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee within 45 days after the IRO receives the request for the external review;
      i. If the IRO's final external review reverses the Plan's adverse benefit determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

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

f. The assigned IRO's decision notice will contain:

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

ii. The date that the IRO received the request to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

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

v. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

vi. A statement that judicial review may be available to you; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

2. External Review of Expedited Urgent Care Claims.

A. You may request an expedited external review if:

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

B. Preliminary Review for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

C. Review of Expedited Claim by an Independent Review Organization (IRO).

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its adverse benefit determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

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

1. If the IRO's final external review reverses the Plan's adverse benefit determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
2. If the final external review upholds the Plan's adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

Prudent Care

In the event the Board of Trustees determines that any medical treatment or prescription drug usage provided extends beyond a period that is considered as prudent care, the Trustees will request a medical reviewer to evaluate the treatment or drug usage. If it is determined that the treatment or drug usage is not an appropriate course of treatment, the Trustees may determine that benefits are no longer payable.

Coordination of Benefits

This Plan has been designed to help you pay for your health care expenses. It is not intended that you receive greater benefits than your actual expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or a covered Eligible Dependent have under other health care plans.

This Plan will generally pay either its regular benefits in full, or a reduced amount that, when added to the benefits payable by the other plan(s), will equal this Plan's total "allowable expenses." However, no more than the maximum benefits payable under this Plan will be paid.

Other Plan

Other plan means any plan providing services for or because of medical, dental, or vision care or treatment for which benefits or services are provided by:

- Group blanket or franchise insurance coverage;
- Group BlueCross and group BlueShield coverage, any group Hospital service prepayment plan, group medical service prepayment plan, group practice, or other group prepayment coverage;

Allowable Expenses
Any Medically Necessary item of expense for medical care or treatment covered under this Plan.

- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group;
- Any coverage under governmental programs, and any coverage required or provided by any statute; or
- Any coverage under the Health Insurance for the Aged and Disabled provisions of the United States Social Security Act (Medicare) except that this item is subject to any government provision or regulation that requires that insurance benefits be utilized before benefits available under Medicare.

Other plan also includes all Dependents' benefits provided by this Plan when an individual is covered as both an eligible Employee and an Eligible Dependent spouse and when a Dependent child is covered as an Eligible Dependent of more than one Employee.

Order of Payment

If you or your Eligible Dependent(s) are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable do not exceed 100% of the allowable Expense Incurred.

If you or your Eligible Dependents are covered under another plan, you must report such duplicate coverage when you file a claim.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary;
- A plan that covers an individual as an employee or a retired employee who is not eligible for Medicare, is primary over a plan that covers an individual as a Dependent;
- A plan that covers an individual as an active employee or Eligible Dependent of an active employee is primary (over a plan that covers an individual as a laid-off or retired employee or Eligible Dependent of such employee). If the other plan includes this rule for a laid-off or retired employee (or is issued in a state that requires this rule by law), then the plan that covers the individual as other than a laid-off or retired employee (or an Eligible Dependent of such an employee) will pay first; and
- A plan that covers a dependent as a spouse is primary over a plan that covers a dependent as a child (children up to age 26 are covered even if they are married).

If an Eligible Dependent child is covered under more than one plan and the parents are not separated (whether or not they have ever been married), the following rules determine which plan is primary:

- The plan that covers the parent whose date of birth occurs earlier in the calendar year (excluding the year of birth) is primary;
- If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary; or
- If a plan uses a gender rule, the plan using the gender rule will pay first.

If an Eligible Dependent child is covered under more than one plan and the parents are separated (whether or not they have ever been married), the following rules determine which plan is primary:

- Where there is a court order that establishes which parent has legal responsibility for the child's medical expenses, the plan covering the Eligible Dependent child of the parent who has legal responsibility is primary;

- Where there is no court order that establishes which parent has legal responsibility for the child's medical expenses, the plan of the parent with custody is primary. If the parent with custody has remarried, then the:
  - Stepparent with custody of the child pays second; and
  - Parent not having custody of the child pays third.

If no other provision applies, the plan that has covered the individual for the longest period is primary.

There is a special provision for plans that cover an individual as an employee and provide alternate coverage to the employee as the result of the existence of another plan. This Plan, as a secondary plan, reserves the right to take into account the primary plan's reduction of benefits when this Plan, as a secondary plan, calculates benefits if the primary plan's coordination of benefits provision permits the plan to reduce its benefits because:

- Another plan exists and the covered person did not enroll in that plan;
- A person is or could have been covered under another plan, except with respect to Medicare Part B; or
- A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

Payment Provisions

When this Plan is secondary and the Plan pays reduced benefits, only the reduced amount is charged against the Plan's payment limits. If another plan pays benefits that should have been paid by their plan under the coordination of benefits provisions, the Plan may pay the other plan any amount due. Any amounts paid to another plan for this reason are considered benefits under this Plan. In addition, if the Plan makes payments it is not required to pay, it may recover and collect those payments from you, your Eligible Dependents or any organization or insurance company that should have made the payment.

If another plan is primary but some or all of the benefits are denied or reduced because you or an Eligible Dependent failed to comply with the plan's required procedures, this Plan's secondary benefits will only be paid as if you or your Eligible Dependent had complied with all of the required procedures of the other plan. The required procedures could include but are not limited to, complying with utilization review or cost containment procedures, such as, Hospital pre-admission review or certification, second surgical opinions, pre-certification of substance abuse or mental health treatment.

The Plan's liability and its benefit payments will not increase because you or your Eligible Dependent elects not to use the primary coverage. You or your Eligible Dependent must file a claim for any benefits from all other sources. Whether or not you or your Eligible Dependent actually file claims with these other sources, this Plan's benefits will be calculated as though you or your Eligible Dependent had.

This Plan pays primary to coverage under Medicaid.

Coordination of Benefits with HMO or DMO Coverage

If you or one of your Eligible Dependents are covered under a Health Maintenance Organization (HMO) or Dental Maintenance Organization (DMO) and choose to go to a non-network provider, this Plan will only pay 80% of the difference paid by the HMO or DMO. For example, if the HMO pays 70% of a network provider's charges and only 30% of a non-network provider's charges, this Plan will pay only 80% of the 30% of charges paid.

Keep in mind that this also applies if the HMO or DMO does not cover non-network provider charges.

If, for example, the HMO or DMO does not cover non-network provider charges, these charges are not eligible under this Plan as well.

Coordination of Benefits with Medicare

Medicare is a multi-part program:

- Part A, Hospital Insurance Benefits for the Aged and Disabled, primarily covers Hospital benefits, although it also provides other benefits;
- Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, primarily covers Physician's services, although it, too, covers a number of other items and services;
- Part C, MedicareAdvantage, is the managed care portion of Medicare and allows more choices in selecting medical coverage by making it possible for people who are eligible for Medicare to select which managed care plan they would like to join. Specific choices under Part C will depend on where you live; and
- Part D, Medicare Prescription Drug Coverage.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, Eligible Dependent widow or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you are covered under a collective bargaining agreement and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Medicare Parts B and D, and possibly, for Medicare Part C.

Any benefits payable to you or your Eligible Dependents under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Eligible Dependents are eligible for Medicare as your primary plan, regardless of whether or not you have made application for such benefits or compensation.

For all purposes of this provision, if you or your Eligible Dependents are entitled to benefits or other compensation under Medicare (Parts A, B, and/or C), the Plan will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

About Medicare Prescription Drug Coverage (Medicare Part D)

If you are an active participant or the dependent of an active participant and you are eligible and enroll for Medicare Prescription Drug Coverage, you will continue to be eligible for the Fund's prescription drug benefits. However, your benefits will be coordinated with Medicare, in accordance with the Fund's and Medicare's coordination provisions.

You are not required to enroll in Medicare Part D. However, Eligible Participants who are covered under the Plan's retiree benefits and are eligible for Part D prescription drug coverage must enroll in Medicare Part D to be eligible for reimbursement of the Medicare Part D premiums, deductibles, and copayments specified in the Summaries of Benefits in the *Appendix*.

Each year, you will receive a notice from the Fund Office informing you of whether or not the Fund's existing prescription drug benefits are, on average, "creditable coverage," which would mean coverage under the Health and Welfare Fund would be expected to pay as much (or more in some cases) in claims for all participants as would standard Medicare Prescription Drug Coverage.

About Prescription Drug Benefits Provided by the Veteran's Administration

Participants eligible for prescription drug benefits provided by the Veteran's Administration must enroll for those benefits for reimbursement of copayments made for prescription drug benefits under the Veteran's Administration program as specified in the Summaries of Benefits in the *Appendix*.

Order of Payment

When this Plan is Primary to Medicare:

This Plan pays primary for Expenses Incurred by eligible Employees and their Eligible Dependents who are:

- Eligible for Medicare Part A; and
- With respect to the Employee only, actively employed by an ADEA Employer who pays all or part of the required contributions for eligibility.

ADEA Employer
An Employer that is subject to the Age Discrimination in Employment Act (ADEA) and has 20 or more Employees who are working each day in 20 or more calendar weeks during the current or proceeding calendar year.

The Plan pays primary for the first 30 months for an Eligible Person eligible for Medicare benefits because of end-stage renal disease when Medicare has secondary responsibility.

When this Plan is Secondary to Medicare:

The Plan pays secondary for the eligible Employee and his Eligible Dependents if the Employee is not actively employed by an ADEA Employer who pays all or part of the required contributions for eligibility.

The Plan pays secondary for claims after 30 months for Expenses Incurred by an Eligible Person eligible for Medicare benefits because of end-stage renal disease when Medicare has primary responsibility.

Information Gathering

To implement the Plan's Coordination of Benefits provisions, the Trustees may release or obtain any information necessary, subject to the privacy provisions of HIPAA. Anyone claiming benefits under this Plan must provide any information necessary to implement the coordination of benefits provisions or to determine their applicability.

Subrogation

Whenever the Plan provides benefits for any Injury or Illness for which any third party may be legally and/or financially liable, including an insurer, the Plan may make a claim or take legal action against the third party. An example of a situation when this might happen would be if you were Injured in a car Accident caused by someone else.

When you accept benefits in a situation like this, you or your Eligible Dependent must assign to the Plan the right to make a claim against the third party to the extent of the amount of the benefits. You also must agree to repay the Plan any money you receive from the third party.

You must provide all requested information and may be asked to complete and sign a Subrogation Acknowledgement. This information and/or agreement should identify all potential liable third parties, their addresses, insurers, adjusters and claim numbers, as well as accident reports and any other necessary information. If the information requested is not provided, the Plan may withhold future benefit payments until the requested information is received.

You also must avoid doing anything that would prejudice the Plan's right of recovery. In the event there is a claim against a third party, you must promptly advise the Administrative Manager in writing.

The proceeds from any settlement or judgment made against a third party will be allocated first to reimburse the Plan fully for all benefits advanced. You will hold any proceeds you receive from any settlement or judgment against a third party in a constructive trust for the benefit of the Plan until the Plan's share of the proceeds is determined.

Proceeds are allocated in this order regardless of whether you or your Eligible Dependent has been fully compensated for the damages arising from the Injury or Illness. This allocation also applies to claims of Eligible Dependents and regardless of whether you or your Eligible Dependent were legally responsible for expenses of treatment.

Failure by the covered person to comply with the subrogation provision allows the Plan, at its discretion to either:

- Take a credit against future claims of the covered person or his or her Dependents up to the amount of the Plan's expenditures on such expenses; or
- Initiate legal proceedings to recover the Plan's expenditures.

Once a settlement is reached, additional bills cannot be submitted with respect to the same Injury or Illness.

Benefit Payments

Benefit payments under the Fund may become payable to a person who is judged to be incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, 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 or purposes for which paid if they are paid:

- Directly to such person;
- To the legally appointed guardian or conservator of such person;
- To any spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of that person; or
- 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.

Privacy Policy

Use and Disclosure of Protected Health Information

The Plan will use protected health information 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.

"Payment" includes activities undertaken by the Plan to obtain premiums or 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:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing Employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews, or reviews of appropriateness of care, or justification of charges;
- Utilization review, including pre-certification, concurrent review and retrospective review;
- 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
- Reimbursement to the Plan.

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

- Quality assessment;
- 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;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- 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);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- 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;
- Business management and general administrative activities of the entity, including, but not limited to:
  - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
  - Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
  - Resolution of internal grievances; and
  - 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.
- Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, including 5500 forms, summary annual reports, and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary for purposes related to administration of these plans.

For purposes of this section, the Board of Trustees of the Sheet Metal Workers Local 265 Welfare Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law;
- 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;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- 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;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- 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 Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the 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 must be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

- The Plan's Administrative Manager; and
- Staff and Trustees designated by the Plan's Administrative Manager.

The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

If the persons described in this section do not comply with this Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and no other plan functions or benefits.

To comply with the Security requirements of HIPAA, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;
- Ensure that the adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Administrative Information

Plan Name

Sheet Metal Workers Local No. 265 Health and Welfare Plan.

Plan Board of Trustees' Employer Identification Number

36-2356062

Plan Number

501

Plan Year

July 1 – June 30

Plan Type

The Sheet Metal Workers Local No. 265 Health and Welfare Plan is an employee welfare benefit plan maintained for the purposes of providing medical, prescription drug, hearing, dental, vision, disability, death, and AD&D benefits to Eligible Participants.

It is intended that at all times this Plan will be fully "qualified" by the Internal Revenue Service. The Trustees have the ability to amend or change the terms and provisions of the Trust Agreement and/or Plan as may be required to maintain this qualified status.

Plan Sponsor and Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator. The Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of Union and Employer representatives selected by the Employers and Local Union (Local Union No. 265 affiliated with the Sheet Metal Workers International Association and its successor), which have entered into collective bargaining agreements that relate to this Plan. If you wish to contact the Board of Trustees, you may use the address, telephone phone number or Internet address below:

Sheet Metal Workers Local No. 265
Health and Welfare Plan
205 Alexandra Way
Carol Stream, Illinois 60188
630-668-7260
benefits@smw265funds.org

The Board of Trustees has designated Scott Wille as Administrative Manager.

The Trustees of this Plan are:

Jack Gengler, Chairman Gengler Lowney Laser Works 899 Sullivan Road Aurora, Illinois 60506	**John Boske, Secretary** Sheet Metal Workers' Local No. 265 205 Alexandra Way Carol Stream, Illinois 60188-2080
John D'Angelo State Mechanical Services 1701 Quincy Avenue Naperville, Illinois 60540	**Donald Moran** Sheet Metal Workers' Local No. 265 205 Alexandra Way Carol Stream, Illinois 60188-2080
Pat Hudgens Elgin Sheet Metal 695 Schneider Drive South Elgin, Illinois 60177	**Jerry Porter** Sheet Metal Workers' Local No. 265 205 Alexandra Way Carol Stream, Illinois 60188-2080
John Shaw Westside Mechanical, Inc. 2007 Corporate Lane Naperville, Illinois 60563-9647	**Kevin Prince** Sheet Metal Workers' Local No. 265 205 Alexandra Way Carol Stream, Illinois 60188-20
Ken Wiesbrook Wiesbrook Sheet Metal 25502 West Ruff Street Plainfield, Illinois 60544	**Charles Ruegge** Sheet Metal Workers' Local No. 265 205 Alexandra Way Carol Stream, Illinois 60188-20

Agent for Service of Legal Process

The Plan's agent for service of legal process is:

James M. Neuman, Esq.
Baum, Sigman, Auerbach & Neuman, Ltd.
200 West Adams Street, Suite 2200
Chicago, Illinois 60606-5208

Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon James M. Neuman, Esq. for service of legal process or any member of the Board of Trustees at the Fund Office.

Collective Bargaining Agreements

This Plan is maintained pursuant to collective bargaining agreements between Local Union No. 265 affiliated with the Sheet Metal Workers International Association and its successor and the various Contributing Employers. You may obtain a copy of your collective bargaining agreement by writing to the Plan's Administrative Manager or you may examine it at the Fund Office.

A complete list of the Employers sponsoring this Plan may be obtained upon written request to the Plan Administrator or be examined at the Fund Office and certain other locations.

Source of Contributions

Benefits described in this booklet are provided through Employer Contributions and Employee self-payment contributions. The exact dollar amount of the contribution is determined by collective bargaining between the Union and the Employers. Although the Trustees and professional advisors make every effort to maintain benefit levels, benefit levels are subject to adjustments depending on changes in economic conditions, results of collective bargaining and other factors.

Trust Assets and Reserves

The Plan's benefits are self-funded. All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Eligible Participants and defraying reasonable administrative expenses. Plan assets may be invested in accordance with the requirement of applicable law. These investments are made only after consultation with professional investment managers employed by the Trust Fund.

Eligibility and Benefits

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

Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described this booklet. The Trustees reserve the right to amend, modify, or terminate the Plan or any of its benefits at any time.

Sole Determination by Trustees

Only the Board of Trustees has the authority to determine eligibility for benefits and the right to participate in the Plan and to exercise all the other powers specified in the Plan. The Trustees may, in their sole and broad discretion, modify, amend, or terminate the Plan in any matter or at any time. No officer, agent or employee of the Union or Employer or any other person, is authorized to speak for, or on behalf of, or to commit the Board of Trustees, on any matter relating to the Health and Welfare Fund or Plan.

The Trustees also decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious.

Plan Interpretation

Only the Board of Trustees is authorized to interpret the Plan described in this booklet. No Employer, Union, or any representative of any Employer or Union, is authorized to interpret the Plan nor can any such person act as agent of the Trustees. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

Benefit Determination

Benefits under the Plan will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the Eligible Participant or beneficiary is entitled to benefits in accordance with the Plan's terms.

Plan Amendment or Termination

The Trustees intend to continue the Plan indefinitely for your benefit and the benefit of all Plan participants. However, the Trustees reserve the right and have been given the discretion to amend, modify, or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant. If this occurs, the Fund Office will send you a written notice explaining the change. Please be sure to read all Fund and Plan communications and keep them with this booklet.

The Trustees may terminate the Plan at any time. Upon termination, the rights of Eligible Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to participants in writing.

Rights and Responsibilities

No benefit payment under this Plan is subject to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same is void. You may however, direct that benefits due to you be paid to an institution in which you or your Eligible Dependent is hospitalized or to any other provider of medical, prescription drug, hearing, dental, or vision services or supplies in consideration for medical, prescription drug, hearing, dental, or vision services rendered or to be rendered. The Plan is not liable for or subject to the debts or liabilities of you or any of your Eligible Dependents or beneficiaries.

In the event the Plan has a contract with a provider for services for you or an Eligible Dependent, the Plan may pay the provider directly for the services received without necessity of assignment.

As someone who is or may be eligible for benefits from the Plan, you should be aware of the fact that the benefits are paid in accordance with Plan provisions out of a Trust Fund that is used solely for that purpose. If you have any questions or problems as to benefit payments, you have the right to get answers from the Trustees who administer the Plan.

The same basic rights have been incorporated in the Employee Retirement Income Security Act, which Congress adopted in 1974, for application to all benefit plans. Those rights are set forth in the following section.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan's operation. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is legally required to furnish each participant with a copy of this summary annual report.

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 because 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; and
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ends.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called Plan fiduciaries, 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 Participating Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description and Plan Document 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

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

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
866-444-3272

Nearest Regional Office:
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600|
Chicago, Illinois 60606
312-353-0900

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website of the EBSA at www.dol.gov/ebsa.

Glossary

Accident means an incident that contains some degree of unexpected violence, such as a fall, blow, laceration, contusion, or abrasion.

Accidental Bodily Injury or **Illness**, with respect to an eligible participant, does not include an Accidental Bodily Injury or Illness that arises out of or in the course of employment; however, an Accidental Bodily Injury or Illness that arises out of or in the course of employment does apply to the Death Benefit and Accidental Death and Dismemberment Benefit.

Allowable Charge means the agreed upon PPO network rate.

Administrative Manager means the person, firm, or corporation employed by the Trustees for recordkeeping, reporting, and disclosure, processing of applications for benefits and related administrative functions of the Trust Fund and the Health and Welfare Plan.

Ambulatory Surgical Center means a specialized facility that is established, equipped, operated, and staffed primarily for performing Surgical Procedures and that fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it:
  - Is operated under the supervision of a licensed Physician who is devoting full-time to supervision and permits a Surgical Procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area;
  - Requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise the anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the Surgical Procedure;
  - Provides at least one operating room and at least one post-anesthesia recovery room;
  - Is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
  - Has trained personnel and necessary equipment to handle the administration of Emergency Services;
  - Has immediate access to a blood bank or blood supplies;
  - Provides the full-time services of one or more graduate registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - Maintains an adequate record for each patient, which contains an admitting Diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests, and/or x-rays), an operative report, and a discharge summary.

An Ambulatory Surgical Center that is part of a Hospital, as defined by the Plan, will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Custodial Care means care, services, or supplies that are furnished mainly to train or to assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. Care, services, or supplies are also considered Custodial Care if they can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider.

Deductible means the amount of covered medical expense the Eligible Participant pays before he or she is entitled to benefits.

Dental Hygienist means a person who is currently licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene and who works under the supervision of a Dentist.

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

Diagnosis means the statement of a medical condition requiring the care of a Physician.

Durable Medical Equipment means equipment that:

- Can withstand repeated use and is not a consumable or disposable item;
- Is exclusively and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of Injury or Illness; and
- Is appropriate for use in the home.

Purchase of Durable Medical Equipment and the cost of maintenance agreements are covered only when the Plan determines that it is cost effective for the Plan. The amount of Plan benefits payable for the purchase of Durable Medical Equipment will be reduced by any benefits paid by the Plan for the rental of such equipment. Equipment that primarily serves a comfort or convenience function for the patient or the patient's caretaker (such as a wheelchair ramp or a vehicle lift device) is not considered Durable Medical Equipment.

Educational Institution means a trade school, college or university, or other organization whose primary purpose is training and which regularly charges tuition for such training. Educational Institution does not include work-study or other training programs during which the trainee receives compensation.

Eligibility Rules means the Eligibility Rules under the Plan that apply to Employees and their Eligible Dependents, Totally Disabled Employees and their Eligible Dependents, Self-Payment Employees and their Eligible Dependents and retired Employees and their Eligible Dependents.

Eligible Dependents means your:

- Legal spouse, not including a spouse from whom you are legally separated;
- Your child who satisfies one of the four categories listed below:
  1. A child who has not reached his or her 26th birthday, and is your natural child, legally adopted child, child placed with you for adoption, or your stepchild who was the natural child or adopted child (including a child placed for adoption) of your spouse prior to your marriage;
  2. A child covered by Qualified Medical Child Support Order (QMCSO) entered by an appropriate court as defined under applicable federal law and determined by the Plan to be a QMCSO;
  3. A child for whom you have been named legal guardian, provided all of the following criteria are met:
     - The guardianship was established at least six months before the child became eligible for Plan coverage;
     - The child lives with you in a regular parent-child relationship and maintains a principal residence with you during the entire calendar year;
     - You contribute more than 50% of the child's support and maintenance during the calendar year; and
     - You present legal documentation, upon request, supporting your dependent's status.

4. A child with one of the relationships to you listed above who is age 26 or older, who was totally disabled before reaching age 26, and who satisfies all of the following conditions:
   - The child is unmarried;
   - The child is certified by a physician to be totally disabled;
   - The child is incapable of self-sustaining employment by reason of a medically determinable mental or physical impairment that is expected to result in death or last for a continuous period of 12 months or more;
   - The child depends on you for more than 50% of his or her financial support and maintenance during the calendar year;
   - The child maintains a principal place of residence with you for more than 50% of the calendar year; and
   - You provide initial proof of the child's disability and financial dependency to the Trustees within 60 days of the date the child reaches age 26, and subsequently when required by the Trustees, but not more often than once per year.

   If the child does not live with an Eligible Employee, the child will be an eligible Dependent, provided that:
   - The child's parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or live apart at all times during the last six months of the Calendar Year,
   - The child is in the custody of one or both of the child's parents for more than one-half of the Calendar Year;
   - The child receives more than one-half of his or her financial support during the Calendar Year from the child's parents, and
   - The child is either a "qualifying child" or "qualifying relative," as such terms are defined under Internal Revenue Code Section 152, of either parent.

Eligible Participant means any person who is:

- Working within the jurisdiction of and is covered under the terms of the collective bargaining or non-bargaining participation agreement entered into between the Union and the Employer; and
- Eligible for benefits (such as a retired Employee or Eligible Dependents) as set forth in this Sheet Metal Workers' Local No. 265 Health and Welfare Plan Document/Summary Plan Description.

Eligible Person means either the eligible Employee or the Employee's Eligible Dependents.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in:

- The patient's health (or with respect to a pregnant woman, the health of her unborn child) being placed in serious jeopardy;
- Serious impairment of bodily function; or
- Serious dysfunction of a bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department (emergency room) to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

Employee means a person employed by an Employer, on whose behalf Employer contributions to this Plan are required.

Employer or **Contributing Employer** means any association or individual employer that has duly executed a collective bargaining agreement with the Union and is required to contribute to this Plan on behalf of its Employees. Any employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included in this definition.

Expense Incurred means only those charges made for services and supplies that are reasonably priced and reasonably necessary in the light of the Accident or Illness being treated. Also with regard to the Dental Benefits, Expense Incurred means the date a dental service or treatment is performed.

Experimental or **Investigative** means services, supplies, and procedures that require approval by an agency of the U.S. Government that has not yet been received.

- Experimental treatments, services, and supplies are also those that largely have been confined to laboratory or research settings.
- Investigative treatments, services, and supplies are also those that have progressed to limited human application, but lack wide recognition as proven and effective in clinical medicine.

The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, service or supply does not in itself make it eligible for payment.

Home Health Care Agency means an agency or organization that provides a program of home health care and meets one of the following tests:

- It is licensed and approved by Medicare; or
- If licensing is not required, it must meet all the following requirements:
  - Has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or registered nurse (RN) to the home;
  - Has a full-time administrator;
  - Maintains written clinical records of services provided to all patients;
  - Has a staff that includes at least one registered nurse (RN) or it has nursing care by a registered nurse (RN) available;
  - Has employees that are bonded; and
  - Maintains malpractice insurance coverage.

Hospital means any legally constituted institution that:

- Maintains permanent and full-time facilities for bed care of five or more resident patients;
- Has a Physician in regular attendance;
- Continually provides a 24-hour a day nursing service by registered nurses;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of Injured and Sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; and
- Is operating lawfully in the jurisdiction where it is located.

Illness, which includes pregnancy, means a deviation from a healthy condition that:

- Alters the state of the body;
- Interrupts or disturbs the performance of vital functions; and
- Tends to undermine or weaken the constitution.

Illness does not include a limitation on or a loss of body function or a temporary indisposition that does not progressively undermine or weaken the constitution.

Injury means any damage to a body part resulting from trauma from an external source.

Inpatient means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

Intensive Care Unit means a special area of a Hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

- Personal care by specialized registered professional nurses and other nursing care on a 24-hour per day basis;
- Special equipment and supplies that are immediately available on a stand-by basis; and
- Care required but not rendered in the general surgical or medical nursing units of the Hospital.

The term Intensive Care Unit will also include an area of the Hospital designated and operated exclusively as a coronary care unit or as a cardiac care unit.

Medically Necessary or **Medical Necessity** means when applied to a service or supply:

- A medical service or supply that is reasonable and necessary for the care or treatment of Bodily Injury or Illness;
- A dental service or supply that is reasonably necessary for dental care; and
- A psychiatric service or supply that is reasonably necessary to provide mental disorder treatment.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in and of itself, make that service or supply reasonably necessary. The determination of Medically Necessary will be made by the Board of Trustees or its delegate in the sole and absolute discretion of the Board of Trustees.

Mental Illness means any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental Illness includes, among other things, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.

Nurse Practitioner means a person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who, in collaboration with a Physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Optician or **Optometrist** means any person who is qualified and currently licensed (if licensing is required in the state) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensure and practice of such a profession and who is acting within the usual scope of his practice.

Outpatient means a person who receives Hospital services and treatments but is not an Inpatient.

Period of Disability Confinement means a period of disability or Hospital confinement. Successive periods of disability or Hospital confinement are considered one continuous disability and period of confinement for determining maximum benefits payable unless:

- The later treatment period is due to causes entirely unrelated to the causes of the prior treatment;
- The periods of treatment are separated by 60 calendar days; or
- For an Employee, the Employee returns to covered employment for at least two weeks.

Physician Assistant is a person legally licensed as a Physician Assistant acting within the scope of his or her license, who:

- Acts under the supervision of a Physician to examine patients and establish medical diagnoses;
- Orders, performs and interprets laboratory, radiographic and other diagnostic tests;
- Identifies, develops, implements and evaluates a plan of patient care;
- Prescribes and dispenses medication within the limits of his or her license;
- Refers to and consults with the supervising Physician;
- May be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered; and
- Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician, Doctor, or **Surgeon** (M.D.) includes Osteopaths, Dentists, and Podiatrists when operating within the scope of their respective licenses. A Chiropractor is not considered a Physician for most benefits under this Plan. A Naprapath is not considered a Physician for benefits under the Plan.

Pregnancy includes resulting childbirth, miscarriage and any complications of Pregnancy.

Reasonable and Customary Charge is determined by uniform reference standards as adopted by the Board of Trustees. For PPO network providers, the Allowable Charge is the network rate. For non-PPO network providers, the acceptable Reasonable and Customary Charge is determined by uniform reference standards as adopted by the Board of Trustees. The Reasonable and Customary Charge for non-PPO network providers will be 100% of the Medicare reimbursement rates for the services provided.

With respect to Durable Medical Equipment, a charge will be considered Reasonable only if the:

- Expense of the equipment is clearly proportionate to the therapeutic benefits ordinarily derived from its use;
- Equipment is not substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and
- Equipment does not serve essentially the same purpose as equipment already available to the patient.

Routine Physical Examination means an examination done by a Physician for screening purposes. If no Diagnosis or symptoms are presented on a claim form or itemized bill by the Physician, the care will be considered routine.

Skilled Nursing Care Facility means an institution or that part of any institution that:

- Operates to provide convalescent or nursing care;
- Is primarily engaged in providing to Inpatients:
  - Skilled nursing care and related services for patients who require medical or nursing care; or
  - Rehabilitation services for the rehabilitation of Injured, disabled or Sick persons;
- Has a requirement that the health care of every patient be under the supervision of a Physician;
- Has a Physician available to furnish necessary medical care in case of an Emergency Medical Condition;
- Has policies, which are developed with the advice (and with provision for review of such policies from time to time) by a group of professional personnel, including one or more Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
- Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies;
- Maintains clinical records on all patients;
- Provides 24-hour nursing services sufficient to meet nursing needs in accordance with developed policies and has at least one full-time registered professional nurse;
- Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law or is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
- Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to its physical facilities.

Surgical Procedure means certain invasive procedures, as well as reduction of fractures or dislocations, in addition to recognized cutting procedures.

Totally Disabled or **Total Disability**, unless specifically defined otherwise, refers to a disability resulting solely from an Illness or Accidental Bodily Injury that prevents an Employee from engaging in any occupation or employment for compensation or profit or prevents an Eligible Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health.

Trust Agreement means the Agreement and Declaration of Trust establishing the Sheet Metal Workers Local 265 Health and Welfare Fund, as amended from time to time.

Trustees mean the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Trust Fund or **Fund** means the Sheet Metal Workers Local 265 Health and Welfare Fund.

Union means those Unions that have executed an agreement of collective bargaining with an Employer that participates in and contributes to the Sheet Metal Workers Local 265 Health and Welfare Plan.

Appendix: Summaries of Benefits

The following charts highlight key features of the Health and Welfare Plan as of January 1, 2013. These benefits are described in detail in this SPD.

CLASS A: EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year

Mental Health and Substance Abuse Benefits	Coverage
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible
Prescription Drug Benefits	**Coverage**
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined

Dental Benefits	Coverage
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
Dental Maximum	$2,000 per person per calendar year; limit does not apply to dependent children under age 18 for preventive services
Lifetime Maximums Orthodontic	 $2,000 per person
Vision Benefits	**Coverage**
Coinsurance Exams/Lenses (including polycarbonate, scratch resistant coating, and ultraviolet coating) PPO Providers Non-PPO Providers Frames PPO Providers Non-PPO Providers	Plan pays: 100% of PPO Allowable Charges, up to negotiated maximum per calendar year; contact lens exams may be subject to copayment 100% of Reasonable and Customary Charges 100% of PPO Allowable Charges, up to retail value of $110 100% of Reasonable and Customary Charges
Maximum PPO Providers Non-PPO Providers	Plan pays: One exam and one pair of glasses or contacts per calendar year; exam limit does not apply to dependent children under age 18 $200 per person per calendar year; limit does not apply to dependent children under age 18
Weekly Loss of Time Benefit (Employees Only)	**Coverage**
Non-Occupational Benefit[5] Maximum Weekly Benefit	90% of your base wage rate times 40 hours $500 per week
[5] *50% due to a second period of disability for treatment of substance abuse (after two courses of treatment, no payment of Weekly Loss of Time Benefits).*	
Benefits Begin Accident, Outpatient Surgery, Illness (Hospital Confined)	First day
Illness (Non-Hospital Confined)	Eighth day
Benefits End	Earlier of recovery or 39 weeks
Death Benefit	**Coverage**
Employee Only	$50,000
Eligible Dependent Spouse	$2,000
Eligible Dependent Child	$2,000
AD&D Benefit (Employees Only)	**Coverage**
Full Benefit Amount	$50,000

CLASS B: NON-MEDICARE-ELIGIBLE RETIRED EMPLOYEES AND NON-MEDICARE-ELIGIBLE DEPENDENTS OF RETIRED EMPLOYEES

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges

Preventive Services Benefit	Coverage
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible
Prescription Drug Benefits	**Coverage**
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined
Dental Benefits	**Coverage**
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
Dental Maximum	$2,000 per person per calendar year; limit does not apply to dependent children under age 18 for preventive services
Lifetime Maximums Orthodontic	 $2,000 per person
Death Benefit	**Coverage**
Retired Employee Only	$25,000

CLASS C: MEDICARE-ELIGIBLE RETIRED EMPLOYEES AND MEDICARE-ELIGIBLE DEPENDENTS OF RETIRED EMPLOYEES*

(HRA) Medical Benefits	Coverage
Medicare Part A Deductible	Plan pays full cost; not subject to, and not included in, Plan maximum
Deductible Amount Under Medicare Part B and Medicare Advantage Plans	Plan pays full cost up to Plan maximum
Medicare Supplement Plan Premiums	Plan reimburses full cost up to Plan maximum
Dental Expenses	Plan pays full cost up to Plan maximum
Medicare Part D Premiums, Deductibles, and Copayments	Plan reimburses full cost up to Plan maximum
Copayments for prescription drugs received through the Veteran's Administration	Plan reimburses full cost up to Plan maximum
Copayments and other charges in excess of Medicare Part A and B and Medicare Advantage	Coordinated with Medicare, up to Plan maximum
Hearing Aid Benefits	Plan pays full cost up to Plan maximum
Vision Benefits	Plan pays full cost up to Plan maximum
Health Reimbursement Arrangement (HRA) Plan Maximum[1]	$1,500 per Employee per calendar year $1,200 per spouse per calendar year
[1] Refer to the supplement to the Summary Plan Description/Plan Document for details about the HRA Plan.	
Death Benefit	**Coverage**
Retired Employee Only	$25,000

** Refer to the supplement to this Summary Plan Description/Plan Document for detailed information about the HRA Plan.*

CLASS D: MEDICARE-ELIGIBLE RETIRED EMPLOYEES UNDER AGE 65 AND MEDICARE-ELIGIBLE DEPENDENT SPOUSES UNDER AGE 65 OF RETIRED EMPLOYEES

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)

Medical Benefits *continued*	**Coverage**
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible

Prescription Drug Benefits	Coverage
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined
Dental Benefits	**Coverage**
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
Dental Maximum	$2,000 per person per calendar year; limit does not apply to dependent children under age 18 for preventive services
Lifetime Maximums Orthodontic	 $2,000 per person
Death Benefit	**Coverage**
Retired Employee Only	$25,000

CLASS E: EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	

Medical Benefits *continued*	**Coverage**
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible

Prescription Drug Benefits	Coverage
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined
Dental Benefits	**Coverage**
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
Dental Maximum	$2,000 per person per calendar year; limit does not apply to dependent children under age 18 for preventive services
Lifetime Maximums Orthodontic	 $2,000 per person
Vision Benefits	**Coverage**
Coinsurance Exams/Lenses (including polycarbonate, scratch resistant coating, and ultraviolet coating) PPO Providers Non-PPO Providers Frames PPO Providers Non-PPO Providers	Plan pays: 100% of PPO Allowable Charges, up to negotiated maximum per calendar year; contact lens exams may be subject to copayment 100% of Reasonable and Customary Charges 100% of PPO Allowable Charges, up to retail value of $110 100% of Reasonable and Customary Charges
Maximum PPO Providers Non-PPO Providers	Plan pays: One exam and one pair of glasses or contacts per calendar year; exam limit does not apply to dependent children under age 18 $200 per person per calendar year; limit does not apply to dependent children under age 18

Weekly Loss of Time Benefit (Employees Only)	Coverage
Non-Occupational Benefit[5] Maximum Weekly Benefit	90% of your base wage rate times 40 hours $500 per week
[5] *50% due to a second period of disability for treatment of substance abuse (after two courses of treatment, no payment of Weekly Loss of Time Benefits).*	
Benefits Begin Accident, Outpatient Surgery, Illness (Hospital Confined) Illness (Non-Hospital Confined)	 First day Eighth day
Benefits End	Earlier of recovery or 39 weeks
Death Benefit	**Coverage**
Employee Only	$50,000
Eligible Dependent Spouse	$2,000
Eligible Dependent Child	$2,000
AD&D Benefit (Employees Only)	**Coverage**
Full Benefit Amount	$50,000

CLASS G: EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year

Medical Benefits *continued*	**Coverage**
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible
Prescription Drug Benefits	**Coverage**
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120

Hearing Benefits	Coverage
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined
Dental Benefits	**Coverage**
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
Dental Maximum	$2,000 per person per calendar year; limit does not apply to dependent children under age 18 for preventive services
Lifetime Maximums Orthodontic	 $2,000 per person
Vision Benefits	**Coverage**
Coinsurance Exams/Lenses (including polycarbonate, scratch resistant coating, and ultraviolet coating) PPO Providers Non-PPO Providers Frames PPO Providers Non-PPO Providers	Plan pays: 100% of PPO Allowable Charges, up to negotiated maximum per calendar year; contact lens exams may be subject to copayment 100% of Reasonable and Customary Charges 100% of PPO Allowable Charges, up to retail value of $110 100% of Reasonable and Customary Charges
Maximum PPO Providers Non-PPO Providers	Plan pays: One exam and one pair of glasses or contacts per calendar year; exam limit does not apply to dependent children under age 18 $200 per person per calendar year; limit does not apply to dependent children under age 18
Weekly Loss of Time Benefit (Employees Only)	**Coverage**
Non-Occupational Benefit[5] Maximum Weekly Benefit	90% of your base wage rate times 40 hours $500 per week
[5] *50% due to a second period of disability for treatment of substance abuse (after two courses of treatment, no payment of Weekly Loss of Time Benefits).*	
Benefits Begin	
Accident, Outpatient Surgery, Illness (Hospital Confined)	First day
Illness (Non-Hospital Confined)	Eighth day
Benefits End	Earlier of recovery or 39 weeks

Death Benefit	Coverage
Employee Only	$50,000
Eligible Dependent Spouse	$2,000
Eligible Dependent Child	$2,000
AD&D Benefit (Employees Only)	**Coverage**
Full Benefit Amount	$50,000

CLASS H: EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime

Medical Benefits *continued*	**Coverage**
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Preventive Services Benefit	**Coverage**
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible
Prescription Drug Benefits	Coverage
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined

Weekly Loss of Time Benefit (Employees Only)	Coverage
Non-Occupational Benefit[5] Maximum Weekly Benefit	90% of your base wage rate times 40 hours $500 per week
[5] *50% due to a second period of disability for treatment of substance abuse (after two courses of treatment, no payment of Weekly Loss of Time Benefits).*	
Benefits Begin	
Accident, Outpatient Surgery, Illness (Hospital Confined)	First day
Illness (Non-Hospital Confined)	Eighth day
Benefits End	Earlier of recovery or 39 weeks
Death Benefit	**Coverage**
Employee Only	$50,000
Eligible Dependent Spouse	$2,000
Eligible Dependent Child	$2,000
AD&D Benefit (Employees Only)	**Coverage**
Full Benefit Amount	$50,000

CLASS I: EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Medical Benefits	Coverage
Deductible	$250 per person per calendar year
Annual Maximum	$1,250,000 per person July 1, 2012 thru June 30, 2013 $2,000,000 per person July 1, 2013 thru June 30, 2014 No limit effective July 1, 2014
Out-of-Pocket Maximum[1]	$2,500 per person per calendar year; $5,000 per family per calendar year (excluding Deductible)
[1] *Certain expenses do not apply toward your out-of-pocket maximum; refer to page 19 for a listing of these expenses.*	
Coinsurance[2] PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
[2] *Certain covered expenses may be paid at a different percentage. Unless specifically stated otherwise, the Plan pays this coinsurance percentage for medical covered expenses after the Deductible is satisfied (including covered expenses not listed on this Summary of Benefits).*	
Home Health Care/ Durable Medical Equipment	Plan pays: 90% if pre-certified (80% of Reasonable and Customary Charges if not pre-certified)
Emergency Room Treatment PPO and Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges or 90% of Reasonable and Customary Charges
Specific Benefit Maximums Developmental Disorder Treatment	Plan pays: $2,000 per person per calendar year
Aural Rehabilitation/ Habilitation Services	Plan pays $3,000 per person per calendar year for individuals with hearing aids or cochlear implants; 10 sessions of auditory rehabilitation required to train about cochlear implants
Physical, Occupational, Rehabilitation Therapy	Up to 25 visits per person per calendar year
Custom Fitted Foot Orthotic Devices (unless under age two and prescribed by a Physician)	Up to two pairs in any three-year period; if ordered by or supplied by a podiatrist, limited to non-surgical maximum for podiatry treatment of $750 per person per calendar year
Disease Awareness/Education Services	$250 per person per calendar year

Medical Benefits *continued*	**Coverage**
Dental Services Caused by Medical Conditions, such as Sjogren's Syndrome	Up to $2,000 per person per year (in addition to the limits provided under the Plan's Dental Benefits)
Podiatry Treatment Surgical Non-Surgical	 $3,500 per person per calendar year $750 per person per calendar year (including orthotics)
Speech Therapy	15 visits per person per calendar year for treatment of developmental disorders
Home Health Care	$150 per person per day, up to $10,000 per calendar year
Surgical Dental Treatment	$5,000 per person per calendar year
Infertility Treatment	$25,000 per family per lifetime
Chiropractic Treatment X-rays/Lab Services	Chiropractic limits apply only to participants age 6 and older $50 per visit up to $1,500 per person per calendar year $200 per person per calendar year
Mental Health and Substance Abuse Benefits	**Coverage**
Inpatient and Outpatient Benefits PPO Network Providers Non-PPO Network Providers	Plan pays: 90% of PPO Allowable Charges 80% of Reasonable and Customary Charges
Preventive Services Benefit	**Coverage**
Routine Physical Examination (Employee and Spouse Only) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Preventive Services[3] PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible Not covered
[3] *Flu shots received from network and non-network providers are covered at 100%, without a Deductible. If an office visit is billed separately from any Preventive Services received during the office visit, and the primary purpose of the office visit is not for receipt of Preventive Services, then the office visit is subject to the Plan's general Deductible and coinsurance provisions.*	
Newborn/Well-Child Care (Preventive) PPO Network Providers Non-PPO Network Providers	Plan pays: 100% of PPO Allowable Charges; no Deductible 80% of Reasonable and Customary Charges, after Deductible
Smoking Cessation Benefit (Employee and Spouse Only)	**Coverage**
Coinsurance	Plan pays 100% (covered providers only); no Deductible
Prescription Drug Benefits	Coverage
Retail Pharmacy Program Copayment[4] Generic Medication Brand Name Medication Specialty Medication	For up to a 30-day supply, you pay: $5 20%, up to $25 20%, up to $70
[4] *If you go to a non-network provider or do not use your ID card, you will need to submit a claim for reimbursement. Reimbursement will be based on the discounted, not the retail price, of the prescription.*	
Mail Order Copayment Generic Medication Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: $10 20%, up to $40 20%, up to $120
Hearing Benefits	**Coverage**
Coinsurance Device, Repair, Ear Molds PPO and Non-PPO Network Providers	Plan pays: 80% of PPO Allowable Charges or 80% of Reasonable and Customary Charges

Hearing Benefits *continued*	**Coverage**
Diagnostic Tests PPO Network Providers Non-PPO Network Providers	 100% of PPO Allowable Charges (Hear USA) 80% of Reasonable and Customary Charges
Benefit Maximum PPO Network Providers Non-PPO Network Providers	Plan pays: $4,000 per person per 24-month period for devices, repairs, and ear molds $4,000 per person per 24-month period for all hearing benefits combined
Dental Benefits	**Coverage**
Coinsurance Preventative and Diagnostic Restorative and Prosthodontic Orthodontia (up to age 19) TMJ and Related Disorders	Plan pays: 100% 80% 80% 80%
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Lifetime Maximums Orthodontic	 $2,000 per person
Vision Benefits	**Coverage**
Coinsurance Exams/Lenses (including polycarbonate, scratch resistant coating, and ultraviolet coating) PPO Providers Non-PPO Providers Frames PPO Providers Non-PPO Providers	Plan pays: 100% of PPO Allowable Charges, up to negotiated maximum per calendar year; contact lens exams may be subject to copayment 100% of Reasonable and Customary Charges 100% of PPO Allowable Charges, up to retail value of $110 100% of Reasonable and Customary Charges
Maximum PPO Providers Non-PPO Providers	Plan pays: One exam and one pair of glasses or contacts per calendar year; exam limit does not apply to dependent children under age 18 $200 per person per calendar year; limit does not apply to dependent children under age 18
Weekly Loss of Time Benefit (Employees Only)	**Coverage**
Non-Occupational Benefit[5] Maximum Weekly Benefit	90% of your base wage rate times 40 hours $400 per week
[5] *50% due to a second period of disability for treatment of substance abuse (after two courses of treatment, no payment of Weekly Loss of Time Benefits).*	
Benefits Begin	
Accident, Outpatient Surgery, Illness (Hospital Confined)	First day
Illness (Non-Hospital Confined)	Eighth day
Benefits End	Earlier of recovery or 13 weeks
Death Benefit	**Coverage**
Employee Only	$50,000
Eligible Dependent Spouse	$2,000
Eligible Dependent Child	$2,000
AD&D Benefit (Employees Only)	**Coverage**
Full Benefit Amount	$50,000

Sheet Metal Workers Local No. 265
Health and Welfare Plan

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