COMBINED
SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT
SHEET METAL WORKERS' UNION
LOCAL 33 CLEVELAND DISTRICT
HEALTH BENEFITS PLAN

BOARD OF TRUSTEES

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August 1, 2020

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August 2020

TO ALL PARTICIPANTS:

This booklet has been prepared for Active Participants and retirees of the Sheet Metal Workers' Union Local 33 Cleveland District Health Benefits Plan and serves as the Plan's Summary Plan Description (SPD) booklet and legal Plan Document as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SPD/Plan Document booklet and supplemental documents such as insurance certificates, and the Plan's Policies and Procedures serve as the Plan's controlling legal documents. These documents are used by the Trustees of the Plan to determine the eligibility of Active Participants and retirees for benefits provided by the Sheet Metal Workers' Union Local 33 Cleveland District Health Benefits Plan and to prescribe the amount, extent, conditions, and methods of payment of such benefits.

The Board of Trustees has full discretion to interpret the terms of the Plan and to determine eligibility for benefits under the Plan. A decision by the Board of Trustees may be reversed by a court of competent jurisdiction only if the decision is arbitrary and capricious. No Employer, Union, or any representative of any Employer or Union is authorized to interpret the Plan, nor can any such person act as agent of the Trustees. You may only rely on information regarding the Plan that is communicated to You in writing and signed on behalf of the Board of Trustees.

The Trustees reserve the right and have been given the discretion to amend, modify, or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant. You have no vested right to benefits in the Plan, and the terms of the Plan may be changed at any time and for any reason.

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

We urge You to read this booklet carefully so that You will be familiar with the benefits available to You and Your family and understand Your rights and obligations under the benefit Plan. If You have any questions about eligibility, benefits, or other matters involving Your health and welfare fund, contact the Fund Office.

SPECIAL NOTICE!

It is extremely important You keep the Fund Office informed of any changes in Your address or marital status. This is Your obligation, and failure to fulfill this obligation could jeopardize Your eligibility for benefits.

The importance of a current and correct address on file in the Fund Office cannot be overstated! It is the ***ONLY*** way the Trustees can keep in touch with You regarding Plan changes and other developments affecting Your interests under the Plan.

Sincerely,
The Board of Trustees

ARTICLE I - INTRODUCTION

The Board of Trustees of the Sheet Metal Workers' Union Local 33 Cleveland District Health Benefits Plan (the "Plan") is proud to provide our Participants with comprehensive health and welfare benefits. As Your Board of Trustees, we continually evaluate the benefits provided and look for opportunities to enhance Plan benefits while maintaining a financially sound fund.

This booklet describes benefits available to Active Participants and retirees as of July 1, 2020. It includes several important sections:

- **Important contact information** – Provides information about who to contact when You have questions about Your benefits.
- **Schedule of benefits** – Summarizes the benefits offered under the Plan for Active Participants and retirees.
- **Eligibility section** – Contains information about how You become a Plan Participant, who You can cover under the Plan, how You maintain Plan Coverage, and how to reinstate Your eligibility when Coverage under the Plan ends.
- **Life events section** – Highlights how Your benefits are affected by different events (for example, marriage or birth of a child) that can occur in Your life.
- **Detailed benefit information** – Provides in-depth information about the types of Coverage available under the Plan, including medical, prescription, dental, vision, death, and disability benefits.
- **Retiree medical information** – Explains retiree eligibility rules and the medical options available to retirees.
- **Dollar Bank account information** – Describes eligibility and use of Your individual accounts set up by the Plan to reimburse medical expenses.
- **A how-to section on filing claims** – Includes information about filing and appealing claims.
- **General Plan information and Your ERISA rights** – These sections include general Plan administrative information and Your rights under ERISA.

We encourage You to read this information and, if You are married, share it with Your Spouse. Also, we recommend that You keep this booklet with Your important papers so You can refer to it when needed.

ARTICLE II - PLAN INFORMATION

The current contact information regarding this Fund follows. However, providers and contact information are subject to change.

If You have a questions or need information about:	Contact	At:
Eligibility and General Benefits Information	Fund Office	(888) 424-7488
Medical, Hospital, and Dental Claims	BeneSys, Inc.	12515 Corporate Drive Parma, OH 44130 (216) 267-3344 (888) 424-7488 Fax (216) 267-3345
PPO Network Provider	Anthem	(800) 676-2583 anthem.com
Medicare Advantage Provider	Humana	(800) 733-9064
Vision Claims	VSP	Member Services (800) 877-7195 www.vsp.com
Pre-Certification, Utilization Review, and Case Management	HealthLink	(877) 284-0102
Employee Assistance Program	Impact	(800) 227-6007 employeeassistance.com
Prescription Drug Benefits and Claims	Envision	(800) 361-4542 envisionrx.com
DenteMax Dental In-Network Providers	DenteMax	(800) 752-1547 dentemax.com
Short-Term Disability, Life Insurance, AD&D Insurance, and Dependent Life Insurance benefits	Fund Office	(216) 267-3344 or (888) 424-7488

ARTICLE III - SCHEDULE OF BENEFITS

A. MEDICAL BENEFITS

The following charts describe Coverage for eligible Participants and Dependents who are not eligible for Medicare:

1. Medical Benefits for Active Participants and Their Dependents and Retirees Under Age 65 and Their Eligible Dependents Under Age 65:

Medical Benefits	Deluxe Plus Plan		Classic Plus Plan		Basic Plus Plan	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible* Per Person	$150 per person		$650 per person		$2,000 per person	
Annual Deductible* Per Family	$300 per family		$1,300 per family		$4,000 per family	
Out-of-Pocket Maximum (includes Deductible)	**Medical:** $1,050 per person/$2,100 per family **Prescription:** $2,500 per person/$5,000 per family		$5,650 per person/$11,300 per family for medical and prescription combined		$6,600 per person/$13,200 per family for medical and prescription combined	
	The applicable Out-of-Pocket Maximum set forth above applies only to in-network Coverage and not to Out-of-Network Coverage. The applicable Out-of-Pocket Maximum set forth above shall never exceed the maximum annual out-of-pocket limitations set forth for non-grandfathered plans by the Affordable Care Act. If the amount set forth above exceeds the maximum annual out-of-pocket limitation set forth for non-grandfathered plans by the Affordable Care Act, the maximum out-of-pocket limitation under the Affordable Care Act shall apply. Coverage for "Non-essential Health Benefit Drugs" will not count toward the out of pocket maximums.					
Hospital Services Room and Board	Plan pays 95% of Semiprivate Room rate after Deductible	Plan pays 85% of Semiprivate Room rate after Deductible	Plan pays 85% of Semiprivate Room rate after Deductible	Plan pays 70% of Semiprivate Room rate after Deductible	Plan pays 80% of Semiprivate Room rate after Deductible	Plan pays 65% of Semiprivate Room rate after Deductible
Intensive Care Unit	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Skilled Nursing Facility	Plan pays 95% of Semiprivate Room rate after Deductible	Plan pays 85% of Semiprivate Room rate after Deductible	Plan pays 85% of Semiprivate Room rate after Deductible	Plan pays 70% of Semiprivate Room rate after Deductible	Plan pays 80% of Semiprivate Room rate after Deductible	Plan pays 65% of Semiprivate Room rate after Deductible

Physician Services Office Visits (not well care)	You pay $10 Co-Pay	Plan pays 85% after Deductible	You pay $30 Co-Pay	Plan pays 70% after Deductible	You pay $50 Co-Pay	Plan pays 65% after Deductible
Medical Benefits	Deluxe Plus Plan		Classic Plus Plan		Basic Plus Plan	
	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Online Telemedicine Services (Medical Only)	You pay $0 Co-Pay		You pay $0 Co-Pay		You pay $0 Co-Pay	
Inpatient Visits	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Surgery	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Emergency Room Visits **	You pay $50 Co-Pay	You pay $50 Co-Pay plus cost difference**	You pay $175 Co-Pay	You pay $175 Co-Pay plus cost difference**	You pay $200 Co-Pay	You pay $200 Co-Pay plus cost difference**
Outpatient Private Duty Nursing	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Home Health Care	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Hospice Care	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Ambulance Services	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Durable Medical Equipment	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Behavioral Health/ Substance Abuse *Inpatient Service* *Outpatient Service*	Plan pays 95% after Deductible Plan pays 95% after Deductible	Plan pays 85% after Deductible Plan pays 85% after Deductible	Plan pays 85% after Deductible Plan pays 85% after Deductible	Plan pays 70% after Deductible Plan pays 70% after Deductible	Plan pays 80% after Deductible Plan pays 80% after Deductible	Plan pays 65% after Deductible Plan pays 65% after Deductible
Jaw Joint/TMJ *Lifetime Max per person*	Plan pays 95% after Deductible $750	Plan pays 85% after Deductible $750	Plan pays 85% after Deductible $750	Plan pays 70% after Deductible $750	Plan pays 80% after Deductible $750	Plan pays 65% after Deductible $750

Physical Therapy***	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Occupational Therapy***	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Speech Therapy***	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Maternity Care and Reproductive Health Services	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible

* The annual Deductible is measured on a calendar year basis and renews every January 1st.

** Cost difference means the difference between (a) the Providers' charges and (b) the amount collected from the Plan and the patient's Co-Pay amount. To ensure the Plan pays a reasonable amount for Out-of-Network Emergency Services, it will pay an amount equal to the greatest of three possible amounts: (1) the amount negotiated with Network Providers for the Emergency Service furnished; (2) the amount for the Emergency Services calculated using the same method the plan generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; and (3) the amount that would be paid under Medicare for the Emergency Services.

*** Physical Therapy, Occupational Therapy, and Speech Therapy are limited to a combined maximum of 30 visits per calendar year, Network and Out-of-Network, combined.

Medical Benefits	Deluxe Pus Plan		Classic Plus Plan		Basic Plus Plan	
Preventive Care	No cost sharing required Annual Deductible does not apply to Preventive Care services. However, the following visitation limits apply to Preventive Care: • Under 1 Year Old: 6 visits per year • 1 Year Old: 3 visits per year • 2 Years Old: 2 visits per year • 3 Years Old to 17 Years Old: 1 visit per year					
Prosthetics	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Spinal Manipulation (Chiropractic) *Calendar Year Maximum per Person*	Plan pays 95% after Deductible $520	Plan pays 85% after Deductible $520	Plan pays 85% after Deductible $520	Plan pays 70% after Deductible $520	Plan pays 80% after Deductible $520	Plan pays 65% after Deductible $520
Wig after Chemotherapy	Plan pays 95% after Deductible	Plan pays 85% after Deductible	Plan pays 85% after Deductible	Plan pays 70% after Deductible	Plan pays 80% after Deductible	Plan pays 65% after Deductible

Hearing Aids – Available every 3 years per person			
Coinsurance	Plan pays 90%	Plan pays 85%	
Exam Maximum Audiometric	$50	$50	Not Available
Maximum	$50	$50	
Appliance Maximum	$1000	$1000	

Prescription Drug Benefits	**Deluxe Plus Plan**	**Classic Plus Plan**	**Basic Plus Plan**
Retail Pharmacy (up to a 30-day supply or 100-unit dose)	No Deductible <u>Plan Pays:</u> 85% Generic Cost 85% Name Brand Cost if No Generic Available 75% Name Brand Cost if Generic Available	No Deductible <u>Plan Pays:</u> 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available	$25.00 Deductible <u>Plan Pays:</u> 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available
	If You choose to use a Name Brand when a Generic is available, You will also be required to pay the difference in cost between the Name Brand and the Generic in addition to the Coinsurance amount. This difference in cost is additional and not counted toward Your overall Out-of-Pocket Maximum.		
Mail Order (up to 90-day supply or 300-unit dose)	No Deductible <u>Plan Pays:</u> 85% Generic Cost 85% Name Brand Cost if No Generic Available 75% Name Brand Cost if Generic Available	No Deductible <u>Plan Pays:</u> 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available	$25.00 Deductible <u>Plan Pays:</u> 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available
	If You choose to use a Name Brand when a Generic is available, You will also be required to pay the difference in cost between the Name Brand and the Generic in addition to the Coinsurance amount. This difference in cost is additional and not counted toward Your overall Out-of-Pocket Maximum.		

2. Short-Term Disability Benefits for Active Participants Only – Benefits are only payable if the Participant is considered an Eligible Participant at the time their Total Disability begins.

Short Term Disability Benefits	Same under Deluxe Plus, Classic Plus, and Basis Plus Plans
Weekly Benefit	$500
Maximum Length	26 Weeks

3. Life and AD&D Benefits for Active Participants and Retirees Under Age 65 – Life Insurance Benefits are available for Retirees over Age 65 who receive benefits from the Medicare Advantage Plan and affirmatively elect coverage.

Life Insurance Benefit	Same under Deluxe Plus, Classic Plus, and Basis Plus Plans
Participant	$50,000
Retiree Over 65	$5,000

AD&D Insurance Benefit	Same under Deluxe Plus, Classic Plus, and Basis Plus Plans
Participant	$50,000 (full amount)

4. Dependent Life Benefits for Active Participants and Retirees Under Age 65 with Family Coverage

Dependent Life Insurance Benefits	Same under Deluxe Plus, Classic Plus, and Basis Plus Plans
Dependent Spouse	$5,000
Each Dependent Child	$2,000

5. Dental and Vision Benefits for Active Participants and Retirees Under Age 65 - Dental and Vision Benefits are available if the Participant or retiree affirmatively elects to receive the Coverage. Dental and Vision are also available to retirees over age 65 who are enrolled in the Medicare Advantage Plan and affirmatively elect to receive benefits.

Dental Benefits	Same under Deluxe Plus, Classic Plus, and Basic Plus Plans
Coinsurance	Plan pays 80% of any dental treatment
Maximum Benefit (Single Coverage)	$1,500 per calendar year
Maximum Benefit (Family Coverage)	$3,000 per calendar year

Vision Benefits	Same under Deluxe Plus, Classic Plus, and Basic Plus Plans
Benefit – Exam/Lenses/Frame Copayment	$10 Co-Pay Exam/ $25 Co-Pay Materials
Network Providers	
Frames	Up to $150.00
Lenses	Covered
Elective Contact Lenses Allowance (in lieu of glasses)	Up to $150.00
Elective Contact Lenses Fitting	$60 Co-Pay
Necessary Contact Lenses	Covered

Out-of-Network Providers	
Exam	Up to $45.00
Single Lenses	Up to $30.00
Bifocal Lenses	Up to $50.00
Trifocal Lenses	Up to $65.00
Lenticular Lenses	Up to $100.00
Frame	Up to $70.00
Elective Contact Lens Allowance (in lieu of glasses)	Up to $105.00
Necessary Contact Lens Allowance (in lieu of glasses)	Up to $210.00

B. THE MEDICARE ADVANTAGE PLAN

If You are receiving benefits under the Medicare Advantage Plan, Your benefits are described in a separate booklet provided by the Plan's Medicare Advantage Provider. If You continue to receive benefits under the Medicare Advantage Plan, You may also continue to receive dental, vision, and life insurance benefits from the Plan, as described in the applicable sections of this SPD.

ARTICLE IV - ELIGIBILITY: BECOMING A PARTICIPANT

A. INTRODUCTION

To be eligible for benefits under the Plan, You must have sufficient contributions in Your Dollar Bank to cover the monthly cost of Coverage that You elect. Each year You elect Your benefit Coverage during the open enrollment period. The amount of contributions necessary to cover the cost of the Coverage depends on what Coverage You elect. Annually, the Trustees determine the monthly cost of Coverage. If You do not have sufficient Employer Contributions to cover the cost of Coverage, You may be able to obtain and continue Coverage for Yourself and any Eligible Dependents by making self-payments.

Non-bargaining Employees may also be eligible for Coverage. For eligibility information, contact the Fund Office.

B. INITIAL ELIGIBILITY

1. You become eligible for Coverage on the first day of the month after the month Your Dollar Bank has sufficient contributions to cover the cost of Coverage. When You accumulate enough Employer Contributions to cover the cost of Coverage, You will be sent notification and a benefits enrollment package.

   However, You can make self-payments so Coverage becomes effective before You have accumulated sufficient Employer Contributions. In order to do so, You must have at least one (1) hour of Employer Contributions contributed to the Plan on Your behalf. For Coverage to be effective the first of the month that You start working in covered employment, Your self-payment must be received by the Fund Office no later than the 20th of that month.

   For Coverage to continue in subsequent months, self-payments must be received by the Fund Office no later than the 20th of the month before the month You wish Coverage to be effective (for example, for Coverage to be effective during the month of November, self-payments for that month must be received by October 20).

2. Self-Paying for Coverage Example – Jack begins working in covered employment on August 1st. Assuming he does not have enough Employer Contributions to cover the cost of Coverage for his first month of work, he needs to provide the Fund Office with the required self-payment by August 15th for Coverage to be effective August 1st. If he does not have enough Employer Contributions to cover the cost of Coverage in September, Jack will need to provide the Fund Office with self-payments by August 20 to continue Coverage for September.

C. DOLLAR BANK

When Employer Contributions are made on Your behalf into the Plan, and they are in excess of the cost of Coverage, they are placed in a Dollar Bank. If Your Employer stops making contributions on Your behalf, or if the contributions are less than the cost of Coverage, the amount necessary to continue Coverage will be deducted from Your Dollar Bank. If You have more than $6,000 in Your Dollar Bank, it may also be used to reimburse eligible medical expenses under the Dollar Bank Account, as provided in Article VIII.

D. ELIGIBLE DEPENDENTS

Your Eligible Dependents become eligible for benefits on the date that You become eligible, or if later, on the date You acquire an Eligible Dependent. Eligible Dependents include Your:

1. Legal Spouse;

2. Your Children from birth to age twenty-six (26), regardless of marital status, work status, living status, or financial dependency. For purposes of this Plan, "Children" include Your:

    a. Your natural children;

    b. Children for whom You are the legal guardian;

    c. Step-children residing in Your principle place of residence provided the natural parent remains married to You and resides in Your principle place of residence as well;

    d. Children who are alternate recipients under a Qualified Medical Child Support Order;

    e. Adopted children;

    f. Foster children for whom the Employee assumes legal guardianship; and

    g. Children placed with You in anticipation of adoption provided:

        i. You intend to adopt the children (whether or not the adoption has become final);

        ii. The children have not attained age 18 as of the date of placement for adoption;

        iii. You are legally obligated for the total or partial support of the children in anticipation of adoption of the children; and

iv. The children are available for adoption and the legal process has begun.

3. Unmarried children who are incapable of self-sustaining employment because of a mental or physical handicap regardless of age provided:

   a. Such children are primarily dependent on You for support and maintenance;

   b. Such children were incapable of self-sustaining employment because of a mental or physical handicap Covered under the Plan when they reached the age of twenty-six (26);

   c. You provide certification of the disability within 31 days of the attainment of age twenty-six (26). A certification form is available from the Third-Party Administrator; and

   d. You periodically provide proof of incapacity to the Fund Office. The Plan Administrator reserves the right to have Your children examined by a Physician of his or her choice, at the Plan's expense, to determine the existence of incapacity. You must notify the Third-Party Administrator if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued Coverage.

E. PERSONS NOT ELIGIBLE FOR COVERAGE

Dependents do not include:

1. Individuals living in Your home who do not meet the provisions of Section D above;

2. Your legally separated or divorced former Spouse;

3. Any person who is on active duty in the military service of any country;

4. Any person who is Covered under the Plan as an Employee; or

5. Grandchildren unless they otherwise meet the provisions of Section D.

F. CONTINUING ELIGIBILITY

Once You meet the initial eligibility requirements, You will continue to be eligible for benefits provided:

1. Your Employer continues to make sufficient contributions on Your behalf to cover the cost of Coverage, and You continue to be employed by a contributing Employer or available for employment in the jurisdiction of the Plan; or

2. You have sufficient dollars in Your Dollar Bank to cover the cost of Coverage under the Plan.

The monthly contributions Your Employer makes on Your behalf are deposited into Your Dollar Bank. Any Employer Contributions made on Your behalf above the amount required for monthly Coverage will accumulate in Your Dollar Bank. During months You do not work or have reduced Employer Contributions made on Your behalf, Your accumulated dollars can be used to continue Coverage. When Your account balance falls below the minimum required level (enough to cover a month's premium), You will be notified and may elect to continue Coverage by making self-payments. You may continue to make self-payments until Your Coverage terminates as described below.

G. TERMINATION OF ELIGIBILITY

Your Coverage will end the first day of the month that You do not have enough contributions (Employer or self-payment contributions) to cover the cost of Coverage. When Your Coverage or Your Eligible Dependent's Coverage ends, Coverage may be continued by making monthly self-payments for COBRA Continuation Coverage (see Article V. Life Events – Continuing Coverage). When Your Coverage ends, You may request a certification of Your length of Coverage under this Plan from the Third-Party Administrator.

If You have no contributions made on Your behalf to the Fund during a 24-month period and Your Fund eligibility is suspended or terminated for any reason (without reinstatement), Your Dollar Bank account balance will be terminated effective the first day of the month following the 24-month period. You will not be entitled to the payment of any benefits that would have otherwise been payable through Your Dollar Bank account balance. (see Article VIII Dollar Bank Account)

1. Your Eligibility under the Plan will terminate when:

    a. Your account does not have sufficient Employer or self-payment contributions;

    b. You are employed in the Sheet Metal Industry, as defined in the Collective Bargaining Agreement, or in any other building trade by an Employer who is not obligated to directly or through a reciprocity agreement make contributions to the Plan on Your behalf;

    c. You become employed with an Employer who is not obligated to make contributions to the Plan on Your behalf;

d. Before retirement (unless You are disabled), You are no longer available for work at the trade in the jurisdiction of the Union for a contributing Employer, which may be evidenced by transfer of Your Union membership or not being available for work on the out of work list;

e. You work one hour in Disqualifying Employment after becoming eligible for Coverage. Disqualifying Employment includes:

i. Any non-covered employment in the Sheet Metal Industry, as defined in the Collective Bargaining Agreement, except employment: (1) as a "salted" organizer; (2) in a related building trade – if that employment is on referral and authorized by the Union, in the Sheet Metal Industry; or (3) if it is covered by a Collective Bargaining Agreement, or stipulation of agreement with another union, and is outside the jurisdiction of the Union.

f. Your COBRA continuation Coverage ends (see COBRA provisions in Article V. Life Events)

g. You enter the armed forces, subject to any requirements of federal law relating to military service (see Article V. Life Events – Section I Services Employment And Reemployment Rights Act of 1994 (USERRA);

h. Your Coverage ends and You do not elect COBRA continuation Coverage; or

i. This Plan ends.

2. Your Eligible Dependent's eligibility for Coverage will end when:

a. Your eligibility for Coverage ends;

b. Your Eligible Dependent no longer meets the Plan's definition of an Eligible Dependent;

c. Your COBRA Continuation Coverage ends (see COBRA provisions in Article V. Life Events)

d. Your Eligible Dependent enters the armed forces, subject to any requirements of federal law relating to military service (see Article V. Life Events – Section I Services Employment And Reemployment Rights Act of 1994 (USERRA);

e. Your Coverage ends and You do not elect COBRA continuation Coverage; or

f. This Plan ends.

H. REINSTATEMENT OF ELIGIBILITY

If Your eligibility for Coverage ends because You do not have enough contributions in Your account, You can reinstate Coverage by:

1. Having sufficient Employer Contributions made on Your behalf; or

2. If You have some hours of contributions but not enough to reestablish eligibility, You may make self-payment contributions.

If Your Coverage ends after having extended it for the full length of time permitted through COBRA continuation Coverage or if Your Coverage ends after You retire due to Your failure to make self-payments, You may not make self-payments to reinstate Your eligibility. However, if You fail to make self-payments for continued Coverage after retirement because You are covered under another health insurance plan, You may exercise Your special enrollment rights and be able to enroll Yourself and Your Dependents in this Plan and begin making self-payments provided that You request to resume Coverage and make such self-payments within 30 days after Your other Coverage ends and You provide proof of other coverage to the Plan. Absent exercising these special enrollment rights, in order to requalify for Coverage after You retire when Your Coverage has terminated due to Your failure to make self-payments, You must return to work and receive Employer Contributions sufficient to cover the cost of one month of Coverage.

I. TRANSFER FROM OTHER FUNDS/LOCALS

If You transfer into the jurisdiction of this Plan from another plan or local that has continued eligibility provisions (for example, a reserved hour or dollar bank), You may continue Your Coverage under the other fund for up to five months. After five months, You must establish eligibility, if You have not already done so, for benefits under this Plan.

ARTICLE V - LIFE EVENTS AFFECTING COVERAGE

A. INTRODUCTION

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

B. GETTING MARRIED

When You get married, Your Spouse may be eligible for medical, Prescription Drug, dental, vision and Dependent life insurance Coverage. The Coverage available to Your Spouse will depend on the medical plan You elect and whether You are an Active Participant or retiree. You should contact the Fund Office for information about benefits available under the Plan.

Within 31 days of Your marriage, You must provide the Fund Office with:

1. A copy of Your marriage certificate;

2. Your Spouse's date of birth;

3. A copy of Your Spouse's medical insurance information if he/she is covered under another Plan.

If You enroll Your Spouse within 31 days of Your marriage, once You provide the required information, Coverage for Your Spouse begins on the date of Your marriage. At this time, You also may want to consider updating Your beneficiary information for Your Life Insurance and AD&D Insurance Benefits (if eligible). If You do not enroll Your Spouse for Coverage within 31 days after Your marriage, You may not enroll Your Spouse until the Plan's next annual open enrollment.

If Your Spouse is covered under another group medical plan, You must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with Your Spouse's other coverage; benefits for Your Spouse under this Plan will be paid after any benefits are payable from Your Spouse's Plan.

C. ADDING A CHILD

Your natural born child will be eligible for Coverage on their date of birth. If You adopt a child or have a child placed with You for adoption, the child will be eligible for Coverage on the date of placement or acceptance for placement, whichever occurs first, as long as You are responsible for health care coverage and Your child meets the Plan's definition of an Eligible Dependent child. Stepchildren are eligible for Coverage on the date of Your marriage, provided that they meet the definition of Eligible Dependent. You must enroll Your child within 31 days of their Birth, Adoption or (for Stepchildren) Your marriage, or (for foster children) when You are declared legally responsible for the Child's healthcare, for Coverage to become effective as of these dates. If You do not enroll Your child for Coverage within 31

days of becoming eligible, You may not enroll Your child until the Plan's next annual open enrollment. Once You provide the Fund Office with any required information, Coverage for Your child will begin. You must provide the Fund Office with:

1. The birth date, effective date of adoption or placement for adoption or (for stepchildren) the date of Your marriage;

2. A copy of the birth certificate, adoption papers, court order or (for stepchildren) marriage certificate; and

3. A copy of Your child's other medical insurance information, if he or she is covered under another plan.

For more information about Dependent eligibility, See Section D of Article IV.

D. LOSS OF OTHER HEALTH INSURANCE COVERAGE

If You are declining or have declined enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

E. IF YOU LEGALLY SEPARATE OR DIVORCE

If You and Your Spouse get a legal separation or divorce, Your Spouse will no longer be eligible for Coverage as a Dependent under the Plan. However, Your Spouse may elect to continue Coverage under COBRA for up to 36 months. You or Your Spouse must notify the Fund Office within 60 days of the divorce or legal separation date for Your Spouse to obtain COBRA continuation Coverage. At this time, You may also want to review Your beneficiary designation for Your Life and AD&D Insurance Benefits. If Your Spouse is listed as Your beneficiary for Your Life or AD&D Insurance Benefits, he or she will cease being Your beneficiary for Life and AD&D Insurance Benefits immediately upon Your divorce.

This Plan, in accordance with the law, must recognize a Qualified Medical Child Support Order. A Medical Child Support Order is a judgment, decree, or order (including approval of a settlement agreement) entered by a court or administrative agency of competent jurisdiction that:

A. Provides for child support with respect to Your child under a group health plan or provides for health benefit coverage to Your child; and

B. Is made pursuant to a State domestic relations law.

A Medical Child Support Order is a Qualified Medical Support Order (QMCSO) if it creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under

a group health plan, specifies required information, and does not alter the amount or form of plan benefits. An "alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Thus, if a Qualified Medical Child Support Order provides health benefit Coverage under the Plan to an alternate recipient, the Trustees are required to comply with the QMCSO.

If You legally separate or divorce, provide the Fund Office with:

1. A copy of Your separation or divorce decree; and

2. If You have children for whom You do not have custody, a copy of any QMCSO.

If Your Spouse wants to continue Coverage, he or she must contact the Fund Office and enroll for COBRA continuation Coverage.

F. CHILD LOSING ELIGIBILITY

Your child is no longer eligible for Coverage when Your Child reaches age 26. You must notify the Fund Office within 60 days of when Your child is no longer eligible for Coverage. Your child may elect to continue Coverage under COBRA for up to 36 months.

If Your child is not capable of self-supporting when he/she reaches the age at which he/she would lose eligibility under the Plan because of a physical handicap or mental disability, You may continue Coverage for that child as explained in Section D of Article IV.

G. WHEN YOU ARE OUT OF WORK DUE TO A DISABILITY

1. Weekly Short-Term Disability Benefits for Non-Work Related Disability

If You are out of work due to a non-work related disability, You may, if eligible, receive weekly Short-Term Disability Benefits. Benefits continue until You recover or receive the maximum number of weeks of benefits for one period of disability as set forth in the Schedule of Benefits, whichever occurs first. During partial weeks of disability, You are paid a daily amount of one-seventh of the weekly benefit. If you are out of work due to a non-work related disability, notify your employer and the Fund Office, provide the Fund Office with proof of your disability, and apply for short-term disability benefits.

The Plan will require initial proof of disability as well as subsequent proof, upon request from the Trustees. The Plan also has the right to require You to submit to a medical examination.

2. Continued Coverage for Total and Permanent Disability

If You apply for and receive a total and permanent disability pension from the Cleveland District Pension Fund, You can continue health coverage as a retiree. When You are awarded Medicare, which usually occurs two years after being awarded Social Security Disability, You can change Your coverage to the Medicare Advantage Plan. After Your Dollar Bank is exhausted, You will have to self-pay for coverage.

3. Continued Medical Coverage for During Periods of Work-Related Disability

If You are out of work due to a work-related disability, You may be eligible for workers' compensation benefits. Inform Your Employer and Physician if You have a work-related disability. The Plan does not provide Coverage for work-related disabilities such as medical treatment provided as a result of a work-related Injury or disease. However, if You are found to have a temporary total disability through workers' compensation, You will be provided a credit of $500.00 per month for up to three months towards self-payments to continue Your Coverage under the Plan in order to provide medical, dental, vision, and life insurance coverage that is not the result of a work-related Injury or disease (i.e., if a Participant or Dependent becomes ill with the flu and goes to the doctor). Notify your Employer and the Fund Office in the event You are out of work due to a work-related disability.

If You become disabled, contact the Fund Office for information about continuing Coverage.

H. TAKING A LEAVE OF ABSENCE UNDER THE FAMILY MEDICAL LEAVE ACT

Under certain circumstances, You may be able to take up to 12 weeks of unpaid leave during any 12-month period due to:

1. The birth of a child or placement of a child with You for adoption; or

2. The care of a seriously ill Spouse, parent, or child; or

3. Your serious illness.

During Your leave, You will maintain all the Coverages You were eligible for at the time of Your leave until the end of the leave, provided Your employer properly grants the leave under the federal law and makes the required notification and contribution to the Fund.

If You and Your Spouse both work for the same Employer, You and Your Spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

Contact Your Employer for more information regarding Your rights under the Family Medical Leave Act.

I. SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

1. *Continuing Coverage*. If You are called into military service (active duty or inactive duty training), You may elect to continue Your health Coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

   If You are called into military service for up to 31 days, Your health care Coverage will continue if You make the required self-payment contributions or if You have unused dollars in Your Dollar Bank. If You are called into military service for more than 31 days, You and Your Eligible Dependents may continue coverage by using dollars left in Your Dollar Bank or by making the required self-payment contributions for up to 24 months under USERRA.

   Your Coverage will continue until the earlier of:

   a. The date You or Your Dependents do not make the required self-payment contributions and there is no longer a balance in Your Dollar Bank;

   b. The date You reinstate Your eligibility for Coverage under the Plan;

   c. The end of the period during which You are eligible to apply for reemployment in accordance with USERRA;

   d. The last day of the month after 24-consecuitve months; or

   e. The date the Fund no longer provides any group health benefits.

   You need to notify the Fund Office in writing when You enter the military. For more information about self-payment contributions under USERRA, contact the Fund Office.

2. *When You Do Not Continue Coverage Under USERRA*. If You do not elect to continue Coverage under USERRA, Your Coverage will end immediately when You enter military service. Your Eligible Dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage.

3. *Reinstating Your Coverage*. Upon Your discharge from military services, You may apply for reemployment with Your former employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered by that Employer. According to

USERRA guidelines, reemployment and reinstatement deadlines are based on Your length of military service.

The following information outlines the deadlines applicable to Your rights to reemployment and reinstatement of health care Coverage. When You are discharged or released from military service that lasted:

a. Less than 31 days, You have one day after discharge (allowing eight hours for travel) to return to work for a contributing Employer;

b. More than 30 days but less than 181 days, You have up to 14 days after discharge to return to work for a contributing Employer; or

c. More than 180 days, You have up to 90 days after discharge to return to work for a contributing Employer.

When You are discharged, if You are hospitalized or recovering from an illness or Injury that was incurred during Your military service, You have until the end of the period that is necessary for You to recover to return to work for a contributing Employer.

If Your Employer reports Your return to the Fund Office during the USERRA required time period, Your eligibility and Your Eligible Dependents' eligibility will be reinstated on the day You return to work.

The Plan will maintain Your prior eligibility status until the end of the leave, provided Your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

J. IN THE EVENT OF DEATH

Depending on the Coverage You elected and whether You are an Active Participant or retiree on the date of Your death, Your beneficiary may receive a Life Insurance Benefit. In addition, if Your death is the result of an accident, Your beneficiary may also receive the AD&D Insurance Benefit. See Article XI: Disability and Death Benefits for more information about the Life and AD&D Insurance Benefits.

If You are an Active Participant at the time of Your death, Your Eligible Dependents may continue Coverage by using dollars accumulated in Your Dollar Bank. After Your Dollar Bank is exhausted, Your Dependents may continue Coverage by making self-payments. Your Spouse's Coverage may continue for as long as he or she makes the required self-payments. Your Eligible Dependents' Coverage continues for as long as self-payments are made on their behalf and they continue to meet the Plan's definition of a Dependent (see Section D of Article IV).

In the event of Your death, Your Spouse or beneficiary should:

1. Notify the Fund Office;

2. Provide the Fund Office with a copy of Your death certificate;

3. Apply for Your Life Insurance Benefit (and AD&D Insurance if applicable); and

4. If Your Dependents want to continue Coverage under the Plan, use amounts accumulated in Your Dollar Bank and/or enroll for COBRA Continuation Coverage.

In the event of Your Spouse or Dependent child's death, You may receive a Dependent Life Insurance Benefit depending on the Coverage You elected and whether You are an Active Participant or retiree. Contact the Fund Office for assistance.

K. WHEN YOU RETIRE

You may continue medical Coverage when You retire. Retiree Coverage includes medical, dental, and life insurance benefits, but not short-term disability. When You become eligible for Medicare, You will be eligible for Medicare Advantage Coverage. You must notify the Fund Office 60 days in advance of starting Medicare. Once You are eligible for Medicare, You can become eligible for Medicare Advantage Coverage. You must meet the eligibility requirements otherwise stated in the Plan, including not working in Disqualifying Employment.

When You retire You must: (1) notify the Fund Office in advance of Your retirement; (2) apply for retiree benefits if You are eligible; and (3) notify the Fund Office 60 days in advance of starting Medicare.

If You are eligible for retiree Coverage and are under age 65, You may continue medical and Prescription Drug Coverage. For retirees under age 65 with Coverage under one of the Plus Plans, You may also continue dental, vision, life and AD&D insurance benefits.

If You are retired, Medicare eligible and 65 or older, You are eligible for the Medicare Advantage Plan, in addition to dental, vision, and life insurance benefits.

L. SPECIAL ENROLLMENT RIGHTS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Employees and Dependents who are eligible for Coverage but who are not enrolled for Coverage may exercise special enrollment rights and enroll in the Plan if the Employee or Dependent:

1. Loses coverage under a Medicaid plan under Title XIX of the Social Security Act; or

2. Loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or

3. Becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arise and the Employee or Dependent wishes to take advantage of these special enrollment rights, the Employee or Dependent must request to enroll for Coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan, or (2) the Employee or Dependent child is determined eligible for state premium assistance.

If You believe You are eligible for special enrollment under this provision, You must contract the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for special enrollment right must be made within 60 days of an event described above that occurs.

M. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Plan provides the benefits required by the Women's Health and Cancer Rights Act of 1998. Under this federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits in connection with a mastectomy must also include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure.

Breast reconstructive surgery in connection with a mastectomy must at a minimum provide for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications for all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's schedule of benefits, this Coverage is subject to the Plan's provisions regarding Deductibles and Coinsurance.

N. REQUIREMENTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Maternity and obstetrical benefits are available only to You and Your Spouse (while You are eligible). The Plan also covers complications arising during pregnancy that result in surgery or treatment in a hospital.

Under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under Federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If You have any questions regarding these requirements under federal law, please contact the Third-Party Administrator.

O. CONTINUING COVERAGE

1. *Continuing Medical Coverage*. If Your Coverage under the Plan ends, You may continue Coverage by making self-payments or by electing COBRA Continuation Coverage. To be eligible to continue Coverage by making self-payments, You must be available for work that is within the trade jurisdiction of the Union and signed on to the out-of-work list at the Union. All Participants, whether or not they available for work that is within the trade jursidciton of the Union, will be offered the ability to extend their Coverage through COBRA Continuation Coverage at the time that their Coverage under the Plan ends.

   If You are eligible and elect to self-pay to continue Coverage, You may continue the same benefits You had while an Active Participant including Life, AD&D, and Dependent Life Insurance Benefits. However, through COBRA Continuation Coverage, You may only continue medical (including Prescription Drug), dental, and vision benefits provided You were eligible for these benefits while an Active Participant. Through COBRA Continuation Coverage, You are not eligible to continue Short-Term Disability, Life, AD&D, or Dependent Life Insurance Benefits.

   If You elect to self-pay to continue Coverage, You may do so indefinitely. You begin to self-pay after Your coverage under the Plan ends and You have exhausted Your Dollar Bank account balance. If You begin to self-pay for Coverage, Your Coverage under the Plan will subsequently end when the

Fund Office stops receiving Your self-payments on a timely basis. Once You fail to pay for continued Coverage on a timely basis, You will not be able to requalify for self-payments under the Plan unless You exercise Your special enrollment rights. Your special enrollment rights may be exercised if You are covered under another health insurance plan at the time You fail to make self-payments and that other coverage ends. In order to exercise Your special enrollment rights, You must request enrollment and begin payments within 30 days after Your other coverage ends and provide proof of such other coverage to the Plan. Absent special enrollment rights, in order to requalify for benefits under the Plan, You will need to return to work and receive Employer Contributions sufficient to cover the cost of Coverage for one month.

However, with COBRA Continuation Coverage, there are restrictions on how long Coverage can be continued as explained below. Therefore, when deciding whether to extend coverage through self-payments or COBRA Continuation Coverage, it is a good idea to consider how long You plan to continue Coverage. You can also obtain information about the cost to continue Coverage through self-payments or COBRA Continuation Coverage by contacting the Fund Office.

2. *Continuing Life and AD&D Insurance Benefit Coverage*. As mentioned above, under certain circumstances (e.g., You are laid off or not working due to strike) You may be eligible to continue Life Insurance and AD&D Insurance Benefits Coverage when Coverage would otherwise end by using dollars accumulated in Your Dollar Bank and then by making self-payments to the insurance carrier.

   If You become ineligible for Plan Coverage, You may convert Your Life, AD&D, and Dependent Life Insurance Benefit Coverage to an individual policy. To do this, contact the Fund Office to receive the necessary forms. The Fund Office can also provide You with the cost to convert the policies to individual policies. Life, AD&D, and Dependent Insurance Benefits cannot be continued through COBRA Continuation Coverage.

3. *COBRA Continuation Coverage*. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, also called COBRA, You and any Eligible Dependents may continue health care coverage past the date the Coverage would normally end. Under certain circumstances, You or Your Dependents may make self-payments to continue medical (including Prescription Drug benefits), dental, and vision benefits.

   The COBRA Continuation Coverage will be identical to the Coverage You had under the Plan with the exception that You will not be eligible to continue Coverage for Short-Term Disability, Life, AD&D, or Dependent Life Insurance Benefits.

If You have a newborn child, adopt a child, or have a child placed with You for adoption (for whom You have financial responsibility) while Your COBRA Continuation Coverage is in effect, You may add the child to Your Coverage. To have the Child added to Your Coverage, You must provide written notification to the Fund Office within 30 days of the birth, adoption, or placement of a child with You for adoption.

Children born, adopted, or placed for adoption as described above, have the same COBRA rights as a Dependent who was Covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, these children's continued Coverage depends on timely and uninterrupted self-payments on their behalf.

a. **Qualifying Events**. You do not have to show that You are insurable for COBRA Continuation Coverage. It is offered to You if You or Your Dependents lose Coverage as a result of a qualifying event regardless of whether or not You have terminated Your association with the Union. Qualifying events include Your:

   i. Termination of employment (other than for gross misconduct);
   ii. Reduction in hours (other than for gross misconduct);
   iii. Death;
   iv. Entitlement to Medicare;
   v. Divorce or legal separation; and
   vi. Child losing Dependent status under the Plan.

   Coverage under the Plan will end on the first day of the month if the qualifying event occurs between the 1st and 15th of the month or on the last day of the month if the qualifying event occurs between the 16th and the last day of the month.

b. **Notifying the Fund Office**. You or Your Dependent must inform the Fund Office of a legal separation, divorce or a child losing Dependent status under the Plan within 60 days of when the Coverage under the Plan ends. If You do not notify the Fund Office within this 60-day period, You and/or Your Dependents will lose Your right to elect COBRA Continuation Coverage.

   In addition, You or a family member should notify the Fund Office if You terminate employment, reduce the number of hours You are working or die. To help ensure that You do not suffer a gap in Coverage, we urge You or Your family to notify the Fund Office of qualifying events as soon as they occur.

c. **The Notification Responsibilities of the Fund Office**. When the Fund Office is notified that one of these events has occurred, You and Your Dependents will be notified of Your right to elect COBRA Continuation Coverage within 30 days of the time that the Fund Office receives notice of a qualifying event. If You or Your Dependents provide notice to the Claims Administrator of a divorce or legal separation, beneficiary ceasing to be Covered under the Plan as a Dependent, or a second qualifying event but are not entitled to COBRA, the Claims Administrator will send You a written notice stating the reason why You are not eligible for COBRA.

If You are eligible for COBRA, the COBRA notice will tell You about Your right to elect COBRA, the due dates for returning the election form, and the amount of the self-payment. Once You receive a COBRA notice, You have 90 days to respond if You want to elect COBRA Continuation Coverage. Your Dependents have the option to elect Coverage independently from You if You choose not to elect COBRA Continuation Coverage.

You should keep the Fund Office informed of any change in Your address or in the addresses of family members to ensure timely receipt of COBRA paperwork.

d. **Periods of Coverage**.

i. *Coverage continues for a maximum of 18 months* if Your Coverage ends due to Your termination of employment (including retirement and lay-off) except when due to Your gross misconduct or Your reduction in hours.

ii. *Coverage continues for a maximum of 29 months* if You or one of Your Dependents is disabled when Your Coverage ends or if You become disabled within 60 days of the date Your Coverage ends. To continue coverage for up to 29 months (an additional 11 months above the original 18 months), You must notify the Fund Office of Your determination of disability by the Social Security Administration within 60 days of the determination and before the end of the first 18 months of continuation Coverage. It is also Your responsibility to notify the Fund Office if You are subsequently not considered disabled by the Social Security Administration, and You must do so within 30 days of such a determination by the Social Security Administration.

iii. *Coverage continues for a maximum of 36 months* if Your Spouse or other Dependents lose Coverage because of Your:

(A) Death;

(B) Entitlement to Medicare;

(C) Divorce or legal separation; and

(D) Child losing Dependent status under the Plan.

e. **Electing COBRA Continuation Coverage**. You or Your Dependents must complete the COBRA election form and send it back to the Fund Office to elect COBRA Continuation Coverage within 90 days of the later of the date You or Your Dependent loses Coverage or the date You receive the election notice. These rules apply to the election of COBRA Continuation Coverage:

i. Each member of Your family who would lose Coverage because of a qualifying event is entitled to make a separate COBRA Continuation Coverage election.

ii. If You do not elect COBRA Continuation Coverage for Your Dependents when they are entitled to COBRA Continuation Coverage, Your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your Spouse may elect COBRA Continuation Coverage for herself or himself and any children who are Covered by the Plan on the day before the qualifying event.

iii. This provision applies if Your employment is adversely affected by international trade. If You are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, You may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If You and/or Your Dependents did not elect COBRA during Your election period but are later certified by the DOL for Trade Act benefits, You may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which You were certified. However, in no event would this benefit allow You to elect COBRA later than six months after Your Coverage ended under the Plan.

Also, under the Trade Act, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid

for qualified health insurance, including continuation Coverage. If You have questions about these tax provisions, You may call the Health Care Tax Credit Customer Contact Center toll-free at (866)628-4282. TTD/TTY callers may call toll-free at (866)628-4282. More information about the Trade Act is also available at www.doleta.go/tradeact/2002act_index.asp. The Claims Administrator may also be able to assist You with Your questions.

f. **When the COBRA Continuation Coverage Period Begins**. If You properly elect COBRA Continuation Coverage, Your period of COBRA Coverage (18, 29, or 36 months) begins when Your Coverage under the Plan ends, which would be either the 1st or last day of the month (as explained above under a. Qualifying Events) for which You or Your Dependents are no longer eligible for Coverage or Your Dollar Bank account no longer has contributions sufficient to cover the cost of Plan Coverage.

If Your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, Your Spouse and Dependent Children, under this Coverage, will receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months. To qualify for this Coverage, proper notice must be given to the Plan. This extension may be available to Your Spouse and any Dependent children receiving continuation Coverage if:

i. The Employee or former Employee dies;

ii. The Employee or former Employee becomes entitled to Medicare benefits (qualified and enrolled in coverage under Medicare Part A, Part B, or both);

iii. The Employee or former Employee gets divorced or legally separated; or

iv. The Dependent child stops being eligible under the Plan as a Dependent child.

The extension is only available if the event would have caused Your Spouse or Dependent child to lose Coverage under the Plan had the first qualifying event not occurred.

You must notify the Plan within 60 days after the second qualifying event occurs at the Fund Office Address listed at the front of the booklet.

g. **Example of when COBRA Continuation Coverage Begins**. Let's assume John terminates employment on August 25th and does not have a sufficient balance in his Dollar Bank to continue Coverage. His Coverage under the Plan will end effective August 31st. Assuming he decides to elect COBRA and provided he does so in a timely manner, his COBRA Coverage will be effective September 1st.

Let's look at another scenario. Assuming John has enough contributions in his Dollar Bank to extend Coverage for three months (September – November), he could elect COBRA effective December 1st (at the point when his Dollar Bank no longer has sufficient contributions to cover the cost of Coverage) provided he elects Coverage in a timely manner.

Another possible scenario would be that John decides to self-pay for Coverage when his Coverage under the Plan ends. Let's assume John does not have enough contributions in his Dollar Bank to continue Coverage and he self-pays for Coverage for six months (September – February). John would have been offered the opportunity to elect COBRA Coverage effective September 1st. Assuming John received his COBRA notice in September, he would have had 90 days from the date he received his COBRA notice to elect Coverage. Since he did not elect COBRA Coverage within that 90-day period, he will not be eligible for COBRA when he stops self-paying for Coverage; however, he would be provided with voluntary continuation under COBRA self-payments information at that time.

h. **Loss of COBRA Continuation Coverage**. The period of COBRA Continuation Coverage for You or Your Dependents may end if:

i. You or Your Dependents do not make the required self-payments on a timely basis;

ii. You or Your Dependents become Covered under any other group health care plan (provided such plan does not contain any exclusions or limitations with respect to any preexisting conditions) after electing COBRA Continuation Coverage;

iii. You or Your Dependents become entitled to Medicare (please note that a qualified beneficiary's entitlement to Medicare only ends that individual's COBRA Continuation Coverage, not Coverage for the other qualified beneficiaries);

iv. The Plan ceases to provide any group health benefits; or

v. You or Your Dependents reach the end of the 18, 29, or 36-month continuation period, as applicable.

If continuation Coverage is terminated before the end of the maximum Coverage period, the Claims Administrator will send You a written notice as soon as practicable following the Claims Administrator's determination that continuation Coverage will terminate. The notice will set out why continuation Coverage will be terminated early, the date of termination, and Your rights, if any, to alternative individual or group coverage. Once Your COBRA Continuation Coverage ends, it cannot be reinstated.

i. **Paying for COBRA Continuation Coverage**. The Fund Office will notify You of the cost of Your COBRA Continuation Coverage when it notifies You of Your right to Coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this Coverage. The cost for extended disability Coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide Coverage

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day You and/or Your Dependents' Coverage under the Plan ended. The Fund Office will notify You of the due date for the first payment. Subsequent payments are due on the 10th of each month for Coverage the following month. If the Fund Office does not receive Your payment by the 15th of the same month for which payment is due, Your Coverage will be terminated immediately. Any amounts accumulated in Your Dollar Bank may not be used to C the cost of COBRA Continuation Coverage.

ARTICLE VI - MEDICAL BENEFITS FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS AND RETIREES UNDER AGE 65 AND THEIR DEPENDENTS

A. ENROLLMENT

Your medical benefits are designed to protect You and Your family against catastrophic medical expenses. The medical program pays benefits for a wide range of services and supplies, including doctor charges, diagnostic testing, hospital charges and surgery.

Each year (or when You initially become eligible for Coverage), You receive an enrollment package explaining Your medical plan options and associated costs. You elect the medical plan under which You want Coverage and whether You want single or family Coverage. You will elect Your medical plan during the annual enrollment period from November 1 to November 30, and that election will be effective the January 1st of the following year.

When electing Coverage You choose between three options: the Deluxe Plus Plan, the Classic Plus Plan, and the Basic Plus Plan. Each option has its own schedule of benefits. See Article III. Schedule of Benefits. If You do not make an election during the annual enrollment period, You will keep the Coverage You had the previous year. If You are a new member, and after five months of contributions You do not make an election, You will be assigned to the Basic Plus Plan with single Coverage. Participants who elect family Coverage at enrollment can later choose single Coverage if they do not have enough money in their Dollar Bank account to cover the cost of family Coverage.

Participants with contribution amounts in their Dollar Bank accounts that total less than one month of the cost of family Coverage, may elect single Coverage with the option of automatically increasing to family Coverage, beginning with the month after the Participant has built up enough contributions into their Dollar Bank account to cover the cost of three months of family Coverage. The increase to family Coverage from single Coverage may only happen once per calendar year. The increase shall be automatic for the Participant unless the Participant can establish that his Dependents have been insured with another plan.

Regardless of the Plan You select, You will have access to the Employee Assistance Program. This program is available to all Active Participants, retirees (including retirees age 65 and older), and Dependents.

B. STEPS TO TAKE WHEN YOU NEED TO SEE A DOCTOR

When You or Your Dependent needs to see a doctor, You should:

1. Contact Your doctor ahead of Your visit to determine if he or she is a Network Provider, or contact the Plan's PPO Provider, using the contact information found in Article II – Plan Information.

2. Call to make an appointment.

3. Write down any questions You may have before Your appointment so You do not forget to ask Your doctor important questions during the appointment.

4. Make a list of any medications You're taking. Be sure to note how often You take the medications.

5. Show Your ID card when You go to Your appointment.

6. You typically will not need to file a claim if You visit a Network Provider. However, if a claim is not filed by Your Provider, it will be Your responsibility to do so (see Article XIII). You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply. You may be billed by Your Network Provider(s) for any Non-Covered Services You receive or when You have not followed the terms of the Plan.

C. EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) helps You and Your Dependents receive professional counseling and guidance when faced with personal problems. This is a voluntary and completely confidential program. The EAP emphasizes early identification of potential problems, which could include stress, job performance difficulties, child and elder care problems, legal referrals, financial concerns, marital or family stress, alcohol or drug abuse, depression, physical fitness and wellness issues, Physician research, and relocation support.

You may call the EAP 24 hours a day, 365 days a year. The program offers to help in three ways:

1. *Referrals*. There are four types of referrals:

   a. **Self-Referral** – an individual seeks help by contacting the EAP directly. The EAP Coordinator works with the individual to identify the problem and the appropriate course of action.

   b. **Family Referral** – A concerned family member seeks the advice of an EAP coordinator in getting help for another family member.

   c. **Peer Referral** – A coworker concerned about another coworker contacts the EAP program.

   d. **Supervisory Referral** – A supervisor, with the assistance of Human Resources, refers an Employee to EAP to help address job performance problems.

2. *Crisis Intervention*. In the event of a crisis (for example, suicide attempt, drug reaction, or the death of a family member), the EAP coordinator provides immediate help, either over the phone or face-to-face, and works to establish the "next step" toward a resolution of the problem.

3. *Counseling*. If through contact with an EAP coordinator it is determined that an assessment session is appropriate for You or a Dependent, counselors are available directly through the EAP program. The initial counseling session is provided at no charge.

There is no charge for short-term EAP services such as referrals, crisis intervention, and initial assessment sessions. If long-term counseling or other treatment is recommended, there may be costs or fees associated with that treatment.

D. YOUR MEDICAL BENEFITS

1. *Maximizing Your Medical Benefits*. The Plan generally pays a percentage of charges for Covered Services and You pay the rest, up to the Out-Of-Pocket Maximum. The amount the Plan pays depends on the type of medical plan You elected. You will need to meet an annual Deductible before the Plan begins to pay benefits for certain services. See Article III. Schedule of Benefits. However, the Plan offers cost management features designed to help manage certain health care expenses for You and for the Plan. The following features can help You maximize Your Plan benefits:

   a. **Network Providers** – To save You and the Plan money, the Plan has contracted with a Network of Providers. When You use Physicians, Hospitals, and other Providers who participate in the Plan's Network (Network Providers), You and the Plan save money. These Providers have agreed to charge negotiated fees – generally lower than their usual charge. When You use these Providers, You save money because these Providers have agreed to charge a reduced amount for services which means Your out-of-pocket costs are less.

      In addition, the Plan generally pays a higher percentage of Covered charges when You use Network Providers, which also lowers Your out-of-pocket expenses. You will have to pay for services that are not Medically necessary and for Non-Covered Services.

   b. **Out-of-Network Providers** – You are not restricted to using the service of Network Providers to receive benefits for Covered Services. When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are Covered at the out-of-network level, unless otherwise indicated in this Summary Plan Description. For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done.

In addition, an Out-of-Network Provider may be treated as a Network provider under the Plan if the Board of Trustees determines, in their sole and absolute discretion, that the Out-of-Network Provider provides medical treatment that no Network Provider Facility in the surrounding area provides. Participants may appeal to the Trustees to treat such Non-Network Providers as Network Providers, and a determination will be made on a case by case basis to treat the Provider as a Network Provider if the Board determines that the treatment provided to the Participant could not have been obtained by a Network Provider in the surrounding area.

If you receive services at an in-network facility, providers, including but not limited to, pathologist, radiologist, emergency room physician, and anesthesiologist, you will be reimbursed at the in-network level of benefits regardless of the provider being an In-Network or Non-Network provider.

c. **Utilization Review**. Utilization Review refers to having your medical care reviewed before receiving it (pre-certification) or immediately afterwards in the case of an emergency (post-certification). The goal of Utilization Review is to ensure you receive the right care at the right time while avoiding unnecessary expenses. It also helps ensure You receive the highest level of benefits possible. To make it work, You must become involved in the decisions regarding your health care. By taking advantage of Utilization Review, You take the first step to using your health care resources as wisely as possible.

The Plan requires that You pre-certify non-emergency hospitalizations at least five days before treatment is received.

The plan requires that You post-certify emergency admissions within five days of the first business day after admission.

The Plan also offers concurrent review, discharge planning from a medical care facility. This service involves monitoring Your medical care facility stay or use of other medical services and coordinating with You, your attending physician, and medical care facility to ensure that You maximize the amount the Plan pays. If Your physician feels that it is Medically Necessary for you to receive additional services or to extend your length of stay in the medical care facility beyond what was initially pre-certified, the utilization review administrator will coordinate this.

Utilization review determines benefits payable by the Plan by evaluating the necessity, appropriateness and efficiency of the use of medical services, procedures, and facilities. It also includes reviews of necessary admissions, services ordered and provided, length of stay, and discharge practices. Utilization review is not a substitute for the medical judgment of an attending physician or other health care provider. If a particular course of treatment or medical service is not pre-certified, the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

How Utilization Review Works. Before a non-emergency Hospital admission or following an emergency admission, contact the Provider listed under Pre-Certification of Medical Treatment Under Network PPO Plans under Article II, Important Contact Information, and provide them with the following information:

i. Name of the patient and relationship to You;

ii. Your name, Social Security number and address;

iii. Name of Your Employer;

iv. Name and telephone number of the attending Physician;

v. Name of the medical care Facility, proposed date of admission and proposed length of stay; and

vi. The diagnosis and/or type of surgery.

The Utilization Review administrator will determine the number of days of medical care facility confinement authorized for payment. Failure to pre-certify Hospital admissions or to post-certify emergency admissions may reduce benefits payable by the Plan by up to 50% or more.

Before non-emergency hospitalization, You must contact the provider listed under Pre-Certification of Medical Treatment Under Network PPO Plans under Article II, Important Contact Information at least five days in advance of admission.

In the event of a Medical Emergency, You, a family member, Your medical care Facility or Your attending Physician must contact the Third-Party Administrator within five days of the first business day after admission.

d. **Second and/or Third Opinion Program**. Certain surgical procedures are performed inappropriately or unnecessarily. Sometimes surgery is one of several treatment options, or not necessary. To prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program protects Your health and helps the Plan save money by limiting unnecessary surgical procedures.

The Plan provides benefits for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance – it is not an emergency or life threatening in nature. You may receive a second or third opinion from any board-certified Specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While You can receive a second opinion for any surgical treatment, these are examples of procedures for which surgery is often performed when other treatments are available:

Appendectomy; Cataract surgery; Cholecystectomy (gall bladder removal); Deviated septum (nose surgery); Hemorrhoidectomy; Hernia surgery; Hysterectomy; Mastectomy; Prostate surgery; Salpingo-oophorectomy (removal of the tubes/ovaries); Spinal surgery; Surgery to the knee, shoulder, elbow, or toe; Tonsillectomy and adenoidectomy; Tympanotomy (inner ear); and Varicose vein ligation.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

e. **Case Management** – If You or a Dependent experience a catastrophic condition, such as a spinal cord injury, cancer, AIDS, or a premature birth, long-term or lifetime care may be required. Case management is a program whereby a case manager monitors patients,

explores, discusses, and recommends coordinated and/or alternative types of appropriate, Medically Necessary care.

A case manager consults with the patient, the family and the attending Physician to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include:

i. Personal support to the patient;

ii. Contacting the family to offer assistance and support;

iii. Monitoring hospital or Skilled Nursing Facility care;

iv. Determining alternative care options; and/or

v. Assisting in obtaining any necessary equipment and services.

The case manager coordinates and implements the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Third-Party Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement is reached on the treatment plan, the Plan will reimburse for Medically Necessary expenses stated in the plan, even if these expenses would normally not be paid by the Plan.

The case manager tailors an individual plan for each patient. Another patient's plan should not be seen as appropriate or recommended for any other patient, even if the patients share the same diagnosis.

Case management is a voluntary program. There are no reductions of benefits or penalties if You or a Dependent do not participate in the program.

4. *Covered Medical Expenses*. The following expenses are Covered up to the maximums shown in the summary of benefits:

a. **Ambulance Services** - Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals.

This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
    - From Your home, the scene of an accident or Medical Emergency to a Hospital;
    - Between Hospitals, including when the Third-Party Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; or
    - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, You are taken:
    - From the scene of an accident or Medical Emergency to a Hospital;
    - Between Hospitals, including when the Third-Party Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; or
    - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Third-Party Administrator. Emergency Ambulance Services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Third-Party Administrator. When using an air ambulance, for non-Emergency transportation, the Third-Party Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Third-Party Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases the Third-Party Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-Covered Ambulance Services include, but are not limited to, trips to:

- a Physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be Covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be Covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be Covered if using a ground ambulance would endanger Your health and if the Hospital that first treats You cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.

b. **Multiple Surgical Procedures/Assistant Surgeons** – If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not 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 two or more surgeons on separate operative fields perform multiple unrelated surgical procedures, benefits will be based on the charge 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 amount allowed for that procedure.

If an assistant surgeon is required for any surgical procedure, the assistant surgeon's covered charge will not exceed 20% of the surgeon's amount.

c. **Behavioral Health Care and Substance Abuse Treatment** – See the Schedule of Benefits for any applicable Deductible, Coinsurance, or Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and substance abuse treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as Covered herein.

Covered Services include the following:

- Inpatient Services in a Hospital or any Facility that must be Covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.

- Residential Treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

    - observation and assessment by a psychiatrist weekly or more often; and
    - rehabilitation, therapy, and education.

- Outpatient services including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.

- Online visits when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online

care panel, benefit precertification, or doctor to doctor discussions. Online visits are not Covered from Providers other than those contracted with LiveHealth Online.

Examples of Providers from whom You can receive Covered Services include:

- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);
- Mental health clinical nurse Specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C.); or
- Any agency licensed by the state to give these services, when they have to be Covered by law.

For more information about Behavioral Health Care, see the information earlier in this Article about the *Employee Assistance Program.*

d. **Breast Cancer Care** – Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Participant. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Participant.

e. **Breast Reconstructive Surgery** – Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

f. **Cardiac Rehabilitation** – Covered Services are provided as outlined in the Schedule of Benefits as long as Medically Necessary and the services are performed:

i. Under the supervision of a Physician;
ii. In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
iii. Initially within 12 weeks after other treatment for the medical condition ends; and
iv. In a medical facility as defined by the PPO Provider.

g. **Clinical Trials** – Benefits include Coverage for services, such as routine patient care costs, given to You as a Participant in an approved clinical

trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    (a) The National Institutes of Health.
    (b) The Centers for Disease Control and Prevention.
    (c) The Agency for Health Care Research and Quality.
    (d) The Centers for Medicare & Medicaid Services.
    (e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    (g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration; and

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and Drugs provided to You in connection with an approved clinical trial that would otherwise be Covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to the Third-Party Administrator's Clinical Coverage Guidelines, related policies and procedures.

The Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

h. **Dental Services** – Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes (bony ridge containing sockets of upper teeth) will be Covered charges under medical benefits only if that care is for the following oral surgical procedures:

(A) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(B) Emergency repair due to accident to sound natural teeth. This repair must be made within 12 months from the date of an accident.

(C) Surgery needed to correct accidental injuries to the jaws, cheeks, lips tongue, floor, and roof of the mouth.

(D) Excision of benign bony growths of the jaw and hard palate.

(E) External incision and drainage of cellulitis.

(F) Incision of sensory sinuses, salivary glands, or ducts.

(G) Removal of impacted teeth.

(H) Reduction of dislocations and excision of temporomandibular joints (TMJ).

No charge will be Covered under medical benefits for dental or oral surgical procedures involving routine maintenance, orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Other Dental Services

The Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Participant meets any of the following conditions:

- the Participant is under the age of five (5); or
- the Participant has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the Participant has a medical condition that requires hospitalization or general anesthesia for dental care.

i. **Durable Medical Equipment** – Rental of Durable Medical Equipment if deemed Medically Necessary. These items, which cost more than $1,500 may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan.

OR

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Participant's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- it can stand repeated use;
- it is manufactured solely to serve a medical purpose;
- it is not merely for comfort or convenience;
- it is normally not useful to a person not ill or Injured;
- it is ordered by a Physician;
- the Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof

at any time of the continuing Medical Necessity of any item; and

- it is related to the Participant's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be Covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Benefits for Durable Medical Equipment includes Coverage for contraceptive devices, implants, and injectables.

j. **Emergency Care** - Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

k. **General Anesthesia Services** – Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a Covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only Covered when billed by the supervising anesthesiologist.

l. **Home Health Care Services** – Home Health Care provides a program for the Participant's care and treatment in the home. Your Coverage is outlined in the Schedule of Benefits. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending Physician. Services may be performed by either Network or Out-of-Network Providers. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
- A Participant must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Participant.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social, and environmental factors resulting from or affecting the Participant's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- food, housing, homemaker services, sitters, home-delivered meals;

- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Participant's home or is a member of the family of either the Participant or Participant's Spouse;
- any services for any period during which the Participant is not under the continuing care of a Physician;
- convalescent or Custodial Care where the Participant has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Participant;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

m. **Hospice Care Services** – The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and

- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Participant's death. Bereavement services are available to surviving Participants of the immediate family for one year after the Member's death. Immediate family means Your Spouse, children, stepchildren, parents, brothers and sisters.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than twelve months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Third-Party Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Participant in Hospice. These additional Covered Services will be Covered under other parts of this SPD.

n. **Hospital Services** – You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also Covered.

- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

- If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

o. **Human Organ and Tissue Transplant Services** –

Notification:

To maximize Your benefits, You need to call the Third-Party Administrator to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact Third-Party Administrator at the number listed in Article II. The Third-Party Administrator will then assist the Participant in maximizing their benefits by providing Coverage information including details regarding what is Covered and whether any medical policies, network requirements or Plan exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Participant.

Covered Transplant Period

At a Network Transplant Provider Facility, the transplant benefit period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Third-Party Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the transplant benefit period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, the Third-Party Administrator strongly encourages You to call its transplant department to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Third-Party Administrator will assist You in maximizing Your benefits by providing Coverage information, including details regarding what is Covered and whether any clinical Coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Third-Party Administrator telephone number in Article II. Even if the Third-Party Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Third-Party Administrator's for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are Covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Third-Party Administrator when You obtain prior approval and are required to travel more than seventy-five miles from Your residence to reach the Facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Participant and one companion for an adult Participant, or two companions for a child patient. The Participant must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Third-Party Administrator when claims are filed. Contact the Third-Party Administrator for detailed information. The Third-Party Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

p. **Licensed Speech Therapist Services** – Services must be ordered and supervised by a Physician as outlined in the Schedule of Benefits. Speech therapy is not Covered when rendered for the treatment of Developmental Delay.

q. **Maternity Care and Reproductive Health Services** – Covered Services are provided for Network Maternity Care as stated in the Schedule of Benefits. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the Schedule of Benefits.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See Article V, Section C, "Adding a Child".)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Participant will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility. Treatment of Infertility is not covered. Covered Services include diagnostic and exploratory procedures to determine whether a Participant suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure.

Sterilization Services
Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of sterilizations are not Covered.

r. **Medical Care** – General diagnostic care and treatment of illness or Injury. Some procedures require precertification.

s. **Out-of-Network Freestanding Ambulatory Facility** – Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

t. **Out-of-Network Hospital Benefits** – If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

u. **Online Visits** – Online Telemedicine Services which provides access to telemedicine services/video virtual visits with board-certified doctor via a smartphone, tablet or a webcam-equipped computer on a 24/7 basis. Access telemedicine services by visiting livehealthonline.com or download the free mobile app and register for free.

v. **Other Covered Services** – Your Plan provides Covered Services when the following services are Medically Necessary:

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes;
- use of operating and treatment rooms and equipment;
- hearing aids are a Covered expense as described in the Schedule of Benefits;
- Medically Necessary services for care and treatment of jaw joint conditions, including temporomanibular joint syndrome; or
- charges associated with the initial purchase of a wig after chemotherapy.

w. **Outpatient Surgery** – Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are Covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

x. **Physical Therapy, Occupational Therapy, Manipulation Therapy** – Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the Schedule of Benefits. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No Coverage is available when such services are necessitated by Developmental Delay.

y. **Physician Services** – You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

z. **Preventive Services** – Covered Services in the Physician's or Specialist Physician's office or independent lab include, but are not limited to:

- treatment or preventive services including periodic health examinations for adults and Dependent children. Employment or insurance-related physicals are not covered;
- well child care;
- preventive lab and x-ray;
- immunizations;
- flu injections;
- gynecological (well woman) exams;
- annual pap smear;
- annual prostate screening;
- annual routine mammogram (also Covered in the Hospital setting);
- colorectal cancer screening including fecal occult blood test, sigmoidoscopy, and colonoscopy;
- audiometric exams (Covered for Dependents under the age of 9);
- routine eye exams (Covered for Dependents under the age of 9);
- and other Preventive Care.

aa. **Prosthetic Appliances** – Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are Covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and

attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

bb. **Reconstructive Surgery** – Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Coverage for reconstructive surgery includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications for all stages of mastectomy, including lymphedemas. Reconstructive services needed as a result of an earlier treatment are Covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery.

cc. **Retail Health Clinic** – Benefits are provided for Covered Services received at a Retail Health Clinic.

dd. **Skilled Nursing Facility Care** – Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Participant's residence.

ee. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the charge will be

allowed for each additional procedure performed through the same incision

5. *Prescription Drug Benefits for Active Participants*. Prescription Drug benefits can play an important role in Your overall health coverage. Recognizing the importance of this Coverage, the Plan offers Prescription Drug benefits for Your short-term and long-term prescription needs.

   a. **Eligibility**. You and Your Eligible Dependents are eligible for the Prescription Drug Coverage described in this section if You are an Active Participant or retiree under age 65 with coverage under one of the PPO Plans (Deluxe Plus Plan, Classic Plus Plan, or Basic Plus Plan).

   b. **How the Prescription Drug Program Works**. When You need a short-term medication (for example, an antibiotic or cold remedy) filled, it's best to use the retail pharmacy program. If You take medication on a long-term basis (maintenance medications), it's usually best to use the mail order program.

      i. Retail Pharmacy Program – The Plan has contracted with the Pharmacy Benefit Manager to administer Prescription Drug benefits. It's always Your decision where You have prescriptions filed, but when You use participating Pharmacy Benefit Manager pharmacies, You save money for Yourself and the Plan because these pharmacies have agreed to charge discounted rates for Prescription Drugs. If You use a non-participating pharmacy or do not show Your ID card when having Your prescription filled, the Plan still provides Coverage, but the amount You pay may be more since You will pay a percentage of an undiscounted price.

         Through the retail pharmacy program, You receive the greater of a 30-day supply or 100-unit dose. When filling a prescription, simply present Your prescription drug ID card and pay the applicable coinsurance amount.

      ii. Mail Order Program – The Plan also offer a mail order program for Your long-term, or maintenance Prescription Drug needs. Maintenance medications are often prescribed for heart disease, high blood pressure, asthma, etc. Through the mail order program, You receive the greater of a 90-day supply or 300-unit dose. With the mail order program, You receive a larger supply of medication at one time and enjoy the convenience of having the medication sent directly to Your home.

iii. Coinsurance – If You have Coverage under the Deluxe Plus Plan or the Classic Plus Plan, You do not need to meet a Deductible before the Plan begins to pay benefits for Covered Prescription Drugs. If You have coverage under the Basic Plus Plan, You must pay the $25.00 Deductible before the Plan begins to pay benefits for Covered Prescription Drugs. Under all three Plans, You will be required to pay a Coinsurance amount. The amount You pay depends on the pharmacy You use and whether You have a generic or brand name prescription filled. The Coinsurance amounts are the same for the retail pharmacy and mail order programs as shown below:

Prescription Drug Benefits	Deluxe Plus Plan	Classic Plus Plan	Basic Plus Plan
Retail Pharmacy (up to a 30-day supply or 100-unit dose)	No Deductible 85% Generic Cost 85% Name Brand Cost if No Generic Available 75% Name Brand Cost if Generic Available	No Deductible 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available	$25.00 Deductible 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available
	If You choose to use a Name Brand when a Generic is available, You will be required to pay the difference in cost between the Name Brand and the Generic in addition to the coinsurance amount. This difference in cost is additional and not counted toward Your overall Out-of-Pocket Maximum.		
Mail Order (up to 90-day supply or 300-unit dose)	No Deductible 85% Generic Cost 85% Name Brand Cost if No Generic Available 75% Name Brand Cost if Generic Available	No Deductible 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available	$25.00 Deductible 80% Generic Cost 80% Name Brand Cost if No Generic Available 60% Name Brand Cost if Generic Available
	If You choose to use a Name Brand when a Generic is available, You will be required to pay the difference in cost between the Name Brand and the Generic in addition to the coinsurance amount. This difference in cost is additional and not counted toward Your overall Out-of-Pocket Maximum.		

Coverage for statins for Participants age forty to seventy-five and Coverage for aspirin for participants age fifty to fifty-nine is provided one hundred percent and without cost sharing for the participant.

iv. Generic Versus Brand Name Medications - Almost all Prescription Drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

While the Plan Covers generic and brand name medications, when You receive a brand name medication even though a generic is available, You pay a higher coinsurance amount. In addition, You pay the difference in price between the brand name medication and the generic medication. This difference in cost is additional and not counted towards establishing Your overall Out-of-Pocket Maximum. When You or Your Dependent needs a prescription, You may want to ask Your doctor whether a generic can be substituted for a brand name medication.

The Plan has adopted step therapy for utilizers of new drugs on or after August 1, 2013 (If You are already taking a brand name drug prior to the implementation of this program, You will not be required to change medications to a generic). Under step therapy, in order for You to use a brand name drug, You must first try to use the generic version if You have not tried the generic version in the previous twelve months unless this requirement is overridden as Medically Necessary by the Plan based on a separate letter from Your Physician establishing that use of the brand name drug is medically necessary.

The Plan has adopted a preferred brand program for specialty drugs as of August 1, 2013. Participants prescribed specialty drugs will first be required to try brands on the Pharmacy Benefit Manager's preferred formulary list prior to using non-preferred specialty drugs. If You are already taking a non-preferred drug prior to the implementation of this program, You will not be required to change medications to a preferred brand. The only exception to this requirement will be if the Physician provides a letter of Medical Necessity demonstrating that it is medically necessary for the Participant to take the non-preferred specialty drug instead of the preferred drug.

v. Formulary Versus Non-Formulary Medications - There are often several types of medications that can be used to treat the same condition. To ensure high quality care and to help manage costs, most Prescription Drug programs have a

formulary that lists preferred drugs. The Plan's formulary (through The Pharmacy Benefit Manager) includes most generic medications and brand name medications that are either more effective than others in their class or as effective and less costly that similar medications. The Plan only Covers non-formulary drugs under special circumstances and only with approval from the Board of Trustees.

When You or Your Dependent needs a prescription, You may want to ask Your doctor whether a formulary medication can be substituted for a non-formulary medication. For information about the drug formulary, contact the Pharmacy Benefit Manager.

vi. Covered Prescription Drug Expenses. Covered prescription drug expenses include:

(A) All medications including oral contraceptives, prescribed by a physician that require a prescription either by federal or state law, except medications specifically listed as not covered under this Plan.

(B) Biotech/specialty injectable and infusion therapy drugs if covered under the Plan's Pharmacy Benefit Manager program. However, such biotech/specialty injectable and infusion therapy drugs (other than insulin) must be pre-certified before they are covered under the Plan. The Board of Trustees may, in its sole and absolute discretion, permit Coverage for biotech/specialty injectable and infusion therapy drugs not covered under the Plan's Pharmacy Benefit Manager program on appeal from a Participant if good cause exists for the exception.

(C) All compounded prescription medications containing at least one prescription ingredient in therapeutic quantity.

(D) Insulin when prescribed by a Physician.

The Covered drug charge for any one prescription will be limited to:

(A) Refills only up to the number of times specified by a Physician; and

(B) Refills up to one year from the date of order by a Physician

vii. Prescription Drug Exclusions. Prescription Drug benefits are not paid for these expenses:

(A) Any charge for the administration of a Covered Prescription Drug.

(B) A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(C) Any drug or medicine that is consumed or administered at the place where it is dispensed.

(D) 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 stockings, support garments or any similar device.

(E) Experimental drugs and medicines, even though a charge is made to the covered person.

(F) Any drug not approved by the Food and Drug Administration (FDA).

(G) Immunization agents or biological sera.

(H) Impotence medication, unless otherwise specified as Covered.

(I) Infertility medication.

(J) A drug or medicine labeled: “Caution – limited by federal law to investigational use.”

(K) A charge excluded under the Plan’s medical exclusions set forth above.

(L) Prescription drugs that may be properly received without charge under local, state, or federal programs.

(M) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(N) Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(O) A charge for Prescription Drugs for smoking cessation (for example, nicotine gum).

(P) A charge for smoking deterrent patches.

viii. Prescription Drug Preauthorization: Preauthorization with the Plan's Pharmacy Benefit Manager is required for certain medications that are on a list of medications requiring preauthorization on file with the Prescription Benefit Manager. This list is frequently updated. If You want a list of the medications requiring preauthorization, You can contact the Fund Office at the address set forth on the title page of this SPD. The Board of Trustees of the Plan reserves the right to waive such preauthorization requirement on a case-by-case basis in their sole discretion.

In emergency situations, You will be permitted to receive an initial five-day dosage of medication requiring preauthorization without going through the preauthorization process.

ix. Non-Covered Brand Drugs. The Plan's Pharmacy Benefit Manager has developed a list of non-covered brand drugs that have multiple therapeutic alternatives available with significant deviations in clinical and economic value. This list may be updated over time. If You want a list of non-covered brand name drugs, You can contact the Fund Office at the address set forth on the title page of this SPD. The Board of Trustees reserves the right to waive exclusion of such drugs on a case-by-case basis in their sole discretion.

x. Letter of Medical Necessity for Compounds. A letter of medical necessity will have to be provided in order for coverage to apply for all compound medications with a total plan cost at or above two hundred dollars ($200.00).

xi. Non-essential Health Benefit Drugs. Your payments for Non-essential Health Benefit Drugs will not count toward Your Out-

of-Pocket Maximums. Non-essential Health Benefit Drugs include blood and blood plasma, bulk powders and chemicals; acne medications; cosmetic drugs; fertility drugs; impotency drugs; multivitamins; nutrients and dietary supplements; smoking cessation drugs; and weight loss drugs.

xii. Drugs Manufactured to Change Inactive Ingredients. Prescription Drugs found by the Pharmacy Benefit Manager to have been manufactured only to change inactive ingredients from a generic drug are excluded from coverage under the Plan as long as there is a generic alternative available. For example, the muscle relaxer drug Amrix was manufactured by changing only inactive ingredients in cyclobenzaprine. The plan will not cover Amrix because the cost of Amrix is substantially higher than cyclobenzaprine, and the active ingredients are the same. Other examples of such drugs include Absorica, Ziana Gel, Pennsaid, and Omepra/Bica.

xiii. Gene therapies that are approved by the Food and Drug Administration are covered services as long as such therapies are Medically Necessary.

ARTICLE VII - RETIREE COVERAGE (FOR ACTIVE PARTICIPANTS AND RETIREES)

A. RETIREE COVERAGE

The Fund is pleased to be able to provide You and Your Eligible Dependents with retiree Coverage. The medical Coverage You are eligible for varies depending on whether or not You or Your Dependents are eligible for Medicare. The chart below summarizes the Coverage available to retirees and their Eligible Dependents:

Type of Coverage Available to Retirees	Retirees and Their Eligible Dependents Under Age 64	Retirees and Their Eligible Dependents Over Age 65 and Medicare Eligible
Medical Benefits	Yes (as described in Article VI: Medical Benefits)	Yes (if You elect Coverage under the Medicare Advantage Plan)
Prescription Drug Benefits	Yes (as described in Article VI: Medical Benefits)	Yes (if You elect Coverage under the Medicare Advantage Plan)
Dental Benefit	Yes (if You elect dental Coverage)	Yes (if You elect coverage under the Medicare Advantage Plan)
Vision Benefits	Yes (if You elect vision Coverage)	Yes (if You elect Coverage under the Medicare Advantage Plan)
Short-Term Disability Benefits	No	No
Life Insurance Benefits	Yes (if You receive Coverage the same Coverage as Active Participants)	Yes (if You are Covered under the Medicare Advantage Plan you will receive a reduced Life Insurance benefit.)
Accidental Death and Dismemberment (AD&D) Insurance Benefits	Yes (if You receive the sa Coverage as Active Participants)	No

B. ELIGIBILITY

If You are eligible for Coverage under the Plan when You retire, You may continue the Coverage You had as an Active Participant by making self-payments (except that You are no longer eligible for Short-Term Disability Benefits) until You become eligible for Medicare Coverage. You must notify the Fund Office 60 days in advance of starting Medicare. Once You are eligible for Medicare, You can become eligible for Medicare Advantage Coverage. You must meet the eligibility requirements otherwise stated in the Plan, including not working in Disqualifying Employment.

When You retire You must: (1) notify the Fund Office in advance of Your retirement; (2) apply for retiree benefits if You are eligible; and (3) notify the Fund Office 60 days in advance of starting Medicare.

If You are eligible for retiree Coverage and are under age 65, You may continue medical and Prescription Drug Coverage. For retirees under age 65 with Coverage under the Deluxe Plus Plan, Classic Plus Plan, or Basic Plus Plan, You may also continue dental, vision, life and AD&D insurance benefits.

If You are retired, Medicare eligible and 65 or older, You are eligible for medical benefits through the Plans Medicare Advantage Provider, as well as Prescription Drug, dental, vision, and life insurance benefits.

C. RETIREE MEDICAL BENEFITS (For Retirees and Their Dependents Over Age 65 and Medicare Eligible)

Retirees who are eligible for Medicare and receive their benefits through the Plan do so through the Medicare Advantage Plan. Information regarding these benefits may be found in the Medicare Advantage Plan's Evidence of Coverage.

For Participants 64 years old and under, benefits under the Deluxe Plus Plan, Classic Plus Plan, and Basic Plus Plan are summarized in Article III – Schedule of Benefits. Retirees also have access to the Impact Employee Assistance Program (EAP) as described at the beginning of Article VI.

D. RIGHTS OF TRUSTEES WITH RESPECT TO RETIREE BENEFITS

The Trustees reserve the right to change or eliminate the Retiree Benefit Programs at their sole discretion at any time and for any reason. Participants, Disabled Employees, Retirees and their Eligible Dependents do not have any vested rights in the Retiree Benefit Programs.

The privilege of making self-payments for Retiree Benefits is not an "accrued" benefit. The right to change, reduce or eliminate any and all aspects of benefits provided for Retirees and their Spouses, including the right to increase the retiree self-payment rate, is a right specifically reserved by the Trustees. For example, if federal legislation is passed that requires the Plan to pay its benefits before Medicare pays its benefits for Medicare-eligible Retirees and Dependents, the Trustees reserve the right to terminate Retiree Benefits or to increase the self-payment rate to an amount deemed necessary.

E. INCORPORATION OF OTHER PLAN DOCUMENTS

All Plan documents and all definitions, terms, conditions and provisions therein are adopted and made a part of the retiree Coverage. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees, but any retiree who is unsatisfied with any determination by the Trustees appeal pursuant to the Plan's appeal procedures in Article XIII.

ARTICLE VIII - DOLLAR BANK ACCOUNTS

A. DOLLAR BANK ACCOUNT BENEFITS

In order to be eligible for benefits from Your Dollar Bank Account as set forth in Section B below, You must have first been actually enrolled in one of the Plans offered by the Sheet Metal Workers' Union Local 33 Cleveland District Health Benefits Plan. The Dollar Bank Accounts will be maintained for the purpose of paying the premiums required for medical coverage, providing reimbursement for expenses not Covered elsewhere under the Plan, payments of for continued healthcare Coverage under the Plan, and Extended Disability Benefits as described below. The Dollar Bank Accounts are funded through Employer Contributions made on Your behalf to this Plan. Your Dollar Bank Account may also consist of amounts transferred to your Dollar Bank Account from the Sheet Metal Workers Local 33 Supplemental Retiree Health Fund that were previously merged into this Plan. If you receive more contributions than are required to pay for medical coverage premiums, then your Dollar Bank Account will gain a reserve balance which can continue to grow as long as you receive more Employer Contributions each month than the premium required to purchase continued medical coverage for that month. The amount of benefits You can receive under Your Dollar Bank Account is dependent on the type of benefit You are requesting. The limitations for each type of benefit are set forth as follows:

1. Payment of Medical Premiums:

   Your Dollar Bank Account will automatically be used to pay for the required premium for the benefit plan in which you choose to enroll. If your Dollar Bank Account does not have a sufficient balance to cover medical premiums, you may provide a self-payment to cover the remainder due to continue coverage under the Plan.

2. Payments for Continued Coverage:

   Any reserves left over in Your Dollar Bank Account will carry over to the next month and may be used to pay premiums necessary to continue Coverage under the Plan.

3. Medical Reimbursement and/or Extended Disability Benefits:

   You may also use a portion of Your Dollar Bank Account for Medical Reimbursement Benefits and/or Extended Disability Benefits described below. The portion of Your Dollar Bank Account that may be used for such benefits depends on the source of the funding of Contributions to Dollar Bank Account. The Dollar Bank Accounts have been funded through both (1) Employer Contributions made directly to this Plan and (2) Employer Contributions made previously to the Sheet Metal Workers Local 33 Supplemental Retiree Health Fund (which were subsequently merged into this Plan on June 1, 2010).

a. Direct Employer Contributions to this Plan. The portion of your Dollar Bank Account that is funded solely through employer contributions made directly to this Plan may only be used for Medical Reimbursement Benefits and/or Extended Disability Benefits described below once the balance of that portion of the Dollar Bank Account exceeds $6,000.00. Any amounts of this portion of the Dollar Bank Account in excess of $6,000.00 may be used for Medical Reimbursement Benefits and/or Extended Disability Benefits. The entire portion (including amounts up to $6,000.00) of your Dollar Bank Account that is funded solely through employer contributions made directly to this Plan may be used for premiums necessary to continue coverage under the Plan.

Temporary Changes to General Account effective March 25, 2020 through December 31, 2020: Notwithstanding the language above, effective on March 25, 2020 through December 31, 2020, your General Account balance is equal to the dollar value of your accumulated future credits (dollar bank) balance that exceeds $3,000. Please note that only dollar bank balances in excess of $3,000 can be used for payment of eligible expenses, *except for non-participating retirees*. Non-participating retirees may exhaust their dollar bank for eligible medical expenses as described below. This provision shall expire on December 31, 2020, unless otherwise indicated by the Board of Trustees, and dollar bank balances shall once again be available for reimbursement of eligible expenses only upon exceeding $6,000.

b. Contributions Received From Merged Sheet Metal Workers Local 33 Supplemental Retiree Health Fund. The entire portion of your Dollar Bank Account that is funded solely through Contributions made previously to the made previously to the Sheet Metal Workers Local 33 Supplemental Retiree Health Fund may be used for all benefits, including payments of premiums to continue coverage under the Plan, Medical Reimbursement Benefits, and Extended Disability Benefits regardless of the amount in that portion of Your Dollar Bank Account.

B. ELIGIBILITY FOR EMPLOYEES

1. *Initial Eligibility* You are eligible for benefits from Your Dollar Bank if You meet all of the following:

a. You are an Employee receiving Employer Contributions under the Collective Bargaining Agreement or separate written agreement with the Plan; and

b. You have a Dollar Bank Account balance; and

c. You are using Your Dollar Bank Account to pay premiums to become eligible for medical coverage benefits under Article IV or have previously become eligible for medical coverage benefits under Article IV.

2. *Continuation of Eligibility*. You will continue to remain eligible for benefits under your Dollar Bank Account so long as You have a balance in Your Dollar Bank Account and are an Employee.

3. *Termination of Coverage*. Your eligibility for benefits under the Dollar Bank Account will end on the earlier of the following:

a. The first day of the month following a 24-month period in which no Employer Contributions were made on Your behalf and Your fund eligibility is terminated for any reason (without reinstatement) (see Article IV(G) Termination of Eligibility, provided, however, that Your Dollar Bank Account shall not be forfeited if and while You are employed by the International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART); or

b. The day the Dollar Bank Account benefit is terminated by the Trustees.

4. *Reinstatement of Eligibility after Termination*. If You terminate Your coverage pursuant to subsection 3 above, Your coverage will be reinstated when You again satisfy the requirements for initial eligibility in the same manner as a new Employee.

5. *Military Service*. Your eligibility to participate in the Dollar Bank Account benefits will end on the day in which you are inducted, enrolled, or enlisted into the military service of this country other than for temporary service. However, any balance in Your Dollar Bank Accounts will be kept on the Plan's records and will be made available when You return from military service, provided You notify the Fund Office in writing that You are entering military service. You may, by written notice, request the Board of Trustees to freeze Your eligibility and any balance in Your Dollar Bank Account at the end of the month You are inducted, enrolled, or enlisted into the military service of this country. Upon discharge from the military service and upon written notice to the Third-Party Administrator within thirty (30) days of the discharge, Your frozen eligibility will be reinstated, and the balance in Your

Dollar Bank Account restored effective on the first (1st) day of the month following the month in which You are discharged from military service. Your accounts will not be subject to forfeiture as set forth in paragraph 8 below while on Military Service.

6. *Change of Eligibility Rules and Removal of Dollar Bank Accounts*. The Dollar Bank Account benefits set forth in this Article are not a vested benefit and are subject to change at any time and for any reason. You never have any vested right to the money accounted for in Your Dollar Bank Accounts. The Trustees in their sole discretion are empowered to change or amend the foregoing rules of eligibility or the benefits provided by the Dollar Bank Accounts at any time for any reason, including the right to eliminate the Dollar Bank Accounts altogether.

7. *Continuation of Group Health Insurance Coverage through Self-Payments*. If You or an Eligible Dependent loses Coverage by reason of a "qualifying event" under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), including related regulations and amendments, You may use the funds in Your Dollar Bank Accounts to make self-payments to the Health and Welfare Plan in order to continue health Coverage on a temporary basis. The rules governing the continuation of Your health insurance Coverage are more fully described in Article V, Section O.

8. Forfeiture of Dollar Bank Account. Your Dollar Bank Account balance will be terminated the first day of the month following the a 24-month period in which no Employer Contributions were made on Your behalf and Your fund eligibility is terminated for any reason (without reinstatement) (see Article IV(G) Termination of Eligibility).

9. Right to Opt Out of Dollar Bank Account. After termination of Your medical Coverage, You may not be entitled to a premium tax credit from the government for the purchase of health insurance from a health insurance exchange unless You may permanently opt out of and waive further reimbursements from Your Dollar Bank Account. Accordingly, upon termination of Your Coverage under the major medical Plan sponsored by the Sheet Metal Workers Local 33 Cleveland Health and Welfare Plan, You are permitted to permanently opt out of and waive future reimbursement from Your Dollar Bank Account. Please contact the Third-Party Administrator to obtain the necessary waiver form.

C. ELIGIBILITY FOR RETIRED EMPLOYEES

1. Eligibility Requirements for Retired Employees. If You retire, You may use the Dollar Bank Account to pay for self-payments required to maintain Coverage under this Plan. Coverage under the Dollar Bank Accounts will continue until the amount of money in Your Dollar Bank Account is

exhausted. If You exhaust the amount of money in Your Dollar Bank Account before retirement, You will not be eligible to participate unless you again satisfy the Employee eligibility requirements. You will be considered an eligible retiree and entitled to self-pay for continued Coverage under Your Dollar Bank Account only if You meet the following requirements:

a. You are retired from active employment; and

b. You were eligible for active Employee coverage under the Plan on the date you retired.

2. Retiree Benefits. The benefits provided to eligible retirees under the Dollar Bank Accounts Plan shall include the Medical Reimbursement Benefits available to active Employees. Eligible Retirees can also use their Dollar Bank Accounts to pay for continued self-pay Coverage under the Basic Plus, Classic Plus, or Deluxe Plus Plans if they are not eligible for Medicare. However, Eligible Retirees may not use their Dollar Bank Accounts for Extended Disability Benefits.

3. No Vested Right to Retiree Dollar Account Benefits. The Trustees reserve the right, in their sole discretion, to change or eliminate retiree Coverage including but not limited to the medical and/or Dollar Bank Account benefits available to Participants at any time and for any reason. Retired Employees do not have any vested rights in their Dollar Bank Accounts or for continued Coverage under the Plan.

4. Cancellation of Coverage. Coverage for eligible retirees under the Dollar Bank Account shall be cancelled as of the earliest of:

a. The date the eligible retiree's Dollar Bank Account is reduced to zero; or

b. The date the Dollar Bank Account benefits are terminated by the Board of Trustees; or

c. The date Coverage for eligible retirees under the Plan is cancelled.

D. SURVIVING SPOUSE/ELIGIBLE DEPENDENT CONTINUATION

If You have any balance remaining in Your Dollar Bank Account, it shall be used, until such balances are depleted, to provide continued premium payments, Medical Reimbursement benefits or Extended Disability Benefits for Your surviving Spouse or, if no Surviving Spouse, Your surviving Eligible Dependents at the time of your death. In order for Your Spouse to qualify for survivorship Dollar Bank Account benefits under the Plan, You must have been married to Your surviving Spouse for at least one year prior to Your death. Your surviving Spouse and/or Eligible Dependents will be permitted to continue Coverage

pursuant to this section, provided they apply for such Coverage within one hundred eighty (180) days after Your death. Upon the death of Your surviving Spouse and all of Your Eligible Dependents, the Coverage will be terminated, and any remaining amounts in Your Dollar Bank Account will be forfeited to the Plan. If Your surviving Spouse remarries, the Coverage will be terminated, and any remaining amounts in Your Dollar Bank Account will be forfeited to the Plan.

E. DOLLAR BANK ACCOUNT BENEFITS

1. Dollar Bank Account. The balances of Your Dollar Bank Account will be funded by Employer Contributions in excess of the Cost of Coverage, as described in Article IV, Section C – Dollar Bank.

2. Premium Payment Benefit. The balance of Your Dollar Bank Account will automatically be used to pay the premium required for continued medical coverage.

3. Dollar Bank Account Medical Reimbursement Benefit. Subject to the limits set forth in Section A above, You are entitled to Medical Reimbursement benefits from Your Dollar Bank Account for any itemized medical bills for treatment. In order for an expense to be reimbursed, the expense must both (1) satisfy the requirements for individual reimbursement for medical care expenses under Section 105(b) of the Internal Revenue Code as defined under Section 213(d) of the Internal Revenue Code and (2) not be eligible for reimbursement from any other health insurance plan or other insurance under which You are covered. Examples of medical bills for which You may be reimbursed under the Dollar Bank Account Benefit are medical bills, pharmaceutical bills, vision and/or dental co-pays, and deductibles. In order to be reimbursed for medical bills, You must provide a copy of an Explanation of Benefits ("EOB") showing the amount of the medical bill for which You or a family member are responsible. In order to be reimbursed for pharmaceutical bills, You must submit an itemized receipt from the pharmacy showing the amounts paid for prescriptions. In order to be reimbursed for dental or vision expenses, You must provide an invoice setting forth the treatment rendered.

4. Extended Disability Benefit. Subject to the limits set forth in Section A above, You may use your Dollar Bank Account to pay for Extended Disability Benefits. Extended Disability Benefits include weekly disability benefits that continue beyond the 26-week maximum for short-term disability benefits under Article XI of the Plan. The weekly disability benefit is $500.00 per week and continues as long as you meet the eligibility requirements set forth in Article XI of the Plan.

F. FILING A CLAIM

Before filing a claim, contact the Fund Office for eligibility verification and a claim form. You must submit claims within 24 months of receiving services or supplies. The Plan may also pay medical Providers directly from Your Dollar Bank Accounts when You qualify for medical reimbursement under the Dollar Bank Accounts. You will need to authorize the Plan to pay the medical provider directly and will also need to submit an Explanation of Benefits demonstrating the portion of the medical treatment not covered by medical insurance.

ARTICLE IX - DENTAL BENEFITS

A. ELIGIBILITY

You and Your Eligible Dependents are eligible for dental benefits if You are an Active Participant or retiree who elected Coverage under the Deluxe Plus Plan, the Classic Plus Plan, or the Basic Plus Plan and You affirmatively elect to receive dental and vision Coverage.

B. HOW THE DENTAL PROGRAM WORKS

1. *Deductible*. If You have Coverage through the Deluxe Plus Plan, the Classic Plus Plan, or the Basic Plus Plan, You do not need to meet a Deductible before the Plan begins to pay dental benefits.

2. *Coinsurance*. When You receive dental treatment that is not Covered under Your medical benefits, the Plan pays 80% and You pay 20% of the Covered treatment. The Plan covers *any* type of dental treatment up to the annual family maximum described below.

3. *Annual Maximums*. The Plan pays dental benefits up to a $1,500 maximum for Single Person Coverage and a $3,000.00 maximum for Family Coverage. This benefit is payable each calendar year (January 1st – December 31st). After submitting a claim for reimbursement for dental treatment, You will be reimbursed up to the annual maximum, minus the applicable Coinsurance. All claims must be filed within one year of treatment.

4. *The Dental Network*. When You or Your family needs dental care, You may receive treatment from any dentist. However, when You choose to use the in-network dental Providers, You maximize Your dental benefits under the Plan.

   The Plan has contracted with network dental Providers to offer a dental network. Dentists in the network (network dentists) agree to provide dental care to You and Your Eligible Dependents at negotiated rates. These dentists have agreed to a dental payment schedule. The dental payment schedule lists the maximum dollar amount the Plan pays for specific dental procedures.

   A network dentist is a dentist or other specialist who agrees to charge negotiated rates for their services. You save money when You use a network dentist.

   Non-network dentists have not agreed to the negotiated rates. Therefore, non-network dentists can charge more than the amounts listed in the dental payment schedule. When this happens, You increase Your Out-of-Pocket expenses.

To find out if Your dentist participates in the dental network or to find a dentist who does, contact the Dental In-Network Provider at the information at the beginning of this SPD.

Dental Benefits	Same under Deluxe Plus, Classic Plus, and Basic Plus Plans
Coinsurance	Plan pays 80% of any dental treatment
Maximum Benefit (Single Coverage)	$1,500 per calendar year
Maximum Benefit (Family Coverage)	$3,000 per calendar year

ARTICLE X - VISION BENEFITS

A. ELIGIBILITY

You and Your Eligible Dependents are eligible for vision benefits if You are an Active Participant or retiree who elected Coverage under the Deluxe Plus Plan, the Classic Plus Plan, or the Basic Plus Plan and You affirmatively elect to receive dental and vision Coverage.

B. HOW THE VISION PROGRAM WORKS

The Plan offers You the choice to receive vision care from any Provider. The Plan pays benefits toward the cost of eye exams and frames or lenses for You and each of Your Eligible Dependents every 12 months. You do not need to meet an annual Deductible before benefits are paid. After You incur vision expenses, You simply file a vision claim form for reimbursement.

The chart below provides a summary of the vision benefits payable by the Plan:

Vision Benefits	Same under Deluxe Plus, Classic Plus, and Basic Plus Plans
Benefit – Exam/Lenses/Frame Copayment	$10 Co-Pay Exam/ $25 Co-Pay Materials
Network Providers	
Frames	Up to $150.00
Lenses	Covered
Elective Contact Lenses Allowance (in lieu of glasses)	Up to $150.00
Elective Contact Lenses Fitting	$60 Co-Pay
Necessary Contact Lenses	Covered
Out-of-Network Providers	
Exam	Up to $45.00
Single Lenses	Up to $30.00
Bifocal Lenses	Up to $50.00
Trifocal Lenses	Up to $65.00
Lenticular Lenses	Up to $100.00
Frame	Up to $70.00
Elective Contact Lens Allowance (in lieu of glasses)	Up to $105.00
Necessary Contact Lens Allowance (in lieu of glasses)	Up to $210.00

Exams, lenses and frames are available once every rolling twelve months. There is a twenty percent (20%) discount off additional pairs of glasses.

If You receive services or supplies from a Provider, You may be responsible for submitting a vision claim form. After submitting Your vision claim form, the Plan will reimburse You or Your Eligible Dependent up to the Plan maximums. If You need a vision claim form, contact the Fund Office.

C. COVERED VISION SERVICES FROM NETWORK PROVIDERS

1. **Eye Examination** - Covered in full* once every 12 months**

   Comprehensive examination of visual functions and prescription of corrective eyewear.

2. **Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)** - Covered in full* once every 12 months**

   Polycarbonate lenses are Covered in full for Eligible Dependents up to age 26.

   Standard Progressive lenses Covered in full.

3. **Lens Options**

   Scratch coating Covered in full once every 12 months.**

4. **Frames - Covered** up to the Plan allowance* once every 12 months**

   The Network Provider will prescribe and order the Participant's lenses, verify the accuracy of finished lenses, and assist the Participant with frame selection and adjustment.

5. **Contact Lenses**

   a. *Elective*

   Elective contact lenses (materials only) are Covered up to $150.00 once every 12 months**

   The elective contact lens fitting and evaluation services are Covered in full once every 12 months, after a maximum $60.00 Copayment.

   b. *Necessary*

   Necessary contact lenses are covered in full* once every 12 months**

   Necessary contact lenses are Covered when specific benefit criteria are satisfied and when prescribed by the Participant's Network Provider.

   Contact lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first date of service.

6. **Low Vision**

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by the Participant's Network Provider.

D. COVERED SERVICES FROM OUT-OF-NETWORK PROVIDERS

1. **Eye Examination:** Up to $ 45.00* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

2. **Spectacle Lenses**

Single Vision Up to $ 30.00* once every 12 months**
Bifocal Up to $ 50.00* once every 12 months**
Trifocal Up to $ 65.00* once every 12 months**
Lenticular Up to $100.00* once every 12 months**

3. **Frames:** Covered **up** to $ 70.00* once every 12 months**

4. **Contact Lenses**

a. Elective

Elective contact lenses are Covered up to $105.00 once every 12 months**

The elective contact lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

b. Necessary

Necessary contact lenses are Covered up to $210.00* once every 12 months**

Necessary contact lenses are Covered when specific benefit criteria are satisfied and when prescribed by the Participant's doctor.

Contact lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first date of service.

5. **Out-of-Network Providers**

- Services from an Out-of-Network Provider are in lieu of services from a network Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- The Plan is unable to require Out-of-Network Provider to adhere to the network's quality standards.

E. DIABETIC EYECARE PLUS PROGRAM

The Diabetic Eyecare Program ("DEP") is intended to be a supplement to Your medical benefits. Any amounts not paid by the medical Plan will be considered for payment by the Plan's vision claims Provider, who is the secondary payer (see Article XIV – Coordination of Benefits)

Examples of symptoms which may result in a Participant seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- "floating" spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- age-related macular degeneration
- glaucoma

Referrals

If the Participant's member doctor cannot provide Covered services, the doctor will refer the Participant to another member doctor or to a Physician whose offices provide the necessary services.

If the Participant requires services beyond the scope of DEP Plus, the member doctor will refer the Insured to a Physician.

Referrals are intended to insure that Participants receive the appropriate level of care for their presenting condition. **Participants do not require a referral from a member doctor in order to obtain Coverage.**

Covered Services (From Network Providers)

1. **Eye Examination:** Covered in full after a Copayment of $20.00.

2. **Special Ophthalmological Services:** Covered in Full.

Exclusions and Limitations of Benefits

The Diabetic Eyecare Plus Program provides Coverage for limited, vision-related medical services. A current list of these procedures will be made available to Participants upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

Not Covered Under the Diabetic Eye Program

1. Services and/or materials not specifically included in this section as covered
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where the Plan is required by law to pay.

F. EXCLUSIONS AND LIMITATIONS

These expenses are not Covered under the Plan's vision benefits:

1. Services and/or materials not specifically included in this Article as Covered benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
3. Two pairs of glasses instead of bifocals.

4. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan benefits are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Refitting of contact lenses after the initial (90-day) fitting period.
8. Contact lens modification, polishing or cleaning.
9. Local, state and/or federal taxes, except where the Plan is required by law to pay.
10. Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

ARTICLE XI - DISABILITY AND DEATH BENEFITS

A. SHORT-TERM DISABILITY BENEFITS (For Active Participants)

The Plan provides Short-Term Disability Benefits in the event that You are disabled and cannot work because of a non-work-related disability. These benefits are important because they continue to provide income to You even though You are unable to work. The amount of the Plan's Short-Term Disability Benefit is $500 per week, payable for up to 26 weeks.

1. If You can't work because of a non-work related Injury or illness:

    a. Call Your Employer and the Fund Office.

    b. See a doctor as soon as possible.

    c. File a claim with the Fund Office. To be eligible for benefits, You must provide written proof that You:

        i. Are Totally Disabled as a result of a non-work related Injury or illness;

        ii. Are an eligible Participant at the time Your Total Disability began; and

        iii. Require the regular care of a doctor.

2. *When Benefits Begin*.

    You must consult Your doctor about Your disabling condition as soon as reasonably possible to be eligible for Short-Term Disability Benefits. It is a good idea to keep a record of this consultation since the Trustees, before authorizing payment of benefits, reserve the right to request a record of consultation.

    To receive Short-Term Disability Benefits, You need to submit a claim form that can be obtained from the Fund Office. Benefits begin on the:

    i. First day of disability if the disability is due to an Injury or Hospital confinement; or

    ii. Eighth day of disability if the disability is due to an illness unless the Participant tests positive for COVID-19, in which case the Participant shall be eligible to begin receiving benefits on the first day of their absence from work.

Part of the workday missed due to the disability will be counted toward the requirements of this section.

3. *When Benefits End*

Your Short-Term Disability Benefits will cease on the earliest of:

a. The date You are no longer Totally Disabled; or

b. The end of the maximum benefit period (26 weeks);

c. The date on which You begin to receive benefits under the Sheet Metal Workers Local 33 Cleveland District Pension Plan or any other retirement plan; or

d. The date that You die.

4. *Successive Periods of Disability*.

Successive periods of disability will be considered one period of disability unless the disabilities are due to:

a. The same or related condition and You return to active work for at least 72 hours during a period of four consecutive weeks; or

b. Unrelated causes and begin after You return to active work for at least one full day.

5. *Benefits Not Payable*.

Short-Term Disability Benefits are not paid for:

a. Any period of disability when You are not under the care of a Physician unless the Participant has tested positive for COVID-19 and is in isolation or quarantine for such illness.

b. Any exclusion or limitation listed in Article XII – General Exclusions and Limitations.

c. Any Injury or illness for which You are entitled to benefits under any workers' compensation or occupational disease law (whether or not You have applied for such benefits).

B. LIFE INSURANCE BENEFIT (For Active Participants and Retirees)

The Life Insurance Benefit is designed to help protect Your family against the sudden loss of Your income in the event of Your death. The Plan provides a $50,000 Life Insurance Benefit if You are an Active Participant or retiree under age 65 with Coverage under one of these Plans:

1. Deluxe Plus Plan;
2. Classic Plus Plan; or
3. Basic Plus Plan.

The Plan also provides a $5,000 Life Insurance Benefit to retirees age 65 or older who elect Coverage under the Medicare Advantage Plan.

Generally, the Life Insurance Benefit is paid in a lump-sum payment to Your beneficiary. In the event of a death, Your beneficiary should contact the Fund Office. The Fund Office will assist Your beneficiary in submitting a claim. Your beneficiary will need to provide a copy of Your death certificate.

If Your death is the result of suicide, the Life Insurance Benefit will be paid in accordance with the terms and conditions of the life insurance company providing benefits at the time of death.

C. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT (For Active Participants and Retirees under age 65 with Plus Plan)

The AD&D Insurance Benefit is paid in the event of Your death or Injury due to an accident, provided the death or Injury results within 90 days of the accident. The full amount of the AD&D Insurance Benefit is $50,000 and is paid as follows:

For Loss Of:	Benefit Amount
Life	Full Amount
Both Hands, Both Feet, Sight in Both Eyes or Any Combination (for example, one hand and one foot)	Full Amount
One Leg, One Arm, One Hand, One Foot, or Sight in One Eye	50% of full amount

1. The term loss means with respect to:
    a. Hands and feet – actual severance through or above the wrist or ankle joint;
    b. Eyes – entire and permanent loss of sight;

c. Leg or arm – actual severance through or above the knee or elbow joint.

2. No more than the full amount of the AD&D Insurance Benefit will be paid for any one accident. If more than one loss is suffered from any one accident, payment will be made for the largest amount payable.

3. In the event of Your death, the benefit is paid to Your beneficiary in a lump-sum payment; otherwise, the AD&D Insurance Benefit is paid to You.

4. *AD&D Insurance Benefits Not Payable*. AD&D Insurance Benefits are not paid for any loss resulting from:

a. Any disease, bodily or mental ailment or medial or surgical treatment for any disease, ailment, infirmity, or any infection, other than a bacterial one that results from an accidental bodily Injury.

b. Self-destruction or any attempt at self-destruction.

c. Taking part in any assault, felony, riot, or revolt.

d. Riding in or descending from any kind of air or spacecraft in which You took part in any duties aboard such craft.

e. War or any act of war, declared or undeclared, or armed aggression by the armed forces of any country or alliance of countries.

f. Any drug, sedative or narcotic, unless dispensed by a Physician (including poison gas or fumes voluntarily administered, absorbed or inhaled).

D. DEPENDENT LIFE INSURANCE BENEFIT (For Active Participants and Retirees under age 65 with Plus Plan Coverage)

The Plan also offers a Dependent Life Insurance Benefit in the event that one of Your Eligible Dependents die. The Plan provides $5,000 in the event of the death of Your Spouse and $2,000 in the event of the death of Your Dependent child. The Dependent's Life Insurance Benefit is payable to You in the event of Your Dependent's death.

E. DESIGNATING YOUR BENEFICIARY

When You become eligible for Coverage under the Plan, You will be asked to designate a beneficiary to receive any insurance benefits in the event of Your death. You may choose one or more beneficiaries and You can change Your beneficiary(ies) at any time by submitting the appropriate form to the Fund Office. The change must be received by the Fund Office to be effective as of the date You signed the form. If there is a question

concerning the beneficiary of a benefit, the beneficiary is determined based on the form on file with the Fund Office at the time of the Participant's death.

If the beneficiary is a minor at the time benefits become payable, the benefits shall be paid to the child's legal guardian pursuant to the Ohio Transfers to Minors Act (R.C. 5814) as the custodian of the minor.

If You designate more than one beneficiary, and any of Your beneficiaries are not living at the time of Your death, Your benefit will be paid in equal shares to the remaining designated beneficiaries. If You don't name a beneficiary or if Your beneficiary(ies) is not living at the time of Your death, Your benefit will be paid to Your:

1. Spouse, or if none;

2. Children in equal shares, or if none;

3. Parents in equal shares; or if none;

4. Estate.

F. THE LIFE AND AD&D INSURANCE BENEFIT PROVIDER

The Plan Trustees have contracted with a Life and AD&D Insurance Benefit Provider to provide Life, AD&D, and Dependent Life Insurance Benefits. The contracts with The Life and AD&D Insurance Benefit Provider set forth the terms and conditions of this insurance Coverage. You may examine or obtain a copy of these contracts by contacting the Fund Office.

ARTICLE XII - EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS AND LIMITATIONS

The Plan provides Coverage for many medical, Prescription Drug, dental, vision, Short-Term Disability, Life Insurance, and AD&D Insurance Benefits. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits are not paid for the following services, supplies, charges, or expenses:

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service or available from the Veterans' Administration or military facilities except as required by law.

2. Services for Custodial Care.

3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care, domiciliary care, or care in a place for the aged or a nursing home.

4. Except as provided under the Plan, dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service, unless Covered under the Plan's dental benefit. .

5. Hospital or Surgical center charges incurred for dental work of any kind. Charges incurred for dental work or treatment except as required by Accidental Injury of sound teeth.

6. Charges for treatment received before Coverage under this Plan began or after it is terminated, except as specifically provided under an extended benefits provision in the Plan.

7. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are Experimental or Investigational for the diagnosis for which the Participant is being treated.

8. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or Injury.

9. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the

diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, subluxations, bunions (except capsular and bone surgery) or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Participants with impaired circulation to the lower extremities.

10. Shoe inserts, orthotics (will be Covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary or are part of a leg brace and are included in the cost of the brace).

11. Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

12. Services for which benefits are payable under Medicare Parts A and/or B or would have been payable if You had applied for Parts A and/or B, except as listed in this SPD or as required by Federal law. If You do not enroll in Medicare Part B, benefits will be calculated as if You had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

13. Services covered under workers' compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

14. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.

15. Outpatient Prescription Drugs prescribed by a Physician and purchased or obtained from a retail Pharmacy or retail pharmacist or a mail service Pharmacy are excluded except as provided by the Plan's Pharmacy Benefit Manager. Although Coverage for outpatient Prescription Drugs obtained from a retail Pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are Covered under Your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to Prescription Drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to Prescription Drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in Your Physician's office.

16. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

17. Care, supplies, or equipment not Medically Necessary, for the treatment of an Injury or illness.

18. Vitamins, minerals and food supplements, as well as vitamin injections. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding.

19. Services for Hospital confinement primarily for diagnostic studies.

20. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an Injury or to correct a congenital defect.

21. Donor search/compatibility, except as otherwise indicated.

22. Contraceptive Drugs, except for any contraceptive drugs or devices approved elsewhere in the SPD.

23. Treatment of Infertility, including, but no limited to in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, studies, test or surgical procedures to promote pregnancy.

24. Reversal of voluntary sterilization.

25. Hair transplants, hair pieces or wigs (except for cancer patients) wig maintenance, or prescriptions or medications related to hair growth.

26. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this SPD.

27. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, sex therapy, treatment for non-organic sexual problems.

28. Christian Science practitioner services.

29. Services provided in a halfway house.

30. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Participant for which, in the absence of any health benefits Coverage, no charge would be made; services provided to the Participant by a local, state or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the Participant is not required to pay for them or they are provided to the Participant for free. However, the following items are not excluded:

    i. Treatment provided for non-service related disabilities rendered by the U.S. to military retirees and Dependents;

    ii. Treatment provided for non-service related disabilities rendered by the Veterans Administration; and

    iii. Inpatient psychiatric treatment provided by a state hospital.

31. Acupuncture.

32. Routine care is not covered, except for Covered Preventive Care services.

33. Services or supplies provided by a member of Your family or household.

34. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Third-Party Administrator.

35. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

36. Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.

37. Charges for any of the following:

    a. Failure to keep a scheduled visit;
    b. Completion of claim forms or medical records or reports unless otherwise required by law;
    c. For Physician or Hospital's stand-by services;
    d. For holiday or overtime rates;
    e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not

limited to, fees charged for educational brochures or calling a patient to provide their test results;

f. Specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation; or

g. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered Facility, which makes their services available.

h. Fees for telephone consultations.

38. Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

39. Charges for or related to sex change surgery or to any treatment of gender identity disorders.

40. Reversal of voluntary sterilization, including vasectomy or reversal of tubal ligation.

41. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.

42. Weight loss surgery, including complications related to such surgery, except for the surgical treatment when Medically Necessary.

43. Services for outpatient therapy or rehabilitation other than those specifically listed as Covered in this SPD. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.

44. Vision care services and supplies are not Covered under Your medical care benefit but are Covered under Your Vision benefits. However, there is Coverage for aphakic patients related to examinations for prescribing and fitting eyeglasses or contact lenses.

45. Vision Surgeries - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

46. Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).

47. Care, services or treatment required as a result of complications from a treatment not Covered under the Plan.

48. Expenses incurred by a Participant or Eligible Dependent resulting from or occurring:

    i. during the commission of a crime;
    ii. during illegal or willful misconduct;
    iii. while engaged in an illegal occupation;
    iv. while committing or attempting to commit a felonious act or assault; or
    v. while participating in a riot or civil insurrection.

    The Trustees will, in their sole discretion, interpret this exclusion and such interpretation will be conclusive.

49. Eating disorders, other than psychological counseling.

50. Counseling or testing concerning inherited (genetic) disorders.

51. Hypnosis.

52. Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another illness. This exclusion includes gastric bypass surgery or any surgical interventions. This exclusion does not include surgery that is Medically Necessary when weight is at least twice the ideal amount.

53. Commodes, stools and benches are not Covered under Durable Medical Equipment.

54. Administration charges associated with blood drawing/Administration charge for injections.

55. Claims incurred while in a foreign country will not be Covered unless such bill is submitted in English including monetary amounts in United States dollars. Such bill must be submitted from the medical Provider.

56. Massage Therapy.

57. Outpatient private duty nursing care except as specifically provided for in the Home Health Care Services section of this SPD.

58. Inpatient private duty unless Medically Necessary or not custodial in nature (Custodial Care) and the hospital's Intensive Care Unit is filled or the hospital has no Intensive Care Unit.

59. Cosmetics, dietary supplements, and health or beauty aids.

60. Hemodialysis for chronic renal failure after You become eligible for hemodialysis under Medicare, Medicaid, or any other governmental program.

61. Received from a dental or medical department, clinic or other facility provided by or maintained by or on behalf of an Employer, mutual benefit association, labor union trust, or similar person or group. This exclusion includes a medical clinic, or similar facility for which services or supplies are or should be available without charge to the participants.

62. Treatment by manual or mechanical means for subluxation or manipulation (chiropractic or spinal manipulation) in excess of the annual maximum stated in the applicable Schedule of Benefits.

63. Treatment of sexual problems not caused by organic disease.

64. Treatment of temporomandibular joint (TMJ) syndrome in excess of the lifetime maximum (if applicable).

65. Topical anesthesia.

66. Air ambulance when not used in a life-threatening situation.

67. Conditions related to an autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or intellectual disability; provided, however, that this exclusion shall not apply to exclude Coverage of treatment or prescriptions for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder and also that this exclusion shall not apply to Coverage for diagnosis and testing of autism for all children age 0 to 19.

68. Anything excluded or limited elsewhere in this Plan.

69. To the extent that any Participant is reimbursed, or entitled to reimbursement, or in any way indemnified for the expenses by or through any public program.

70. Telephone, television, radio, guest trays, personal hygiene or convenience items, take-home drugs following discharge from a Hospital or any sales tax or other tax that may be imposed.

71. Research studies or fluoroscopy without film.

72. Charge for the first three pints of blood, blood components, and blood derivatives or for pints that are replaced and blood which is available without charge and for outpatient blood processing and storage services.

73. Drugs, biologicals, and solutions not listed in the latest edition of the United States Pharmacopeia, the National Formulary or the New and Non-Official Drugs.

74. Services or supplies rendered for hearing aids or examination for the prescription and fitting of the same, except for those specified elsewhere in the Plan.

75. Any loss due to an intentionally self-inflicted Injury, including suicide, attempted suicide, or resulting from the intentional ingestion of any gas or fumes. Injury intentionally inflicted by one member of a family unit on another member of a family unit will not exclude coverage for the injured, Covered person being such other member of the family unit. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

76. Tests of any kind not in connection with or not necessary for the diagnosis or treatment of a sickness or injury except those specified elsewhere in the Plan.

ARTICLE XIII - CLAIMS AND APPEALS PROCEDURES

A. FILING CLAIM FORMS

Filing a claim is easy if You follow the steps described in this section. If a claim is denied, in whole or in part, there is a process You can follow to have Your claim reviewed by the Trustees.

If a claim is denied or reduced, You may file an appeal to have Your claim reconsidered.

For medical services, Providers generally file claim forms for You. However, if You need to file a claim, contact the Fund Office. The staff there will provide You with all the necessary forms for filing Your claim and explain the procedures for submitting claims.

You should file Your initial claim for Plan benefits **within 60 days** after the date You received services. If this is not possible, You must file Your claim no later than one year after You received the services.

1. To assist in processing claims as quickly as possible, please follow these steps:

    a. Obtain the appropriate claim form from the Fund Office.

    b. Complete the form by filling in all information requested.

        i. If You or a Dependent has coverage under more than one plan, be sure to include the name of the other plan(s).

        ii. Be sure to include Your Social Security number and sign Your form. If the claim is for an Eligible Dependent, provide the name of the Dependent.

    c. When necessary, have Your doctor or dentist complete the appropriate portion of the claim form, including the diagnosis.

    d. Attach any bills or receipts relating to the services provided. Make sure each bill clearly identifies the diagnosis, the service or supply, the fee, the patient's name, and the date of service.

    e. Forward the completed form and all related attachments to the address specified on the form.

2. *Health Care Claims*. Many Providers will submit claims for You. Health care claims include medical, Prescription Drug, dental and vision benefits. Be sure to show Your ID card so Your Provider knows where to submit Your claim.

If Your Provider does not submit Your claim for You, it is then Your responsibly to do so.

If You or an Eligible Dependent has coverage under two or more health plans, be sure to include the name of the other health plan(s) on Your claim form. In addition, if Medicare and/or another plan also covers You, attach a copy of the itemized bill relating to the health service provided and a copy of any explanation of benefits. Both the bill and explanation of benefits must be submitted.

a. **Types of Health Care Claims**. There are four basic types of health care claims:

i. Urgent Care. An urgent care claim is a claim for medical treatment that:

(A) Would seriously jeopardize Your life, health or ability to regain maximum function if normal pre-service standards were applied; or

(B) Would subject You to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a doctor with knowledge of Your condition.

ii. Pre-Service. A pre-service claim is a claim for benefits where pre-certification is required. The Plan will not deny benefits for these procedures or services if:

(A) It is not possible for You to obtain pre-certification; or

(B) The pre-certification process would jeopardize Your life or health.

iii. Post-Service. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When You file a post-service claim, You have already received the services in Your claim.

iv. Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of a Hospital stay) and the reconsideration results in:

(A) Reduced benefits; or

(B) Termination of benefits.

3. *Short-Term Disability Benefit Claims*. Be sure to notify Your Employer and the Fund Office if You are sick or injured and are unable to work. The Fund Office will send You a claim form. Have Your doctor complete the form. Then send the completed form to the Fund Office as soon as possible. Benefits are not payable until You apply for and submit the required information.

4. *Life, AD&D, and Dependent Life Insurance Benefit Claims*. In the event of the death of one of Your Eligible Dependents, You should contact the Fund Office. In the event of Your death, Your beneficiary should call the Fund Office for help in filing a claim.

B. CLAIM DECISIONS AND BENEFIT PAYMENT

When You submit a claim for benefits to the Fund Office, the Fund Office will determine if You are eligible for benefits and calculate the amount of benefits payable, if any. At its discretion, the Plan has the right to request a physical exam by a doctor of its choice (at the Plan's expense).

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

1. *Health Care Claims*. All health care benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, You will receive a written notice of the decision on Your claim.

   The deadlines differ for the different types of claims as shown in the following information:

   a. **Urgent Care Claims**. An initial determination will be made as soon as possible consistent with medical exigencies involved but in no event later than 72 hours from receipt of Your claim. Notice of a decision on Your urgent care claim may be provided to You orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process Your claim, You will be notified within 48 hours of receipt of Your claim. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner. The Plan will defer to the attending Provider with respect to the decision as to whether a claim constitutes urgent care.

b. **Pre-Service and Post-Service Claims**. An initial determination will be made within 15 days from receipt of Your pre-service claim or 30 days from receipt of Your post-service claim. If additional time is necessary, up to 15 additional days, due to matters beyond the control of the Plan, You will be informed of the extension within this initial timeframe. In addition, if additional information is needed to process Your claim, You will be notified within 15 days of receipt of Your claim and You then have up to 45 days to provide the requested information. After 45 days, or, if sooner, after the information is received, a determination will be made within 15 days.

When Providers submit the claims, payment is made directly to the Provider, and the Providers handle all the paperwork for You. However, if You submit the claim, payments are generally made directly to You, unless You assign benefits to the Provider.

2. *Disability Benefit Claims*. You will receive written notice of a decision on Your initial claim within 45 days of receipt of Your claim, unless an extension of time is necessary. If additional time is required to make a determination on Your claim (for reasons beyond the control of the Plan), You will be notified within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, You will be notified that an additional 30 days is necessary.

In some instances, the Plan may require additional information to process and make a determination of Your claim. If such information is required, the Plan will notify You within 45 days of receiving Your request. You then have up to 45 days in which to submit the additional information. If You do not provide the information within this time, then Your claim may be denied.

3. *Life, AD&D, and Dependent Life Insurance Benefit Claims*. You will receive written notice on a decision on Your claim within 90 days after the Plan receives Your claim, unless an extension of time is necessary. If circumstances require an extension of time for processing Your claim, You will be notified in writing that an extension is necessary. The extension will not be for more than 90 days, from the end of the initial 90-day period.

C. IF A CLAIM IS DENIED

If a claim is denied (in whole or in part), the Plan will provide You with certain information about Your claim and notify You of the denial of Your claim within certain timeframes. In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure You can follow to have Your claim reconsidered. This formal procedure applies to any adverse benefit determination, including a rescission of Coverage (whether or not the rescission has

an adverse effect on any particular benefit at the time). Additionally, all notices provided to Participants will be provided in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any "applicable non-English language" and providing assistance with filing claims and appeals in "any applicable non-English language." In addition, the Plan will provide, upon request, a notice in any "applicable non-English language" and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. "Applicable non-English languages" include, with respect to an address in any United States county to which a notice is sent, a non-English language in which ten percent or more of the population residing in the county is literate only in that language.

All claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

1. *Information Requirements*. When the Plan notifies You of its initial denial on Your claim, it will provide:

    a. The specific reason or reasons for the decision, and (for medical claims) the denial code and its corresponding meaning will be included in the initial decision; and

    b. Reference to the Plan provisions or rules and regulations on which the decision was based; and

    c. A description of any additional information or material needed to properly process Your claim and an explanation of the reason it is needed; and

    d. A copy of the Plan's internal review procedures and time periods to appeal Your claim, plus a statement that You may bring a lawsuit under ERISA following the review of Your claim; and

    e. For medical claims, information sufficient to identify the claim involved, including the date of service, the health care Provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes; and

    f. For medical claims, a description of the Plan's standard, if any, that was used in denying the claim; and

g. For medical claims, a description of available internal appeals and external review processes including information regarding how to initiate an appeal; and

h. For medical claims, information regarding the availability of and contact information for the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with the internal claims and appeals and external review process; and

i. For medical and disability claims, the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards or similar criteria of the Plan do not exist; and

j. For medical and disability claims, a copy of the scientific or clinical judgment, or statement that it is available to You at no cost upon request, if Your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit; and

k. For health claims, if Your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

In addition, in the event the determination disagrees with the views of (1) a health care professional treating You; (2) vocational professionals who have evaluated You; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with Your claim; or (4) a disability determination regarding You made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

The decision shall be final and binding upon You unless that decision is appealed as hereinafter set forth below.

D. APPEALING A DENIED CLAIM

If Your claim is denied or You disagree with the amount of the benefit, You have the right to have the initial decision reviewed. You must follow the appeals procedure before You appeal through the external claims review process and before You file a lawsuit under ERISA, the federal law governing employee benefits.

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

1. 180 days from the date of a decision for **medical care** or **Short-Term Disability Benefit** claims; or

2. 60 days from the date of a decision for **Life, AD&D, or Dependent Life Insurance Benefit** claims.

When appealing a claim, You may authorize a representative to act on Your behalf. However, You must provide notification to the Fund Office authorizing this representative. A health care Provider that has knowledge of Your medical condition may act as Your authorized representative for urgent care claims.

Your written appeal must explain the reasons You disagree with the decision on Your claim and You may provide any supporting documents or additional comments related to this review. When filing an appeal You may:

1. Submit additional materials, including comments, statements or documents; and

2. Request to review all relevant information (free of charge).

In addition, if Your claim is for **medical care** or **Short-Term Disability Benefits** and is denied based on:

1. An internal rule, guideline, protocol or other similar exclusion or limit, You have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

2. A Medical Necessity, Experimental treatment or similar exclusion or limit, You have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

The review of a Short-Term Disability benefit appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject of the appeal nor a subordinate of such individual. If the appeal of a Short-Term Disability decision is based in whole or in part on medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the

subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny a Short-Term Disability appeal, You will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give You a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the Plan Administrator shall provide You, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review of a Short-Term Disability claim is provided so as to give You a reasonable opportunity to respond prior to that date.

E. CONTINUED COVERAGE PENDING THE OUTCOME OF AN INTERNAL APPEAL FOR MEDICAL CLAIMS

If Your claim is a medical claim, You will receive continued Coverage under the Plan pending the outcome of Your internal appeal. This means that the Plan will not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review.

F. APPEAL DECISIONS

If You file Your appeal on time and follow any applicable required procedures, a new, full and independent review of Your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will provide You with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination will be provided to You in order to give You an opportunity to respond prior to that date.

The Plan will notify You, in writing, of the decision on any appeal within five calendar days. However, oral notice of a determination on Your urgent care claims may be provided to You sooner.

1. *Appeal Time Frames. The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:*

a. **Health Care Claims**.

i. Urgent Care Claims – A determination will be made within 72 hours from receipt of Your appeal.

ii. Pre-Service Claims – A determination will be made within 30 calendar days from receipt of Your appeal.

iii. Post-Service Claims – A determination will be made within 60 calendar days from receipt of Your appeal. However, the determination may be made at the Plan's next meeting if the appeal is received within 30 days of that meeting.

iv. Concurrent Care Claims – A determination will be made before termination of Your benefit.

b. **Short-Term Disability Benefits**. A determination will be made within 45 calendar days from receipt of Your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives Your request for review. However, the Plan may:

i. Make its decision at the next quarterly meeting of the Board of Trustees; or

ii. If Your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

c. **Life, AD&D and Dependent Life Insurance Benefits**. A determination will be made within 60 calendar days from receipt of Your appeal. If special circumstance require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives Your request for review. However, the Plan may:

i. Make its decision at the next quarterly meeting of the Board of Trustees; or

ii. If Your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting; or

iii. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal. If such extension is required, You will be provided with written notice of the extension, describing the special circumstances and the date as of which the benefit

determination will be made prior to commencement of the extension; or

iv. After consideration of the appeal as above, the Board of Trustees shall advise You of its decision in writing within five (5) days after the benefit determination is made.

2. *Medical Judgments*. If Your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

a. Has appropriate training and experience in the field of medicine involved in the medical judgment; and

b. Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of Your claim.

You have the right to be advised of the identity of any medical experts consulted in making a determination of Your appeal.

3. *Information Requirements*. When the Plan notifies You of its determination on Your appeal, it will provide:

a. The specific reason or reasons for the decision, including reference to the Plan provision on which the decision was based; and

b. A statement notifying You that You have the right to request a free copy of all documents, records and relevant information; and

c. Information relating to any additional voluntary appeal procedures offered by the Plan; and

d. A statement that You may bring a civil action suit under Section 502(a) of ERISA; and

e. The applicable contractual limitations period that applies to Your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim; and

f. For medical claims, information sufficient to identify the claim involved, including the date of service, the health care Provider, and the claim amount (if applicable) as well as the diagnosis code, the treatment code, and the corresponding meanings of those codes; and

g. For medical claims, inclusion of the denial code and its corresponding meaning in the description of the reason or reasons for the adverse benefit determination; and

h. For medical claims, a description of the plan's standard, if any, that was used in denying the claim and a discussion of the decision; and

i. For medical claims, a description of available external review processes including information regarding how to initiate an appeal;

j. For medical claims, information regarding the availability of and contact information for the Consumer Affairs Division of the Ohio Department of Insurance to assist individuals with the internal claims and appeals and external review process; and

k. For medical and Short-Term Disability claims, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

l. For medical and Short-Term Disability claims, a copy of the scientific or clinical judgment, or statement that is available to You at no cost upon request, if Your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit; and

m. For Short-Term Disability claims, a discussion of the decision including an explanation for disagreeing with or not following any of the following:

    i. the views of health care professionals treating You; or

    ii. the views of vocational professionals who evaluated You; or

    iii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or

    iv. a disability determination made by the Social Security Administration.

The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if You are entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon You.

G. EXTERNAL REVIEW PROCESS

After exhausting the internal review process described above, You may appeal an adverse benefit determination through an external review process if the claim is for medical or prescription benefits. If the Plan fails to adhere to the information requirements set forth in Section C or Section F of Article XIII of the Plan, You will be deemed to have exhausted the internal claims and appeals process and may initiate an external review. You may also pursue any remedies under section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. However, minor violations that do not cause, and are not likely to cause, prejudice or harm to You will not trigger a deemed exhaustion of the internal review process if the Plan demonstrates the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing good faith exchange of information between You and the Plan.

For more information regarding the external review process, contact the Third-Party Administrator at the number listed in Article II.

H. OFFICIAL PLAN RECORDS

You may submit whatever records and evidence You believe are appropriate in support of Your claim for benefits. However, the Trustees shall rely upon the records of the Plan ("Official Plan Records") in determining Your eligibility for benefits and, if You are eligible, the amount of Your benefits. In the event of a discrepancy between the Official Plan Records and the records or other evidence supporting the claim asserted by You or Your beneficiary, the Trustees shall rely upon the Official Plan Records unless shown to their satisfaction that the additional or other records/evidence You submitted are valid and that the Trustees should rely upon those records/evidence. The burden of proving a claim for benefits which differs from the Official Plan Records shall be upon You or Your beneficiary.

I. SOLE DISCRETIONARY AUTHORITY ON PLAN BENEFITS

Under the documents creating the Fund (and the terms of the Plan), the Board of Trustees has sole discretionary authority to make a final determination regarding any application for benefits, the interpretation of the Plan and any administrative rule adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or person to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decides the Participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan, and the decisions and interpretations of the Board shall not be reversed by a court of competent jurisdiction unless the decisions and interpretations are determined to be arbitrary or capricious.

You must follow the Plan's claims and appeals procedures completely before You bring an action in court under the Employee Retirement Income Security Act of 1974 (ERISA) to obtain Your benefits. You or any other Claimant may not begin any legal action, including

proceedings before administrative agencies, until You have followed and exhausted the review procedures described in this section. You may, at Your own expense, have legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement of the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

ARTICLE XIV - COORDINATION OF BENEFITS

This Plan is designed to help You pay for Your health care expenses, including medical, Prescription Drug, dental and vision. It is not intended that You receive greater benefits than Your actual healthcare expenses. The amount of benefits payable under this Plan will be coordinated with any coverage You or an Eligible Dependent has under other health care plans, including Medicare.

The Plan will always pay to You or on Your behalf either its regular benefits in full or a reduced amount that, when added to the benefits payable to You by other plans, will equal the Maximum Allowed Amount. However, no more than the maximum benefits payable under this Plan will be paid.

1. **Order of Payment**. If You or Your Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefits payment so that the total benefits payable does not exceed 100% of the allowable expense incurred.

    a. In general, the following rules determine which plan is the primary plan:

        i. A plan that does not have a coordination of benefits rule is always primary;

        ii. A plan that covers an individual as an employee is primary;

        iii. A plan that covers an Eligible Dependent through the Eligible Dependent's employer is primary for that Eligible Dependent; and

        iv. A plan that covers an individual as an active employee or Dependent of an active employee is primary (over a plan that covers an individual as a laid-off or retired employee or dependent of such employee).

    b. If a Dependent child is covered under more than one plan and the parents are not divorced or separated, the following rules determine which plan is primary:

        i. The plan that covers the parent whose date of birth occurs earlier in the calendar year (excluding the year of birth) is primary;

ii. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary; or

iii. If a plan does not use the "birthday rule," the rules of the other plan determine the order of benefit payments.

c. If a Dependent child is covered under more than one plan and the parents are divorced or separated, the following rules determine which plan is primary:

i. Where there is a court decree that establishes legal responsibility, the plan covering the Dependent child of the parent who has legal responsibility is primary.

ii. Where there is no court decree or a court order does not specify which plan is primary, the plan of the parent with custody is primary.

iii. Where there is no court decree or a court order does not specify which plan is primary, the plan of the:

1. Parent with custody pays first; then

2. Spouse of the parent with custody (if applicable) pays next; then

3. Parent without custody pays next.

iv. If none of the above determines the primary plan, the plan that has covered the individual for the longest period of time is primary.

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

3. **Coordination of Benefits with Medicare**. The Plan's benefit payment coordinates with Medicare's payment. Medicare consists of three parts, Part A, Hospital Insurance Benefits for the Aged and Disabled, primarily covers

Hospital benefits, although it also provides other benefits. Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, primarily covers Physician's services, although it, too, covers a number of other items and services. Part C, commonly referred to as Medicare Advantage, is the managed care program under Medicare. Part D, Medicare Prescription Drug Benefit, covers Prescription Drugs. If You are eligible for Medicare, the Plan's payment is based on both Medicare Part A and Part B benefits.

Typically, You become eligible for Medicare upon reaching age 65. Under certain circumstances, You may become eligible for Medicare before age 65 if You are a disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). If You are eligible for Medicare based solely on permanent kidney failure (ERD), Medicare coverage will not start until the fourth month of dialysis. Therefore, the Plan is generally Your only Coverage for the first three months of dialysis. When You obtain Medicare because of ERD, there is a period of time when the Plan is primary and will pay health care bills first. This is called the 30-Month Coordination Period. The 30-Month Coordination Period starts the first of the month You are able to get Medicare because of ERD, even if You have not enrolled in Medicare yet.

You should be aware that even if You do not choose to retire and do not begin receiving Social Security monthly payments when You are eligible, You are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, You should apply for it as soon as You are eligible. You will be required to pay a monthly premium for Part B of Medicare.

The Plan is primary while You are actively working, even if You are eligible for Medicare. If You or Your Dependents are eligible for Medicare and are not actively working, Your claims should be submitted to Medicare first. After Medicare pays the claim, submit an itemized statement along with the Medicare Explanation of Benefits to the Fund Office.

Any benefits payable to You or Your Dependents under any portion of the Plan will be reduced by the amount of any benefits or other compensation to which You are entitled under any Federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if You or Your Dependents are above age 65 and Medicare is the primary plan over the Plan for the same Injury or illness, regardless of whether or not You have received or made application for such benefits or compensation.

ARTICLE XV - SUBROGATION

The Plan's right of subrogation and reimbursement arises and will be exercised when any benefits are paid to or on behalf of You or an Eligible Dependent (referred to in this section as "Covered Person") due to a loss, Injury, or illness for which another person or entity may be legally responsible.

1. This includes but is not limited to a loss, Injury or illness:

    a. Compensable under any workers' compensation system;

    b. Due to medical malpractice, negligence, tortuous, or criminal conduct of a third party; or

    c. Any other circumstance.

2. In consideration of the Plan's advancement of benefits in these situations, the Plan has a first priority lien and right of subrogation and reimbursement, as described in the following paragraphs. The Plan is to be fully reimbursed when recovery occurs or is available from any source (referred to here as the "responsible person") including, but not limited to:

    a. The person or entity that may be responsible for such loss, Injury or illness;

    b. The insurer of such person or entity;

    c. The Covered Person's insurer (including coverage for medical payments, underinsured and/or uninsured motorists' coverage, at fault or no-fault insurance, casualty insurance, or liability insurance);

    d. Any workers' compensation system; or

    e. Any other source.

    Such recovery includes, but is not limited to court judgments, administrative or agency orders, private settlements or any other payments, regardless of how characterized. No settlement is to be made or release given for claims arising out of the Covered Person's loss, Injury, or illness without prior written consent of the Plan.

    The Plan will be reimbursed for the full gross amount of any and all benefits paid or otherwise provided by the Plan. The Plan will receive full and complete reimbursement first and prior to any other disbursements, including disbursement to the Covered Person, payment of attorneys' fees, and/or expenses. The Plan's right to full reimbursement is not subject to reduction

for any reason including, but not limited to, the Covered Person's failure to recover the perceived full or actual value of his or her claim for whatever reason, attorneys' fees, expenses, or other costs, and/or the Plan's failure to actively participate in the claim or recovery. Further, the Plan expressly rejects and prohibits application of the "make-whole," "common fund," and "equitable subrogation" doctrines and any similar doctrines or common law rules with respect to its subrogation and reimbursement rights.

Notwithstanding anything written here to the contrary, the Plan may elect to compromise or otherwise settle its right or claim of subrogation or reimbursement when, under the circumstances, it deems it appropriate to do so.

The Covered Person must complete any paperwork deemed necessary by the Plan or its agents to protect its subrogation interests, including the signing of subrogation and/or reimbursement agreement; failure to do so entitles the Plan to deny Coverage for the subject loss, Injury, or illness.

The Covered Person will do nothing to impair or negate the Plan's right of subrogation and will fully cooperate with the Plan to protect and enforce such right. If the Covered Person performs any act, fails to act, or otherwise compromises the Plan's rights, the Plan may immediately seek recovery of all benefit amounts previously paid by any available means, including legal action. The Plan will also have a lien and the right to offset against any future benefit payments that would otherwise be payable to or on behalf of the Covered Person, to the extent of the amounts previously paid. The Covered Person will permanently forfeit these offset benefits and the Covered Person will be legally responsible for any unpaid amounts of such offset benefits.

The Covered Person assigns to the Plan any and all claims, demands, and contractual rights the Covered Person has or may have against responsible person(s) arising from or related in any way to the Covered Person's loss, Injury, or illness, and agrees that the Plan is substituted in the place of the Covered Person against such responsible person(s) to the extent of the amount paid by the Plan as a result of such loss, Injury, or illness. This entitles the Plan to make a claim or file suit in the name of the Covered Person. The Covered Person agrees that the Plan may at any time notify or otherwise communicate with the responsible person(s), and, if necessary, to commence and prosecute a lawsuit against such responsible person(s) with all due diligence.

ARTICLE XVI - DEFINITIONS

A. ACCIDENTAL INJURY

"Accidental Injury" means bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law.

B. ACTIVE PARTICIPANT

"Active Participant" means a Participant currently has Employer Contributions paid to the Trust Fund on his/her behalf and/or is making self-payments under the terms of the Plan.

C. AGREEMENT AND DECLARATION OF TRUST

"Agreement and Declaration of Trust" or "Trust Agreement" means the Amended and Restated Agreement and Declaration of Trust of the Sheet Metal Workers Local No. 33 Cleveland Health and Welfare Trust, which has been entered into by and between the Union and the Association and those Employers who, by virtue of Collective Bargaining Agreements with the Union, have agreed to participate in and contribute to this Trust Fund and who became parties thereto and that document, as may from time to time be amended.

D. AMBULANCE SERVICES

"Ambulance Services" means a state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

E. ASSOCIATION

"Association" means the Cleveland Chapter of the Sheet Metal and Air Conditioning Contractors National Association ("SMACNA").

F. AUTHORIZED SERVICE

"Authorized Service" means Covered Services rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Third-Party Administrator to be paid at the Network level. The Participant may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible.

G. BEHAVIORAL HEALTH CARE

"Behavioral Health Care" includes services for mental health and substance abuse. Mental health and substance abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

H. BOARD OF TRUSTEES

"Board of Trustees" or "Board" or the "Trustees" means the Plan's Board of Trustees. The Board of Trustees shall be the "Plan Administrator," as that term is used in ERISA.

I. CENTERS OF EXCELLENCE (COE) NETWORK

"Centers of Excellence (COE) Network" means a network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Participants access select types of benefits through a specific network of medical centers. A network of health care professionals contracted with the Third-Party Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

J. CLAIMANT

"Claimant" means the person making a claim.

K. CODE

"Code" means the Internal Revenue Code of 1986, as originally enacted and subsequently amended.

L. COINSURANCE

"Coinsurance" means, if a Participant's Coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Participant is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

M. COLLECTIVE BARGAINING AGREEMENT

"Collective Bargaining Agreement" means any Collective Bargaining Agreement existing between an Employer and the Union which provides for contributions into the Trust Fund as well as any extension or extensions, renewal or renewals of any such Collective Bargaining Agreement or any Collective Bargaining Agreement which provides for contributions into this Trust Fund.

N. COPAYMENT

"Copayment" or "Co-Pay" means a cost-sharing arrangement in which a Participant pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Participant is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

O. COSMETIC SURGERY

"Cosmetic Surgery" means any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

P. COVERAGE

"Coverage" means the benefits payable under this Plan as a consequence of Injury or illness, which are allowed under the Plan.

Q. COVERED SERVICES

"Covered Services" means Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative, and (d) provided in accordance with such Plan.

R. COVERED TRANSPLANT PROCEDURE

"Covered Transplant Procedure" means any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Third-Party Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

S. CUSTODIAL CARE

"Custodial Care" means any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the

maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

T. DEDUCTIBLE

"Deductible" means the portion of the bill You must pay before Your medical expenses become Covered Services. It is applied on a calendar year basis.

U. DEPENDENT

"Dependent" means an Eligible Dependent meeting the requirements for Eligible Dependents identified in Article IV.

V. DETOXIFICATION

"Detoxification" means the process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

W. DEVELOPMENTAL DELAY

"Developmental Delay" means the statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

X. DISQUALIFYING EMPLOYMENT

"Disqualifying Employment" means any non-covered employment in the Sheet Metal Industry, as defined in the Collective Bargaining Agreement, except employment: (1) as a "salted" organizer; (2) in a related building trade – if that employment is on referral and authorized by the Union, in the Sheet Metal Industry; or (3) if it is covered by a Collective

Bargaining Agreement, or stipulation of agreement with another union, and is outside the jurisdiction of the Union.

Y. DOLLAR BANK

"Dollar Bank" means Your accumulated future contribution credits, which are placed in an account identified in Article IV. Section C.

Z. DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" or "DME" means Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

AA. ELIGIBLE DEPENDENT

"Eligible Dependent" means any Dependent in a Participant's family who meets all the requirements of the Eligibility section of this SPD and has enrolled in the Plan.

BB. EMPLOYEE

"Employee" means and includes

1. A member of a collective bargaining unit represented by the Union who is eligible to participate in and receive the benefits of the Plan in accordance with the Agreement and Declaration of Trust; and

2. A full-time, regular Employee of the Union, its associated apprenticeship programs, and/or the Trustees, subject to the review and approval of, and any conditions regarding contributions and participation imposed on the Trustees; and

3. A full-time, nonseasonal, Employee of an Employer who is not a member of a Union collective bargaining unit represented by the Union including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other full-time employee (hereinafter collectively referred to as "Non-Bargaining Unit Employees"), but only if: (i) equal contributions are made for all Employees, (ii) all Employees receive benefits, (iii) all full-time Employees are Covered under the Plan established hereunder, and (iv) subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees. The Employer shall contribute to the Fund for all of its full-time, nonseasonal, Employees subject to the non-discrimination requirements of applicable provisions of the Internal Revenue Code and the Regulations thereunder. At no time may such non-bargaining unit Employees exceed ten

percent (10%) of the Participants Covered by and receiving benefits under the Plan.

4. An individual formerly employed by an Employer as a member of the collective bargaining unit represented by the Union for purposes of allowing self-payments to the Fund in accordance with the rules and regulations adopted by the Trustees and as set forth herein.

CC. EMPLOYER

"Employer" means:

1. Any individual, firm, association, partnership or corporation which is a member of the Association and/or is represented in collective bargaining by the Association and which is bound by the Collective Bargaining Agreement with the Union and in accordance therewith agrees to contribute to the Trust Fund.

2. Any individual, firm, association, partnership or corporation which is not a member of nor represented in collective bargaining by the Association, but which has duly executed and/or is bound by the Collective Bargaining Agreement with the Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in and contribute to the Trust Fund.

3. The Union and its associated apprenticeship programs, to the extent and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes contributions to the Trust Fund in accordance with the Collective Bargaining Agreement or other written agreement.

4. The Trustees, to the extent and solely to the extent, that they act as an Employer of their Employees on whose behalf they make contributions to the Fund in accordance with the Collective Bargaining Agreement or other written agreement.

5. The Employers, as defined herein, shall, by the making of payments to the Trust Fund in a manner provided by the Collective Bargaining Agreement and/or participation agreement, be conclusively deemed to have accepted and be bound by the Trust Agreement, the Collective Bargaining Agreement, this Plan, the Rules and Regulations and all actions of the Trustees.

DD. EMPLOYER CONTRIBUTIONS

"Employer Contributions" means payments made to the Trust Fund by an Employer.

EE. ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as originally enacted and subsequently amended.

FF. EXPERIMENTAL/INVESTIGATIVE

"Experimental" or "Investigative" means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Third-Party Administrator determines to be unproven.

The Third-Party Administrator will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Third-Party Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Third-Party Administrator. In determining whether a service is Experimental/Investigative, the Third-Party Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be

proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Third-Party Administrator to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other Federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Third-Party Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

GG. FREESTANDING AMBULATORY FACILITY

"Freestanding Ambulatory Facility" means a Facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The Facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

HH. HOME HEALTH CARE

"Home Health Care" means care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

II. HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

JJ. HOSPICE

"Hospice" means a Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

KK. HOSPITAL

"Hospital" means an institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

LL. INELIGIBLE PROVIDER

"Ineligible Provider" means a Provider which does not meet the minimum requirements to become a contracted Provider with the Third-Party Administrator. Services rendered to a Participant by such a Provider are not eligible for payment.

MM. INFERTILITY

"Infertility" means the condition of a presumably healthy Participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual, vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

NN. INJURY

"Injury" means bodily harm from a non-occupational accident.

OO. INPATIENT

"Inpatient" means a Participant or Dependent who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

PP. INTENSIVE CARE UNIT

"Intensive Care Unit" means a special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

QQ. INTENSIVE OUTPATIENT PROGRAMS

"Intensive Outpatient Programs" means short-term behavioral health treatment that provides a combination of individual, group and family therapy.

RR. MATERNITY CARE

"Maternity Care" means obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a Covered benefit and the newborn infant is an eligible Participant under the Plan.

SS. MAXIMUM ALLOWED AMOUNT

"Maximum Allowed Amount" means the maximum amount that the Plan will allow for Covered Services You receive.

TT. MEDICAL CHILD SUPPORT ORDER

"Medical Child Support Order" or "MCSO" means any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

UU. MEDICAL EMERGENCY

"Emergency Services," "Emergency Care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity,

including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

VV. MEDICAL FACILITY

"Medical Facility" or "Facility" means a Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined herein. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Third-Party Administrator.

WW. MEDICALLY NECESSARY

"Medically Necessary" or "Medical Necessity" means an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or Injury and that is determined by the Third-Party Administrator to be:

- medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Participant's condition, illness, disease or Injury;
- obtained from a Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- the most appropriate supply, setting or level of service that can safely be provided to the Participant and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Participant's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- not Experimental/Investigative;
- not primarily for the convenience of the Participant, the Participant's family or the Provider; and,

- not otherwise subject to an exclusion under this SPD.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment

XX. MEDICARE

"Medicare" means the program of health care for the aged and disabled established by Title XVIII of Social Security Act of 1965, as amended, and included under Medicare Parts A and Part B.

YY. NETWORK PROVIDER

"Network Provider" means a Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Third-Party Administrator to provide Covered Services to Participants through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another.

ZZ. NON-COVERED SERVICES

"Non-Covered Services" means services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

AAA. OFFICIAL PLAN RECORDS

"Official Plan Records" means the records of the Plan, as maintained by the Third-Party Administrator.

BBB. OUT-OF-NETWORK PROVIDER

"Out-of-Network Provider" means a Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Third-Party Administrator to provide services to Plan Participants at the time services are rendered. Benefit payments and other provisions of this Plan are limited when a Participant uses the services of Out-of-Network Providers.

CCC. OUT-OF-POCKET-MAXIMUM

"Out-of-Pocket Maximum" means the maximum amount of a Participant's Coinsurance payments during a given calendar year. Note, this is different from the Plan Year which is used for reporting purposes. When the Out-of-Pocket Maximum is reached, the level of

benefits is increased to 100% of the Maximum Allowed Amount for Covered Services**,** exclusive of Copayments and other scheduled charges.

DDD. PARTIAL HOSPITALIZATION PROGRAM

"Partial Hospitalization Program" or "Partial Hospitalization" means structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

EEE. PARTICIPANT

"Participant" means individuals, including an eligible Employee and his/her Dependents, who have satisfied the eligibility requirements of the Plan.

FFF. PHARMACY

"Pharmacy" means an establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

GGG. PHYSICAL THERAPY

"Physical Therapy" means the care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

HHH. PHYSICIAN

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D.) are also Providers when acting within the scope of their licenses and when rendering services Covered under this Plan.

III. PLAN

"Plan" means the Sheet Metal Workers Local 33 Cleveland District Health Benefits Plan Document, as the same may, from time to time, be amended as hereinafter provided.

JJJ. PLAN ADMINISTRATOR

"Plan Administrator" or "Fund Administrator" or "Administrative Manager" means the Board of Trustees of the Sheet Metal Workers Local No. 33 Cleveland District Health and Welfare Trust. **The Plan Administrator is not the Third-Party Administrator.**

KKK. PLAN SPONSOR

"Plan Sponsor" means the Board of Trustees of the Sheet Metal Workers Local No. 33 Cleveland District Health and Welfare Trust. **The Plan Sponsor is not the Third-Party Administrator.**

LLL. PLAN YEAR

"Plan Year" is the same as the Plan's fiscal year, which begins on May 1 and ends on April 30 of each year.

MMM. PRESCRIPTION DRUGS

"Prescription Drugs" means a medicine that is approved by the Food & Drug Administration (FDA) to treat illness or Injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book*: Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

NNN. PREVENTIVE CARE

"Preventive Care" means care means all of the following:

i. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

ii. Immunizations that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

iii. With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

iv. With respect to women, such additional Preventive Care and screenings not described in paragraph (i) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

v. Flu shots for all members of the Cleveland District of the Sheet Metal Workers International Association Local Union No. 33, Cleveland District, working under a Collective Bargaining Agreement providing for contributions to this Plan are provided under this Plan at no cost to the individual regardless of whether the individual has qualified for Coverage under the eligibility rules of this Plan.

Lists of all of the current items and services provided for in the guidelines discussed in subsections i. through iv. can be found at the following website: http://www.healthcare.gov/center/regulations/prevention.html.

OOO. PROVIDER

"Provider" means a duly licensed person or Facility that provides services within the scope of an applicable license and is a person or Facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be Covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this SPD. If You have a question if a Provider is covered, please contact the PPO network provider at the information provided in the front of this SPD.

PPP. QUALIFIED MEDICAL CHILD SUPPORT ORDER

"Qualified Medical Child Support Order" or "QMCSO" means a court order that creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the Plan to receive benefits for which the Participant Employee is entitled under the Plan; and includes the name and last known address of the Participant Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

QQQ. RESIDENTIAL TREATMENT CENTER

"Residential Treatment Center Facility" or "Residential Treatment Center Facility" means a Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;
- A staff with one or more Doctors available at all times;
- Residential treatment takes place in a structured Facility-based setting;
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care; and
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated

Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

RRR. RETAIL HEALTH CLINIC

"Retail Health Clinic" means a Facility that provides limited basic medical care services to Participants on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physicians assistants and nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

SSS. SEMIPRIVATE ROOM

"Semiprivate Room" means a Hospital room which contains two or more beds.

TTT. SKILLED CONVALESCENT CARE

"Skilled Convalescent Care" means care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

UUU. SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution operated alone or with a Hospital which gives care after a Participant leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Third-Party Administrator.

VVV. SPECIALIST

"Specialist," "Special Care Physician," "Special Care Provider," or "SCP" means a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

WWW. SPOUSE

"Spouse" means that person, if any, who:

1. Is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship; and

2. Has not been declared legally separated or divorced from the Participant by judicial order.

XXX. THIRD PARTY ADMINISTRATOR

"Third Party Administrator" means a third party which, pursuant to an administrative services agreement with the Plan's Board of Trustees, is responsible for performing the day-to-day operations the Plan.

YYY. TOTAL DISABILITY

"Total Disability" or "Totally Disabled" means that You are prevented from performing the material and substantial duties pertaining to Your occupation and You receive no remuneration for any other work or service.

ZZZ. TRANSPLANT PROVIDERS

"Network Transplant Provider" means a Provider that has been designated as a "Center of Excellence" for Transplants by the Third-Party Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

"Out-of-Network Transplant Provider" means Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Third-Party Administrator nor has it been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

AAAA. TRUSTEE

"Trustee" means any natural person designated as Trustee under the terms of the original Agreement and Declaration of Trust and his successor or successors in office.

BBBB. TRUST AGREEMENT

"Trust Agreement" means the Amended and Restated Declaration of Trust of the Sheet Metal Workers Local No. 33 Cleveland District Health and Welfare Trust.

CCCC. TRUST FUND

"Trust Fund," "Trust" or "Fund" means the Sheet Metal Workers Local No. 33 Cleveland District Health and Welfare Trust and the entire assets thereof, including all funds received by the Trustees in the form of Employer Contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any and all other property of funds received and held by the Trustees under the Trust Agreement.

DDDD. UNION

"Union" means the Sheet Metal Workers International Association Local Union No. 33, Cleveland District, and any other local union that by contract with an Employer approved by the Board of Trustees agrees to become a part of the Sheet Metal Workers Local No. 33 Cleveland Health and Welfare Trust and to be bound by the Trust Agreement, Plan document and the rules and procedures prescribed by the Trustees.

EEEE. URGENT CARE

"Urgent Care" means services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

FFFF. UTILIZATION REVIEW

"Utilization Review" means evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section D(5) of Article VI), procedures, and/or Facilities.

GGGG. YOU

"You" and "Your" mean the Participant and each Eligible Dependent.

ARTICLE XVII - PRIVACY POLICY IN COMPLIANCE WITH THE HEALTH INSURANCE AND PORTABILITY ACCOUNTABILITY ACT

The Plan is required to protect the confidentiality of Your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

1. Definition of Protected Health Information.

The Board of Trustees of the Plan is the Plan's designated Plan Sponsor. The Plan's administrative staff and other professionals service providers to the Plan may create, receive, maintain or transmit individually identifiable health information of Plan Participants, required for the Plan's administrative functions. When this health information is provided by the Plan to the Plan Sponsor, Business Associates, subcontractors, and other service providers to the Plan, such information is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA, as amended.

On January 25, 2013, HIPAA's Privacy, Security, Enforcement and Breach Notification rules were modified by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (collectively referred to as the "HIPAA Omnibus Rules" or "HIPAA Rules"). These modifications were effective on or after March 26, 2013.

The following definition of PHI shall apply for purposes of compliance with all HIPAA Omnibus Rules and HIPAA regulations:

a. PHI is information that is created or received by the Plan and relates to the past, present, or future:

   i. physical or mental health condition of a Covered Person;

   ii. provision of health care to a Covered Person;

   iii. payment for the provision of health care to a Covered Person;

   iv. identification of the Covered Person; or

   v. belief that the information can be used to identify the Covered Person.

b. PHI may be created, received, maintained, or transmitted to or from the Plan according to the following methods:

i. by electronic media;

ii. in electronic media; or

iii. in any other written or oral form or medium.

c. PHI excludes individually identifiable health information contained in:

i. education records covered by the Family Educational Rights and Privacy Act, as amended;

ii. medical records described at 20 U.S.C. 1232g(a)(4)(B)(iv);

iii. employment records held by a covered entity in its role as Employer; and

iv. records of a Covered Person who has been deceased for more than 50 years.

2. Permitted Uses of Protected Health Information-Payment

The Plan will use and disclose PHI for purposes related to payment, health care treatment, and health care operations. For this purpose, payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for Coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These payment activities include, but are not limited to, the following:

a. determination of eligibility, Coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim);

b. coordination of benefits;

c. adjudication of health benefit claims (including appeals and other payment disputes);

d. subrogation of health benefit claims;

e. establishing Employee contributions;

f. calculation of amounts due to risk adjustments or other factors;

g. billing, collection activities, and related health care data processing;

h. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participants' (and their authorized representatives') inquiries about payments;

i. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary, in the future;

j. Medical Necessity reviews, or reviews of appropriateness of care or justification of charges;

k. Utilization Review, including pre-certification, preauthorization, concurrent review, and retrospective review; and

l. reimbursements to the Plan.

3. Health Care Operations

For purposes of determining uses or disclosures of PHI relating to health care operations, the term "health care operations" includes, but is not limited to, the following activities:

a. quality assessment;

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

c. rating Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

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

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

f. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or Coverage policies; and

g. the Plan's management and general administrative activities, including, but not limited to:

i. management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;

ii. Participant and Provider service, including the provision of data analysis;

iii. resolution of internal grievances; and

iv. filing of governmental forms, including Internal Revenue Service Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

v. For "research" purposes, defined by current HIPAA Omnibus Rules and Regulations as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. An Employer may use or disclose PHI which has been appropriately de-identified according to HIPAA regulations for research purposes.

The Plan will use and disclose PHI for administrative purposes only as required by law and permitted by authorization of Covered Persons or their beneficiaries. The Plan will disclose PHI to other related benefit plans which may provide retirement and/or disability benefits to a Covered Person or beneficiary, but only upon written authorization from such Covered Person and the execution of a Business Associate Agreement by such benefit plan. Such uses and disclosures will be made for purposes solely related to administration of the Plan.

4. Permitted Uses and Disclosure of Summary Health Information.

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

a. obtaining premium bids from health plans for providing health insurance Coverage under the Plan; or

b. modifying, amending, interpreting, or terminating the Plan.

For this purpose, the term "Summary Health Information" means information that:

i. summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and

ii. has been de-identified in accordance with the HIPAA Omnibus Rules.

5. Activities That Require Permission for Use or Disclosure of Protected Health Information.

In accordance with rules promulgated by the HIPAA Omnibus Rules, the Plan must have the express written permission/authorization of any Covered Persons (or their beneficiaries) to use or disclose PHI to engage in the following activities:

i. the use or transmission of psychotherapy notes related to the treatment of any Covered Person;

ii. the use of PHI when the Plan receives financial remuneration from a third party for communications regarding treatment and health care, when that third party is marketing its product or service to the Plan or eligible Employees;

iii. the sale of PHI for any reason; or

iv. activities which are not specified or described in the Plan.

Covered Persons who wish to provide written permission/authorization to the Plan to use or disclose PHI for such activities may obtain permission/authorization forms from the Fund Office. In addition, Covered Persons may revoke such express written permission/authorization at any time by contacting the Fund Office and executing an updated form.

6. Use of Genetic Protected Health Information Prohibited.

In accordance with regulations under GINA, the Plan is prohibited from using any Covered Person's "genetic information" for any underwriting purposes. Genetic information includes manifestations of diseases or

disorders that have appeared in a Covered Person's family history but have not appeared in the Covered Person's health record.

7. Disclosure Restrictions on Protected Health Information for Health Care Expenses Paid in Full by Covered Persons.

In accordance with regulations under HITECH, a Covered Person has the right to restrict disclosures of his or her PHI to the Plan when the Covered Person pays out of pocket, in full, for any health care item or service.

8. Opting Out of Fundraising Activities Involving Protected Health Information.

All Covered Persons have the right to opt out of fundraising activities sponsored by, or engaged in, by the Plan Sponsor which involve the use of PHI. However, the Plan Sponsor may include the use of demographic information, health insurance status, or dates of health care for Covered Persons in order to raise money for a non-profit organization or charity.

The Plan Sponsor shall include a reminder of a Covered Person's rights and methods to opt out fundraising activities whenever the Plan Sponsor sends fundraising communications.

9. Protected Health Information Breaches Required to be Disclosed under HIPAA Regulations.

The Board of Trustees shall report to the Plan any breach of PHI of which it becomes aware. All Covered Persons will receive a detailed written explanation whenever an event occurs that results in a breach of unsecured PHI. For this purpose, the term "breach" means the acquisition, access, use, or disclosure of PHI in a manner which is prohibited by HIPAA regulations and which compromises the security or privacy of PHI. The impermissible use or disclosure of PHI is presumed to be a breach unless the Plan Sponsor or Business Associate specifically demonstrates that there is a low probability that PHI has been comprised.

10. Covered Person's Right to Receive Protected Health Information from the Plan Sponsor.

All Covered Persons have the right to obtain a copy of their PHI from the Plan Sponsor in electronic or hardcopy format. To obtain this information, a Covered Person must make a written request to the Fund Office.

11. Conditions of Disclosure for Plan Administration Purposes.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified in accordance with the HIPAA Omnibus Rules) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor shall:

a. not use or further disclose PHI, other than as permitted or required by plan documents, privacy notices, Business Associate Agreements, or as required by current laws and regulations;

b. ensure that any Business Associates, providers, agents or Plan representatives, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information by executing written Business Associate Agreements;

c. not use or disclose PHI for employment-related actions and decisions unless authorized by Covered Persons or their beneficiaries;

d. not use or disclose PHI in connection with any other benefit or employee benefit plan unless authorized by the Covered Persons or as otherwise specifically provided herein;

e. report to the Plan and Covered Persons any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Omnibus Rules of which it becomes aware;

f. make PHI available to a Covered Person in accordance with the current access requirements of the HIPAA Omnibus Rules;

g. make PHI available to a Covered Persons to permit the individual affected by such information to make amendments to such PHI in accordance with the HIPAA Omnibus Rules;

h. make available the PHI required to provide an accounting of PHI disclosures in accordance with the HIPAA Omnibus Rules;

i. make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the United States Department of Health and Human Services ("HHS") for the purposes of determining compliance by the Plan with the HIPAA Omnibus Rules and regulations;

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

k. implement administrative, physical, and technical safeguards that reasonably de-identifies and appropriately protects the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; and provide for adequate separation, which is supported by reasonable and appropriate security measures between the Plan and the Board of Trustees, as set forth below.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified accordance with the HIPAA Omnibus Rules) on behalf of the covered entity, the Board of Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Further, the Plan Sponsor shall ensure that any agents, Business Associates (including subcontractors) to whom it provides such electronic PHI agree to implement similar safeguards, using reasonable and appropriate security measures to de-identify or otherwise protect the information. For these purposes, "electronic PHI" means any PHI that is transmitted by, or maintained in, electronic media.

12. Business Associate Agreements.

Any contract between the Plan and a Business Associate must be set forth in a Business Associate Agreement that complies with the requirements of the HIPAA Omnibus Rules. For this purpose, the term "Business Associate" means a person or entity that performs certain functions or activities on behalf of, or that provides certain services to, the Plan involving access by the Business Associate to PHI. The term "Business Associate" also includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of another Business Associate.

Functions and activities that are performed by a Business Associate include the following:

1. claims processing or administration;
2. data analysis, processing, or administration;
3. Utilization Review;
4. quality assurance; billing;

5. benefit management;
6. practice management; and
7. repricing.

Services that are performed by a Business Associate include the following:

1. legal services;
2. actuarial services;
3. accounting services;
4. consulting services;
5. data aggregation;
6. management;
7. administrative services;
8. accreditation; and
9. financial services.

For purposes of compliance with the HIPAA Omnibus Rules, the term "Business Associate Agreement" means a contract between the Plan and a Business Associate that satisfies the requirements of the HIPAA Omnibus Rules, including the following:

1. establishes the permitted and required uses of PHI by the Business Associate;

2. provides that the Business Associate will not use or further disclose the PHI other than as permitted or required by the Business Associate Agreement or as required by law;

3. requires the Business Associate to use appropriate safeguards to prevent a use or disclosure of PHI other than as provided for by the Business Associate Agreement;

4. requires the Business Associate to report to the Plan any use or disclosure of the information not provided for by its Business Associate Agreement, including incidents that constitute breaches of unsecured PHI;

5. requires the Business Associate to disclose PHI as specified in its contract to satisfy a Plan's obligation with respect to individuals' requests for copies of their PHI, as well as make available PHI for amendments (and incorporate any amendments, if required) and accountings;

6. to the extent the Business Associate is to carry out a Plan's obligation under HIPAA, requires the Business Associate to comply with the requirements applicable to the obligation;

7. requires the Business Associate to make available to HHS the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Plan for purposes of allowing HHS to assess the Plan's compliance with the HIPAA's privacy requirements;

8. at termination of the contract, if feasible, requires the Business Associate to return or destroy all PHI received from, or created or received by the Business Associate on behalf of, the Plan;

9. requires the Business Associate to ensure that any subcontractors it may engage on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the Business Associate with respect to such information; and

10. authorizes termination of the contract by the Plan if the Business Associate violates a material term of the contract.

Contracts between Business Associates and Business Associates that are subcontractors are subject to the same requirements under the HIPAA Omnibus Rules as contracts between the Plan and Business Associates.

13. Persons Entitled to Access to Protected Health Information.

In accordance with the HIPAA Omnibus Rules, only the following employees or classes of employees may be given access to PHI:

1. the Plan's Administrative Manager;

2. staff designated by the Plan's Administrative Manager, investment manager, or other approved Business Associates; and

3. members of the Board of Trustees and the Plan's legal counsel.

These persons may have access to and use and disclose PHI only for plan administration functions that are performed on behalf of the Plan. If these persons do not comply with the Plan's limitation on the use of PHI, the Board of Trustees shall provide for the resolution of issues of noncompliance, including notifying Covered Persons in writing and imposing disciplinary sanctions.

14. Adequate Separation between Plan and Plan Sponsor.

The Plan Sponsor will allow third party service providers access to PHI, subject to the Business Associate Agreement restrictions under Section 12 above. No other persons shall have access to PHI. These specified individuals or entities shall only have access to and use PHI to the extent

necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers fail to comply with the Business Associate Agreement restrictions under Section 12 above, such service provider shall be subject to termination pursuant to the Business Associate Agreement in place.

The Plan Sponsor shall ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

15. Certification of Plan Sponsor.

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in 11 above.

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (a) that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance Coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor will, in accordance with the Security Regulations, take the following measures:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the "ePHI" that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means that the Plan Sponsor will use ePHI only for activities related to the Plan's administration and not for employment-related actions or for any purpose unrelated to the Plan's administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in

violation of the Plan's security or privacy policies and procedures or the Plan's provisions regarding such policies and procedures is subject to the Plan's disciplinary procedure.

3. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Report to the Plan any security incident of which it becomes aware.

The Plan and the Plan Sponsor will take the measures necessary to comply with the requirements of the HITECH Act and regulations issued by HHS implementing the HITECH Act. These measures include the following:

1. Modify and expand existing HIPAA privacy and security rules to protect PHI.

2. Comply with breach notification procedures that require the Plan Sponsor to notify an individual and HHS (and a prominent media outlet in any breach affecting more than 500 individuals in a state or jurisdiction) when there is a breach of unsecured PHI that affects such individual. For this purpose, "unsecured PHI" is PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technology or methodology specified in guidance issued by HHS.

3. Disclose expanded information to any individual who requests an accounting of PHI disclosures.

ARTICLE XVIII - MISCELLANEOUS PROVISIONS

A. CHANGE OF PLAN PROVISIONS

The Board of Trustees, in their sole discretion, are empowered to change or amend any Plan provision, including but not limited to, the Eligibility Rules or Schedule of Benefits at any time by amendment or resolution duly executed. You have no vested right to any of the benefits set forth herein.

B. CHANGE IN TERMS

The terms of this Plan may be changed at any time without advance notice to You or Your Dependent, except as prohibited by law. All changes in Coverage will be made on a uniform basis, affecting similarly situated Participants, Employees and Eligible Dependents equally, and will not apply to claims incurred before the amendment or termination is effective.

C. AMENDMENTS

The Board of Trustees is empowered to amend this Plan from time to time in their sole discretion, as they deem necessary to carry out the purposes and objectives of the Plan and Trust Agreement.

D. CONSTRUCTION BY TRUSTEES

The Board of Trustees has complete authority and sole discretion to determine eligibility for benefits and to construe and interpret the provisions of the Plan and Trust Agreement such that any determination of benefits eligibility or construction of Plan terms shall not be reversed by a court of competent jurisdiction unless such determination or construction is determined to be both arbitrary and capricious. This means that if You challenge a decision of the Board of Trustees in court, the judge will be required to defer to the Trustees' determinations. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the Claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

E. LEGAL ACTIONS

No action, at law or in equity, shall be brought against the Plan to recover benefits within 60 days after the Plan receives written proof in accordance with this Benefit Book that Covered Services have been given to You. No such action may be brought later than two years after expiration of the required claim filing limit as specified in the Proof of Loss Section.

F. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

Upon the request of the Trustees, You or Your Dependent may be required as a condition to continue eligibility under this Plan to apply for Social Security Benefits, Medicare and Medicaid or the program then in effect. You or Your Dependent may also be required as a condition to continue eligibility under this Plan to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from the Participant or Dependent and appropriate government agencies pertaining to their claim for Social Security Benefits, Medicare and Medicaid benefits.

G. RIGHT OF RECOVERY

Whenever payments have been made by the Trust Fund 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 Trust Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Trust Fund shall determine: Any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior payment to any Participant, Employee and/or Dependent.

H. NONDISCRIMINATION RIGHTS

The Plan shall not discriminate against You or Your Dependents based on health status in either eligibility, enrollment or premium contributions in accordance with Federal law. However, the Trustees shall have the right to require You or Your Dependent to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process a claim.

I. PAYMENT OF BENEFITS

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, the Association, any Employer, or the Trustees. The Trustees, the Employers and the Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

J. SEVERABILITY

In the event that any provision of this Plan Document/Summary Plan Description is determined to be illegal or invalid, such illegality or invalidity shall not affect the remaining provisions of this Plan Document/Summary Plan Description as presently written or subsequently amended.

K. GOVERNING LAW

This Plan shall be construed, enforced and administered and the validity determined in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Internal Revenue Code of 1986, as amended, and, to the extent not preempted by Federal law, the law of the State of Ohio.

L. INFORMATION GATHERING

The Trustees, or their appointed representatives, may release or obtain any information necessary in accordance with any applicable legislation. Anyone claiming benefits under this Plan must provide any information necessary to implement the Plan provisions or to determine their applicability. This provision is subject to the Plan's Privacy Policy.

M. HEALTH CARE FRAUD

Health care fraud is not only unethical, immoral and illegal, it is costly to the Plan and each and every Participant pays for the dishonesty of the person who commits health care fraud. If the Trustees determine, in their sole and absolute discretion, that a Participant has defrauded the Plan, the Trustees may rescind the Coverage of that Participant. The Plan will provide the Participant with thirty days written notice prior to rescinding Coverage under the Plan as a result of fraud or intentional misrepresentation. The Participant and/or Dependent who engages in such activity may face disciplinary action from the Union and criminal prosecution.

Furthermore, any Participant or Dependent who receives money from the Plan or has benefits paid on his/her behalf to which he/she is not entitled will be required to fully reimburse the Plan. If not fully reimbursed the Trustees have the right to: offset the unpaid amount against (a) any future medical claims for which the Participant and/or Dependent(s) may be entitled to have paid for by the Plan and/or (b) retain Employer Contributions to the Plan made on behalf of the Participant while said Participant and/or Dependent(s) are suspended.

ARTICLE XIX - YOUR ERISA RIGHTS

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

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

B. CONTINUE GROUP HEALTH COVERAGE

You may continue health care Coverage for Yourself, Spouse or Dependents if there is a loss of Coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such Coverage. Review this Summary Plan Description and the documents governing the Plan and the rules governing Your COBRA continuation Coverage rights

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

D. ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 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 or a Medical Child Support Order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the United States Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

E. ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Fund Office at (216) 267-3344. 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, United States 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. The nearest Area Office of the Employee Benefits Security Administration is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 at (859) 578-4680.

ARTICLE XX - GENERAL INFORMATION

A. NAME OF PLAN

The formal name of the Plan is the "SHEET METAL WORKERS LOCAL NO. 33, CLEVELAND DISTRICT, HEALTH BENEFITS PLAN."

B. THE NAMES AND ADDRESSES OF THE EMPLOYERS

This is a multiemployer Plan as that term is defined in the Employee Retirement Income Security Act of 1974 (ERISA), and numerous Employers contribute to it. It would not be practical to list them all here. However, upon written request to the Administrative Manager of the Plan, You will receive information as to whether a particular Employer or Union is contributing to the Plan, and if so, its address.

C. THE NAME AND ADDRESS OF THE PLAN ADMINISTRATOR

Board of Trustees
Sheet Metal Workers Local No. 33
Cleveland District Health and Welfare Trust
12515 Corporate Dr.
Parma, Ohio 44130
Ph. (216) 267-3344
Fax (216) 267-3345

D. THE NAME AND ADDRESS OF THE THIRD-PARTY ADMINISTRATOR

BeneSys, Inc.
12515 Corporate Dr.
Parma, Ohio 44130
Ph. (216) 267-3344
Fax (216) 267-3345

E. PLAN NUMBERS ASSIGNED TO THE PLAN

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 34-6746427, and the Plan Number for the purposes of identification is 501.

F. TYPE OF PLAN

The Plan is maintained for the purpose of providing death, dismemberment, disability, hospitalization, surgical, medical, Prescription Drug, dental, vision, and other related benefits as described herein.

G. THE PLAN YEAR

The Plan Year is a twelve (12) month period beginning May 1 and ending April 30 for all benefits.

H. TYPE OF ADMINISTRATION USED FOR THE PLAN ASSETS

The Trust Fund is administered by a Board of Trustees consisting of not more than four (4) Trustees, two (2) of whom are designated by the Employers (Employer Trustees), and two (2) of whom are designated by the Union (Union Trustees). At the present time, they are:

UNION TRUSTEES	EMPLOYER TRUSTEES
Joseph Stastny, Jr.	Thomas E. Martin
John Anderson	Don Skala
Hank Strahan, Alternate	Mike Steidel, Alternate

Correspondence can be made to the Board of Trustees at: Board of Trustees, Local No. 33 Cleveland District Health and Welfare Trust, 12515 Corporate Dr., Parma, Ohio 44130.

I. ATTORNEYS FOR THE FUND AND AGENT FOR SERVICE OF PROCESS

Allotta | Farley Co., LPA
2222 Centennial Road
Toledo, Ohio 43617
Ph. (419) 535-0075
Fax (419) 535-1935

J. FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS

Assets are accumulated and benefits are provided directly by the Trust Fund. The principal and income of this Plan are to be used for the exclusive benefit of the Plan's Participants, their beneficiaries and for defraying proper expenses of administering the Plan.

K. EFFECTIVE DATE WHEN PLAN BEGAN

May 1, 1976

L. EFFECTIVE DATE OF RESTATED PLAN

May 1, 2020

M. SOURCES OF CONTRIBUTIONS TO THE PLAN

Employers make contributions to the Plan together with the self-pay contributions by Participants in accordance with the terms and conditions of the Plan and the requirements of the Fund Office as set by the Board of Trustees and outlined in this Summary Plan

Description. Contributions to this Plan made by Employers shall be made to the Trust Fund only under the obligations of the Collective Bargaining Agreement and/or other written agreement between the Employer and the Union. The Union shall be the authority for the specific provisions of the Collective Bargaining Agreement establishing the obligation of the Employer to make contributions.

N. PLAN AMENDMENT AND TERMINATION

The Trustees reserve the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended or terminated, You and other active and retired Employees may not receive benefits as described in other sections of this Summary Plan Description/Plan Document. You may be entitled to receive different benefits or benefits under different conditions. However, it is possible that You will lose all benefit Coverage. This may happen at any time, even after You retire, if the Trustees decide to terminate the Plan or Your Coverage under the Plan. In no event will You become entitled to any vested rights under this Plan. Further, the provisions of this paragraph cannot be modified in any manner except by resolution formally adopted and signed by the Board of Trustees.

O. PLAN IS NOT A CONTRACT

The Plan shall not be deemed to be a contract between the Plan Administrator and any Participant and/or beneficiary, or to be an inducement to or condition of employment. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

P. SCOPE OF COVERAGE OF PLAN

The provisions of Coverage of this Plan shall be limited to those benefits as provided herein or in the Schedule of Benefits only where accident, Injury, illness or related illnesses are incurred when the Participant and/or Dependent is eligible for Coverage under the Plan.

This Summary Plan Description/Plan Document has been executed this 22nd day of January 2020, to be effective May 1, 2020.

BOARD OF TRUSTEES
SHEET METAL WORKERS' UNION LOCAL 33
CLEVELAND DISTRICT HEALTH BENEFITS PLAN

ON BEHALF OF UNION TRUSTEES:	**ON BEHALF OF EMPLOYER TRUSTEES:**
Joseph Stastny, Chair	Thomas E. Martin, Secretary

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BOARD OF TRUSTEES
SHEET METAL WORKERS' UNION LOCAL 33
CLEVELAND DISTRICT HEALTH BENEFITS PLAN

ON BEHALF OF
UNION TRUSTEES:

Joseph Stasny, Chair

ON BEHALF OF
EMPLOYER TRUSTEES:

Thomas E. Martin, Secretary