SUMMARY PLAN DESCRIPTION

SHEET METAL WORKERS'
LOCAL UNION NO. 28 WELFARE FUND

RETIREES
BUILDING TRADES DIVISION

Updated as of November 1, 2021

SHEET METAL WORKERS
LOCAL UNION NO. 28 WELFARE FUND

RETIREES
BUILDING TRADES DIVISION

195 Mineola Boulevard
Mineola, New York 11501

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SUMMARY PLAN DESCRIPTION

This booklet constitutes the “Summary Plan Description” (“SPD”) required by the Employee Retirement Income Security Act of 1974 (“ERISA”). This SPD sets forth the terms and provisions of the Sheet Metal Workers' Local Union No. 28 Welfare Fund (the “Plan” or “Fund”) that provide for the payment or reimbursement of all or a portion of certain medical and other expenses. This booklet serves as both the “Plan Document” and the “SPD” and supersedes all prior SPDs, Plan rules and other notices.

The benefits provided by the Plan are financed by contributions from Participating Employers who are signatories to the Collective Bargaining Agreement between the Sheet Metal Workers Local Union No. 28 (the “Union”) and premium payments made by you for retiree coverage.

This SPD constitutes the Fund's Plan document and contains the Fund's complete Welfare Benefit program as of the date of publication. The rate of benefit contributions is defined in the Collective Bargaining Agreement between Participating Employers and the Union.

From time to time, the Fund's Trustees may amend the Plan or the eligibility rules for receiving benefits. If the Trustees change any of the benefits or eligibility rules described in this booklet, you will be notified accordingly. Please keep any such notices with this booklet so that you will always have complete and up to date information about the Plan.

This booklet outlines the eligibility rules, describes the conditions governing the payment of benefits, and explains the procedures you should follow in filing a claim as well as an appeal procedure should your claim be denied.

It is strongly recommended that you read the entire SPD to ensure a complete understanding of the benefits provided by the Plan. You may also contact the Third-Party Administrator or Fund Office for assistance.

What is the Purpose of the Plan?

The Plan has been established to help offset, for you and your eligible dependents, the economic effects arising from an injury or illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and the Plan Administrator must abide by the terms of the SPD, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

How Will This Document Be Interpreted?

The use of masculine pronouns in this SPD will apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this SPD are used for convenience of reference only. You should not rely on any provision solely because of the heading.

The use of the words, “you” and “your” throughout this SPD apply to eligible or covered members and, where appropriate in context, their covered Dependents.

The Trustees may, in their sole discretion and authority, modify or eliminate any of the benefits described herein or the qualification requirements for such benefits. The Trustees have the sole and complete authority to interpret the Plan as described in this SPD, and to make final determinations regarding its provisions. No benefits are guaranteed.

Patient Protection and Affordable Care Act

The Plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted.

A Grandfathered Health Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Board of Trustees
Sheet Metal Workers' Local Union No. 28 Welfare Fund
195 Mineola Boulevard
Mineola, NY 11501
(516) 742-9478

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or visit www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Questions?

We suggest that you share this booklet with your Family since they may have an interest in the Plan. We also suggest that you keep this booklet for future reference and let members of your Family know where you keep it.

If you have any questions concerning your benefits or your eligibility to participate, please call the Fund Office's Welfare Department at (516) 742-9478. Office hours are 8:30 am - 4:30 pm, Monday through Friday.

Si tiene alguna pregunta sobre sus beneficios o su elegibilidad para participar, llame a la Oficina del Fondo, Departamento de Bienestar Social al (516) 742-9478. El horario de atención es de 8:30 am a 4:30 pm, de lunes a viernes.

Sincerely,

The Board of Trustees
Sheet Metal Workers' Local Union No. 28 Welfare Fund

GENERAL PLAN INFORMATION YOU SHOULD KNOW

Name of Plan:	**Sheet Metal Workers Local Union No. 28 Welfare Fund**
Plan Sponsor:	**Board of Trustees** **Sheet Metal Workers Local Union No. 28 Welfare Fund** **195 Mineola Boulevard** **Mineola, NY 11501**
Plan Administrator: **(Named Fiduciary)**	**Board of Trustees** **Sheet Metal Workers Local Union No. 28 Welfare Fund** **195 Mineola Boulevard** **Mineola, NY 11501**
Plan Sponsor ID No. (EIN):	**13-5530847**
Plan Year:	**January 1 through December 31**
Plan Number:	**501**
Plan Type:	**Welfare Plan**
Third Party Administrator:	**Dickinson Group, LLC.** **50 Charles Lindbergh Boulevard** **Suite 207** **Uniondale, NY 11553** **(877) 347-7225**
Agent for Service of Process:	**Board of Trustees** **Sheet Metal Workers Local Union No. 28 Welfare Fund** **195 Mineola Boulevard** **Mineola, NY 11501** **(516) 742-9478** **Fax: (516) 742-6360** **Email: benefits@local28funds.com**

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

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ELIGIBILITY FOR PARTICIPATION

If you retire and satisfy the following requirements, you can purchase coverage for yourself and your eligible Dependent(s).

- Retire after the age of 55;

- Received 25 years of credited service covered under one or more collective bargaining agreements between a Participating Employer(s) and SMART Local Union No. 28 without a permanent break-in-service; or a combination of 25 years of service under one or more collective bargaining agreements between a Participating Employer and Local Union No. 28 and the former Sheet Metal Locals 13, 10, or 22 from New Jersey if you first became covered under a Local Union No. 28 collective bargaining agreement as a result of the merger of these New Jersey Local unions into Local Union No. 28 and remained covered under a Local Union No. 28 collective bargaining agreement thereafter; or

- You have up to 5 years of service with any SMART Local which may be combined with the years of service at Local 28, providing that at least 20 continuous years of active service were worked at Local 28 immediately preceding your retirement;

- Worked at least 400 hours in the 24-month period immediately prior to the date of your retirement. If you lost coverage due to a lack of hours and elected COBRA and are making the COBRA payments to maintain your health coverage, the time spent while on COBRA coverage will be counted to prevent you from losing eligibility for retiree coverage (this must be established at time of retirement);

- You must elect to purchase coverage within 60 days of your retirement. If your Spouse is also a member of the Union or an Employee of the Funds or Union and is still covered under the Plan, the election to purchase coverage must be made within 60 days of their retirement or separation of employment if they are not eligible for retiree coverage. If you do not make an election within the time frame, you, your Spouse and Dependent(s) cannot be added at a later time. Notwithstanding the preceding sentence, if you do not elect to purchase coverage for you and/or your Spouse and Dependent(s) within the 60 day period of your retirement, the Fund will permit a one-time election of coverage if you provide written evidence satisfactory to the Fund that all of you were continuously covered under another group health plan or governmental health program from your retirement to the date of your election of coverage under the Fund, and

- You pay the required monthly premium after you have run out your active service eligibility under the Plan as described under the section titled “Continuation and Termination of Coverage.” Your payment is due within 10 days after the beginning of each month.

If you lost your eligibility for benefits before your date of retirement and have no coverage, you will have no health and welfare benefits as a Pensioner.

If coverage for your Spouse or Dependent(s) initially begins within the 12 months prior to your retirement, your Spouse or Dependent(s) will not be eligible for benefits after your retirement date.

Health Benefits

If you satisfy the above requirements, then the following benefits are available for you and your Spouse and Dependent(s) during your retirement:

Until You Become Eligible for Medicare – Ages 55-64

The same medical, Hospital, dental, hearing, and optical benefits that are provided for eligible actively-working members, with the exception of prescription Drugs which have an annual Family maximum as described in the section titled “Prescription Drug Benefits.”

If your Spouse or Dependent(s) have not yet become Medicare eligible, they will continue to receive coverage up until they become Medicare eligible.

When You Become Medicare Eligible

If you satisfy the above requirements, you will only be eligible for prescription Drug coverage, the Member Assistance Program (MAP) and death benefits. Your medical and Hospital coverage under the Plan will end and Medicare will be primary for these benefits.

If you and/or your Spouse are Medicare eligible and you have not enrolled in the SMW+ Program, you should contact them at (800) 831-4914 for more information on this voluntary program. The address for the SMW+ Program is: PO Box 1449, Goodlettsville, TN 37070.

Continuation of Coverage for Surviving Spouse and Dependents

Coverage will continue for the surviving Spouse and covered Dependents of an eligible retired member for a period of 12 months following the date of his or her death provided similar coverage would not otherwise be provided under another group health plan. This 12 month period will count towards the maximum period under COBRA, as established by the Plan or by law. Refer to the section of this SPD titled “Termination of Coverage” for more information about continuation of coverage through COBRA. Following the COBRA period, prescription drug coverage will be offered to Medicare eligible surviving spouses on a self-pay basis directly with Labor First.

Are My Dependents Eligible to Participate in the Plan?

Yes, if coverage for your Spouse or Dependent(s) initially begins within the 12 months prior to your retirement, your Spouse or Dependent(s) will not be eligible for benefits after your retirement date.

Family Status Changes

It is important that you give prompt, written notice to the Fund office of any change in your Family status, such as death of your spouse or dependent child, divorce, or separation.

Failure to report changes result in a delay of payment of benefits at a future date or may adversely affect your COBRA right to continuation coverage.

What if a Court Orders Coverage for a Child?

If your eligible dependent is already covered under the Plan, Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The Fund will provide coverage to a child if required to do so under the terms of a qualified medical child support order (referred to as a "QMCSO"). The Fund will provide coverage to a Child under a QMCSO even if you do not have legal custody of the Child, the Child is not dependent on you for support, or the Child does not reside with you. You can request a copy of the Fund's procedures for determining whether an order is a QMCSO free of charge.

TERMINATION OF COVERAGE

When Does Participation End?

Participation will end at 12:01 A.M. on the earliest of the following dates:

- If you fail to make any required premium payments when it is due;
- The date the Plan terminates;
- The last day of the month in which you cease to be eligible for coverage under the Plan; or
- The date on which you or your Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

When Does Participation End for My Dependents?

Coverage for your Dependents will end at 12:01 a.m. on the earliest of the following dates:

- If you fail to make any required premium payments when it is due;
- The date the Plan terminates;
- The last date of the month in which the Plan discontinues coverage for Dependents;
- The date your Dependent becomes covered as an Employee under the Plan;
- The last date of the month in which your coverage terminates;
- When such Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any calendar year;
- In the case of a Child for whom coverage is being continued due to mental or physical inability to earn his or her own living, the last day of the month in which earliest of the following events occurs:
    - Cessation of the inability;
    - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
- In the case of a Child, other than a Child for whom coverage is continued due to mental or physical inability to earn his or her own living, the last day of the month in which the Child reaches age 26;
- The date on which you or your Dependent, submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

- The last date of the month in which your dependent ceases to be an eligible Dependent.

Will the Plan Provide Evidence of Coverage?

The Plan will automatically provide a Certificate of Coverage to anyone who loses coverage under the Plan. In addition, a Certificate of Coverage will be provided upon request at any time.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

See the section titled “Continuation and Termination of Coverage” for more information.

HOSPITAL AND MEDICAL BENEFITS

Who Administers the Program?

The Plan has entered into an agreement with the Empire Blue Cross Blue Shield (Empire) Network of Hospitals and Physicians, called Preferred Provider Organization (PPO). The PPO Network offers Covered Persons health care services at discounted rates. Using a PPO Network Provider will normally result in a lower cost to the Plan as well as to the Covered Person. There is no requirement for any Covered Person to seek care from a Provider who participates in the PPO Network. The choice of Provider is entirely up to the Covered Person.

The Plan has also entered into an agreement with a Third-Party Administrator, Dickinson Group, LLC, to assist with the administration and processing of hospital and medical claims.

Selection of Your Health Care Provider

A current list of PPO Network Providers is available, without charge, by accessing the Empire/Anthem website at www.anthem.com, or by calling the Provider locator telephone number listed on your Plan ID card (800-810-2583).

It is important to note that before you make a medical appointment, you should ask your Provider if they participate with the local Blue Cross Blue Shield PPO Plan. The www.anthem.com website is only a guide. Even though a Provider is listed on the website, you should call to make sure that they are still an In-Network Provider.

In addition, if you are receiving medical services that require multiple Providers, you need to make sure that all the Providers treating you participate or you might be responsible for additional charges above the Copay as discussed below.

Each Covered Person has a free choice of any Provider, and the Covered Person, together with his or her Provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO Network Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO Network Provider.

Some PPO Network Provider Hospitals have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the Plan will reimburse the Hospital based upon the agreed per diem or DRG rates.

Your Costs

You must pay your required monthly premium and for a certain portion of the cost of Covered Expenses under the Plan, including Deductibles, Copayments and the Coinsurance percentage that is not paid by the Plan. This is called Out-of-Pocket Expense. There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a PPO Network Provider or a non-PPO Network Provider. You must pay any expenses that are in excess of the Plan's allowance rate for out-of-Network claims, and any penalties for failure to comply with requirements of the "Medical Care Management Pre-Authorization Program" section or penalties that are otherwise stated in the Plan. The Plan's payment levels are described below and are also

shown in the Schedule of Benefits. The Plan will not reimburse any expense that is not a Covered Expense.

Maximum Medical Allowance

The Plan's allowance for non-PPO Network Providers is 100% of the Maximum Medical Allowance (MMA). The MMA rate is determined as follows:

- For Institutional (Hospital and facility) services, MMA is determined based upon rates provided by EMC Captiva® at the 50th percentile;

- For Professional services, MMA is determined based upon the National Medicare fee schedule at 100% with the exception of the following two services:

    - Office visit for evaluation and management of established patient – CPT 99213 – the MMA rate allowance is $40.

    - Office visit for evaluation and management of established patient, detailed – CPT 99214 – the MMA rate allowance is $60.

Dollar and Visit Limitations

Certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the Schedule of Benefits and throughout this SPD.

Using an In-Network (Participating) Provider

Currently, if you use an In-Network Provider or facility, some services require a Copay. The Copay for a basic office visit is $20, $35 for an emergency room, and $250 for an Inpatient Hospital stay. If you use an In-Network Provider, you will only be responsible for these Copays. There will be no balance billing. There are similar Copays for some of the Plan's other basic services as discussed in this SPD.

> **Example:** Let's say you use an In-Network Provider for an office visit and that Provider normally charges $500.00 for a visit. You would only be responsible for the $20 Network Copay. Because the Provider participates with Empire, they will be reimbursed at the negotiated rate which would be something much less than their normal charges. Many times it can be 50-75% less than the billed charges.

Using an Out-of-Network (Non-Participating) Provider

If you decide to use a Provider that does not participate with Empire, you will most likely be responsible for additional costs. In addition to the Copay and Coinsurance that is charged, your Provider might balance bill you for amounts that they charge which are in excess of the Plan's MMA.

Examples:

Let's say you decide to use an out-of-Network Provider for an office visit and that Provider normally charges $500.00 for that visit and the Plan's MMA rate was determined to be $60.00. First, you would still be responsible for the $30 out-of-Network Copay which is your share of the Plan's reimbursement to your out-of-Network Provider. So, the Plan would pay $30 and you would pay $30. In addition to your $30 Copay, your out-of-Network Provider will most likely bill you for the balance of the unpaid charges. In this case, that would be an additional $440 ($500 that is billed by your out-of-Network Provider, less your $30 Copay, less $30 paid by the Plan = $440). Therefore, your total Out-of-Pocket Expense could possibly be $470 (your $30 Copay plus the $440 balance bill) rather than just a $20 Copay if you went In-Network.

Next, suppose you went to an out-of-Network Hospital that charges $1,500 for an overnight stay and the MMA amount is determined to be $750. You will most likely be responsible for $1,000 of that bill. Again, you will be responsible for your Copay which in this case which would be $250. Then, after the Plan pays its allowance of $500 ($750 MMA less your $250 Copay), there would be a balance of $750 that your out-of-Network Provider might try to collect from you. Therefore, your total Out-of-Pocket Expense would be $1,000 (your $250 Copay plus your out-of-Network Providers balance bill of $750) rather than just the $250 Copay if you went In-Network.

Lastly, in the more extreme case, let's say you scheduled elective Surgery with out-of-Network Providers and the total charges being billed for all institutional Hospital, facility and Physician service were $100,000 and the MMA was determined to be $20,000 (combined facility and Physicians) which will be offset by your $250 Copay. You might be at risk of being balanced billed $80,250 ($100,000 billed by your out-of-Network Providers, less your $250 Copay, less $19,750 reimbursed by the Plan= $80,250). In this case, if you would have used Network Providers, you would have only been responsible for your $250 Copay and the Plan would have been billed a significantly lower amount based on the Empire negotiated rate.

Please note that these examples are for illustrative purposes only. Your Out-of-Pocket Expense could be much different depending upon the nature of your medical needs, the prices that your out-of-Network Provider charges, and the MMA determined by the Plan.

Schedule of Benefits

The schedules below are provided as a convenience only and are not all-inclusive. Important information is contained in sections, “Medical Benefits” and “Exclusions and Limitations.”

Maximums stated apply to the amount of benefit payments unless otherwise indicated.

Hospital Inpatient Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Medical/Surgical, Room & Board & Ancillary	100% of PPO Rate for semi-private room and ancillary charges $250 Copayment	100% of MMA Rate for semi-private room and ancillary charges $250 Copayment, plus balance billing	Pre-authorization required

Intensive Care Unit Room & Board	100% of PPO $250 Copayment	100% of MMA $250 Copayment, plus balance billing	Pre-authorization required
Skilled Nursing Facility, Room & Board & Ancillary – With Prior Hospitalization	100% of PPO Rate Subject to $50 Deductible	75% of MMA Rate Subject to $50 Deductible, plus balance billing	If confinement begins within 7 days of Inpatient confinement of at least 3 days, deductible will be waived Benefits limited to 30 days per confinement Pre-authorization required
Skilled Nursing Facility, Room & Board & Ancillary – Without Prior Hospitalization	100% of PPO Rate Subject to $50 Deductible	75% of MMA Rate Subject to $50 Deductible, plus balance billing	30 days per confinement Pre-authorization required

Hospital Newborn Care

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Neo-Natal Room & Board & Ancillary	100% of PPO Rate	100% of MMA Rate	Pre-authorization required
Newborn Nursery & Ancillary	100% of PPO Rate	100% of MMA Rate	Pre-authorization required

Physician In-Hospital Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Physician Medical Hospital Visit	100% of PPO Rate	100% of MMA Rate	
Physician Newborn Visit	100% of PPO Rate	100% of MMA Rate	
Consultant Visit	100% of PPO Rate	100% of MMA Rate	

Surgical Inpatient Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Anesthesia	100% of PPO Rate	80% of Charge	
Assistant Surgeon	100% of PPO Rate	100% of MMA Rate	
Obstetrical	100% of PPO Rate	100% of MMA Rate	
Surgeon	100% of PPO Rate	100% of MMA Rate	

Gastric Surgery	100% of PPO Rate	100% of MMA Rate	1 procedure per lifetime for all related services Pre-authorization required

Professional Interpretation Services Inpatient and Outpatient

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Pathologist Fee	100% of PPO Rate	100% of MMA Rate	
Radiologist Fee	100% of PPO Rate	100% of MMA Rate	

Surgical Outpatient Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Anesthesia	100% of PPO Rate	80% of Charge	Pre-authorization required for pain management services
Assistant Surgeon	100% of PPO Rate	100% of MMA Rate	
Obstetrical	100% of PPO Rate	100% of MMA Rate	
Surgeon	100% of PPO Rate	100% of MMA Rate	
Gastric Surgery	100% of PPO Rate	100% of MMA Rate	1 procedure per lifetime for all related services Pre-authorization required

Hospital Emergency Room Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Emergency Room - Accident or Sudden and Serious Illness	100% of PPO Rate $35 Copayment per visit	100% of MMA Rate $35 Copayment per visit, plus balance billing	
Emergency Room Physician – Accident or Sudden and Serious Illness	100% of PPO Rate	100% of MMA Rate	
Emergency Room – Non Emergent Illness	Not Covered	Not Covered	
Emergency Room Physician – Non-Emergent Illness	100% of PPO office visit rate $20 Copayment per visit	100% of MMA office visit rate	

		$30 Copayment per visit, plus balance billing	
Emergency Room – Treatment for Withdrawal	100% of PPO Rate $35 Copayment per visit	100% of MMA Rate $35 Copayment per visit, plus balance billing	See section titled "Mental Health and Substance Abuse Programs" for more benefit details

Outpatient Facility Diagnostic Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Diagnostic Laboratory	100% of PPO Rate	100% of MMA Rate	
Diagnostic X-ray	100% of PPO Rate	100% of MMA Rate	
Imaging (CT/PET/SPECT scans, MRI, MRA)	100% of PPO Rate	100% of MMA Rate	Pre-authorization required for MRA, PET and SPECT scans Pre-authorization required for CT and MRI's for Dependents under age 16
Pre-Admission or Pre-Surgical Testing within 7 days of admission	100% of PPO Rate	100% of MMA Rate	

Outpatient Facility Fees

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Ambulatory Surgery Center	100% of PPO Rate	100% of MMA Rate	25 visits per calendar year for all outpatient visits combined Pre-authorization required
Urgent Care Center	100% of PPO Rate $20 Copayment per visit	100% of MMA Rate $30 Copayment per visit, plus balance billing	25 visits per calendar year for all outpatient visits combined

Outpatient Therapy Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Acupuncture	100% of PPO Rate Maximum daily benefit $30	100% of MMA Rate Maximum daily benefit $20	15 visits in a calendar year
Cardiac Rehabilitation	100% of PPO Rate	100% of MMA Rate	30 visits per course of treatment Pre-authorization required
Chemotherapy	100% of PPO Rate	100% of MMA Rate	
Dialysis	100% of PPO Rate	100% of MMA Rate	
Physical Therapy	100% of PPO Rate $15 Copayment per visit	100% of MMA Rate $25 Copayment per visit, plus balance billing	15 visits per calendar year Pre-authorization required Up to an additional 10 visits if Medically Necessary
Rehabilitation Therapy	100% of PPO Rate $15 Copayment per visit	100% of MMA Rate $25 Copayment per visit, plus balance billing	15 visits per calendar year Pre-authorization required Up to an additional 10 visits if Medically Necessary
Radiation Therapy	100% of PPO Rate	100% MMA Rate	
Speech Therapy	100% of PPO Rate $20 Copayment per visit	100% of MMA Rate $30 Copayment per visit, plus balance billing	15 visits per calendar year, 25 visits for autism Pre-authorization required Up to an additional 10 visits if Medically Necessary

Physician's Office Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Office Visit	100% of PPO Rate	100% of MMA Rate	25 visits per calendar year for all

	$20 Copayment per visit	$30 Copayment per visit, plus balance billing	outpatient visits combined
Allergy Care & Testing (extracts, serums, injections)	100% of PPO Rate	100% of MMA Rate	
Injections	100% of PPO Rate	100% of MMA Rate	Pain management requires Pre-authorization
Podiatric Office Visit	100% of PPO Rate $20 Copayment per visit	100% of MMA Rate $30 Copayment per visit, plus balance billing	Limited to 15 visits in calendar year Pre-authorization required for surgery
Diagnostic X-ray	100% of PPO Rate	100% of MMA Rate	
Diagnostic Laboratory	100% of PPO Rate	100% of MMA Rate	

Chiropractic Services

Services	**PPO Network Providers**	**Non-PPO Network Providers**	**Limits & Notes**
Chiropractic Visit and Therapies	100% of PPO Rate $15 Copayment per visit Maximum benefit $40 per visit	100% of MMA Rate $20 Copayment per visit, plus balance billing Maximum benefit $40 per visit	15 visits per calendar year
Chiropractic X-ray	100% of PPO Rate	100% of MMA Rate	

Preventive Care Services

Services	**PPO Network Providers**	**Non-PPO Network Providers**	**Limits & Notes**
Annual Physical Examination	100% of PPO Rate	100% of MMA Rate $30 Copayment per visit, plus balance billing	Once in a 12-month period
Routine Eye Examination	Not Covered	Not Covered	Contact the Fund Office. Also see section titled “Vision Benefits”
Hearing Examination & Hearing Aid	100% of PPO Rate	100% of MMA Rate	Maximum hearing aid benefit of $1,500 per ear in a 3-year period
Immunization	100% of PPO Rate	100% of MMA Rate	In accordance with Center for Disease Control

Preventive Lab Screening	100% of PPO Rate	100% of MMA Rate	
Preventive X-ray Screening	100% of PPO Rate	100% of MMA Rate	
Prostate Examination	100% of PPO Rate	100% of MMA Rate	1 exam per 12 month period
Well Child Care (for Children up to age 26)	100% of PPO Rate	100% of MMA Rate $30 Copayment per visit, plus balance billing	

Preventive Care Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Gynecology Annual Exam	100% of PPO Rate	100% of MMA Rate $30 Copayment per visit, plus balance billing	Once in a 12-month period
Mammogram (for asymptomatic over the age of 40)	100% of PPO Rate	100% of MMA Rate	Over age 40 Once in a 12-month period
Mammogram (for asymptomatic under the age of 40)	100% of PPO Rate	100% of MMA Rate	Prior to age 40 1 every other 12-month period
Pap Test	100% of PPO Rate	100% of MMA Rate	

Second Surgical Opinion Services

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Office Visit for Second Surgical Opinion	100% of PPO Rate	Office Visit for Second Surgical Opinion	100% of PPO Rate

Other Covered Expenses

Services	PPO Network Providers	Non-PPO Network Providers	Limits & Notes
Ambulance - Air Transportation	100% of PPO Rate	100% of MMA Rate	Limited to a maximum benefit of $1,000
Ambulance - Ground Transportation	100% of PPO Rate	100% of MMA Rate	Limited to a maximum benefit of $1,000
Blood and Administration	100% of PPO Rate	100% of MMA Rate	Blood storage is not covered
Cataract Lenses Following Cataract Surgery	100% of PPO Rate	100% of MMA Rate	Only initial purchase after

			cataract Surgery is covered
Diabetic Supplies	100% of PPO Rate	100% of MMA Rate	
Durable Medical Equipment	100% of PPO Rate	100% of MMA Rate	Pre-authorization required for equipment over $750
Home Health Services – with Prior Hospitalization	100% of PPO Rate	75% of MMA Rate Subject to $50 Deductible	Limited to maximum of 200 visits per calendar year 4 hours equals one visit Pre-authorization required
Home Health Services – without Prior Hospitalization	75% of PPO Rate Subject to $50 Deductible	75% of MMA Rate Subject to $50 Deductible	40 visits per calendar year 4 hours equals one visit Pre-authorization required
Hospice	100% of PPO Rate	100% of MMA Rate	Limited to maximum of 210 days lifetime Pre-authorization required
Lasik Surgery	100% of PPO Rate	100% of MMA Rate	Maximum lifetime benefit of up to $750 per eye
Orthotics	100% of PPO Rate	100% of MMA Rate	Pre-authorization required for devices over $750
Oxygen and Administration	100% of PPO Rate	100% of MMA Rate	
Prosthetic Devices	100% of PPO Rate	100% of MMA Rate	Pre-authorization required for device over $750
RN & LPN Services – Outpatient	100% of PPO Rate	100% of MMA Rate	30 days of care per calendar year

Replacement of Organs/Tissues (Transplant Procedures)

Services	**PPO Network Providers**	**Non-PPO Network Providers**	**Limits & Notes**
Organ Procurement and Acquisition	Not Covered	Not Covered	
Transplant Procedure	100% of PPO Rate	100% of MMA Rate	Pre-authorization required

Hospital Charges for Transplant Procedure	100% of PPO Rate $250 Copayment	100% of MMA Rate $250 Copayment, plus balance billing	Pre-authorization required

Hospital and Medical Covered Expenses

The following Covered Expenses must be custodial care while coverage is in force under this Plan. Reimbursement will be made according to the "Schedule of Benefits," and will be subject to all Plan maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

Inpatient Care – For medical or surgical care of an Illness or Injury, the Plan will reimburse Covered Expenses for semi-private Room and Board and necessary ancillary expenses. If the Hospital does not have semi-private accommodations, the Plan will allow coverage for an amount equal to the average semi-private rate for other Hospitals in that geographic area. Covered Expenses will include Cardiac Care Units and Intensive Care Units, when appropriate for the Covered Person's Illness or Injury.

Maternity Care – Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or surgical care of an Illness, shown in the "Schedule of Benefits" and this section, and subject to the same maximums.

Newborn Care – Coverage for a newborn Child will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section. Covered Expenses for newborn Children include nursery and neo-natal intensive care Room and Board, necessary ancillary expenses, and routine newborn care during the period of Hospital confinement, including circumcision.

In-Hospital Physicians' Services

In-Hospital Medical Services – Covered Expenses include professional services rendered by the attending Physician while the Covered Person is hospitalized.

In-Hospital Concurrent Medical Care – Covered Expenses include services rendered concurrently by a Physician other than the attending Physician when the Covered Person is being treated for multiple, unrelated Illnesses or Injuries, or which require the skills of a Physician specialist.

In-Hospital Consultant Services – Covered Expenses include the services of a Physician consultant when required for the diagnosis or treatment of an Illness or Injury.

Surgical Inpatient and Outpatient Services

Anesthesia Services – Covered Expenses include the administration of spinal, rectal or local anesthesia, or a Drug or other anesthetic agent by injection or inhalation, rendered by a licensed Provider. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA). Covered Expenses do not include anesthesia administered by the surgeon Physician.

Obstetrical Services – Covered Expenses include obstetrical services rendered by the Physician in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the Plan provisions in effect on the date the services are rendered.

Surgical Assistants – Covered Expenses include services by a licensed Physician who actively assists the operating surgeon in the performance of Surgical Procedures when the condition of the patient and complexity of the Surgery warrant such assistance.

Surgical Services – Covered Expenses include Surgical Procedures, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one Surgical Procedure is performed during the same operative session, the allowed expense is calculated as follows:

- If bilateral or multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the PPO rate (for both in and out of Network services) that is allowed for the primary procedures. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

- If multiple unrelated Surgical Procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the PPO rate (for both in and out of Network services) for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the PPO rate allowed for that procedure; and

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the allowable percentage of the surgeon's Network allowance.

Second Surgical Opinions – Covered Expenses include a second opinion to determine the Medical Necessity for a recommended Surgical Procedure. The Physician rendering the second opinion must not be affiliated with the Physician who recommended the Surgical Procedure. A third opinion will be covered if the two opinions differ, and if it is performed by a Physician who is not affiliated with the Physicians who have rendered opinions.

Surgical and Related Services for Gastric Surgery – Any gastric Surgery procedure deemed Medically Necessary (based on an independent medical review) for Morbid Obesity and/or complications of gastric bypass Surgery will be limited to one procedure per lifetime. This gastric Surgery benefit does not cover and specifically excludes any Cosmetic Surgery, services and/or repair.

Professional Interpretation Services - Inpatient and Outpatient

Covered Expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an Illness or Injury, unless otherwise provided under "Preventive Care."

Emergency Non-Participating Provider Services

For Inpatient, Outpatient, Emergency Room and Ambulatory Surgical services, if you are treated at an In-Network Hospital, In-Network Emergency Room, In-Network outpatient facility or an In-Network Ambulatory Surgical Center and in the course of receiving Emergency medical services, you are treated by an out-of-Network (Non-Participating) Emergency Room Physician, Surgeon, Assistant Surgeon, Pathologist or Radiologist, the cost of such services will be paid based on the Provider's charge at 100% reimbursement up to a maximum benefit of $20,000 per service.

Hospital Emergency Room Services

Covered Expenses include:

- Emergency treatment of an accidental Injury.
- Emergency treatment of an Illness.

Covered Expenses also include Physician's charges, and charges for radiology and pathology, for Emergency surgical or medical care rendered in the Hospital Emergency room.

No payment will be made for Emergency Room Facility Charges for a non-emergent condition. A Copayment of $20 for In-Network services or $30 for out-of-Network services, and payment up to the PPO office visit rate will be applied for Physician Services for a non-emergent condition.

Pre-Admission Testing

Benefits are provided for pre-admission testing for expenses Incurred within seven days prior to the scheduled Hospital admission, and only when the testing is not duplicated on admission.

Outpatient Facility Services

Covered Expenses include the following services when provided in an outpatient department of a Hospital or other Institution:

Cardiac Rehabilitation – Benefits are provided for cardiac rehabilitation program services when certified as Medically Necessary by the attending Physician in a treatment program that is appropriate for the Covered Person's Illness.

Chemotherapy Services – Benefits are provided for administration of chemotherapy treatment, including the Drugs and supplies used during the treatment.

Dialysis – Benefits are provided for kidney dialysis treatment, including the Drugs and supplies used during the treatment.

Intravenous Therapy – Benefits are provided for administration of intravenous therapy, including the Drugs and supplies used during the treatment.

Outpatient Diagnostic Examinations – Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an Illness or Injury.

Outpatient Surgery/Ambulatory Surgery Center – Benefits are provided for charges by a Hospital, Ambulatory Surgical Center, or in a Physician's office, for services required for a Surgical Procedure. The facility fees may include both services and supplies required for the Surgery.

Physical Therapy – Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following Illness, Injury or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the Illness or Injury, and which is ordered by the attending Physician.

Radiation Therapy – Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the fee for materials.

Speech Therapy – Benefits are provided for the evaluation and treatment of Covered Persons who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the Illness or Injury, and which is ordered by the attending Physician.

Rehabilitation Facilities Benefits

Covered Expenses for Inpatient rehabilitation facilities include semi-private Room and Board accommodations and necessary ancillary charges. A maximum of 30 days per confinement will be considered a Covered Expense under the Plan.

Skilled Nursing (or Extended Care) Facilities Benefits

Covered Expenses for Inpatient skilled nursing or (extended care) facilities include semi-private Room and Board accommodations, and necessary ancillary charges. The confinement must begin following an Inpatient stay of at least three days in a Hospital and must be for continued treatment of the Illness or Injury being treated in the Hospital.

Physician's Office Services

Covered Expenses include the following services rendered in a Physician's office:

Office Visits – Benefits are provided for services given in a Physician's office which are required for the diagnosis or treatment of an Illness or Injury. Covered services include the services of a Physician's assistant ("P.A.") rendered under the supervision of the Physician and billed by the Physician.

Allergy Care – Benefits are provided for allergy care, including injections, serums and extracts, given in a Physician's office. Covered services include the services of a Physician's assistant ("P.A.") rendered under the supervision of the Physician and billed by the Physician.

Diagnostic X-Ray and Laboratory Services – Benefits are provided for diagnostic x-ray and laboratory services given in a Physician's office which are required for the diagnosis or treatment of an Illness or Injury. Covered services include the services of a Physician's assistant ("P.A.") rendered under the supervision of the Physician and billed by the Physician.

Injections – Benefits are provided for therapeutic injections given in a Physician's office which are required for the treatment of an Illness or Injury. Immunizations and other injections which are not for the treatment of an Illness or Injury are not covered unless specified under "Preventive Care." Covered services include the services of a Physician's assistant ("P.A.") rendered under the supervision of the Physician and billed by the Physician.

Chiropractic Care Services

Covered Expenses include spinal manipulation and other related therapy treatments, and X-rays. Chiropractic Care must be rendered for the active treatment of an Illness or Injury. Maintenance care is not covered.

Preventive Care Benefit

Covered Expenses include the services listed below for preventive care for each Covered Person, subject to any limits described in the "Schedule of Benefits" section.

- General Medical Examination by a Physician;
- Gynecology Examination;
- Hearing Examinations;
- Immunizations;
- Mammogram Test;
- Pap Test;
- Preventive Laboratory Screenings;
- Preventive X-rays;
- Prostate Exam; and
- Well Child Care.

Other Covered Expenses

Acupuncture – When performed by a licensed medical doctor (M.D.).

Ambulance Service – Covered Expenses include local professional ground ambulance service from your home to a Hospital, or from the scene of an Accident or medical Emergency, to the nearest Institution able to treat the condition. Air transport services will be covered when Medically Necessary to transport the Covered Person to the nearest Institution capable of treating the Illness or Injury.

Blood Transfusions and Blood Products – The Plan does not cover expenses in connection with autologous blood acquisition and storage.

Cataract Lenses – Initial set of (contact or frame-type), following Surgery for cataracts.

Cochlear Implants – Limited to Dependent Children under the age of 18.

Durable Medical Equipment – Covered Expenses includes purchase and rental of Durable Medical Equipment. Benefits for rental will not exceed the usual, customary and reasonable (MMA rate) fee for purchase.

Home Health Care– Covered Expenses include home health services when rendered by a licensed and accredited Home Health Care Agency. These services must be provided through a formal, written Home Health Care treatment plan, certified as Medically Necessary by the attending Physician, and approved by the Plan. Services must be applied for within seven days of being discharged from a Hospital admission. Benefits are provided for:

- Medical supplies, medicines and equipment prescribed by a Physician and provided by the Home Health Care Agency, if such items would have been covered while Hospital confined;
- Physical, occupational, and speech therapy;
- Services provided by a home health aide;
- Services provided by a licensed social worker with a Masters in Social Work (M.S.W.); and
- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate Family.

On-going home health services will require re-certification by the attending Physician and approval by the Plan in order to qualify for continued coverage.

Each visit by a member of a Home Health Care Agency will be considered as one Home Health Care visit and four hours of home health aide services will be considered as one Home Health Care visit.

In addition to the General Limitations of the Plan, benefits will not be provided for any of the following:

- Any period during which the Covered Person is not under the continuing care of a Physician;
- Any service or supplies not included in the Home Health Care treatment plan or not specifically set forth as a covered service;
- Custodial Care provided to an individual primarily to assist in the activities of daily living;

- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Homemaker or housekeeping services except by home health aides as ordered in the Home Health Care treatment plan;
- Separate charges for records, reports or transportation;
- Services performed by volunteer workers;
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Hospice Care benefit;
- Services rendered or supplies furnished to other than the Covered Person;
- Social services, dietary assistance, "Meals on Wheels" or nutritional guidance; and
- Supportive environmental materials such as handrails, ramps, air conditioners and telephone.

Hospice Care – Covered Expenses include services for a terminally ill Covered Person when provided by a Hospice Care Agency. The services must be provided through a formal, written hospice care treatment program and certified by the attending Physician as Medically Necessary.

The attending Physician must certify that the Covered Person is expected to continue to live for six months or less in order to qualify for this benefit, that it is not medically advisable for the person to leave home and that a Hospital confinement would be required in the absence of Hospice care.

If the Covered Person lives beyond six months, the Plan will approve additional hospice care benefits on receipt of satisfactory evidence of the continued Medical Necessity of the services.

Benefits are provided for:

- Counseling services by a licensed social worker or a licensed counselor;
- Drugs and medicines for the terminal Illness that are legally obtainable only upon a Physician's written prescription;
- Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions, intravenous solutions and other medical supplies including splints, trusses, braces, or crutches;
- Nutrition services and/or special meals;
- Part-time nursing care by or under the supervision of a registered nurse;
- Rental of Durable Medical Equipment such as wheelchairs, Hospital beds, and respirators;
- Respite services;

- Room and Board for confinement in a licensed, accredited hospice facility; and
- Services and supplies furnished by the hospice while the patient is confined.

In addition to the General Limitations in this Plan, Hospice benefits will not be provided for any of the following:

- Any services or supplies not included in the Hospice treatment plan or not specifically set forth as a covered service;
- Bereavement, pastoral or spiritual counseling;
- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Homemaker or housekeeping services except by home health aides as ordered in the Hospice treatment plan;
- Legal and financial counseling services;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports or transportation;
- Services performed by family members or volunteer workers;
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Home Health Care benefit;
- Services rendered or supplies furnished to other than the terminally ill Covered Person; and
- Supportive environmental materials such as handrails, ramps, air conditioners and telephones.

Mastectomy – For breast cancer patients, as required under the Women's Health and Cancer Rights Act of 1998 (WHCRA), coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

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

These benefits will be provided subject to the same Copayments, Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

Oral Surgical Procedures – Including:

- Emergency repair due to Injury to sound natural teeth;

- Excision of benign bony growths of the jaw and hard palate;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- External incision and drainage of cellulitis;
- Incision of sensory sinuses, salivary glands or ducts; and
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Prosthetics – Artificial limbs and eyes (initial purchase only of basic prosthetic devices). Charges for replacement will be covered only when required because of pathological change or natural growth process of a Child. Replacements of prosthetics are not covered unless due to a significant change in the Covered Person's physical structure and the current device cannot be made serviceable.

Prosthetic Devices and Supplies – Including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the Covered Person's physical structure and the current device cannot be made serviceable.

Registered Nurse (RN) and Licensed Practical Nurse (LPN) – Private duty nursing services for outpatient care when Medically Necessary.

Sterilization Procedures

Surgical Dressings, Splints, Casts, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an Illness or Injury.

Replacement of Organs/Tissues and Related Services

Services in connection with any transplant not considered Experimental or Investigational must be authorized prior to services being performed. If no prior authorization is obtained, the transplant is not covered, regardless of Medical Necessity.

Covered Expenses include the following types of transplants:

Bone Marrow Transplants – Benefits are provided for Medically Necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

Solid Organs – Benefits are provided for the transplantation of solid human organs with other human organs and related services. This Plan excludes transplantation of non-human organs.

Tissue Replacement – Benefits are provided for the replacement of human tissue with human tissue or prosthetic devices.

No Benefits are Provided for:

- The preparation, evaluation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.

- Transportation of the organ recipient, to and from the site of the transplant procedure.

- No coverage is provided under this Plan for any expenses Incurred by or on behalf of the donor.

Hospital and Medical Exclusions and Limitations

This Plan will not reimburse any expense that is not a Covered Expense. This Plan does not cover any charge for services or supplies related to the following. This is not an exhaustive list.

Abortion – That is Incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or if the Pregnancy is the result of rape or incest.

Artificial Heart – Charges incurred in connection with the placement or maintenance of an artificial heart.

Biofeedback

Birth Control Drugs or Devices – For birth control Drugs or devices, not dispensed by prescription.

Cochlear Implants – For cochlear implants for any Covered Person over the age of eighteen.

Corrective Shoes **–** Unless medically necessary.

Cosmetic Services – Any Cosmetic Surgery other than reconstruction of the breast following a Mastectomy, including charges Incurred in connection with complications or the removal of breast implants originally placed for Cosmetic reasons.

Counseling – Charges related to counseling, except as specifically the result of a mental or nervous condition for:

- Alcohol outpatient treatment for group therapy except as provided elsewhere in this Plan;

- Behavioral issues;

- Financial issues;

- Lack of discipline or other antisocial action;

- Marital difficulties;

- Pastoral issues; and

- Social maladjustment.

Custodial Care – For Custodial Care, except as specified.

Dental – Charges that are related to dental treatment, except as specifically provided in this Plan. Refer to the section of this SPD titled "Dental Benefits" for a summary of covered benefits, exclusions and limitations.

Dental Hospital Admissions – Related to dental Hospital admissions.

Dental Prescriptions – For dental prescriptions (e.g., Peridex, fluoride).

Developmental Delay – For developmental disorders, including learning disabilities, mental retardation or autism.

Eating Disorders – That is related to eating disorders (e.g., anorexia and bulimia). This does not apply to any care for an underlying mental or nervous condition.

Educational – That is related to education or vocational training.

Excess Over Semi-Private Rate – That are in excess of the semi-private room rate, except as otherwise noted.

Excluded Providers and Facilities – That are rendered or provided by the following excluded Providers or facilities:

- Charges Incurred for services or supplies rendered by the member, member's Spouse and/or Children, brothers, sisters, parents and grandparents of either the member or the member's Spouse;

- Facilities owned or operated by the United States or any state or local government unless the Covered Person is legally obligated to pay;

- Hypnotists;

- Marriage counselors;

- Naturopaths;

- Rolfers; and

- Services provided in a medical or dental department or clinic maintained by a Participating Employer, labor union or mutual benefit organization.

Experimental – Services that are Experimental. In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered Experimental, and hence, not covered by this Plan.

Eyeglasses, Contact Lenses, Refractions – For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except one pair of lenses following Surgery for cataracts. Refer to the section of this SPD titled "Vision Benefits" for a summary of covered benefits, exclusions and limitations.

Eye Exercises or Training and Orthoptics – For eye exercises or training and orthoptics.

This exclusion does not apply to:

- Aphakic patients;
- One pair of lenses following cataract Surgery; or
- Soft lenses or sclera shells intended for use as corneal bandages.

Food Supplements – Related to food supplements or augmentation, in any form (unless Medically Necessary to sustain life in a critically ill person).

Foot Care Services, Routine – For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized Illness, Injury or symptoms involving the foot. This exclusion does not apply to open cutting operations and necessary treatment of metabolic or peripheral vascular disease.

Genetic Testing and/or Counseling – Unless Medically Necessary.

Growth Hormone Therapy

Hair Loss – Charges incurred for the treatment of hair loss, including wigs (except as a result of chemotherapy), hair transplants, or any Drug that promises hair growth whether prescribed by a Physician or not.

Illegal Actions – Charges for treatment of a condition resulting from voluntary participation in a riot, insurrection or civil disobedience.

Impotence; Sexual Dysfunction – For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or Drugs pertaining to sexual dysfunction or impotence, unless due to an organic disease.

Incurred After Termination of Coverage – Charges commencing or services and supplies provided after the termination of coverage under this Plan.

Infertility Treatment – For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility Drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), and reversal of a sterilization procedure, surrogate mother or donor eggs.

Mailing – Mailing, shipping, handling or sales tax expenses.

Marital Counseling

Massage Therapy – For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered Illness or Injury, and approved as Medically Necessary by the Plan Administrator.

Medically Unnecessary – That are not Medically Necessary for the care and treatment of an Injury or Illness, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

Medication for Sexual Stimulation – Any medication that enhances sexual stimulation, whether prescribed or not, regardless of Medical Necessity.

Narcotics – Charges for narcotic or hallucinogenic Drugs, unless prescribed by a Physician, with the exception of medical marijuana.

Never Events **–** In addition, serious preventable adverse events ("never events") will, in no event be covered under the Plan. These never events include:

- Abduction of patient of any age;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Any instance of care ordered by or provided by someone impersonating a Physician, nurse, pharmacist, or other Provider;
- Artificial insemination with the wrong donor sperm or wrong egg;
- Infant discharged to the wrong person;
- Inoperative or immediate postoperative death in an ASA Class I patient;
- Maternal death or serious disability associated with labor and delivery in a low-risk Pregnancy while being cared for in a healthcare facility;
- Patient death or serious disability associated with:
    - a burn Incurred from any source while being cared for in a healthcare facility;
    - a fall while being cared for in a healthcare facility;
    - a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
    - a medication error (e.g. error involving the wrong Drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);
    - an electric shock while being cared for in a healthcare facility;
    - failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;
    - hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;

- Injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility;
- intravascular air embolism that occurs while being cared for in a healthcare facility;
- patient leaving the facility without permission;
- spinal manipulative therapy;
- the use of contaminated Drugs, devices, or biologics provided by the healthcare facility;
- the use or function of a device in a patient in which the device is used or functions other than as intended; and
- the use of restraints or bedrails while being cared for in a healthcare facility.

- Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;
- Sexual assault of a patient within or on the grounds of a healthcare facility;
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;
- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Unintentional retention of a foreign object in a patient after Surgery or other procedure; and
- Wrong Surgical Procedure performed on a patient.

Non-Prescription Medicines and Supplies – That can be purchased without a prescription from a licensed Physician or facility.

Non-Medical Services – Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

Not Legally Required to Pay – Charges which the Covered Person is not legally required to pay; charges which would not have been made if no coverage had existed; charges for services for which no charge is made.

Occupational Therapy

Obesity Treatment – Charges for any routine treatment of obesity, or weight control counseling unless necessitated as a result of a specifically identifiable condition of disease etiology.

Orthopedic Shoes – Unless Medically Necessary.

Orthognathic Surgery – Jaw realignment Surgery to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.

Patient Convenience – Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an Illness or Injury that are solely for the personal comfort and convenience of the patient, even if prescribed by a Physician.

Personal Hygiene – For personal hygiene or convenience items.

Prenatal Vitamins

Prenatal Genetic Testing – Charges for testing for sex determinations and to determine fetal age.

Vision Correction – For radial keratotomy, keratomileusis or other vision correction procedures.

Reversal of Elective Sterilizations

Residential Care Facility – Provided by or at a residential care facility or halfway house.

Sex Change – Expenses for all services and supplies in connection with sex change operations or procedures.

Sleep Disorders – Charges for Sleep Disorders not determined Medically Necessary prior to services being provided.

Smoking Cessation – For smoking cessation programs, Nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency, except for as provided under the Beacon Wellbeing program.

Surrogate Expenses – Expenses Incurred for Pregnancy for other than the member or eligible Spouse.

Therapy – That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.

Temporomandibular Joint Dysfunction (TMJ) – Office visit charges for treatment of TMJ.

Travel – For travel, even though prescribed by a Physician.

Trusses, Corsets and Other Support Devices

Vitamins, Minerals and Food Supplements – Whether or not prescribed by a Physician.

War – Charges for treatment of a condition resulting from war or an act of war, declared or undeclared, or an Injury sustained or Illness contracted while on duty with any military service for any country.

Without Approval – Furnished without recommendation and approval of a Physician acting within the scope of his or her license.

Weekend Admissions – For weekend admission (Friday, Saturday or Sunday) to a Hospital unless due to an Emergency or if Surgery is performed within 24 hours of admission.

Work-Related Illness or Injury – Charges for or in connection with an Injury or Illness which arises out of or in the course of any employment for wage or profit, or for which the individual is entitled to benefits under any Workers' Compensation Law, Occupational Disease Law, or similar legislation.

MEDICAL CARE MANAGEMENT AND PRE-AUTHORIZATION PROGRAM

Who Administers the Program?

The Plan Administrator has retained HealthLink Medical Management (HealthLink) to provide medical care management and pre-authorization services for the Fund, its members and eligible Dependents.

HealthLink also provides assistance to individuals who experience difficulties with certain medical conditions, such as, but not limited to, asthma, chronic kidney disease (CKD), chronic pain (osteoarthritis, rheumatoid arthritis or low back pain), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, hyperlipidemia, and hypertension.

As patient advocates, HealthLink works with patients, their physicians and families in providing inpatient and outpatient precertification, patient education and coordination of appropriate and necessary healthcare and services that may be needed.

These services are provided free to you to help you manage and maintain your health. You can call HealthLink at (877) 284-0102 from 8:00 am – 6:00 pm EST or fax (800) 510-2162 anytime to initiate a precertification, request a care manager, or if you have any questions or concerns about your medical condition.

Pre-Authorization Program for Inpatient Services

The program works by establishing a communication among you, your attending Physician and HealthLink to discuss the proposed course of treatment and any options that may be available for your treatment. The pre-authorization program does not establish your eligibility for coverage under the Plan, nor does it approve the services for coverage or reimbursement under the Plan. Those responsibilities rest with the Plan Administrator.

Because communication is the basis for the program, the Plan requires that you contact HealthLink at least five days before any non-Emergency Inpatient admission. The contact may be made by you, a family member, friend, your Physician or a facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. Failure to contact HealthLink within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.

Urgent Care or Emergency Admissions

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his or her life or health because of the requirements of this pre-authorization program. For urgent, Emergency admissions, follow your Physician's instructions carefully, and contact HealthLink within 48 hours of the admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the Plan does not require you or a covered Dependent to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or Emergency situation, you or a

covered Dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Concurrent Inpatient Review

Once the Inpatient setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your Physician, HealthLink will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

HealthLink will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this pre-authorization program.

Penalty

If you fail to notify HealthLink within the time periods described in this section for Emergency and non-Emergency Inpatient care, the benefits that otherwise would be available for the facility's expenses under the Plan will be reduced by $250 per day, and this amount will not accumulate toward any Out-of-Pocket Expense limits.

Pre-Determination of Medical/Surgical Benefits

This is a service offered by the Plan to help you determine, in advance, whether a proposed treatment will be a Covered Expense under the Plan. It is a voluntary provision, and you are under no obligation to obtain pre-approval of your treatment. However, you are encouraged to use this service to avoid incurring non-covered expenses for which you will be responsible.

In order to evaluate the proposed treatment, HealthLink will require detailed medical information from your Physician, including:

- The identity of the patient (including date of birth and sex);
- The diagnosis code;
- The procedure code (CPT); and
- The amount of the proposed charge.

This information should be submitted to:

HealthLink
P.O. Box 411424
St. Louis, MO, 63141
(877) 284-0102

You will receive a written response with the Plan Administrator's determination, which you may furnish to your Physician if you so desire.

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize their life or health in order to pre-determine benefits. Pre-determination of benefits is not recommended under these circumstances.

HealthLink will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this pre-certification program.

Services That Require Pre-Authorization

Contact HealthLink to review Non-Emergency outpatient care and services for the following services:

Inpatient Services (Medical/Surgical)

Bariatric Surgery	Lumbar Spine Surgery
Cervical Spine Surgery	OB Delivery stays beyond the Federal Mandate minimum (including newborn stays beyond mother's stay)
Computer Navigation for Orthopedic Surgery	Rehabilitation Facility Admissions
Elective Admissions	Sacroiliac Joint Fusion
Emergency Admissions – Requires notification no later than 2 business days after admission	Skilled Nursing Facility Admissions
Hospice	Transplants
LTAC Admissions	

Surgical Procedures – Ambulatory

Bariatric Surgery	IDET Procedure
Blepharoplasty/Blepharoptosis	Implantable Cardioverter-Defibrillator (ICD)
Bone-Anchored Hearing Aids	Lumbar Spine Surgery
Breast Procedures	Mandibular/Maxillary Surgery (Orthognathic)
Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter Defibrillator (CRT/ICD) for Treatment of Heart Failure	Mastectomy for Gynecomastia
Cartilage Transplant Knee	Nasal Septoplasty
Cervical Spine Surgery	Panniculectomy and Lipectomy/ Diastasis Recti Repair
Cochlear Implant	Reduction Mammoplasty
Computer Navigation for Orthopedic Surgery	Rhinoplasty
Cosmetic and Reconstructive Services of Head, Neck, Trunk and Groin	Sacroiliac Joint Fusion
Elective Total Hip Arthroplasty	Sinus Endoscopy
Elective Total Knee Arthroplasty	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty
	Treatment of Varicose Veins (Lower Extremities)

Ancillary Services

Air Ambulance – Non-Emergent	Home Hospice
Botulinum Toxin – Review for Migraine Use Only	Home Infusion Services
Home Health Services	Hyperbaric Oxygen Therapy (Systemic/Topical)
Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Physical Therapy
Genetic Testing for Inherited Peripheral Neuropathies	Private Duty Nursing
Genetic Testing for PTEN Hamartoma	Speech Therapy
	Tumor Syndrome

Durable Medical Equipment

Any DME equipment in excess of $750 purchase price	Limb Prosthetics
Bone Stimulator	LVAD – Reviewed by Transplant
Cardio/External Defibrillator	Myoelectric prosthetics
Cooling Devices	Orthotics
CPAP/BIPAP	Neuromuscular Stimulators
Electric Scooters	TENS Unit
Infusion Pumps	Wheelchairs (Custom)
Insulin Pumps	Wheelchairs (Power)
	Wound Vacs

Diagnostic Imaging

Magnetic Resonance Angiography (MRA)	Positron Emission Tomography (PET)

Specialty Infusion Drugs

Any infusion/injection in excess of $750 purchase price	Ipilimumab (Yervoy)
Azacitidine (Vidaza)	Nivolumab (Opdivo)
Bevacizumab (Avastin) – Review for Non-Eye Only	Nusinersen (Spinraza)
Bortezomib (Velcade)	Paclitaxel (Abraxane Only)
CAR-T Cell Therapy (Yescarta and Kymriah)	Panitumubab (Vectibix)
Etanercept (Enbrel)	Pembrolizumab (Keytruda)
Fulvestrant (Faslodex)	Pemetrexed (Alimta)
Immune Globulin (Intravenous)	Rituximab (Rituxan) – Review for Non-Oncology Diagnosis/Treatment Only
Infliximab (Remicade)	Voretigene Neparvovec (Luxturna)
	Zolgensma

MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAMS

Who Administers the Program?

Mental health and substance use disorder (MHSUD) coverage is administered by Beacon Health Options (Beacon) through a Network of Providers to promote the delivery of care in the most appropriate settings.

There is a predetermination or "managed care" process for MHSUD services. Most inpatient benefit services must be approved in advance by Beacon to determine the appropriateness of the treatment, while routine outpatient services do not require predetermination.

For all inpatient benefit level services (inpatient, residential treatment, and Partial Hospitalization), a Beacon behavioral health benefits manager evaluates each case and approves treatment, which may include an acute inpatient Hospital or residential treatment facility admission, an appointment for assessment and diagnosis, outpatient mental health services or a referral to a Network Provider.

When services for treatment of a mental health or substance use disorder condition are needed, you should first call Beacon at (855) 748-3121. Beacon's member services representatives are on staff 24 hours per day, 7 days a week to assist you. If you do not call Beacon before accessing inpatient level mental health care, the program may not pay the full benefits.

Selection of Your Provider

To find a Participating Provider, contact Beacon at (855) 748-3121 or visit their website at www.beaconhealthoptions.com. The website is only a guide. It is important to note that before you make an appointment for services, you should ask your Provider if they still participate with Beacon.

Using a Network Provider will normally result in a lower cost to the Covered Person as well as to the Plan. There is no requirement for any Covered Person to seek care from a Provider who participates in the Network. Each Covered Person has a free choice of any Provider, and the Covered Person, together with his or her Provider, is ultimately responsible for determining the appropriate course of treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. See the section titled "Using and Out-Of-Network Provider (Non-Participating) Provider" and "Your Cost" for more details and for information on balance billing.

Schedule of Benefits

The following table provides a quick overview of your MHSUD benefits under the program. It is provided as a convenience only and is not all-inclusive.

Services	Network Providers	Non- Network Providers	Limits & Notes
Inpatient Treatment	100% of PPO Rate	70th percentile of UCR	Reduced by $250 per day if no notification within 48 hours

	Subject to $250 Copayment per admission	Subject to $250 Copayment per admission, plus balance billing	Pre-authorization required
Residential Treatment	100% of PPO Rate Subject to $250 Copayment per admission	100% of Medicare Allowance Subject to $250 Copayment per admission, plus balance billing	Benefit limited to 30 days per confinement Pre-authorization required Reduced by $250 per day if no notification within 48 hours
Partial Hospitalization Program (PHP)	100% of PPO Rate	100% of Medicare Allowance	Must begin following Inpatient stay of 3 days and commence within 7 days of discharge
Outpatient Visit – Psychiatric and Substance Abuse (Individual Therapy, Brief Therapy, Crisis Psychotherapy)	100% of PPO Rate $20 Copayment per visit	100% of Medicare Allowance $30 Copayment per visit, plus balance billing	PPO Network – 25 annual visits for all outpatient services combined Non-PPO Network – 25 annual visits for all outpatient services combined Not combined with Medical program visits Up to an additional 15 visits if Medically Necessary
Family and Group Therapy – Psychiatric and Substance Abuse (Individual Therapy, Brief Therapy, Crisis Psychotherapy, Medication Management)	100% of PPO Rate $20 Copayment per visit	100% of Medicare Allowance $30 Copayment per visit, plus balance billing	PPO Network – 25 annual visits for all outpatient services combined Non-PPO Network – 25 annual visits for all outpatient services combined Not combined with Medical program visits

			Up to an additional 15 visits if Medically Necessary
Home Care Psych	100% of PPO Rate	75% of MMA rate Subject to $50 deductible and balance billing	
Intensive Outpatient Program	100% of PPO Rate $20 Copayment per visit	100% of Medicare Allowance $30 Copayment per visit, plus balance billing	Limited to 25 visits per calendar year for all outpatient services combined
Psych Testing	100% of PPO Rate	100% of Medicare Allowance	
Emergency Room	100% of PPO Rate $35 Copayment per visit	100% of Medicare Allowance $35 Copayment per visit, plus balance billing	

If you use a Beacon Network Provider, they will file claims on your behalf. If you use a non-Network Provider, you may be responsible for filing the claims.

Covered Services

The Plan provides benefits for the following Medically Necessary MHSUD services:

- Mental health or substance abuse inpatient care within a benefit period at a Hospital or residential treatment or Partial Hospitalization facility.

- Covered outpatient MHSUD services.

- Psychological testing when authorized by Beacon Health Options.

Exclusions and Limitations

In addition to the Medical Exclusions, MHSUD services are subject to the following exclusions and limitations. This list is subject to change and is not an exhaustive list.

- Coverage is not available for treatment of mental disorders that, according to generally accepted medical standards, are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification.

- Group Home

- Halfway House

- Biofeedback
- Hypnotherapy
- Methadone Maintenance

LOCAL 28 MEMBERS' ASSISTANCE PROGRAM (MAP)

Overview

The Local 28 Members' Assistance Program ("MAP") is a three-tiered program. The MAP is comprised of Beacon Wellbeing's Members Assistance Program, the Local 28 Members Assistance Program Counselor and the Peer-to-Peer program. This program is designed to help you and your family members balance responsibilities at work and personal life.

MAP offers free and confidential assistance with many of the work-life challenges you face each day. Your MAP benefit provides practical solutions, information, advice and support for a wide range of work-life issues including, but not limited to anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns, parenting challenges, and support to members returning back to work.

Eligibility

All members and their immediate family members are eligible. Immediate family members or Dependents are defined as those residing in your household and eligible Dependents away at school.

When Coverage Begins

You and your family members are automatically covered on your date of hire.

When Coverage Ends

See the section titled "Termination of Coverage."

Reimbursement of Claims

You do not have to file MAP claims. There are no copays, coinsurance, or deductibles. You should not make any payment to a provider for MAP services. You should not make any agreement with a MAP Counselor to pay the counselor for MAP services. You will be responsible to pay for services that you obtain on your own outside of the MAP program.

Services Offered

Depending on your situation, the MAP Counselor may do the following:

- Refer you to a licensed network MAP provider in your community;
- Link you to available resources in your community; or
- Offer you support over the telephone.

Additionally, if the counselor determines the situation requires it, you may be referred for additional assistance through the Plan's Mental Health and Substance Use Disorder program.

The three options available to you under the MAP Program (Beacon Wellbeing, Peer to Peer Counseling, and MAP Counseling) are described in detail below:

1. Beacon Wellbeing

Beacon Wellbeing offers confidential access 24 hours a day, 365 days a year to trained professionals who can discuss your question, problem, or concern. You can reach a representative by phone at (855) 748-3121.

Online Services

Beacon Wellbeing is a dynamic online resource for Beacon Health Options members, offering information, tools and other resources on more than 200 behavioral health and wellness topics, including depression, stress, anxiety, alcohol, marriage, grief and loss, child/elder care, and work/life balance. Its mission is to help members obtain credible and vetted resource information, access behavioral health services and resolve personal concerns in a convenient, confidential manner. The content is continually updated to reflect new research, articles and topical material. You may navigate local28.mybeaconwellbeing.com anonymously or may choose to initiate an anonymous "Call Back Request", whereby a clinically trained professional will respond via phone to provide added guidance or assistance. The website also includes program information under "About Services," describing the MAP service available.

Beacon Wellbeing Care Managers will fax or mail relevant articles, news, quizzes and other helpful resources if you don't have internet access.

Training

Beacon Wellbeing incorporates training sessions to engage you in actively improving your life, resulting in reduced stress and greater self-care skills. Topics include "Effective Communication," "Balancing Work and Family," "Dealing With Challenging People" and "Relationship Success."

Legal and Financial Solutions

Beacon Wellbeing provides access to a national network of independent attorneys who have experience in a variety of legal areas including bankruptcy, estate planning, taxes, family law, consumer and financial matters and traffic violations. For financial concerns, MAP provides telephonic information and advisory services utilizing independent professionals with experience in financial matters, such as financial planners, certified public accountants and insurance specialists. If legal representation is needed, MAP will provide a referral to a local network attorney who will provide an initial one-half (1/2) hour face-to-face consultation at no charge and will provide additional legal services at a 25 percent reduction of their customary fees. You are responsible for all fees beyond the free initial consultation. The attorneys and financial professionals will assist you with most situations, but some restrictions do apply.

Identity Theft Program component allows members a free, 30-minute consultation with a Fraud Resolution Specialist, which includes emergency response activities for your protection.

Beacon Health Options provides no warranties or representations regarding the quality of services provided by each individual attorney or financial professional.

Legal and Financial Solutions Exclusions

The following services are specifically excluded from services provided under this program. These restrictions include, but are not limited to:

- Employment Issues – No advice will be offered on disputes between members and employers;
- Corporate Law – Questions pertaining to corporate law, including those generated from member or spousal owned businesses will not be answered;
- Second Opinions – Advice will not be given on how another attorney is handling a legal situation or rendering a subsequent opinion in case law;
- Third-Party Callers – Participants cannot seek advice to help with someone else's legal problems; and
- Investments – Financial professionals will not provide advice regarding specific investments vehicles such as stocks, bonds, or mutual funds. They can, however, provide advice on investment strategies.

Work/Life Services Program

Balancing work, life and family responsibilities is no easy task. You and family members must constantly juggle competing demands, from making deadlines to running errands to finding quality child care and caring for aging relatives. The Work/Life Service Program can provide extensive assistance, information, and support to you, helping you to achieve a better balance between home and work.

The Work/Life Service Program covers a variety of needs and programs or services for any circumstance. The scope of the Work/Life Service Program includes, but is not limited to:

- Adoption;
- Aging;
- Balancing work and family;
- Child care;
- Children and adults with special needs;
- Convenience services;
- Emergency dependent care;
- Education;
- End-of-life issues;
- Health and wellness;

- Moving and relocation;
- Older adult care;
- Parenting and child development;
- Pet care;
- Retirement; and
- Smoking cessation (two treatment plans per lifetime)

Other MAP services include educational materials that are provided to supplement referrals and include articles, checklists, booklets and pamphlets. This additional information and support includes resources such as child and adult care providers, schools, colleges, and adoption services.

2. Peer to Peer Counseling

MAP Peer to Peer Counselors assist with evaluating options for intervention and/or treatment including inpatient or outpatient treatment using Beacon's Network of Providers. By reaching out to a Peer Counselor you will receive support to deal with problems caused by mental health disorders and signs of alcohol or substance abuse. Their compassion and deep understanding of a member's situation makes a powerful combination that cannot be offered by many other professionals. The Peer to Peer Program offers members and their families help accessing appropriate in-network treatment and on-going support. When members finish initial treatment, getting back into their home and work life can present steep obstacles. Peer Counselors offer ongoing support. This is often the difference between recovery and relapse. If you are not sure what to do, call a Peer Counselor and talk about it.

Peer Counselors can be reached at (516) 262-4971 or at (516) 262-4957. All calls to the Peer Counselors are confidential.

3. MAP Counseling

Finding a balance between the demands of work, a training program and your personal life can be overwhelming, leading an individual to feel like their life is not in their control. The Local 28 MAP Counselor is a New York State licensed counselor who is able to identify, assess and together with you, develop an appropriate course of action to help you alleviate these stressors.

The relationship with an individual and their therapist is one that is supportive and empathetic. It builds the foundations of trust and ultimately, change. The MAP Counselor is in-house to support you as you explore how to improve your quality of life, one step at a time.

The MAP Counselor can be reached at (212) 625-6393 from 8:30 am to 4:30 pm, Monday through Friday. Everything discussed in counseling sessions is completely confidential except for situations that require preventing serious harm (to self or others) or stopping abuse of a child or elderly person.

PRESCRIPTION DRUG BENEFITS FOR NON-MEDICARE ELIGIBLE RETIREES

Who Administers the Program?

Benefits are provided for the purchase of prescription Drugs through the Plan's prescription Drug card program. The program is administered by OptumRx. OptumRx has a Network of pharmacies which can identify Covered Persons and the Plan's coverage provisions. To find out which pharmacies participate, contact OptumRx at (855) 577-6513 or visit their website at www.optumrx.com. The website is only a guide. Even though a pharmacy is listed on the website, you should call to make sure that they are still an In-Network pharmacy.

The Covered Person must purchase prescription Drugs through the prescription Drug card program, and use either a participating retail pharmacy or home delivery.

If you choose not to use a participating pharmacy, for any reason, you will be responsible for paying the entire retail price for the prescription. You can then submit a claim form for reimbursement to OptumRx. Your reimbursement will be at the same rate as a participating pharmacy would be paid. You can request a copy of the claim form from OptumRx or the Fund Office. Your completed claim form and receipts should be mailed to OptumRx within 90 days of the purchase date.

How the Program Works

In order for a prescription medication to be covered under the program, the medication must require a prescription and must be prescribed by a Physician who is licensed to do so.

There are two ways to purchase Drugs through the Plan's program, either at a participating pharmacy or through the Plan's "home delivery option."

You may save money by using the home delivery option if you have prescription Drug(s) that you must take on an on-going basis. These medications, often referred to as maintenance medications, which would include medications that treat chronic conditions such as arthritis, diabetes, high blood pressure, ulcers and others. You can fill also fill maintenance medications for up to a 90 day supply at a participating retail pharmacy.

Some medications may have a program or limit which may include:

- Age Restrictions – Some restrictions may apply based on your age,
- Prior Authorization – Your Physician is required to provide additional information to determine coverage,
- Quantity Limits – Amount of medication covered per Copayment or in a specific time period,
- Step Therapy – Trial of lower cost medication(s) is required before a higher-cost medication is covered,
- Specialty Medication – Medication is designated as a specialty pharmacy Drug.

Retail Pharmacy

To fill a prescription at a participating pharmacy, simply present the Plan's prescription Drug card and pay your portion of the cost (shown in the "Schedule of Benefits"). The pharmacist will file the claim for you.

Home Delivery Program

To fill a prescription for maintenance Drugs through the home delivery program:

- Obtain a copy of the mail order form from OptumRx;
- Complete the patient profile questionnaire (for your first order only);
- Ask your Physician to prescribe the needed medication for a 90 day supply, plus refills;
- If you need the medication immediately, but will be taking it on an on-going basis, ask your Physician for two prescriptions: one for a 30 day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90 day supply, that you can submit through Home Delivery.
- Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the "Schedule of Benefits").

  Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.

Schedule of Benefits

The prescription Drug program has a Family maximum allowance of $50,000 per calendar year.

You must pay a Copayment for each prescription filled. Your Copayment will vary based on the type of medication prescribed and whether you receive your prescription from a retail pharmacy or through the home delivery program.

Your Physician can prescribe brand Drugs or generic equivalents of brand Drugs. Typically, Copayments for generic Drugs are less than the Copayments for brand medications. Unless your Physician specifically states, "brand only," or "dispense as written (DAW)," your pharmacist can dispense a generic equivalent, if one is available.

Retail - Prescription Drug Benefits

Drug Type	Copayment
Generic	$10 for 30 day supply, $20 for a 31-90 day supply
Preferred Brand	$25 for a 30 day supply, $50 for a 31-90 day supply
Non-Preferred Brand	$40 for a 30 day, $80 for a 31-90 day supply

Home Delivery - Prescription Drug Benefits

Drug Type	Copayment
Generic	$20 for a 90 day supply
Preferred Brand	$50 for a 90 day supply
Non-Preferred Brand	$80 for a 90 day supply

Specialty Prescription Drug Benefits

Drug Type	Copayment
Generic	$10 for a 30 day supply
Preferred Brand	$25 for a 30 day supply
Non-Preferred Brands	$40 for a 30 day supply

Vaccines for influenza, pneumonia and shingles are available at participating pharmacies with a $0 Copay. Not all pharmacies offer this service, so you will need to check with your local pharmacy about its in-store vaccination program. Also, in some cases, your pharmacy might need a script from your Physician.

Covered Prescriptions

Under the prescription program, Covered Expenses include the following.

- Anaphylaxis Agents;
- Family Planning (with exception to Implantable Contraceptives and Intrauterine Devices);
- Federal legend Drugs;
- Immunology;
- Insulin;
- Spacers (for use with asthma inhalers);
- State-restricted Drugs; and
- Syringes and needles used only to inject insulin.

Certain Drugs are not covered, even when prescribed by your Physician. Please refer to the list of “Exclusions and Limitations” below.

Generic Drugs

Generic Drugs are the same medicines as brand Drugs, just produced by a different manufacturer. They are a safe way to lower your prescription bill. When the patent expires, other manufactures may develop generic versions of the original brand Drug. Just remember, generics:

- Are approved by the FDA;
- Meet the same FDA standards for purity, strength, and quality as brand Drugs; and

- Have the same ingredients and are expected to have the same therapeutic effect as their brand equivalents.

To find out if a generic equivalent is right for you, consult with your Physician or pharmacist.

Prescription Drug Formulary Program

The prescription Drug program includes a formulary feature. A formulary is a list of carefully selected medications that have been selected based on their clinical effectiveness and opportunity for cost savings to the Plan. Under the formulary program, the Plan requires a lower Copayment for preferred brand formulary medications, and a higher Copayment for non-preferred brand medications.

Specialty Pharmacy Program

If you require certain specialty prescription Drugs, Optum® Specialty pharmacy is the primary pharmacy. If they are not able to fill your prescription, they will direct you to a designated pharmacy with whom it has an arrangement to provide those prescription Drugs. Specialty Drugs are often biologics Drugs that are injectable or infused (although some are oral medications). Specialty medications are used to treat complex, long-term conditions such as cancer, rheumatoid arthritis or multiple sclerosis (MS), Parkinson Disease, etc.

OptumRx offers extra support to help you manage your care, such as:

- 24/7 access to pharmacists;
- Consultations with expert clinicians trained in your condition;
- Free shipping and timely delivery;
- Clinical and adherence programs; and
- Medication supplies at no extra cost.

You can also visit specialty.optumrx.com or download the mobile app to:

- Request refills and schedule delivery dates;
- Track order status;
- Make payments and manage credit card information;
- View and update account information; and
- Receive one on one support with a care team member or pharmacist through secure video or live chat.

If you choose not to obtain your specialty prescription Drugs from Optum® Specialty Pharmacy, no benefits will be paid and you will be responsible for paying all charges. Use of the specialty program is mandatory under the Plan.

Call (855) 427-4682 for help or more information regarding the Optum® Specialty pharmacy program.

Step Therapy

Step Therapy is a program designed especially for people who take prescription Drugs regularly to treat ongoing medical conditions, such as arthritis and high blood pressure. The program is an approach to get you the prescription Drugs that you need, with safety, cost, and most importantly, your health in mind. Most medical conditions have multiple medication options. The program encourages the use of less costly yet effective medications before more costly medications are approved for coverage. You may be able to choose from several different safe and effective prescription medications to treat your condition. Generic medications, which have the same quality, strength, purity and stability as brand name medications typically cost less, while brand name medications are usually the most expensive.

How Does the Step Therapy Program Work?

Step Therapy medications are grouped into three “steps.” In general, you are required to try a Step 1 medication before a Step 2 medication is eligible for coverage. And likewise, you are required to try a Step 2 medication before a Step 3 medication is eligible for coverage.

Step 1 medications are usually generic medications. proven to be safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost. These medications do not require Step Therapy and are automatically covered.

Step 2 medications are usually preferred brand named drugs that you see advertised on the television. These medications sometimes require Step Therapy. If your doctor feels that your treatment plan should begin with a Step 2 medication, he or she will need to contact your pharmacist and have it approved. You will typically pay more for Step 2 medications.

Step 3 medications are usually non-preferred brands. These medications require Step Therapy. If your doctor feels that your treatment plan should start with a Step 3 medication, they will need to contact your pharmacist and obtain approval before it is covered. You will typically pay more for Step 3 medications.

Contact OptumRx for a complete list of prescription drugs under the Step Therapy program.

Exclusions and Limitations

The Plan will not cover the following Drugs, even when prescribed by the Covered Person’s Physician. This list is subject to change and is not an exhaustive list.

- Administration – Charges for the administration of a covered prescription Drug;
- Anorexiants – Weight control Drugs;
- Blood Components;
- Bulk Chemicals;

- Consumed on Premise – Any Drug or medication that is consumed or administered at the place where it is dispensed, with the exception of influenza, pneumonia and shingles vaccinations;

- Cosmetic Alteration Drugs;

- Devices – Devices of any type, even though such devices may require a prescription. These include but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar device. These types of devices may be covered under the Plan's Durable Medical Equipment benefit;

- Diagnostic Agents (other than Diabetic);

- Experimental or Investigational Drugs;

- Any Drug not approved by the Food and Drug Administration (FDA);

- Fertility Medications – Prior Authorization Required;

- Fluoride Products;

- General Anesthetic;

- Growth Hormones – Unless Medically Necessary;

- Hair Replacement Products;

- Immunizations – Immunization agents or biological sera. These may be covered under the Plan's medical benefits;

- Injectable Supplies – Charges for hypodermic syringes and/or needles (other than for insulin) or specialty medications;

- Inpatient Medications – Drugs or medications that are taken, in whole or in part, while confined in a hospital. This includes being confined in any Institution that has a facility for the dispensing of Drugs and medicines on its premise. These may be covered under the Plan's medical benefits;

- No Charge – A charge for prescription Drugs that may be properly received without charge under local, state, or federal programs;

- No Prescription – Drugs or medicines that can legally be bought without a written prescription. This does not apply to injectable insulin;

- Non Legend Drugs – Other than insulin;

- Non-Medically Necessary – Drugs that are not Medically Necessary for the treatment of an Illness, Injury or Pregnancy;

- Over the Counter (OTC) Contraceptives;

- Over the Counter (OTC) Medications – Medications that do not require a prescription by state or federal law and any prescription medicine that is available as an over-the counter medication;

- Payments for Which You are Responsible:

    - The cost of medications not covered under the prescription benefit;

    - The Copayment amount of each prescription;

    - The cost of any quantity of Drugs in excess of the allowed supply.

- Physician's Office – Drugs provided in or through a Physician's office, Hospital or other facility;

- Refills – Any refill that is requested more than one year after the prescription is written or any refill that is more than the number of refills ordered by the Physician;

- Retin A - Prior Authorization required;

- Rogaine;

- Smoking Cessation Product, except for as provided under the Beacon Wellbeing program;

- Surgical Supplies;

- Vitamins – Except prenatal; and

- Workers' Compensation – Prescriptions which an eligible person is entitled to receive, without charge, under any Workers' Compensation law, or under any municipal, state or federal program.

PRESCRIPTION DRUG BENEFITS FOR MEDICARE ELIGIBLE RETIREES

Who Administers the Program?

Benefits are provided for the purchase of prescription Drugs through the Plan's prescription Drug card program. The program is administered by Labor First LLC (1000 Midlantic Drive, Suite 100, Mt. Laurel, NJ 08054 Tel: (212) 776-4295) on a fully insured basis. The program is insured through Express Scripts Medicare PDP (Express Scripts). To find out which pharmacies participate, contact Labor First or visit Express Scripts website at https://www.express-scripts.com/pharmacies. The website is only a guide. Even though a pharmacy is listed on the website, you should call them to make sure that they are still an In-Network pharmacy.

This is an Employer Group Waiver Plan (EGWP) Part D plan and follows CMS guidelines.

What is Covered?

Benefits will be provided for covered Drugs for out-of-hospital use, when prescribed by a legally licensed Physician and dispensed by a legally licensed pharmacy on and after the coverage effective date. This benefit includes prescription orders which the pharmacy receives by phone from your doctor. Benefits are available for up to a 90 day supply at the retail pharmacy and a 90 day supply through the mail.

How Retail Pharmacy Benefits are Received

You can obtain up to a 90 day supply of prescription Drugs at participating retail pharmacies. Certain Drugs such as specialty Drugs may only be available at specific mail order facilities and may be limited to a 30 day supply.

How Mail Order Prescriptions are Received

The mail order prescription program provides you with the convenience of receiving prescription maintenance medication right at your home. The purpose of the program is to offer maintenance Drugs used for chronic ailments such as high blood pressure, heart conditions, diabetes, asthma, arthritis, etc., at a savings, with the added convenience of having a three-month supply delivered to your home.

When your doctor prescribes a maintenance Drug therapy, ask them to prescribe a 90 day supply, plus refills. Members will receive specific instructions on using mail order program directly from Humana. If you need this information, call Labor First at (212) 776-4295 and request a mail order packet.

Schedule of Benefits

The Copayments for brand name Drugs are different than for generic Drugs. In most cases your Out-of-Pocket expenses will be higher for brand name Drugs. You are not required to use generic Drugs if you or your doctor prefers the brand name Drug, however, if you choose a brand name Drug that has a generic equivalent you will have a higher Out-of-Pocket expense. The following Copayment(s) will be made by you for each separate prescription order and refill:

Prescription Drug Benefits	30 Day Retail Copays	90 Day Retail/Mail Order
Deductible	$0	$0
Generic (Tier 1)	$2	$4
Preferred Brands (Tier 2)	$25	$50
Non-Preferred Brands (Tier 3)	$40	$80
Specialty (Tier 4)	$40	N/A

*Some Drugs may not be available for a 90 day supply.

**If the cost of the prescription is less than the listed copay amount, the Copayment will be the actual cost of the prescription.

The prescription Drug program has no deductible.

Generic Drugs are the same medicines as brand Drugs, just produced by a different manufacturer. They are a safe way to lower your prescription bill. When the patent expires, other manufactures may develop generic versions of the original brand Drug. Just remember, generics:

- Are approved by the FDA;
- Meet the same FDA standards for purity, strength, and quality as brand Drugs; and
- Have the same ingredients and are expected to have the same therapeutic effect as their brand equivalents.

To find out if a generic equivalent is right for you, consult with your Physician or pharmacist.

Shingles Vaccination

The prescription program provides coverage for the Shingles Vaccination for all Medicare Eligible Participants. The vaccination will cost you $25 per prescription at a retail pharmacy. You need to have prescription from your doctor to have it administered at a retail pharmacy. Failure to do so may result in higher Out-of-Pocket costs.

Step Therapy

Step Therapy is a program designed especially for people who take prescription Drugs regularly to treat ongoing medical conditions, such as arthritis and high blood pressure. The program is an approach to get patients the prescription Drugs they need, with safety, cost, and most importantly, their health in mind.

In Step Therapy, medications are grouped in categories based on cost:

- Front-line Drugs – The first step – Are generic Drugs proven to be safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.

- Back-up Drugs – Step 2 and Step 3 Drugs – Are brand-name Drugs like those that you see advertised on TV.

- There are lower-cost brand Drugs (Step 2) and higher-cost brand Drugs (Step 3). Back-up Drugs typically cost more than front-line Drugs.

- If your doctor writes you a new prescription for a maintenance Drug that you will be taking on a regular basis, ask your doctor if a generic medication, front-line Drug is right for you. It makes good sense to ask for these prescription Drugs first because, for most everyone, they work as well as brand-name Drugs, and they almost always cost less. And, because these medications have been on the market for a long time, they have a more established safety record.

- If you have already tried a front-line Drug and have experienced adverse effects or your doctor decides one of these prescription Drugs is not appropriate for you, then your doctor can prescribe a back-up Drug. If you have any questions about Step Therapies, call Labor First at (212) 776-4295.

Prior Authorization/Quantity Limits

Certain Drugs have additional requirements which need to be met for coverage. Your doctor may need to submit additional documentation for certain Drugs in order for them to be covered. These Drugs are indicated on the full formulary which you will receive directly from Express Scripts. If you need a copy of your formulary, please call Labor First at (212) 776-4295. The Drugs requiring these authorizations are re-determined on a regular basis based on changes in commercially available Drugs and a number of other factors. To get approval, your doctor will need to call the Express Scrips authorization line at (844) 374-7377.

Exclusions and Limitations

The following items are not covered by the prescription Drug program. This list is subject to change and is not an exhaustive list.

- Items lawfully obtained without a prescription;

- Prescription Drugs which have not been approved by the U.S. Food and Drug Administration for a course of treatment;

- Any quantity or use of prescription Drugs not approved by the U.S. Food and Drug Administration;

- Drugs labeled “caution-limited by Federal law to Investigational use,” or Experimental Drugs;

- Non-prescription Drugs and vitamins (including, without limitation, pre-natal vitamins), minerals, laetrile, enzymes, diet foods, or dietary supplements whether prescribed or not;

- Prescription Drugs which have been prescribed primarily for a Cosmetic purpose;

- Prescription Drugs which have been prescribed for sexual dysfunction except when it has been medically certified that the individual has previously been treated for sexual dysfunction, has

completed a course of treatment for this condition, and such treatment has proven unsuccessful. Preauthorization will be required and a maximum of six tablets per 30 days will be authorized;

- Any charge for administration of Drugs;

- The charge for any prescription order refill in excess of the number specified by a doctor or allowed by the Fund or any refill dispensed after one year from the date of the original prescription order;

- The charge for any medication which has not been prescribed by a doctor of medicine, osteopathic medicine, dental Surgery, dental medicine or surgical chiropody;

- The charge for any medication for which you are entitled to receive reimbursement under any Workers' Compensation Law or entitled to from any municipal, state or Federal program of any sort whether contributory or not;

- The charge for medications covered under another prescription Drug coverage plan or policy of insurance;

- Devices (except contraceptive devices for non-contraceptive purposes) even though such devices may require a prescription Drug order including but not limited to ostomy supplies, and therapeutic devices or artificial appliances.

Additional Information

Upon enrollment in the Express Scripts prescription drug plan, you will receive information directly from them including a formulary, Evidence of Coverage and mail order instructions.

DENTAL BENEFITS

Who Administers the Program?

The Plan has entered into an agreement with Sele-Dent to provide dental care services. For assistance or questions regarding the dental program, you can contact Sele-Dent by calling their customer service department at (800) 520-DENTAL (3368). You can also call the Fund Office at (516) 742-9478 for assistance.

A dental identification card is not issued for this benefit. Do not use your medical card when obtaining dental services. Your Social Security Number serves as your identification to obtain Network dental coverage.

Selection of Your Dental Care Provider

A current list of Network Providers is available by accessing the Sele-Dent website at https://www.sele-dent.com or by calling Sele-Dent. It is important to note that before you make an appointment for dental services, you should ask your Provider if they participate with Sele-Dent. The website is only a guide. Even though a Provider is listed on the website, you should call to make sure that they are still a Network Provider.

Using a Network Provider will normally result in a lower cost to the Covered Person as well as to the Plan. There is no requirement for any Covered Person to seek care from a Provider who participates in the Network. Each Covered Person has a free choice of any Provider, and the Covered Person, together with his or her Provider, is ultimately responsible for determining the appropriate course of treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Participants Who Reside Outside of New York and New Jersey

If you reside outside of the New York and New Jersey region, contact Sele-Dent to locate a Network Provider through their national partners.

For out-of-Network Providers, submit all claim forms directly to Sele-Dent, Inc., One Huntington Quadrangle, Suite 1S03, Melville, N.Y. 11747. For customer service questions regarding the dental program or claim status, call Sele-Dent's customer service department.

Covered Expenses in General

The following is a brief description of the types of expenses that will be considered for coverage under the Plan. Charges must be for services and supplies customarily employed for treatment of the dental condition and rendered in accordance with ADA accepted standards of practice.

No referral is necessary for treatment from any specialist when endodontic, periodontal, surgical or orthodontic treatment is needed.

Class I Services (Preventive Care)

- Palliative Emergency treatment of an acute condition requiring immediate care;

- Periapical x-rays, as required, and bitewing x-rays;
- Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth);
- Sealants for Dependent Children;
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children; and
- Topical application of fluoride for Dependent Children.

Class II Services (Repair and Restoration)

- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
- Anesthetic services (except local infiltration or block anesthetics) performed by, or under the direct personal supervision of, and billed for by a Provider other than the operating Dentist or his or her assistant;
- Consultations;
- Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
- Full mouth x-rays;
- Panoramic x-rays;
- Periodontal examinations, treatment and Surgery; and
- Simple extractions, except for orthodontia.

Class III Services (Major Dental Repair and Restoration)

- Prosthodontic services (initial installation or replacement of bridgework or dentures);
- Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
- Oral Surgery;
- Periodontal root scaling and planing;
- Repair or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures;
- Replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
    - Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or

- Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months.

Class IV Services (Orthodontics)

Orthodontic services will be eligible only when provided to covered Dependent Children ages 8 through 18 when expenses are incurred.

- Extractions in connection with orthodontic services;
- Fixed and removable appliance placement, and active treatment per month after the first month;
- Interceptive, interventive or preventive orthodontic services; and
- Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan.

Your Costs

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including Copayments and other amounts above the Plan's maximums. This is called Out-of-Pocket Expense.

The Sele-Dent fee schedule is utilized for both in and out-of-Network services. The Fund's allowance for out-of-Network Providers is 100% of the Sele-Dent fee schedule, less the applicable Copayment. You can contact Sele-Dent for a full list of its fee schedule. You must pay any expenses that are in excess of the Network allowance for out-of-Network claims.

Certain types of expenses may also be subject to dollar maximums. These payment levels are described below.

The Plan will not reimburse any expense that is not a Covered Expense.

When using a Sele-Dent Participating Provider, most services are covered at 100%, with the exception of the few procedures with $20 Copayments listed below.

Procedure Code	Explanation of Code
2750	Crown – Porcelain Fused to High Nobel Metal
2751	Crown – Porcelain Fused to Predominately Base Metal
2752	Crown – Porcelain/Noble
2952	Post & Core in Addition to Crown
2954	Prefabricated Post & Core
3320	Root Canal – 2 Canals
3330	Root Canal – 3 Canals
3410	Apicoectomy Anterior
4210	Gingivectomy – Per Quad
4260	Osseous Surgery with Flap – Per Quad
5110	Complete Denture – Upper
5120	Complete Denture – Lower

5213	Partial Denture Upper Cast 2 Clasp
5214	Partial Denture Lower Cast 2 Clasp
6240	Bridge Porcelain High Noble Metal
6241	Bridge Porcelain Predominantly Base Metal
6242	Bridge Porcelain Noble Metal
****	****Implants
6750	Crown – Porcelain High Noble Metal
6751	Crown – Porcelain Predominantly Base Metal
6752	Crown – Porcelain Noble Metal
7230	Extract Impacted Tooth Partially Bony
7240	Extract Impacted Tooth Completely Bony

Individual Calendar Year Maximum $3,000.00

****Implants** – A single Implant will be paid at the same reimbursement level as that of a three-unit bridge (after the $20.00 Copayment). You will be responsible for any balance that your Provider may charge.

Orthodontics – Dependent Children only for ages 8 through 18

Lifetime Maximum Case Fee - 24 months $3,000.00

Retainer – One per lifetime. . . . . Up to $500

Pallet Expander – Necessary for use prior to orthodontic treatment

Lifetime Maximum $300.00

Temporomandibular Joint Dysfunction (TMJ) – Lifetime Maximum $250.00

Pre-Determination of Dental Benefits

If a Covered Person's proposed course of treatment reasonably can be expected to involve dental charges of $450 or more, a description of the procedures to be performed and an estimate of the charges may be filed with Sele-Dent prior to the commencement of the course of treatment. However, approval is not required prior to treatment. Any pre-determination of dental benefits is provided only as a convenience to the Covered Person.

If requested, Sele-Dent will notify the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.

Exclusions and Limitations

This Plan does not cover any charge for the following services or supplies. This list is subject to change and is not an exhaustive list.

After the Termination Date – The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for Covered Expenses Incurred for the following procedures will be payable as though the coverage had continued in force:

- A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Covered Person in the Plan, and delivers and installs the device within two months following termination of coverage;

- A crown, if the Dentist prepared the tooth for the crown while the patient was a Covered Person in the Plan, and installs the crown within two months following termination of coverage; and

- Root canal therapy if the Dentist opened the tooth while the patient was a Covered Person in the Plan, and completes the treatment within two months following termination of coverage;

Cosmetic – Charges for Cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to Cosmetic work needed as a result of accidental injuries, but damage resulting from biting or chewing is not considered an accidental Injury. This exclusion also does not apply to covered orthodontic treatment;

Education – Charges for instruction in oral hygiene, plaque control or diet;

Experimental – Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the ADA;

Government Provided – Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the member or Dependent is legally required to pay;

Miscellaneous – The Plan does not cover any charge, service or supply which is:

- For treatment other than by a Dentist or Physician, except:

    - Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and

    - Non-Experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;

- For local infiltration anesthetic when billed for separately by a Dentist;

- For personalization or characterization of dentures or veneers or any Cosmetic procedures or supplies;

- For oral hygiene or dietary instruction;

- For a plaque control program (a series of instructions on the care of the teeth);

- For implants, including any appliances and/or crowns and the surgical insertion or removal of implants. However, as noted above, implant dentistry will be paid as an alternative treatment like a three-unit bridge;

- For periodontal splinting;

- For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;

- Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;

- Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured to the minimum coverage mandated by the governing state insurance law;

- Charges for missed appointments or completion of claim forms; and

- Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

Missing Appliances – Charges for replacement of lost, missing or stolen appliances or prosthetic devices;

More Expensive Course of Treatment – In all cases involving Covered Expenses in which the Provider and the Covered Person select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the less expensive procedure;

Not Necessary – Charges for care which is not dentally necessary treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;

Not Recommended – Charges for services or supplies which are not recommended and approved by a Dentist or Physician;

Replacements – Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Covered Person. (Damage resulting from biting or chewing is not considered an accidental Injury); and

Single Provider Care – In the event a Covered Person transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan will consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the usual, customary and reasonable fee.

VISION BENEFITS

Selection of Your Vision Care Provider

The Plan has entered into agreements with three vision care programs, Comprehensive Professional Systems Inc. (CPS Optical), Davis Vision Inc., and Vision Screening Inc. A current list of licensed Providers in their Networks is available by accessing their websites or by calling them at the numbers listed below. Even though a Provider is listed on the website, you should call the Provider before making your appointment to make sure that they are still a Network Provider. Using a Network Provider will normally result in a lower cost to the Covered Person as well as to the Plan. There is no requirement for any Covered Person to seek care from a Provider who participates in the Network. Each Covered Person has a free choice of any Provider.

CPS Optical
www.cpsoptical.com
(212) 675-5745

Davis Vision, Inc.
www.davisvision.com
(800) 999-5431

Vision Screening, Inc.
www.vscreening.com
(800) 652-0063

How to Use the Vision Program

Vision benefits are provided for an eligible member or eligible Dependents only if 12 months or more have elapsed since the date of the individual's last examination and/or the date lenses or frames were last paid for under the program.

Making an Appointment

It is important to note that before you make an appointment for vision services, you must contact the Fund Office at (516) 742-9478 to advise that you are scheduling an appointment.

If you are making an appointment with a Provider within the Davis Vision Network, you must contact the Fund Office first to verify your eligibility. The Fund Office will contact Davis Vision to provide an authorization for the optical service to be performed. You can then contact a Davis Vision Network Provider of your choice.

If you are making an appointment with a Provider within the CPS Optical or Vision Screening Networks, a voucher must be obtained from the Welfare Fund Office for each person who will be using the program. The voucher is usable until the date which is printed in the upper right hand corner and must be presented to your Network Provider in order to receive services.

If you go to a participating vision center, an eye examination and a pair of glasses will be provided without additional cost in most cases. Some special services and materials, however, are only partially covered.

Schedule of Benefits

The following maximums apply to each Covered Person.

Type of Expense	Payment Level
Comprehensive Eye Exam	$40
Frames with lenses	$110
Contact Lenses	$110

You may choose from a selection of frames from the “collection" in most Network Provider offices. A wholesale credit will be applied toward a Network Provider's own frame. If you choose a frame with a price that exceeds the credit or allowance, you will be responsible for any balance.

Standard, soft, daily-wear, disposable or planned replacement contact lenses may be selected in lieu of eyeglasses. A credit will be applied toward contact lenses from the Provider's own supply. Medically Necessary contact lenses will be covered in full at all Provider locations with prior approval.

If you go to a non-participating vision Provider, you will be reimbursed up to a maximum of $150 based on the schedule above. Contact the Fund Office at (516) 742-9478 for a reimbursement claim form. You will also need to submit a copy of an itemized bill from your non-participating vision Provider.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan. Most services are covered in full. When you contact the Fund Office to obtain your voucher(s), you will receive a listing of covered services and any possible Copayments.

Eye Examination (Including Tonometry)

Lenses

- Single Vision – Glass or plastic;
- Bifocal – Glass or plastic;
- Trifocals;
- Contact lenses, including disposable lenses;
- Basic progressive lenses;
- Oversized lenses;
- Photosensitive – Single vision and Bifocals (glass);
- Polycarbonate lenses for Dependent Children up to age 13;

- Safety Glasses – When a prescription is required (for members only). This is in addition to regular prescription glasses;
- Basic scratch resistant lenses;
- Sunglasses – When a prescription is required; and
- Standard tinting.

Frames

- Plastic;
- Metal;
- Designer; and
- Safety – When prescription lens is required (for members only). This is in addition to regular prescription glasses.

May I Use the Benefit at Different Times?

You may split your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from your Provider.

Exclusions and Limitations

This Plan does not cover any charge for the following services or supplies. This list is subject to change and is not an exhaustive list.

Appointment Charges – Charges for failure to keep an appointment;

Consultations Charges – Charges for consultations by phone;

Contact Lenses and Eyeglasses – Coverage for both contact lenses and eyeglasses in the same benefit cycle;

Form Charges – Charges for the completion of forms;

Government Provided – Charges for vision care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the member or Dependent is legally required to pay;

Medical Treatment – Medical treatment of eye disease or Injury;

Non-Prescription Lenses – Charges for lenses ordered without a prescription;

Orthoptics – Charges for eye muscle exercises;

Prior to or After Coverage – Care, treatment or supplies for which a charge was Incurred before or after a person was covered under this Plan;

Radial Keratotomy – Radial keratotomy or other surgeries on the cornea in lieu of eyeglasses;

Replacements – Broken lenses or frames, including contact lenses, except as provided for by each Provider. (One year unconditional replacement of lost eyeglasses supplied through the Davis Vision collection);

Two Pair of Glasses – In lieu of a bifocal;

Unlicensed Provider – Services performed by an unlicensed Provider;

Special Lenses – Special lens designs or coatings, other than those previously described;

Transition Lenses; and

Vision Therapy and Training – Charges for vision therapy and training or subnormal vision aids.

DEATH BENEFITS

The amount of the Death Benefit for an eligible retiree is $10,000. The Death Benefit for the Spouse of an eligible Retiree is $2,000.

If you have 30 or more years of actively working service, without a permanent break in service, you will automatically be eligible for the death benefit.

Should you retire from active coverage and die within 31 days of your retirement, your beneficiary will receive the death benefit amount that you accrued up until the date of your retirement.

Who Will Receive Your Death Benefit?

Any person or persons who you assign through the enrollment and beneficiary designation form will become your designated beneficiary or beneficiaries. You must submit a completed beneficiary designation form to the Welfare Fund Office as soon as you become a Local 28 Union member. You may change your designated beneficiary(ies) at any time by contacting the Fund Office and requesting and submitting a new beneficiary designation form. Upon the death of your beneficiary, you must submit an updated beneficiary designation form to Fund Office. You will automatically be the beneficiary if your Spouse predeceases you.

How to Claim Death Benefits

When the Spouse or eligible member passes away, the designated beneficiary(ies) or next-of-kin should contact the Fund Office and request a Death Benefit Application. The application should be submitted along with a Certified Death Certificate (with a raised or colored seal) indicating the final cause of death.

Limitations for All Death Benefits

There is no coverage for loss caused by or resulting from attempting or committing an act of crime.

SCHOLARSHIP BENEFIT PROGRAM

The Scholarship Program was established to provide financial assistance to eligible members to help defray the costs of a quality education for their Dependent Children and grandchildren.

Who Is Eligible for a Scholarship?

A person is eligible to apply for a scholarship when they have established, to the satisfaction of the Trustees, that they are:

- A Dependent Child of a member in good standing with the Union; or
- A grandchild of a member in good standing with the Union; or
- A Child of a deceased member, applying within two years of the member's death; and
- Planning to attend or currently enrolled full-time in an accredited two or four year college or university as a matriculated student pursuing an Associate or Baccalaureate degree. Full-time is defined by a scholarship recipient taking 12 or more credits.

Documentation must be provided to the Fund Office to establish the relationship between the member and the scholarship applicant before the scholarship exam.

How are Applicants Notified of the Examination?

Applications are mailed annually in December to all members in good standing with the Union and must be received by the Fund Office no later than March 31st of each year. The application will explain all of the program's filing requirements. The applicant will be given more details regarding the examination after their application is received.

If you have not received an application, contact the Fund Office at (516) 742-9478. Applications are also available online during the application period by logging on to the Union's "Member Welcome Page" at smw28.unionfusion.net.

How are Scholarships Awarded and Winners Selected?

Scholarships are awarded in accordance with a competitive testing system. The Trustees, in their discretion, will determine which competitive system will be utilized and by which learning/testing institution it will be administered and supervised. Scholarship competitive testing will be held no later than June of each year.

Applicants with the highest scores will be selected as recipients of the program's scholarships. If a scholarship has not been accepted by a successful applicant, it will be awarded to the next eligible applicant with the highest score. Winners and non-winners are notified by mail of the results of the scholarship exam.

Prior scholarship award winners are not excluded from applying for future awards.

How Many Scholarships Are Awarded and at What Value?

Seven scholarships are awarded each year as noted below. Of the number of scholarships awarded each year, only one scholarship will be awarded to the grandchild of an eligible member.

- Two one-year scholarships up to an amount of $7,000 per semester for the top two test scores; and

- Five one-year scholarships up to an amount of $3,000 per semester for the next top five test scores.

Scholarship recipients are required to use the award before the next competitive exam.

Eligible Expenses

In general, the scholarship covers the following tax-exempt school-related costs:

- Tuition;

- Textbooks; and

- Required fees.

Room and board expenses related to education are covered by the scholarship award but are a taxable reimbursement. If the scholarship award is used for these expenses, the recipient of the award will be issued a 1099-Misc tax form at year end.

The scholarship award will be made payable directly to the academic institution. All expenses combined are not to exceed the scholarship award amount. If expenses fall short of the scholarship award for the semester, the balance of the money remains in the Scholarship program.

If the applicant receives a grant or another scholarship that does not require repayment, that amount is deducted from the school's education costs. Student loans or other funding that must be repaid are not deducted from the scholarship amount.

Required Documentation and Grade Point Average

For the first semester award, scholarship recipients must provide an official copy of their tuition statement, or invoice showing the amount due from the academic institution.

For the second semester award, all documentation must be provided as stated above and include an official transcript showing that the scholarship recipient achieved an overall grade point average (GPA) of "B" or 3.0 or better in order to receive scholarship money for the semester.

- If a scholarship recipient does not earn an overall GPA of B/3.0 in the first semester but has at least an overall GPA of C/2.0, they will be eligible to receive their scholarship award for the second semester providing that they earn an overall GPA of B/3.0 or better in the second semester. The scholarship award will only be paid out upon completion of the second semester and receipt of the appropriate transcript showing the required GPA.

- If the scholarship recipient does not earn an overall GPA of B/3.0 or better, they forfeit the award for the semester and it will be added back to the Scholarship program for future award winners.

What Happens if Your Application is Denied?

If for any reason your application is being denied, you will be notified of the specific reason(s) so that you can provide additional documentation or information for your application to be reconsidered. If your application is ultimately denied, you may appeal the decision. Refer to the section of this SPD titled “Claim & Appeals Procedures” for more information.

GENERAL EXCLUSIONS AND LIMITATIONS

This Plan does not cover any charge for services or supplies in connection with any of the items listed below. This list is subject to change and is not an exhaustive list. This section applies to all benefits provided by the Plan.

Absence of Coverage – That would not have been made in the absence of coverage. This includes charges that are submitted to the Plan equal to any amount for which the Provider has discounted fees or has "written off" amounts due.

Civil Insurrection or Riot – Resulting from injuries Incurred or exacerbated while participating in a civil insurrection or riot**.**

Crime – Resulting from injuries Incurred or exacerbated while attempting or committing an act of crime. With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for the treatment of an Injury for the victim of a domestic violence act (including both physical and mental health conditions).

Complications – That result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure.

Cosmetic – For Cosmetic Surgery or procedures, or aesthetic services (including complications arising therefrom).

- This exclusion does not apply to procedures required as the result of an Injury, or if approved as Medically Necessary for a covered Illness.

- This exclusion does not apply to reconstruction of a breast following a Mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a Mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

Court-Ordered Services – That are ordered by a court, unless determined by the Plan Trustees to otherwise be appropriate and covered.

Deductibles, Copayments and Coinsurance – That are not payable due to the application of any specified Deductible, Copayment or Coinsurance provisions of the Plan.

Excess – That are not payable under the Plan due to application of any Plan maximum or limit.

Forms – For the completion of medical reports, claim forms or itemized billings.

Government Services – To the extent paid, or which the Covered Person is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.

Immediate Relative – Provided by an immediate relative or an individual residing in your home.

Late Claims – For which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

Malpractice – That are required as a result of malpractice, malfeasance or misfeasance or that are to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under the care of a Provider for a condition wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense.

Military Service – Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.

Missed Appointments – Related to missed appointments.

No Legal Obligation – That are provided to a Covered Person for which the Provider customarily makes no direct charge or for which the Covered Person is not legally obligated to pay.

Not Actually Rendered – That are not actually rendered.

Not Eligible – That were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided for in this SPD.

Not Specifically Covered – That are not specifically covered under the Plan.

Outside of the U.S.A. – For any care, services, Drugs or supplies Incurred outside of the U.S.A. if the Covered Person traveled to such a location for the purpose of obtaining the care, services, Drugs or supplies.

Penalties – That are related to failure to comply with any requirements for coverage under this Plan, or for any Copayment amounts identified as a “penalty” in this SPD.

Prohibited by Law – For which the Plan is prohibited by law or regulation from providing benefits.

Subrogation, Reimbursement, and/or Third Party Responsibility – Services, supplies, care, and/or treatment of an Injury or sickness not payable by virtue of the Plan’s subrogation, reimbursement, and/or third party responsibility provisions.

Telephone Consultations – For telephone consultations, except for approved telehealth services.

Tax and Shipping – For taxes and shipping charges levied on Medically Necessary items and services. This exclusion does not apply to surcharges required by law to be paid by the Plan in applicable states.

War – Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom.

CONTINUATION OF COVERAGE

Continuation of Coverage applies to all coverage under this Plan, except for Death benefits.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

In some cases, if you and/or your Dependents may become ineligible for coverage under the Fund's benefits, you have certain rights, under certain conditions, to temporarily continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can be available when coverage would otherwise terminate because of a life event known as a "qualifying event."

If a "qualifying event" occurs, you or your Dependents may be eligible for a temporary extension of health coverage at group rates.

The entire cost (plus a reasonable administration fee) of the COBRA premium rate must be paid in order to receive COBRA continuation coverage.

How Long Does COBRA Continuation Coverage Last?

Under the law, COBRA continuation coverage generally lasts up to a total of 18 months following a qualifying event. It can be extended up to an additional 11 to 18 months for a maximum of 36 months if a second qualifying event occurs such as your disability, divorce or legal separation, or if a Dependent Child loses eligibility as a Dependent Child.

Under this Plan, COBRA continuation coverage is more generous than what the law requires. If you have a qualifying event, coverage automatically last 36 months from the date of the qualifying event. There are no further extensions beyond the 36 month period as they are already included in this period.

COBRA continuation coverage will also end if you or your Dependents fail to make timely payment of premiums.

What is a Qualifying Event?

A "qualifying event" is an event in your life that causes your health coverage to terminate. Specific qualifying events are listed below.

After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Children can become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you are the Spouse of a covered member, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;

- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-covered member dies;

- The parent-covered member becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or

- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

Giving Notice of Qualifying Events

When the qualifying event is due to the death of the covered member, or the covered member becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered member and/or qualified beneficiary must notify the Plan Administrator of the qualifying event.

Each covered member or qualified beneficiary is responsible for providing the Plan Administrator with the following notices:

- Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered member from his or her Spouse; and

- Notice of the occurrence of a qualifying event that is an individual's ceasing to be eligible as a Dependent under the terms of the Plan.

The above notices must be provided to the Plan Administrator in writing by mail to the following address:

Sheet Metal Workers' Local Union No. 28 Welfare Fund
195 Mineola Boulevard
Mineola, NY 11501

A form of notice is available, free of charge, by contacting the Fund Office at (516) 742-9478.

What is the Deadline for Providing Your COBRA Election Notice?

For qualifying events described above, the notice must be furnished to the Fund Office by the date that is 60 days after the latest of:

- The date on which the relevant qualifying event occurs;

- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or

- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's COBRA notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed) or received by the Plan Administrator (if hand delivered) by the deadline set forth above. If the notice is late, the opportunity to elect COBRA continuation coverage is lost.

If you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan.

Who Can Provide the Notice?

Any individual who is the covered member, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered member or qualified beneficiary, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

What are the Required Contents of the Notice?

The notice must contain the following information:

- Name and address of the covered member;

- A description of the qualifying event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the covered member, death of the covered member;

- In the case of a qualifying event that is divorce or legal separation, name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

- In the case of a qualifying event that is Medicare entitlement of the covered member, date of entitlement, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan;

- In the case of a qualifying event that is a Dependent Child’s cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);

- In the case of a qualifying event that is the death of the covered member, the date of death, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan;

- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, will be available until the copy of the decree of divorce or legal separation is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered member, the qualified beneficiaries, the qualifying event or disability, and the date on which the qualifying event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA continuation coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your qualifying event. You then have 60 days in which to elect COBRA continuation coverage. The 60 day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA continuation coverage is not elected in that 60 day period, then the right to elect it ceases.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

Does COBRA Continuation Coverage Ever End Early?

COBRA continuation coverage may end before the end of the 36 month period on the earliest of the following dates:

- The date the Plan ceases to provide health coverage;

- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium; or

- The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an member or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules).

Payment for COBRA Continuation Coverage

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The Plan will be permitted to retroactively recover the amounts paid for benefits during the time period in which you failed to pay the required COBRA premium.

The Trade Act of 2002

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65%

tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60 day period to elect COBRA continuation coverage. If the qualified beneficiary elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Current Addresses

In order to protect you and your Family's rights, you should keep the Plan Administrator informed of any changes in the addresses of you and/or your Family members/Dependents.

COORDINATION OF BENEFITS

What is Coordination of Benefits (COB)

It is common for Family members to be covered by more than one health plan. This happens, for example, when you and your Spouse both work and your Spouse elects to have Family coverage through their employer.

When you are covered by more than one health plan, the law permits the Plan to follow a procedure called "coordination of benefits" to determine how much each plan should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Benefits Subject to This Provision

This section applies to all benefits provided by the Plan except for Weekly Accident and Sickness, Death, Vacation, Scholarship and Supplemental Unemployment Benefits.

Other Plan

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical care or treatment:

- Group, blanket, franchise insurance coverage or other group prepayment coverage;
- Any coverage under labor-management plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

Allowable Expenses

"Allowable expenses" means any Medically Necessary, usual, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of other plan(s) for payment of benefits. If you fail to properly file for, and receive payment by, any other plan(s), this Plan will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the "Application to Benefit Determination" calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the section titled "Order of Benefit Determination" will pay as if there were no other plan involved. If this Plan is a secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative allowable expenses for that calendar year; however, in no event will this Plan pay more than it would have in the absence of any other plan(s). When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

When medical payments are available under automobile insurance, this Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

- The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

- The rules in the section titled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

Order of Benefit Determination

For the purposes of the section titled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;

- The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, will be determined before the benefits of a plan which covers such person as a Dependent. If the person on whose expenses the claim is based is an inactive Employee (e.g. retired or on layoff) or the Dependent of an inactive Employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status;

- If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

- When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or

- When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the Child as a Dependent Child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan will be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan will have the right to recover such payments, to the extent of such excess, in accordance with the "Recovery of Payments" provision of this Plan.

Coordination of Benefits with Medicare

If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you and/or any of your Dependents are covered by both this Plan and by Medicare, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and your Dependents will terminate, but they may be entitled to COBRA Continuation Coverage. If any of your Dependents are covered by Medicare and you cancel that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under the Plan of a Medicare participant is yours and yours alone. This Plan will not provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan.

Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease

If you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of Injuries or Illnesses you sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's (including your own) liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a recovery, it will be subject to these provisions.

The Plan Administrator of the Welfare Fund retained Meridian Resource Company LLC to assist the Fund with seeking reimbursement for the amounts paid for these types of claims.

Subrogation

The Plan has the right to recover payments it makes to you or on your behalf from any person or party responsible for compensating you for any expenses that you Incurred or were Incurred on your behalf in connection with or in any way relating to your Illnesses or Injuries. The following apply:

- The Plan has first priority from any recovery for the full amount of benefits it has paid to you or on your behalf regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;

- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights;

- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan will be entitled to:

    - Deduct the amount the Plan paid from any future benefits to which you become entitled under the Plan; and/or

    - Suspend you from continued participation in the Plan until the Plan has recovered the full amount of benefits it has paid.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan;

- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim will be first satisfied before any part of a recovery is applied to your claim, your attorney's fees, other expenses or costs; and

- The Plan is not responsible for any attorney's fees, attorney's liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a recovery and the Plan has not been repaid for the benefits the Plan paid to you or on your behalf, the Plan will have a right to be repaid from the recovery in the amount of the benefits paid to you or on your behalf and the following provisions will apply:

- You must promptly notify the Plan that you have received a recovery. Such notification should be directed to the Plan Administrator;

- You must promptly reimburse the Plan from any recovery to the extent of benefits the Plan paid to you or on your behalf regardless of whether the payments you receive make you whole for your losses, Illnesses and/or Injuries;

- Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan will have a right of full recovery, in first priority, against any recovery. Further, the Plan's rights will not be reduced due to your negligence;

- You and your legal representative must hold "in trust" for the Plan under principles of common law and under ERISA the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney's fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the recovery. You and your legal representative acknowledge that the portion of the recovery to which the Plan's equitable lien applies is a "Plan asset;"

- Any recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions;

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney's fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan;

- If you fail to repay the Plan, the Plan will be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your recovery whichever is less, from any future benefit under the Plan if:

    - The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or

    - You fail to cooperate.

- The Plan also reserves the right to suspend you from continued participation in the Plan until the Plan has recovered the full amount of benefits it has paid to you or on your behalf;

- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan will be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan and/or to suspend you from continued participation in the Plan until the Plan has recovered the full amount of benefits it has paid to you or on your behalf;

- The Plan will also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you; and

- The Plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an Accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan;

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan will be entitled to deduct the amount the Plan paid from any future benefits under the Plan;

- You must not do anything to prejudice the Plan's rights;

- You must send the Plan copies of all police reports, notices or other papers received in connection with the Accident or incident resulting in personal Injury or Illness to you;

- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf; and

- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the Covered Person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, will be subject to this provision. Likewise, if the Covered Person’s relatives, heirs, and/or assignees make any recovery because of injuries sustained by the Covered Person, that recovery will be subject to this provision.

The Plan is entitled to recover its attorney’s fees and costs incurred in enforcing this provision.

The Plan will be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan will also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

CLAIM & APPEALS PROCEDURES

You will receive Plan identification (ID) cards which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show your ID card to your Provider of service. In most cases, your Provider will file your claim for you. You may file the claim yourself by submitting the required information to the appropriate program vendor under the Plan.

Most claims under the Plan will be "post-service claims," which are defined below. Post-service claims must include the following information in order to be considered filed with the Plan: date of service; the Provider's information; place where the services were rendered; any diagnosis and procedure code; the amount of charges; the name of the covered member; the name of the Plan; and name of the patient.

A Provider's inquiry about whether an individual is covered or whether a certain procedure or treatment is a Covered Expense before the treatment is rendered is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures for All Claims

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan. Other benefits under this Plan (e.g. Death benefits) will generally be treated as "post-service claims."

Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator will be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the SPD may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Covered Person claiming benefits under the Plan will be responsible for supplying, as required by the Plan Administrator in its sole discretion, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Covered Person has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Covered Person fails to furnish such proof as requested, no benefits will be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

Pre-Service Claims – A “pre-service claim” is a claim for a benefit under the Plan where the Plan determines receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Covered Person needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

Further, if the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims – A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan determines that the course of treatment should be reduced or terminated; or

- The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

Since the Plan does not require the Covered Person to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claims – A “Post-service Claim” is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed?

Post-service claims must be filed with the Third Party Administrator within 180 days of the date charges for the service were Incurred. Failure to file a claim within this time limit will not invalidate the claim if the Covered Person submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. Benefits are based upon the Plan’s provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. Claims filed later than that date will be denied.

A Pre-service Claim (including pre-service Concurrent Claims) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan’s procedures.

Upon receipt of the appropriate information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested, and the Covered Person must provide this information within 45 days from their receipt of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator will notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Non-Urgent Care Claims

- If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended by the Plan for an additional 15 days, provided that the Plan Administrator determines that the extension is necessary due to matters beyond the Plan's control and notifies the Covered Person, prior to the expiration of the initial 15 day processing period.

- If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

Concurrent Claims

- Plan Notice of Reduction or Termination – If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

- Request by Covered Person Involving Non-urgent Care – If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-Service Claims

- If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator

determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30 day processing period.

- If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

Notification of an Adverse Benefit Determination

The Plan Administrator will provide a Covered Person with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the SPD upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

In addition to the notice standards described in this section, to the extent required by the Patient Protection and Affordable Care Act ("PPACA"), any notice of denial to you must include the following:

- Information identifying the claim involved, including the date of service, the health care Provider, the claim amount, and a statement describing the availability, upon request, of

the diagnosis and treatment codes (and the corresponding meaning of those codes);

- The reason(s) for the Adverse Benefit Determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim;

- A description of available internal appeals and external review processes, including how to initiate an appeal; and

- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

Appeal of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person or their authorized representative (as detailed below) may file a written appeal with the Plan of the denial.

A Covered Person must file an appeal within 180 days following receipt of a notification of an initial adverse benefit determination. At that time, the Covered Person will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

Any appeal will not afford deference to the previous adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan, who will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The named fiduciary will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination. The fiduciary will consult with a health care professional who has appropriate training and experience in the medicinal field where the adverse benefit determination was based in whole or in part upon a medical judgment. The health care professional who is consulted on appeal will not be the same individual (or a subordinate of that individual) who was consulted regarding the initial benefit decision.

A Covered Person will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and appeal. If the advice of one or more medical or vocational experts was obtained in connection with the initial Benefit decision, the name of each such expert will be provided to the Covered person, regardless of whether the advice was relied on by the Plan.

Requirements for Appeals

To file a Hospital or medical appeal, the Covered Person must send the appeal to:

Dickinson Group, L.L.C.
50 Charles Lindbergh Blvd.
Suite 207
Uniondale, NY 11553
Phone: (877) 347-7225

Fax: (516) 833-9350

Appeals for all other benefits provided under the Plan should be sent to the Fund Office at:

Sheet Metal Workers' Local Union No. 28 Welfare Fund
195 Mineola Blvd.
Mineola, NY 11501
Attention: Appeals Department
or Fax: (516) 742-6360

It will be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Upon receipt, an appeal will be deemed to be filed with the Plan provided all of the information listed below is included.

- The name of the member /Covered Person;
- The member /Covered Person's Social Security Number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that, in the case of a health claim, the expenses will be eligible for payment under the Plan, or in the case of a disability claim, the Covered Person will be eligible for disability benefits under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator will notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims – Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Trustees' next regularly scheduled quarterly meeting following receipt of the appeal.

Concurrent Claims – The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims – Within a reasonable period of time, but not later than 60 days after the Trustees' next regularly scheduled quarterly meeting following receipt of the appeal.

The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the Covered Person prior to the termination of the initial 45 day period. In no event will such extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

In the event the circumstances requiring an extension include the need for more information, the Covered Person must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 45 day period, then the remainder of time left in that initial period is lost, and, upon receipt of the information, the 45 day extension period begins to run. If the additional information is requested during the 45 day extension period, then the remainder of time left in the extension period is lost, and the Plan must obtain the Covered Person's consent for an extension of time to process the additional information once it is received by the Plan.

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator will provide a Covered Person with notification in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the SPD on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;

- A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

In addition to the notice standards described in this section, to the extent required by the PPACA, any notice of denial to you must include the following:

- Information identifying the claim involved, including the date of service, the health care Provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes (and the corresponding meaning of those codes);

- The reason(s) for the Adverse Benefit Determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim;

- A description of available internal appeals and external review processes, including how to initiate an appeal; and

- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator will provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Federal External Review Program

For group health plan claims only, if a Covered Person is not satisfied with the determination on appeal, or if the fiduciary fails to respond to the appeal in accordance with applicable regulations regarding timing, the Covered Person may be entitled to request an external review of the appeals determination. The process is available at no charge. A request for an external review must be made within four months after receipt of the appeal decision or after the timeframe to respond expired.

An external review may be requested for adverse benefit determinations made on appeal with respect to group health plan claims based upon any of the following:

- Clinical reasons;

- Medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;

- Any exclusions for experimental or investigational treatment or services;

- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- Whether the plan is complying with the Mental Health Parity and Addiction Equity Act ("MHPAEA") and its implementing regulations.

An external review request should include: a specific request for an external review; the name, address and insurance ID number of the member /Covered Person; any authorized representative's name and address; the service that was denied; and any new, relevant information that was not provided during the appeal.

An external review will be performed by an Independent Review Organization ("IRO"). The Fund has entered into agreements with three or more IROs that have agreed to perform such reviews.

Standard External Review

A standard external review under the Federal External Review Program is comprised of all of the following: a preliminary review by the Fund of the request; a referral of the request by the Plan Administrator to the IRO; and a decision by the IRO.

A Covered Person or their Authorized Representative may request a standard external review by sending a written request to the address set out in the appeal determination letter.

Within the applicable timeframe after receipt of the request, the Plan Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted is or was covered under the Plan at the time of the service or procedure at issue, exhausted the internal appeals process, and provided all necessary information and forms.

Within one business day after the Plan Administrator completes the preliminary review, the Plan Administrator will issue a notification in writing to you. If the request is eligible for external review, the Fund will assign an IRO to conduct such review. The Plan Administrator will also notify you in writing if your request is not eligible for an external review or if it is incomplete. If your request is complete but not eligible, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the period required by law to cure any defect. The Plan Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify the Covered Person or their authorized representative in writing of the request's eligibility and acceptance for external review. The Covered Person may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

The Plan Administrator will provide to the assigned IRO the documents and information considered in making the fiduciary's determination on appeal. The documents include:

- All relevant medical records;

- All other documents relied upon by the fiduciary; and

- All other information or evidence that the Covered Person or their physician submitted. If there is any information or evidence that was not previously provided, they may include this information with the external review request and the Plan Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Board of Trustees. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Fund, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Board of Trustees determination, the Plan will immediately provide coverage or payment for the claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the health care service or procedure.

A Covered Person or their authorized representative may contact the Fund Office for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation on When a Lawsuit May Be Filed

All claim review procedures provided for in the Plan (excluding the Federal External Review Program) must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 90 days after the Plan's claim review procedures have been exhausted.

Furthermore, failure to file a petition for review of the denial within the 60 or 180 day period or the failure to appear and participate at a scheduled hearing will constitute a waiver of your right to a review of the denial.

No lawsuit may be started more than three years after the end of the year in which medical care was provided. If a participant fails to file a lawsuit or fails to appear and participate at a scheduled hearing or any other action with respect to the denial within one year of receiving the denial, the claim is barred and no action may be brought.

Please note that an authorized representative appointed pursuant to the below section entitled "Appointment of Authorized Representative" may not commence a legal action on your behalf.

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. A Provider may be your authorized representative for purposes of a benefit claim or appeal. The Covered Person must provide written documentation to the Fund Office or Third Party Administrator naming the entity or individual who is authorized representative. In the event a Covered Person designates an authorized representative, all future communications from the Plan specific to the benefit appeal will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan

Administrator, in writing, to the contrary. It is important to note that an appointment of an authorized representative will not constitute an assignment of benefits.

Other Procedures

Assignments – The right of a Covered Person to receive benefit payments under this Plan is personal to that Covered Person and is not assignable in whole or in part to any person, Hospital, Provider, or other entity, for any reason. This prohibition against assignments includes, but is not limited to, a purported assignment to any third party of the Covered Person's right to sue to recover benefit payments due to them under this Plan.

Autopsy – The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose Illness or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Medicaid Coverage – A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Non-U.S. Providers – Medical expenses for care, supplies or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. Provider;
- The Covered Person is responsible for making all payments to non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
- The non-U.S. Provider will be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

Payment of Benefits – All benefits that are payable under this Plan for Out-of-Network Providers are paid in U.S. dollars to the covered member whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered member and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such member.

Physical Examinations – The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan

Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Recovery of Payments – Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or Dependent on whose behalf such payment was made; such overpayment shall be repaid within 30 days of discovery or demand by the Covered Person, Dependent, Provider, other benefit plan, insurer, or other person or entity who received it. The Plan Administrator will have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator will have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment will be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator will have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 - HIPAA

Privacy Practices

The following is a description of certain uses and disclosures of your health information that may be made by the Plan:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

- Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order for the Plan Sponsor to receive and use PHI for Plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

- 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 PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or member benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

- Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318);

- Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of

the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318);

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, will be given access to the PHI to be disclosed:

        - All of our departments, including, e.g., our medical records, claims processing and information technology departments;

        - All of our employees, staff, and other personnel who work for us or on our behalf.

    - The access to and use of PHI by the individuals described above will be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the Privacy Standards.

Security Practices

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI;

- Report to the Plan any Security Incident of which it becomes aware;

- Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318); and

- Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Any terms not otherwise defined in this section will have the meanings set forth in the Security Standards.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health Plan or health insurance issuer on request or when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion or limitation for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including a Participating Employer or any other person, may discriminate against you in any way to prevent you from obtaining a benefit from this Plan or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, 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 would 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN ADMINISTRATION

Who Has the Authority to Make Decisions in Connection With the Plan?

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator determines that the Covered Person is entitled to them.

The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Covered Person's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a Third Party Administrator to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether Medical Child Support Orders (MCSOs) and National Medical Support Notices (NMSNs) are Qualified Medical Child Support Orders (QMCSOs);
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

- To perform each and every function necessary for or related to the Plan's administration.

May Changes Be Made to the Plan?

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination will be enacted by resolution of the Plan's Trustees, which will be acted upon as provided in the Plan's Trust Agreement and in accordance with applicable federal and state law. Notice will be provided as required by ERISA.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan will become effective as of a date established by the Plan Sponsor.

Who Pays the Cost of the Plan?

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

Will the Plan Release My Information to Anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits under this Plan. In so acting, the Plan Administrator will be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with HIPAA Privacy Standards. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

What if the Plan Makes an Error?

Clerical errors made on the records of the Plan and delays in making entries on such records will not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage will be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Will the Plan Conform to Applicable Laws?

This Plan will be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this SPD. It is intended that

the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

What Constitutes a Fraudulent Claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
- Attempting to file a claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing any false or misleading information to the Plan.

The Plan will be permitted to retroactively rescind an individual's coverage only for fraud or intentional misrepresentation of material facts or, in the case of COBRA, for the non-payment of premiums. The Plan will also be permitted to retroactively recover the amounts paid for any benefits as a result of a fraudulent claim.

How May a Plan Provision Be Waived?

No term, condition or provision of this Plan will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Will the Plan Cover an Alternate Course of Treatment?

The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this SPD.

If a Covered Person, in cooperation with his or her Provider, elect a course of treatment that is deemed by the Plan Administrator to be more extensive or costly than is necessary to satisfactorily treat the Illness or Injury, this Plan will allow coverage for the usual, customary and reasonable value (MMA rate) of the less costly or extensive course of treatment.

Assets of the Fund

The assets of the Fund consist of:

- All investments made therewith, the proceeds thereof and the income there from;

- Supplies, property and other assets used by the Trustees in the administration of the Fund;

- The sums of money that have been or will be paid or which are due and owing to the Fund by Participating Employers as required by Collective Bargaining Agreements; and

- All other contributions and payments to or due and owing to the Trustees from any source to the extent permitted by law.

DEFINITIONS

In this section you will find the definitions for most of the capitalized words found throughout this SPD. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this SPD for that information.

Accident means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

ADA means the American Dental Association.

AHA means the American Hospital Association.

AMA means the American Medical Association.

Ambulatory Surgical Center means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the Institution, and which does not provide service or other accommodations for patients to stay overnight.

Birthing Center means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24 hour nursing services by registered graduate nurses and certified nurse midwives. An obstetrician or a Physician qualified to practice obstetrics with Hospital admitting privileges must be available for consultation and referral and on call during labor and delivery. A Birthing Center must be equipped, staffed, and operating for the purpose of providing:

- Family centered obstetrical care for patients during uncomplicated Pregnancy, delivery, and immediate postpartum periods;

- Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and

- Care for obstetrical patients and infants born in the center who require Emergency and immediate life support measures to sustain life pending transfer to a Hospital.

A Birthing Center must have an agreement with an ambulance service and a Hospital to accept transfer.

Brand Name Drug means Drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

Cardiac Care Unit means a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;

- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

Certificate of Coverage means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Child(ren) means, in addition to the member's own blood descendant of the first degree or lawfully adopted Child, a Child placed with the member in anticipation of adoption, a Child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other Child for whom the member has obtained legal guardianship.

Chiropractic Care means all services related to a chiropractic visit.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the amount that you will most likely be responsible to pay above the Plan's reimbursement to an out-of-Network Provider that you decided to use. See the section titled "Using and out-of-Network (Non-Participating) Provider for more details.

Complications of Pregnancy means:

- Conditions whose diagnoses are distinct from Pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia;

- A non-elective cesarean section Surgical Procedure; or

- A terminated ectopic Pregnancy.

Complications of Pregnancy does not mean:

- False labor;

- Occasional spotting;

- Prescribed rest during the period of Pregnancy; or

- Similar conditions associated with the management of a difficult Pregnancy, but not constituting a distinct complication of Pregnancy.

Copayment or **Copay** means the fixed dollar amount you pay for covered services.

Cosmetic or **Cosmetic Surgery** means any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense means a Medically Necessary service or supply which is usual, customary and reasonable, and which is listed for coverage in this Plan.

Covered Person means a covered member and his or her covered Dependents that are eligible for benefits under the Plan.

Creditable Coverage means coverage for the cost of medical care whether provided directly, through insurance, reimbursement, or otherwise and as required by federal law. Creditable Coverage is generally other health coverage that you had before you became a Participant in the Fund, as long as you did not go 63 days or longer without coverage. To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible means an amount of money that must be paid by a Covered Person for Covered Expenses before the Plan will reimburse additional Covered Expenses Incurred during that Plan Year.

Dentist means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice Dentistry in the jurisdiction where such services are provided.

Dependent means one or more of the following person(s):

- A member's lawfully married Spouse possessing a marriage license who is not divorced or legally separated from the member;

- A member's Child who is less than 26 years of age; or

- A member's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullet above, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan

must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullet above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

Dependent does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

Detoxification means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of Substance Abuse, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with Drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Diagnostic Service means a test or procedure performed for specified symptoms to detect or to monitor an Illness or Injury. It must be ordered by a Physician or other professional Provider.

Drug means insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a state restricted Drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment means equipment which:

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

Eligibility Period means an interval of time before the member becomes eligible to participate in the Plan.

Emergency means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist.

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 absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department 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, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies. All phases of clinical trials will be considered Experimental.

Drugs are considered Experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Family means the member, his or her Spouse and his or her Dependent Children.

Generic Drug means Drugs not protected by a trademark, usually descriptive of Drug's chemical structure.

GINA means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans and issuers of individual health care policies from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;

- The genetic tests of Family members of such individual; and

- The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

Health Breach Notification Rule means 16 CFR Part 318.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care means certain services and supplies required for treatment of an Illness or Injury in the Covered Person’s home as part of a formal treatment plan certified by the attending Physician and approved by the Plan Administrator.

Home Health Care Agency means an agency or organization which provides a program of Home Health Care and which:

- Is approved as a home health agency under Medicare;

- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or

- Meets all of the following requirements:

    - It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;

    - It has a full-time administrator;

    - It maintains written records of services provided to the patient;

    - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and

    - Its employees are bonded and it provides malpractice insurance.

Hospice Care Agency means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;

- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;

- Has a full-time coordinator;

- Keeps written records of services provided to each patient;

- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and

- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

Hospital means an Institution that meets all of the following requirements:

- It provides medical and surgical facilities for the treatment and care of injured or sick persons on an Inpatient basis;

- It is under the supervision of a staff of Physicians;

- It provides 24 hour-a-day nursing service by registered nurses;

- It is duly licensed as a Hospital, except that this requirement will not apply in the case of a state tax-supported Institution;

- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a federal government fund; and

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

The requirement of surgical facilities will not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such an Institution by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

Illness means a condition, sickness or disease not resulting from trauma.

Immediate Relative means Spouse, Child, brother, sister or parent of the Covered Person, whether by birth, adoption or marriage.

Impregnation and Infertility Treatment means artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

Institution means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, Psychiatric Hospital, Substance Abuse Treatment Center, alternative Birthing Center, Home Health Care center, or any other such facility that the Plan approves.

Intensive Care Unit means a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;

- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24 hour a day basis.

Mastectomy means the surgical removal of all or part of a breast.

Medically Necessary means services or supplies which are determined by the Plan Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, Injury or Illness;

- Provided for the diagnosis or direct care and treatment of the medical condition, Injury or Illness;

- Within standards of good medical practice within the organized medical community;

- Not primarily for the convenience of the Covered Person, the Covered Person's Physician or another Provider; and

- The most appropriate supply or level of service which can safely be provided.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Disorder means any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network means the Preferred Provider Organization (PPO) Network of Providers offering discounted fees for services and supplies to Covered Persons. The Network will be identified on the Covered Person's Plan Identification Card.

Out-of-Pocket Expense means the cost to the Covered Person for Deductibles, Coinsurance, Copayments, penalties and non-covered expenses.

Partial Hospitalization Program (PHP) means outpatient care in a hospital setting on a part-time basis, which can mean only during the day, only at night, or only during weekends**. Partial Hospitalization**, also known as PHP, is a type of program used to treat mental illness and substance abuse. In Partial Hospitalization, the patient continues to reside at home, but commutes to a treatment center up to seven days a week. Partial Hospitalization focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization.

Participating Employer(s) means any employer operating under the terms of a collective bargaining agreement with SMART Local Union No. 28,

Participating Provider means a Provider who has agreed to provide health care services to Plan Participants. It includes a hospital, doctor, pharmacy, group practice, nurse, nursing home, pharmacy, or other health professional or entity. A Participating Provider must be licensed in the state of provision and must be contracted with the Plan's Network. Participating Providers undertake to hold Plan Participants harmless from payment with an expectation of receiving payment, other than Copayments or deductibles, directly or indirectly from the Network.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

Plan means the Sheet Metal Workers' Local Union No. 28 Welfare Fund.

Plan Administrator means Board of Trustees of the Sheet Metal Workers' Local Union No. 28 Welfare Fund.

Plan Document means this SPD.

Plan Sponsor means the Board of Trustees of the Sheet Metal Workers' Local Union No. 28 Welfare Fund.

Plan Year means the period commencing January 1 and ending December 31.

Pre-Admission Tests means those Diagnostic Services done before a scheduled Hospital Inpatient admission, provided that:

- The tests are required by the Hospital and approved by the Physician;
- The tests are performed on an outpatient basis prior to Hospital admission;
- The tests are not duplicated on admission to the Hospital; and
- The tests are performed at the Hospital where the confinement is scheduled, or at a qualified facility approved by the Hospital to perform the tests.

Preferred Provider Organization or **PPO** means the Network of Providers offering discounted fees for services and supplies to Covered Persons. The Network will be identified on the Covered Person's Plan Identification Card.

Pregnancy means carrying a Child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as an Illness for the purpose of determining benefits.

Privacy Standards means the standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

Provider means a Physician, a licensed speech therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Psychiatric Hospital means an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;

- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;

- It is licensed as a Psychiatric Hospital;

- It requires that every patient be under the care of a Physician; and

- It provides 24-hour-a-day nursing service.

It does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

Rehabilitation Hospital means an Institution which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;

- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or

- It is approved for its stated purpose by Medicare.

Room and Board means an Institution's charge for:

- Room and linen service;

- Dietary service, including meals, special diets and nourishment;

- General nursing service; and

- Other conditions of occupancy which are Medically Necessary.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Spouse means the person to whom the member is legally married under applicable federal law and from whom the member is not legally separated.

Substance Abuse means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Treatment Center means an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or

- Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a state agency having legal authority to do so.

Summary Plan Description (SPD) means this document.

Surgery or **Surgical Procedure** means any of the following:

- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

- Biopsy;

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;

- Obstetrical delivery and dilation and curettage; or

- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

- The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

- The induction of artificial pneumothorax and the injection of sclerosing solutions;

Third Party Administrator means the organization that processes claims and performs other administrative services in accordance with its service agreement with the Welfare Fund.

Trade Act means the Trade Act of 2002, as amended.