



**SHEET METAL, AIR, RAIL AND TRANSPORTATION ASSOCIATION
LOCAL UNION NO. 33 YOUNGSTOWN DISTRICT
HEALTH & WELFARE FUND PLAN**

SUMMARY PLAN DESCRIPTION

2024

**Sheet Metal, Air, Rail and Transportation Association
Local Union No. 33 Youngstown District
Health & Welfare Fund**

To: All Eligible Participants and Dependents:

We are pleased to distribute this Summary Plan Description (SPD) for the Sheet Metal, Air, Rail and Transportation Local Union No. 33 Youngstown District Health & Welfare Fund (the Fund). This document summarizes the terms of the Sheet Metal, Air, Rail and Transportation Local Union No. 33 Youngstown District Health & Welfare Fund Plan Documents (the Plan).

This SPD is not intended to cover every detail of the Plan or every situation that may occur. It is simply a *summary*. The complete Plan is available for inspection at any time at the Fund Office. If there is any conflict between the provisions in this SPD and the Plan, the Plan controls. For a more detailed statement of your rights, benefits, and obligations, please consult the complete Plan.

The Trustees reserve the right to amend the Plan at any time. THERE ARE NO VESTED BENEFITS UNDER THE PLAN.

Please read this SPD carefully and keep it for future reference. This SPD replaces all other Summary Plan Descriptions and amendments thereto previously provided. If you have any questions, please contact the Fund Office.

Respectfully,

**THE BOARD OF TRUSTEES OF THE SHEET METAL, AIR, RAIL AND
TRANSPORTATION ASSOCIATION LOCAL UNION NO. 33 YOUNGSTOWN
DISTRICT HEALTH & WELFARE FUND.**

STATEMENT OF GRANDFATHERED STATUS

We believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Fund Office at 330-779-8863. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

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ARTICLE 1 – DEFINITIONS

As used in this document, the following words are defined as follows:

Ancillary Services means emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a participating or nonparticipating provider; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests per federal guidance or rulemaking).

Apprentice means a person designated as such under the Collective Bargaining Agreement.

Association means Sheet Metal and Roofing Chapter of Eastern Ohio and Western Pennsylvania.

Children or Child means:

- a. Any person up until the first of the month following the month in which he/she turns 26 years of age and either:
 1. is a Participant's natural child or adopted child;
 2. has been placed with a Participant for adoption; or
 3. is a Participant's step-child.
- b. An alternate recipient under a Qualified Medical Child Support Order of a Participant.

COBRA means the Consolidate Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance: A payment that represents the portion of the allowed amount the Participant is responsible for paying after meeting the deductible. The covered services which require a coinsurance payment are specified in the Schedule of Benefits.

Collective Bargaining Agreement. The term "Collective Bargaining Agreement" means any contract entered into between the Union and the Association or any Employer under which the Employer has agreed to contribute to the Fund.

Confinement or Confined means being an in-patient using and being charged for the room and board facilities of an institution.

Consent to Out of Network Services means:

- a. a covered person provided informed consent under applicable law to receive either:
 - post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or
 - nonemergency services from an out-of-network provider at an in-network facility; and
- b. the Plan receives notice of such consent.

Notwithstanding, Consent to Out of Network Services does not include Ancillary Services or items or services provided as a result of unforeseen, urgent medical needs that arise at the time an items or service is furnished.

Continuing Care Patient: If a covered person is a Continuing Care Patient of a provider or facility that terminates its participating provider status with the Plan as a result of: (a) termination of its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or (b) termination of benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network, the Plan will:

- a. notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c, below;

- b. provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and
- c. allow such individual to elect to continue to benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a Continuing Care Patient had such termination not occurred, during the period beginning on the date on which the notice under a), above, is provided and ending on the earlier 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

Covered Expense is an expense covered by, and not excluded by, the terms of this Plan,

Covered Person means a Participant and Dependent eligible for benefits under the terms of this Plan.

Covered Service means a service or supply covered by the terms of this Plan.

Custodial Care means care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications.

Dependent means an Employee's or Retiree's Spouse and Children. No person eligible for coverage as an employee can be covered as a dependent; no person may be the dependent of more than one employee. Notwithstanding, Dependents of Retirees are only those who were covered as Dependents prior to retirement.

Diagnostic Service means a test or procedure performed to detect or monitor a disease or condition and ordered by a physician or other professional provider.

Disability or Disabled means a physical or mental condition resulting from a non-occupational accidental bodily injury or illness (including pregnancy) that prevents an individual from working at his/her regular occupation and requires the regular care and attendance of a legally qualified physician.

Doctor or Physician is a medical practitioner licensed to prescribe and administer drugs or to perform surgery.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Medical Condition means a medical condition (including a mental health condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition means:

- a. a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
- b. medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department as required to Stabilize the patient (regardless of the department of the hospital in which such items or services are furnished), and
- c. unless Consent to Out of Network Services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after the Covered Person is Stabilized and as part of

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outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Employee or Active Employee means any employee on whose behalf an Employer is required to make Contributions to this Fund.

Employer means:

- a. a member of the Association who is bound by the terms of a Collective Bargaining Agreement to make Contributions to the Fund;
- b. any other employer engaged in work coming within the jurisdiction of the Union who is obliged, by a collective bargaining agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund; and
- c. the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund.

Employer Contributions or Contributions mean payments to the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Fund Office means BeneSys, Inc., 3660 Stutz Drive, Suite 101 Canfield, OH 44406.

Health and Welfare Fund or Fund means the Sheet Metal, Air, Rail and Transportation Association Local Union No. 33 Youngstown District Health & Welfare Fund.

Incurred means a charge is considered incurred on the date the covered person receives the service or supply for which the charge is made.

Medically Necessary (or Medical Necessity) means a service, supply, and/or Prescription Drug that is required to diagnose or treat a medical condition and which is:

- Appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- Not primarily for convenience of the patient or Provider;
- Medically proven to be effective treatment of the condition; and
- The most appropriate supply or level of service which can be safely provided. When applied to inpatient care, this means that the medical symptoms or condition requires that the services cannot be safely or adequately provided on an outpatient basis. When applied to Prescription Drugs, this means the Prescription Drugs that produce comparable effective clinical results.

Mental Health or Mental/Behavioral Health Disorder means any disease or condition, regardless of whether the cause is organic, that is either (1) classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Service or (2) listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Notwithstanding, covered Mental Health Benefits do not include benefits for conditions related to Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD), developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems, or intellectual disability.

Other Provider - the following entities which are licensed, where required, and which receive compensation from their patients for rendered covered services.

Professional Other Provider includes only the following:

- Psychologist
- Physical Therapist

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- Podiatrist
- Doctor of Chiropractic Medicine
- Laboratory (must be Medicare approved)
- Dentist
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Worker

Other Facility Provider includes only the following institutions:

- Alcoholism Treatment Facility: a facility which mainly provides detoxification and rehabilitation treatment for alcoholism.
- Day/Night Psychiatric Facility: a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of mental illness only during the day or during the night.
- Dialysis Facility: a facility which mainly provides dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
- Drug Abuse Treatment Facility: a facility which provides detoxification and rehabilitation treatment for drug abuse.
- Home Health Care Agency: a facility which meets the specifications of Chapter 1739 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio and which:
 - provides skilled nursing and other services on a visiting basis in the covered person's home; and
 - is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending physician.
- Outpatient Psychiatric Facility: a facility which mainly provides diagnostic services and therapeutic services for the treatment of mental illness on an outpatient basis.
- Psychiatric Hospital: a facility which is primarily engaged in providing diagnostic services and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Out-of-Network Rate means: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; (3) if neither (1) or (2) apply, the amount agreed upon; (4) if there is no agreement, then the amount determined by IDR.

Participant means an Employee or Retiree. After the death of a Retiree, his/her Surviving Spouse becomes a Participant.

Plan means this document.

Plan Year, or Year if not otherwise defined, means the calendar year.

Pregnancy means childbirth and conditions associated with Pregnancy, including complications.

Provider means a licensed hospital, physician, or Other Provider.

Recognized Amount with respect to an item or service furnished by a nonparticipating provider is: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; or (3)

if neither of the above apply, the lesser of (a) the amount billed by the provider or facility or (b) the Qualifying Payment Amount (QPA).

Retiree means an individual entitled to coverage under §2.3 and was an active Plan participant immediately preceding the date of his or her retirement.

Serious and Complex Condition means:

- (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- (b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Spouse is an Employee or Retiree's lawful spouse as recognized in the state of marriage or domicile.

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Surviving Spouse means that person who was married to the Participant on the date of the Participant's death.

Trustees mean the Trustees of the Sheet Metal, Air, Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund.

Uniformed Service means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Union means Sheet Metal, Air, Rail and Transportation Association Local Union No. 33 Youngstown District.

Usual, Customary and Reasonable Charges - An amount paid by the Fund to out of network providers which is the lower of the actual charge or the charges customarily made for similar services and supplies to individuals of similar medical condition in the locality concerned as determined in the sole discretion of the Trustees.

ARTICLE 2 – ELIGIBILITY

2.1 Eligibility Requirements for Active Employees

(a) Dollar Bank System

- (1) The Fund shall maintain a bookkeeping account for each Active Employee. The account shall be credited with Contributions received on behalf of each Active Employee, and the cumulative amount credited to the account shall be referred to as the Active Employee's "Bank." The Bank shall be credited to a maximum of twelve times the current Cost of Coverage. The Cost of Coverage is the monthly cost of coverage for the plan of benefits elected by the Employee. The Cost of Coverage is established from time to time in the sole discretion of the Trustees and may be changed at any time. As of January 1, 2024, the Cost of Coverage is \$1,293.30, but if the Optional Dental Plan is elected the Cost of Coverage is \$1,357.40
- (2) The Cost of Coverage shall be deducted monthly from each Active Employee's Bank.
- (3) An Active Employee has no right or title to any amounts credited to his/her Bank. All amounts in the Bank are at all times Plan assets. The Bank shall be used exclusively

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for determining eligibility for benefits. The Trustees may at any time and for any reason terminate the Bank and any credit in any Active Employee's Bank at such time will remain a Plan asset.

(b) Initial Eligibility

An Employee becomes eligible for benefits on the first day of the month following the month in which Contributions received by the Fund Office equal three times the Cost of Coverage, provided such amount was accumulated within 12 consecutive months. Initial eligibility will continue for six months thereafter, as follows:

If the Month in Which Contributions Received (within the 12 prior months) equals three times the Cost of Coverage is:	Then Eligibility will be Effective the first day of:	And Will Remain in Effect Through:
January	February	July
February	March	August
March	April	September
April	May	October
May	June	November
June	July	December
July	August	January
August	September	February
September	October	March
October	November	April
November	December	May
December	January	June

Special Rule: An individual working under a collective bargaining agreement that did not previously require Contributions to the Fund may make a single self-payment to obtain initial eligibility if:

- (1) the Trustees agree to the terms of such collective bargaining agreement; and
- (2) such individual is not eligible for participation in another health and welfare fund pursuant to the existing or prior terms of such collective bargaining agreement.

If approved, the amount of the self-payment will be the difference between actual contributions received by the Fund on behalf of such an individual and three times the Cost of Coverage.

(c) Continuation of Eligibility

Eligibility will continue so long as an Active Employee's Bank is sufficient to pay the cost of coverage. For such purposes, Contributions will be credited as follows:

Contributions Received for Work Month of:	Will be Credited to the Bank for Eligibility Month of:
January	July

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February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

(d) Self-Payment

- (1) Once an Employee's Bank is insufficient to cover the Cost of Coverage, he/she may maintain eligibility by making a self-payment in an amount determined in the sole discretion of the Trustees from time to time, as set forth in (2), below. The self-payment amount will be subsidized (i.e. reduced) by 50% for all first year Apprentices and trainees.
- (2) An Employee may continue eligibility by making a partial self-payment for an unlimited number of months or full self-payments for up to (6) six months, provided he/she:
 - a. is laid off or is unemployed and he is actively seeking work through the Union, which means he/she is on the Union's out of work list, registers at least every 30 days with the Union and is available for work;
 - b. is on strike;
 - c. is Disabled; or
 - d. is on an authorized leave of absence granted in accordance with the terms of the Collective Bargaining Agreement, or by reason of Union activities or governmental service or actively related to the construction industry.
- (3) Once an Employee has exhausted self-payments or fails to make a self-payment required to maintain eligibility, he/she will be offered COBRA continuation coverage. If a partial self-payment is not received when required to maintain eligibility, any remaining amounts in the Employee's Bank will be forfeited.
- (4) An Employee who loses eligibility under Section 2.1(e)(3)-(5) is not allowed to self-pay to maintain coverage and will be offered COBRA.

(e) Termination of Eligibility

Notwithstanding any term of the Plan to the contrary, all coverage (including medical reimbursement account) terminates on the earliest of the following:

- (1) The last day of the month the Participant maintains eligibility via the Dollar Bank or self-payments;
- (2) The last day of the month a Participant begins active duty in the armed forces;
- (3) The date a Participant accepts employment in the sheet metal industry with a noncontributing employer;

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- (4) The date an Active Employee ceases Covered Employment and is not on the Union's out-of-work list;
- (5) The date an Active Employee performs work of any type covered by the Collective Bargaining Agreement for a noncontributing employer; or
- (6) The date the Plan terminates.

(f) Reinstatement of Eligibility

Following a loss of eligibility, eligibility will be reinstated the first day of the sixth month following the month in which Contributions equal to one month's Cost of Coverage are received, provided such Contributions are received in the six-month period following termination of eligibility. If an Employee does not reinstate within six months, he/she will have to establish eligibility again under the initial eligibility rules under section 2.1(b).

2.2. Eligibility While Disabled

An eligible Employee's Bank will be credited with three hours a day up to a maximum of 20 hours of Contributions per week for a period not to exceed 26 weeks for the purpose of maintaining eligibility as follows:

- (a) While receiving weekly accident and sickness benefits from the Fund; or
- (b) While receiving weekly compensation from the Industrial Commission (Workers' Compensation); or
- (c) While working light duty as a result of a work injury. The eligible employee's light duty employment must be with a Contributing Employer in a position which does not qualify for fringe benefit contributions.

To receive credit under (b) or (c), above, an Employee must contact the Fund office and provide documentation acceptable in the sole discretion of the Trustees showing the amount of compensation received and the period for which the compensation has been paid.

2.3 Retiree Coverage

(a) In General

(1) Bank Upon Retirement

Upon retirement, Retiree eligibility for coverage will continue in the same manner as when Active so long as his/her Bank permits, including self-payments for the month for which there is an insufficient amount in his/her Bank to pay the monthly Cost of Coverage. After a Retiree's Bank is depleted, self-payments to maintain coverage will be required as set forth in (b), below.

(2) Medicare Eligibility

Retiree coverage, for the Retiree and his/her Spouse or other Dependents, terminates once an individual is Medicare eligible, either at age 65 or, if earlier, due to any other reason such as disability or renal failure. Eligibility will terminate even if the Retiree, Spouse, or Dependent has not applied for, obtained, or paid for Medicare. It is the obligation of the Retiree, Spouse, or Dependent to ensure Medicare coverage has been secured prior to the date he/she becomes Medicare eligible.

(b) Retiree Self-Payments

(1) In General

Retirees must make monthly self-payments to maintain coverage. These self-payment rates are set from time to time in the sole discretion of the Trustees and may be changed at any time. The amount owed by a Retiree may be reduced, based on eligibility, by the Pre-Medicare Funding Program, set forth below. Any lapse in self-payment will result in the termination of Retiree coverage, which cannot thereafter be reinstated.

(2) Pre-Medicare Funding Program

The Pre-Medicare Funding Program was a credit applied to the required monthly self-payment necessary to maintain coverage for eligible Retirees under age 65 who retired on or before May 31, 2022. For further information regarding this program, including eligibility and subsidy amounts, please contact the Fund Office.

(c) Termination of Coverage

Retiree coverage terminates the earlier of the date a Retiree:

- (1) Engages in Disqualifying Employment, which is determined to be, in the sole discretion of the Trustees:
 - Employment in work of any type covered by the terms of the Collective Bargaining Agreement in effect between the Union and the Association, or in any type of work normally performed by Sheet Metal Workers; or
 - Self-employment in the same or related business as any Contributing Employer.
- (2) Becomes eligible for Medicare; or
- (3) Fails to make required self-payments to maintain coverage.

(d) Retiree Coverage

Retirees and their Dependents are covered for medical and prescription drug benefits, Medical Reimbursement Account, and a death benefit.

2.4 Dependent Coverage

(a) General Rules

Dependents are eligible for coverage the date an Employee becomes eligible, provided the Employee provides completed written enrollment materials to the Fund Office within 31 days of the date he/she first becomes eligible. In the event such enrollment materials are not completed and provided to the Fund Office within 31 days of the date the Employee first becomes eligible, coverage will commence the first day of the month enrollment materials are received, if received by the Fund Office by the 15th day of that month, or, the first day of the month following receipt if received by the Fund Office after the 15th day of the month. No person eligible for coverage as an Employee or Retiree can be covered as a Dependent; no person may be the Dependent of more than one Employee.

(b) Initial Enrollment of New Dependents

For new Dependents, a Child will be eligible for coverage as of the date of birth or date of placement for adoption and a Spouse will be eligible for coverage the first of the month following the date of marriage, provided the Participant submits completed enrollment forms and required documentation to the Fund Office within 90 days of the date of birth or placement for adoption or within 31 days of the date of marriage. If not timely enrolled: (a) coverage for a Child, except as set forth in (c), shall be effective the date such person became

a Child as defined in Article 1 upon receipt of completed enrollment materials, (b) coverage for a Spouse shall be effective the first day of the first month following receipt of completed enrollment materials, and (c) coverage of an individual who is a Child due to status as a stepchild shall be effective the first day of the first month following receipt of completed enrollment materials.

(c) Effect of Divorce of Dependent Coverage

If a Participant with a Child/Children divorces from his/her Spouse, the Participant and Spouse must inform the Fund Office within 60 days of the divorce so proper coordination of coverage for the Child/Children can be determined. Failure to do so is considered a fraud on the Fund. A participant's former spouse is entitled to continue coverage under the Fund pursuant to COBRA Continuation Coverage. If the Judgment of Divorce requires the Participant to provide health insurance coverage for his former spouse, it is the Participant's responsibility to arrange for this coverage. A divorced spouse cannot be covered as a Dependent under the Fund. Failure to inform the Fund office of a divorce is considered a fraud on the Fund.

(d) Surviving Spouse

(1) Surviving Spouse of an Active Employee

In the event of the death of an eligible Employee's, eligibility for his/her eligible Dependents shall continue until the earlier of the date the Surviving Spouse:

- (i) becomes eligible to participate in employer group health coverage, meeting minimum value standards and offering coverage that as determined in the sole discretion of the Trustees is not significantly less than those benefits offered by the Plan; or
- (ii) becomes covered under another group program, or
- (iii) becomes eligible for Medicare; or
- (iv) remarries.

Coverage will continue for Dependents so long as the Employee's Bank permits. Thereafter self-payment, in an amount determined in the sole discretion of the Trustees, amended from time to time, is required for continued coverage.

(2) Surviving Spouse of a Retiree

Upon the death of an eligible Retiree, eligibility for his/her eligible Dependents will continue until the earlier of the date the Surviving Spouse:

- (i) becomes eligible to participate in employer group health coverage, meeting minimum value standards and offering coverage that as determined in the sole discretion of the Trustees is not significantly less than those benefits offered by the Plan; or
- (ii) becomes covered under another group program, or
- (iii) becomes eligible for Medicare; or
- (iv) remarries.

Self-payment, in an amount determined in the sole discretion of the Trustees, amended from time to time, is required for this continued coverage. A Surviving Spouse must apply for this coverage within sixty (60) days of the date of the Retiree's death.

(e) Termination of Coverage

Coverage under this Plan will terminate for Dependents the earlier of the date:

- (1) Coverage for the Employee or Retiree upon whom they are dependent terminates;
- (2) He/she no longer meets the definition of Dependent;
- (3) He/she becomes eligible for Medicare;
- (4) He/she fails to make required self-payments to maintain coverage; or
- (5) The date the Plan terminates.

ARTICLE 3 - MEDICAL AND PRESCRIPTION DRUG BENEFITS

3.1 Medical Network

Medical benefits are self-insured. The Plan has contracted with Anthem Blue Cross Blue Shield (Anthem), a preferred provider network. A list of participating physicians and facilities, known as in-network providers, is available at the Fund Office free of charge. Covered Persons are encouraged to use in-network providers to save money for themselves and the Plan but can choose treatment from an out-of-network provider and pay greater out of pocket expenses. To verify whether a doctor or hospital participates on an in-network basis, contact Anthem at www.anthem.com or ask the medical provider before receiving services.

For Out-of-Network Providers and Physicians, other than in certain emergency situations, charges above usual, customary, and reasonable charge (UCR) will not be covered by the Plan. The Participant will be responsible for the charges exceeding UCR.

Services Provided by Nonparticipating Provider at Participating Facility: Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating providers at participating facilities, in the absence of Consent to Out of Network Services, the Plan will:

- (a) not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;
- (b) calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount for such services; and
- (c) apply any cost-sharing payments with respect to such items and services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

3.2 Schedule of Benefits

Subject to the exclusions below, the following summarizes the medical benefits provided under the Fund.

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

Medical Benefits	In-Network	Out-of-Network
Annual or Lifetime Maximum on Essential Health Benefits	None	None
Annual Deductibles	\$500/person \$1000/family	\$1000/person \$2,000/family
Annual Out of Pocket Limit - (includes deductibles, co-insurance and co-pays for medical and Rx)	\$2,000/person \$4,000/family	\$4,000/person \$8,000/family

In-network benefits will be subject to the deductible shown above, after which the Plan will pay 80% of the eligible charges. The Participant will be responsible for 20% of the eligible charge subject to an out-of-pocket maximum of \$2,000 for an individual participant and \$4,000 for a family. After the out-of-pocket maximums for in-network charges has been met, the Plan will pay 100% of eligible in-network charges for the remainder of that calendar year. The benefits for out-of-network providers will be subject to a separate deductible as shown above after which all eligible charges will be payable at 70%. The Participant will be responsible for 30% of the eligible charge subject to an out-of-pocket maximum of \$4,000 for an individual and an out-of-pocket maximum of \$8,000 for a family. After the out-of-pocket maximums for out-of-network charges have been met, the Plan will pay 100% of out-of-network charges for the remainder of that calendar year.

Deductible amounts are based on a Calendar Year from January 1 through December 31 and must be met each year. **Deductible Carry-over:** Covered Expenses incurred during the last 3 months of the Calendar Year which are used toward satisfaction of the deductible can be carried over and used to satisfy the next calendar year's deductible.

(a) Chart of Benefits

The below percentages represent the percentage paid by the Plan. All benefits are subject to deductible unless otherwise noted.

Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
Inpatient Hospital			
Facility - Inpatient Hospital	80%	70%	Semi-Private room; Private room covered at hospital's average semi-private room rate if no semi-private rooms available. After an initial 365 days, payment will be made for additional 365-day periods for the same or related conditions if a lapse of 90 days has occurred between the patient's discharge and next admission to the hospital.
Physician/Surgeon Fee	80%	70%	
Anesthesia	80%	70%	
Assistant Surgeon	80%	70%	
Certified registered nurse anesthetist	80%	70%	

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
Surgical Services	80%	70%	If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.
Diagnostic Lab/X-Ray	80%	70%	
Imaging (CT/PET scans, MRI)	80%	70%	
Diagnostic Medical Examination (EKG/EEG)	80%	70%	
Organ Transplant Benefits (pre-certification required and other restrictions apply)	80%	70%	<p>Coverage for human organ transplants of heart, heart-lung, pancreas, liver, and bone marrow. Kidney transplants will be a covered expense payable as any other illness. Pre-authorization is only granted if medically necessary, the procedure is not experimental and if the transplant surgery is to be performed in an approved hospital.</p> <p>This plan pays for medically necessary covered services related to transplant surgery if the expense is incurred during the five (5) days prior to the surgery and the 365 days thereafter.</p> <p>With prior approval by the Fund Office, benefits will be paid for other services (such as home health care and certain therapy services) when such services are medically necessary, directly related to a covered transplant, and ordered by the physician.</p>
Outpatient Care			
Pre-Admission Testing	80%	70%	

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
Diagnostic Lab/X-Ray	80%	70%	
Surgery, Surgical services: Anesthesiologist and Assistant Surgeon	80%	70%	If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.
Second Surgical opinion	80%	70%	
Emergency Services for an Emergency Medical Condition	80%	80% of the Recognized Amount (in-network deductible and out-of-pocket maximums apply and co-insurance for these Emergency Services to be counted towards in-network out of pocket maximums.	If Emergency Facilities are used and it is determined by the Plan that the situation was not for an Emergency Medical Condition, Covered Services will be paid at the level of coverage stated in the Schedule of Benefits under Non-Emergency Care.
Rehabilitation Services	80%	70%	
Habilitation Services	80%	70%	
Physical Therapy	80%	70%	No massage / maintenance / education
Speech Therapy	80%	70%	Must be restorative. Benefits are not payable to correct learning problems or developmental speech impediments with no medical cause, but benefits are payable for expenses incurred in the initial diagnosis of the problem.
Occupational Therapy	80%	70%	Must be restorative
Radiation and Chemotherapy	80%	70%	
Dialysis	80%	70%	
Hemodialysis	80%	70%	
Cardiac Rehabilitation	80%	70%	

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
Mental Health/Behavioral Health/Substance Abuse			
Outpatient Services	80%	70%	In addition to these Benefits, an Employee Assistance Program (EAP) is available through Anthem Blue Cross Blue Shield at 1-800-865-1044.
Inpatient Services	80%	70%	
Substance Abuse Treatment - Inpatient	80%	70%	
Substance Abuse Treatment - Outpatient	80%	70%	
Physician's Office/Urgent Care/On-Line			
Primary care - visit for Illness/Injury	80%	70%	
Specialists & Consultations	80%	70%	
Urgent Care	80%	70%	
Diagnostic Lab/X-Ray	80%	70%	
Allergy Testing/Injections	80%	70%	
Telemedicine/Telehealth (other than LiveHealth Online)	Plan guidelines copays and deductibles apply		
LiveHealth Online	100%	Not Covered	
Maternity*			
*A complication of pregnancy, however, is treated under the Plan as an illness separate from pregnancy			
Office Visits – Routine pre- and post-natal care.	80%	70%	
Childbirth/delivery professional services including midwife	80%	70%	Newborn care and hospital stay not covered for dependent's child
Childbirth/delivery facility services	80%	70%	Newborn care and hospital stay not covered for dependent's child
Routine Nursery Care	80%	70%	Hospital charges for room and board, supplies and services including circumcision, if applicable, for a newborn child while the mother is confined in hospital due to delivery. Maximum of five days.
Preventive Care			
Preventative Care/screening/immunization	100%	100%	Deductible does not apply. Includes routine physical exams, cholesterol screening, routine GYN exam, mammogram, hearing tests, PAP tests, and pediatric immunizations between ages 1 and 15 based on physician recommendation and the American Academy of Pediatrics (AAP) recommended immunization schedule.
Routine Colonoscopy	100%	100%	Deductible does not apply
Well Baby Care	100%	100%	Birth to 1 year - Coverage for a History and Physical examination, development

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
			assessment, anticipatory guidance and laboratory services and immunizations at intervals based on the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.
Chiropractic Services			
Office Visits	80%	70%	
Manipulations	80%	70%	Spinal manipulations limited to \$1000 per person, per calendar year
Other Services			
Skilled Nursing Facility	80%	70%	<p>If a Covered Person who has been confined in a hospital for 3 or more days during the acute stage of an illness is moved to an extended Care facility within 14 days of discharge from the hospital, the Fund will pay the benefit shown in the schedule of benefits, as well as other services provided by the facility for the period shown in the schedule of benefits.</p> <p>Charges for prescription drugs will not be paid under this benefit.</p> <p>Benefits must have been payable while confined in the hospital. The attending doctor must certify that if not confined in the extended care facility, the patient would have to be confined in a hospital. Two or more confinements due to the same or related cause or condition will be considered to be in the same period of disability.</p>
Private duty Nursing	80%	70%	Limited to \$10,000 maximum per person per calendar year
Hospice Care	No charge up to \$5,000,	No charge up to \$5,000, then 70%	Requires written certification of terminal illness with a life expectancy of six months or less. Inpatient stay limited to 30 days,

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
	then, 80%		<p>including respite care. Recertification will be required before benefits can be paid beyond the maximum benefit period.</p> <p>Benefits will not be paid for the following services:</p> <ul style="list-style-type: none"> • services provided by volunteers or others who do not regularly charge for their services; • counseling of any type which is not: (1) provided by or through the Hospice Care Plan; or (2) for the sole purpose of adjusting to the terminally ill person's death; • services provided by homemakers, caretakers and the like; • funeral services and arrangements; • legal or financial counseling or services; • treatment intended to cure the terminal illness; • hospice care not recommended or started by the attending doctor or a hospice program doctor; and • charges which are not for the palliation and management or a terminal illness;
Durable Medical Equipment	80%	70%	Rental benefits are limited to the purchase price of the equipment.
Prosthetics	80%	70%	Includes Purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that: replace all or part of a missing body organ and its adjoining tissues; or replace all or part of the

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Medical Benefits	In-Network	Out-of-Network	Limitations/Additional Information
			function of permanently useless or malfunctioning body organ.
Abortion – therapeutic and elective.	80%	70%	
Ambulance	80%	Ground Ambulance: 80% Air Ambulance: 80% of the lesser of billed charged of the Qualified Payment Amount, after deductible (in-network deductible and in network out-of-pocket maximums apply and this co-insurance and deductible for air ambulance to be counted towards in-network out of pocket maximums).	
Orthotic Devices	80%	70%	
Coronavirus/Covid-19			
COVID-19 testing	80%	70%	
COVID-19 Treatment	80%	70%	
COVID-19 Vaccines approved for distribution and use by the FDA	100%	100%	

Benchmark Plan for the purposes of defining Essential Health Benefits: The Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act. Grandfathered health plans are prohibited from imposing annual and lifetime dollar limits on any essential health benefits they offer. Therefore, the Plan adopts the Utah State benchmark plan for purposes of defining essential health benefits.

Special Notice Regarding Maternity Benefits: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not,

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under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(b) Exclusions

This coverage does not cover, and covered expenses will not include, charges incurred for:

1. Services, devices, prescription drugs or any other item that is not Medically Necessary.
2. Any expense or cost incurred that was recommended or ordered by a provider not acting within the scope of his license.
3. Any expense incurred when a person was not eligible for coverage under this Plan.
4. For examinations or tests not made as part of the treatment of illness.
5. Unless the covered person would be legally required to pay the charge if there was no coverage.
6. For service in a facility provided by an employer or by a union employee benefit association or similar group of which the covered person is a member.
7. For any care or treatment furnished by the employer or any of its employees.
8. Illness or injury arising out of or in the course of employment, or for a sickness covered by Worker's Compensation.
9. Care received without cost under the laws of the United States or any political subdivision thereof.
10. Disease or injury resulting from war, whether declared or undeclared, or from an act of war.
11. Charges that exceed the Reasonable and Customary allowance.
12. Cosmetic Surgery except due to: (1) accidental injury or (2) treatment is rendered for reconstruction of the breast, surgery and reconstruction of the other breast for symmetrical appearance, or prostheses and physical complications in all stages of mastectomy reconstructive surgery following mastectomy. This coverage is subject to a Plan's annual deductibles and coinsurance provisions.
13. Routine physical examinations and preventive care not incidental or necessary to the treatment of an illness or injury, except as specified elsewhere in this Plan.
14. The treatment of illness or injury or services or supplies not specifically listed as covered medical expenses.
15. For services provided by a "Close Relative." Close relative means the spouse, parent, brother, sister or child of the covered person, or the spouse of the covered person's parent, brother, sister or child.
16. Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group of which the covered person is a member.
17. For a provider not charging for services.
18. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. However, if under law, you may elect this coverage, instead of Medicare, to pay first and if you so elect, then this exclusion will not apply.
19. To the extent those expenses are in any way reimbursable through any public program, other than Medicare.
20. For confinement in, or treatment received from, a hospital owned or operated by the United States government.
21. For charges which would not have been made had medical coverage not existed.
22. For a condition resulting from service in the armed forces of any country or service in a civilian unit serving with such forces.

23. For charges for appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion (bite).
24. To the extent that payment under this plan is prohibited by any law to which you or your family member is subject at the time expenses are incurred.
25. For unnecessary care or treatment, as determined by a review board.
26. For or in connection with custodial care, education and training.
27. For any injury or illness arising from a Motor Vehicle Accident for which there in in effect, or is required to be in effect, any policy of No-Fault automobile insurance.
28. Any expenses incurred for any service or treatment which is not provided or recommended by a physician.
29. Experimental services, procedures, or substances which have not been recognized as accepted standards of medical practice; (Federal Drug Administration, American Medical Association).
30. Treatment of obesity or for weight reduction.
31. Services and/or supplies furnished during periods when the patient is temporarily absent from the hospital.
32. Charges for care, items, services or treatment for gender dysphoria (e.g., sexual reassignment surgery and related treatment). This exclusion includes all medications, implants, surgery, medical or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.
33. Services and/or supplies for personal comfort items such as television, telephone, admission kits, lotion, powder, etc.
34. Exercise equipment and Nutritional supplements.
35. Services rendered or billed for, by a school or halfway house or by a member of its staff.
36. Any confinement in an institution primarily to change or control one's environment (milieu therapy).
37. In vitro fertilization, artificial insemination, reversal of sterilization, or any charges relating to infertility.
38. Services and/or supplies for treatment of an accident or illness resulting from commission of a felony or active participation in a riot.
39. For any care or treatment furnished by an employer or any of its employees.
40. For treatment of sexual problems not caused by organic disease.
41. Dental benefits and services except those rendered by a Physician or Dentist for: (1) an accidental injury to the jaw, sound natural teeth, mouth or face; (2) removal of full or partial bony impacted wisdom teeth. Services will be covered subject to deductible & co-insurance (in & out of network cost-sharing applies).
42. Radial keratotomy or keratoplasty.
43. Chelation therapy.
44. missed appointments, or completion of claim forms.
45. Foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions, calluses, toenails (except capsular, bone surgery) or arch supports or corrective shoes.
46. For hearing aids or examinations for prescribing or fitting them.
47. Charges for care, items, services, or treatment for conditions related to Autism Spectrum Disorder (ASD), hyperkinetic syndromes (including Attention Deficit Hyperactivity Disorder (ADHD)), learning disabilities, behavioral problems or intellectual disability.
48. Incurred after your cancellation date except as specified in the Benefits after Termination Section.
49. Charges billed by a massotherapist.
50. For charges and/or services relating to temporomandibular joint dysfunction.

51. Expenses incurred after termination of this plan.
52. For hospital admission which begins on a Friday or Saturday; but only the hospital expense for those days, and only if surgery does not occur on either of those days and the admission is not an emergency.
53. Replacement of artificial eye or limb prosthetic devices. Initial prosthetic eye or limb covered.
54. Transportation.
55. Home services by a person who resides in the covered person's home.
56. Gene therapy.
57. Vision Benefits.
58. Expenses for an artificial organ.

3.3 Prescription Drug Benefits

(a) Co-Payments and Co-Insurance

Prescription Drug benefits are provided by a pharmacy benefit manager (PBM). The following chart sets forth applicable co-payments and co-insurances to be paid by the covered person. These amounts are based on the PBM's Formulary, which is subject to change at any time. The PBM, Express-Scripts, can be contacted at: www.express-scripts.com.

Prescription Benefits	In-Network	Out-of-Network	Limitations/Additional Information
Generic drugs	10% coinsurance (retail and mail order) with a \$15 copayment per fill minimum fill requirement	Not Covered	30-day supply for retail. 90-day supply available at CVS or Express Scripts mail order pharmacy. Mandatory mail order for maintenance medications after 2 retail fills.
Brand Name drugs	25% coinsurance (retail & mail order) with a \$30 copayment/ per fill minimum fill requirement. If a generic is available, you pay the difference in cost between the brand and generic plus the brand coinsurance, unless your physician has indicated that the brand should be "dispensed as written"	Not Covered	30-day supply for retail. 90-day supply available at CVS or Express Scripts pharmacy. Mandatory mail order for maintenance medications after 2 retail fills.
Specialty drugs	Generic: 10% coinsurance (\$15 minimum) Retail and Mail Order. Preferred and Non-Preferred Brand Drugs: 25% coinsurance (\$30 minimum) Retail and Mail Order.	Not Covered	Limited to designated drugs. Non-urgent medications are required to be filled at Accredo. Urgent Specialty Medications must move to Accredo after 1 retail fill. Mandatory mail order.

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(b) Exclusions/Limitations of Coverage

All exclusions related to medical under Section 3.2(b) apply to prescription drug coverage. Exclusions to coverage also include, but are not limited to:

Over-the counter drugs	Cosmetic Products
Anti-wrinkle agents	Hair Growth stimulants
Nutritional Supplements	Contraceptive Ring
Device Contraceptives	Emergency Kit Contraceptives
Transdermal Contraceptives	Diet Medications
Injectable and Inter-Urethral	Smoking cessation
Erectile Dysfunction*	Gene therapy

*Except for six (6) pills per 30 days at retail or eighteen (18) pills for 90 days via mail service for Viagra, Levitra or Cialis.

ARTICLE 4 SUPPLEMENTAL BENEFITS

4.1. Death Benefits

The Fund will pay an eligible Participant’s beneficiary the death benefit amount below upon receipt of due proof of such Participant’s death while eligible under this Plan.

	Eligible Employees	Eligible Retirees
Death Benefit Amount	\$6,000	\$1,500

Death benefits are payable to the beneficiary designated by the Participant. If a beneficiary is not designated, or if the designated beneficiary predeceases the Participant, then beneficiary shall mean, in the following order:

- The Participant’s spouse;
- The Participant’s parent or parents;
- The Participant’s child or children;
- The executors or administrators of the Participant’s estate.

Payment in accordance with this provision will release the Fund from all liability for the amount so paid.

Beneficiary. A Participant may designate a beneficiary or beneficiaries to receive a death benefit. A Participant may, from time to time, change the designation of beneficiary. Any designation or change will take effect when received by the Fund Office. The Fund will be released from any liability for payment made before it receives the designation or change of beneficiary.

4.2. Accidental Death and Dismemberment

The Fund will pay the benefit specified below to eligible Active Participants when it receives due proof that:

1. The Participant sustained an accidental bodily injury while eligible under this Plan;
2. The Participant suffered a loss shown in the table below solely as a result of the injury; and
3. the loss occurred within 90 days of the accident.

Loss	Benefit
Accidental Death	\$6,000
Loss of Both Hands	\$6,000
Loss of Both Feet	\$6,000
Loss of Both Eyes	\$6,000
Loss of One Hand and One Foot	\$6,000
Loss of One Hand and One Eye	\$6,000
Loss of One Foot and One Eye	\$6,000
Loss of One Hand	\$3,000
Loss of One Foot	\$3,000
Loss of One Eye	\$3,000

The accidental death and dismemberment benefit amount is the maximum payable for all losses as a result of one accident. For this purpose, loss means:

- a. as to hands, severance through or above the wrist;
- b. as to feet, severance through or above the ankle; and
- c. as to eyes, entire and irrecoverable loss of sight.

All benefits other than for loss of life are payable to the Participant after receipt of due proof of loss; except, if applicable, such benefits may be payable to the Participant's Beneficiary. The accidental death and dismemberment benefit is not available to Retirees or their Beneficiaries.

Exclusions. No benefit will be paid for a loss which directly or indirectly results from:

- a. suicide or intentionally self-inflicted injury;
- b. combat, war - declared or not, or act of war;
- c. physical or mental sickness or disease;
- d. the taking of a drug, chemical or poison of any kind;
- e. travel in an aircraft if:
 - i. suicide or intentionally self-inflicted injury;
 - ii. the aircraft is being used for training purposes; or
 - iii. the aircraft is being used by the army, navy, air force, coast guard or other military unit;
- f. commission of a felony.

4.3. Weekly Disability Benefit

Covered Employees Only

Payments will be made at the Weekly Disability Benefit rate stated below when the Covered Employee is wholly and continuously Disabled, provided he/she was available for work for a contributing Employer and eligible under the Plan when he/she became Disabled. Benefits for Covered Employees begin with the 1st day of disability due to accidental bodily injury, or the 8th day of disability due to a sickness and will continue up to the maximum number of weeks stated in the Schedule of Benefits for any one period of disability.

Successive periods of disability due to the same or related causes not separated by return to active employment for a period of two (2) full weeks shall be considered one period of disability. There are no Weekly Disability Benefits for a Participant's dependents. There are no Weekly Disability Benefits available for Retirees.

Payment of Weekly Disability benefit (if any) will be made weekly during the period for which proof of disability has been furnished. Any balance which remains unpaid at the end of the period for which the Participant is owed will be paid at that time.

Maximum Weekly Benefit Amount (net benefit)	\$555 (gross) per week
Maximum Duration	26 Weeks

To receive a Weekly Disability Benefit, a Participant must not be receiving wages or any remuneration for any type of work from any employer or other person or entity.

4.4. Dental Care Benefits

A Voluntary buy-up dental program will be available through Delta Dental. An election to participate in the buy-up dental program will be binding for one year. The cost of this coverage will be deducted from your Dollar Bank. Effective January 1, 2023, the cost for dental coverage is \$61.00 per month. The benefit provision for the dental program is outlined in the table below:

Benefit Provisions	
Buy-up Dental Plan effective	1/1/23
Plan Coinsurance	
Preventive Services	100%
Basic Restorative Services	80%
Major Restorative Services	80%
Orthodontia	80%
Other Provisions	
Deductible	None
Annual Maximum (excludes preventive services)	\$1,000 per individual
Ortho Lifetime Maximum per individual	\$1,000 per individual

ARTICLE 5 MEDICAL REIMBURSEMENT ACCOUNTS

5.1 Establishment and Maintenance of Medical Reimbursement Accounts

The Trustees have established medical reimbursement accounts for Employees for whom contributions are made pursuant to collective bargaining agreements between the Union and an Employer. Except as provided in Section 5.6, below, upon termination of coverage, any balance remaining in a Retiree's or Employee's Account reverts to the Fund.

These contributions shall not create or constitute a vested benefit.

5.2 Eligible Medical Expenses

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") §213 which have not been paid under the Sheet Metal Air Rail and Transportation Association Local No. 33 Youngstown District Health and Welfare Fund or other plan or arrangement. Such expenses, to the extent the participant has funds in his/her individual Medical Reimbursement Account, include, but are not limited to:

- Deductibles and co-payments applied to covered medical expenses under the Sheet Metal Workers Local 33 Youngstown District Health and Welfare Fund or a qualified plan of a dependent spouse;

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- Self-payments to maintain eligibility under the Sheet Metal Workers Local 33 Youngstown District Health and Welfare Fund or premium or other payments required to maintain coverage under the Plan of an Employee's Spouse;
- Unreimbursed prescription medicines (prescribed by a doctor), including co-pays;
- Unreimbursed medical services fees (from doctors, chiropractors, dentists, surgeons, registered nurses, specialists, and other medical practitioners);
- Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);
- Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
- Unreimbursed dental expenses; and
- Any other medical expenses identified in Internal Revenue Code §213 including over-the-counter drugs as defined by the FDA, and amounts paid for menstrual care products.

5.3 Non-Eligible Expenses

Non-reimbursable medical expenses are those medical expenses excluded by Internal Revenue Code ("Code") §213. Such expenses include, but are not limited to:

- Expenses for which the Employee claims or will claim a medical expense deduction on the Employee's tax returns;
- Expenses incurred before the Employee became Initially Eligible for medical benefits under this Sheet Metal Air Rail and Transportation Association Local No. 33 Youngstown District Health and Welfare Fund;
- Expenses incurred after termination of employment and eligibility.

Medical Expenses will be reimbursed only to the extent that reimbursement for such Medical Expenses is not available to the Eligible Person under any health insurance policy or plan provided through any employer of the Eligible Person. If there is such a policy or plan in effect, providing for reimbursement or payment in whole or in part, then to the extent of the coverage under such other policy or plan, the Plan shall be relieved of any liability hereunder.

5.4 Reimbursement

When an Eligible Employee or Dependent has unreimbursed medical expenses and a balance in the Employee's Medical Reimbursement Account, the Employee should submit proof of such out-of-pocket expenses on forms available from the Fund Office. Separate bills may be itemized on the same claim form. Forms must be accompanied by receipts for bills. The Plan will send reimbursement checks as claims are received and approved. Claims for medical expense reimbursement must be filed no later than twelve (12) months following the date of service. Benefits are subject to IRS limitations (§213 of the Internal Revenue Code) and the Plan will be administered in accordance with these limitations. The Plan may assess an administrative fee against the Eligible Person's Account for processing reimbursement claims. Any unused balances in the Employee's Medical Reimbursement Account will be carried over to the next Plan Year, subject to provisions below about "Cancellation of Account" and "Changes."

Eligible Employees will also be issued a debit account card, called a BeneCard, to pay for eligible medical expenses which are not otherwise paid or payable by the Fund. BeneCards may be subject to an administrative fee. Payment for eligible medical expenses will be limited to the balance of an Employee's Medical Reimbursement Account.

5.5 Opt-Out/Cancellation of Account

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Any Employee or Retiree, or the Spouse or Dependents of a deceased Employee or Retiree, may at any time permanently opt-out of coverage and waive future reimbursement under this Section.

5.6 Use of Medical Reimbursement Accounts After Termination of Coverage

Any amount in an Employee or Retiree's Medical Reimbursement Account as of the date his/her eligibility terminates may continue to be used for reimbursement of medical expenses only as follows:

- 1) Retirees may continue to use these funds after termination of eligibility under Section 2.3(c)(2) (Medicare eligibility) or 2.3(c)(3) (fails to make required self-payment);
- 2) Spouses and Children of deceased Employees may continue to use these funds, provided such Spouse/Child was covered under the Plan at the time of death (reimbursement of claims for a Child allowed until age 26);
- 3) Spouses and Children of deceased Retirees may continue to use these funds, provided such Spouse/Child was covered under the Plan the earlier of the time of death or the Retiree's termination of eligibility under Section 2.3(c)(2) or 2.3(c)(3) (reimbursement of claims for a Child allowed until age 26); and
- 4) An Employee whose eligibility terminates following an occupational or nonoccupational injury or illness may continue to use these funds, but only for the period that he/she is disabled from performing work of the type covered by the Collective Bargaining Agreement.

ARTICLE 6 - COORDINATION OF BENEFITS (COB)

This provision shall apply in determining the benefits for an Allowable Expense when a Participant or his/her Dependents have other coverage. This provision applies only to those coverages shown in the schedule of benefits which provide benefits on account of certain hospital, surgical, or medical expenses covered under the policy.

6.1 Definitions

- A. "Plan" means any of the following under which benefits are payable or services are provided for medical or dental treatment:
1. group, blanket or franchise insurance;
 2. a pre-payment service type arrangement, such as a group Blue Cross, group Blue Shield, individual and group practice plans, and health maintenance organizations;
 3. an employer(s), union(s) or joint employers(s)/union trust or other organization or employee benefit association;
 4. a plan or program solely or largely tax supported or provided by or through government action, other than Medicare or Medicaid; or
 5. to the extent permitted by law, an automobile liability policy paying benefits without regard to fault (no-fault).
- Each plan or part of a plan which has a right to coordinate benefits will be considered a separate plan.
- B. "This plan" means any hospital, medical, major medical or dental insurance benefits, as a part of this policy.
- C. "Allowable expense" means a necessary, reasonable and customary item of expense, all or a part of which is covered under one of the plans covering the person for whom claim is made.

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D. "Claim period" means a calendar year or that part of the year in which the person has been insured under this plan. The definitions in the other section apply also to the COB provision.

6.2 Application of COB Provisions

If, for any claim period, the sum of:

- i. the benefits payable under this plan in the absence of the provision; and
- ii. the benefits payable under all other plans in the absence of a similar provision would exceed the allowable expenses incurred for a covered person payable under this Plan, this provision applies.

Except as provided below, benefits under this plan will be reduced to the extent required so that the sum of:

- iii. the reduced benefits under this plan; and
- iv. all benefits payable for allowable expenses under all plans does not exceed the total of allowable expenses. Benefits payable under a plan include benefits that would be payable if proper claim were made. If a plan's benefits are in the form of services, the reasonable value of the services will be both an allowable expense and a benefit paid.

Benefits of another plan will be ignored in determining the reduction if:

- i. the order of benefits rules of this plan required this plan to determine benefits before the other plan; and
- ii. the other plan has a coordination provision that would, under its rules, determine its benefits after this plan.

When benefits are reduced, each benefit payable will be reduced pro rate. The reduced amount will be charged to any benefit limits in this plan.

6.3 Order of Benefit Rules

The rules which follow describe in descending order which plan is primary when there are two or more plans. As used here, "primary" means the benefits of a described plan will be determined before the benefits of another plan:

1. The plan which covers the person as an employee will be primary.
2. The plan of the parent whose birthday occurs first in a year will be primary for a dependent child who is covered under both parents' plans; if a Plan does not have this rule, the rules of that plan will determine which plan is primary.
3. Rule 2 will not apply if the parents are divorced or separated. In that event, the plans will be primary in this order:
 - a. first, the plan of the parent with custody;
 - b. next, the plan of the spouse of the parent with custody; and
 - c. last, the plan of the parent without custody.However, if there is a court decree establishing one parent as financially responsible for the child's medical or dental expenses, the plan of the parent with that responsibility will be primary.
4. If the person is a laid-off or retired employee, the plans will be primary in this order:
 - a. first, the plan which covers the person as an active employee (or as that employee's dependent);

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- b. next, the plan covers the person as a laid-off or retired employee (or that employee's dependent); and
- c. last, all other plans.

This rule will not apply if a plan covering the person has no provision for laid-off or retired employees and, as a result, each plan considers the other plan or plans as primary.

5. When none of the preceding rules apply, the plan covering the person for the longer period of time will be primary.
6. For Medicare-eligible Participants and/or Dependents, this section supersedes all other rules regarding coordination of benefits.
 - (1) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.
 - (2) The following addresses specific situations where MSP Rules are applicable:
 - (A) Coordination with Coverage by Virtue of Current Employment Status: In the event a Medicare-eligible Covered Person in this Plan is also eligible under any Other Plan as a dependent of an actively employed spouse:
 - Medicare is secondary to the Other Plan and primary to this Plan; and
 - The Other Plan is primary to this Plan.
 - (B) End Stage Renal Disease
 After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by Medicare's Secondary Payer rules.
7. With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this plan will be secondary.
8. Motor Vehicle Accidents
 If coverage for a motor vehicle accident is not excluded under this plan, the Fund will only provide coverage on a secondary basis. If coverage is provided on a secondary basis, this means that if the Participant or Dependent is involved in a motor vehicle accident, the claims should first be submitted to his/her no-fault carrier (or other auto carrier) and any expenses not paid by such carrier (for example, deductibles, co-payments, etc.) will be paid by the Fund. If the motor vehicle accident involves a Medicare eligible individual, the order of payment is the no-fault carrier (or other auto carrier) primary, Medicare secondary, and then the Fund if not otherwise excluded.

ARTICLE 7 – INTERNAL CLAIMS AND APPEALS PROCEDURES

7.1 Types of Claims Covered

These procedures are to be used for all benefits available under the Fund.

Urgent health claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;

Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;

Post-service health claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician;

Concurrent claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination; and

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Disability Claims: initial claims for disability benefits or any rescission of coverage of a disability benefit.

7.2. Initial Submission of Claims

Eligible expenses will be reimbursed for the Plan Year in which they were incurred, even if submission of a claim occurs following that Plan Year. Claims must be submitted within 12 months of the date incurred. However, when a Participant or Dependent's coverage terminates for any reason, written proof of claim must be submitted within 90 days of the date of termination of coverage.

Most expenses will be submitted by the provider directly to the Fund. In the event it is not, claims must be submitted to the: Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund 3660 Stutz Drive, Suite 101 Canfield, Ohio 44406. Claim forms are available at the Plan Office. All claims must include (1) a written statement from an independent third party verifying that a medical expense in a specified amount has been incurred, and (2) a written statement from the Participant that the expense has not been reimbursed by or is not reimbursable under any other health plan coverage.

7.3 Notice that Additional Information is Needed to Process Claim

After the claim is submitted, the Plan deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

For Urgent Health Claims – 24 hours after receiving improper claim

For Pre-Service health claims – 5 days after receiving improper claim.

After receipt of notice from Plan that claim is incomplete, this is the Claimant's deadline to supply the Plan the information requested to complete claim:

For Urgent Health Claims – 48 hours after receiving notice

For Pre-Service Health Claims – 45 days after receiving notice

For Post-Service Health Claims – 45 days after receiving notice

For Disability Claims – 45 days after receiving notice.

7.4 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are 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 expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

7.5 Initial Decision on a Claim

(a) Additional Evidence

- (1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and
- (2) Before the Fund can issue an initial benefit determination based on a new or

additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Plan Deadline for Making an Initial Decision on A Claim

For Urgent Health Claims – 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.

For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15-day period. Plan deadline for responding is tolled while awaiting requested information from Claimant.

For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30-day period. The Plan deadline for responding is tolled while awaiting requested information from Claimant.

For Disability Claims – 45 days after receiving the initial claim. A 30-day extension permitted if Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to claimant during first 30-day extension. The Plan deadline for responding is tolled while awaiting additional information from Claimant.

(c) Information to be Included in Benefit Denials

Notice of a benefit denial will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- a description of the Plan's appeal procedures (including a statement of the Claimant's right to bring a civil action after a further denial on appeal);
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist; and,
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

With respect to benefit denials for disability claims only, the benefit denial must also include the following:

- an explanation of the basis for disagreeing with any of the following:
 - The health care professionals that treated the Claimant;
 - The advice of the health professional obtained by the Plan; or
 - A disability determination from the Social Security Administration.
- a statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the

- claims for benefits.
- The benefit denial must be in a culturally and linguistically appropriate manner.

7.6 Submission of Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Claimants are entitled to two appeals. The first appeal (“Level 1 Appeal”) is to be submitted to the Plan Manager at the Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund 3660 Stutz Drive, Suite 101 Canfield, Ohio 44406. The second and final appeal (“Level 2 Appeal”), is to be submitted to the Board of Trustees at the same address.

The reviews on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In deciding the second appeal, the Trustees will not provide deference to the decision of the Plan Manager on the first appeal.

Level 1 Appeals must be submitted in the time frames set forth below:

For Urgent Health Claims – 180 days after receiving denial.

For Pre-Service Health Claims - 180 days after receiving denial.

For Post-Service Health Claims – 180 days after receiving denial.

For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.

For Disability Claims – 180 days after receiving denial.

Level 2 Appeals must be submitted within 60 days of a denial of the Level 1 Appeal.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED BY THE PLAN OR IN A COURT OF LAW.

7.7 Notice of Decision on Appeal

The notice of a decision on appeal will include:

- The specific reasons for the denial;
- The specific Plan provision or provisions on which the decision was based;
- A statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- if the denial was based on medical necessity, experimental nature of treatment, or similar matter, an explanation of same;
- The internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist;
- A statement of the Claimant’s right to bring a civil action under ERISA;
- A statement describing any contractual limitation period that applies to a Claimant’s right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation expires;

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

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided, above, to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to the date.

In addition, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

- An explanation of the basis for disagreeing with any of the following:
 - The health care professionals that treated the Claimant;
 - The advice of the health professional obtained by the Plan; or
 - A disability determination from the Social Security Administration.
- The benefit denial must be in a culturally and linguistically appropriate manner.

The deadline for deciding Level 1 Appeals is:

For Urgent Health Claims – 72 hours after receiving appeal.

For Pre-Service Health Claims – 15 days after receiving the appeal.

For Concurrent Claims – Prior to termination of previously approved course of treatment.

For Post-Service Health Claims – 30 days after receiving the appeal.

For Disability Claims – 30 days after receiving the appeal.

The deadline for deciding Level 2 Appeals is:

For Urgent Health Claims – 72 hours after receiving appeal.

For Pre-Service Health Claims – 15 days after receiving the appeal.

For Concurrent Claims – Prior to termination of previously approved course of treatment.

For Post-Service Health Claims – The Trustees shall decide the appeal at the next regularly scheduled Board Meeting.*

For Disability Claims – The Trustees shall decide the appeal at the next regularly scheduled Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such a case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of the appeal. The Plan shall notify the Claimant of the Trustees’ decision on appeal no later than 5 days after the decision is made.

7.8 Discretion of the Trustees

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7.9 Limitations of Actions

No action may be brought if a Claimant has failed to exhaust the claims and appeal procedures set forth herein. No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

7.10 Deemed Exhaustion of the Internal Claims and Appeals Process

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that 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 the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

ARTICLE 7A: EXTERNAL REVIEW PROCESS

7A.1 Eligibility for External Review

This external review process applies to final internal adverse benefit determinations involving items and services required under the No Surprises Act for out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services.

7A.2 Request for External Review

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

A Claimant must file a request for an external review with the Fund within four months after receipt of notice of denial of a final internal appeal. If you fail to do so, you waive the right to an external review or review in a court of law.

7A.3 Preliminary Review

Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

- (i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
- (ii) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- (iii) The Claimant has exhausted the Plan's internal appeal process; and
- (iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

7A.4 Referral to Independent Review Organization

- (a) The Fund must assign an independent review organization (IRO) to conduct the external review.
- (b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

- (c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.
- (d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:
 - The Claimant's medical records;
 - The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant’s treating provider;
 - The terms of the Claimant’s Plan to ensure that the IRO’s decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.
- (e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.
- (f) The IRO’s decision notice will contain:
- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - the date the IRO received the assignment and the date of the IRO decision;
 - references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
 - A statement that judicial review may be available to the Claimant; and
 - Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.
- (g) The external reviewer’s decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.
- (h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

7A.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives:

- (a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant’s ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

- (b) A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as outlined above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

The contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

7A.6 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

7A.7 Limitations of Actions

No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Participant does not bring an action within 180 days, the Participant waives the right to any further review of an adverse determination in a court of law.

ARTICLE 8- CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available when a Participant would otherwise lose group health coverage. It can also become available to other members of a Participant's family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Fund Office.

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8.1 COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A Participant, his spouse and his dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Type of coverage. If a Participant chooses COBRA continuation coverage, he will be entitled to the same type of coverage that he had before the event that triggered COBRA. This includes Medical, Prescription Drug, Vision, Hearing and Dental Benefits. However, COBRA coverage does not include Death, Accidental Death and Dismemberment or Short-term Disability Benefits.

8.2 Cost of Coverage

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Fund is permitted to charge the full cost for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 50% for members of a COBRA family unit that includes the disabled person for the 11-month disability extension period.

8.3 Qualifying Events

A Participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

1. His hours of employment are reduced such that hours are insufficient to maintain eligibility, or
2. Employment ends for any reason other than his gross misconduct.

The Spouse of a Participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happen:

1. Death of Spouse;
2. Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
3. Spouse's employment ends for any reason other than his or her gross misconduct;
4. Spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
5. Divorce from the participant.

Dependent children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happen:

1. The parent-participant dies;
2. The parent-participant's hours of employment are reduced such that hours are insufficient to maintain eligibility;
3. The parent-participant's employment ends for any reason other than his or her gross misconduct;
4. The parent-participant becomes entitled to Medicare benefits (under Part A, Part B or both).
5. The parents become divorced or; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

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8.4 Availability of COBRA Coverage

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Manager has been notified that a qualifying event has occurred.

The Employer Must Give Notice of Some Qualifying Events. The employer must notify the Plan Manager of the qualifying event when the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both).

Participant Responsibility to Give Notice of Some Qualifying Events. The Participant must notify the Plan in writing within 60 days after the qualifying event in the event of divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited. Notice must be sent to:

Sheet Metal Air Rail and Transportation
Association Local Union No. 33
Youngstown District Health & Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, Ohio 44406

Once the Plan Manager receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

8.5 COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both), your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. However, the covered employee's maximum coverage period will be 18 months. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). The employee's COBRA coverage period in this case is 18 months from the termination of employment and is not related to the employee's Medicare entitlement.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts only for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended that are explained in the next two paragraphs.

Disability Extension of 18-Month Period of Continuation Coverage. If the Participant or anyone covered under the Plan through COBRA is determined by the Social Security Administration to be disabled and the Participant notifies the Plan Manager in a timely fashion, the Participant and their entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Participant must notify the Plan of the disability within 60 days of the determination of disability by the Social Security Administration and before the end of the 18-month continuation period. If the Social Security Administration later determines that a Participant is no longer disabled, the Participant must notify the Plan of that determination within 30 days of the determination. Written Notice must be sent to:

Sheet Metal Air Rail and Transportation
Association Local Union No. 33
Youngstown District Health & Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, Ohio, 44406

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. If a Participant's family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in the family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if:

1. The employee or former employee dies,
2. The employee or former employee becomes entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both),
3. The employee or former employee gets divorced, or
4. The dependent child stops being eligible under the Plan as a dependent child.

The extension is available only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Participant must notify the Plan within 60 days after the second qualifying event occurs. Notice must be sent to:

Sheet Metal Air Rail and Transportation Association Local Union No. 33
Youngstown District Health & Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, Ohio 44406

8.6 Questions

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Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the Fund Office. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA's website at www.dol.gov/ebsa.

8.7 Keep Plan Informed of Address Changes

In order to protect a Participant's rights, the Participant should keep the Plan's Manager informed of any changes in the addresses of family members. The Participant should also keep a copy of any notices sent to the Plan's Manager.

Plan Contact Information

Sheet Metal Air Rail and Transportation Association Local Union No. 33
Youngstown District Health & Welfare Fund
3660 Stutz Drive, Suite 101
Canfield, Ohio 44406
Telephone: (330) 270-0453
Toll-Free: (800) 589-8041

ARTICLE 9 – QUALIFIED MEDICAL SUPPORT ORDER

As set forth below, and in accordance with §609 of ERISA, the Fund shall provide benefits as required by a Qualified Medical Support Order (“QMCSO”). In general, a QMCSO is a medical child support order which creates or recognizes the right of an alternate recipient (i.e. a child of the Participant) to receive benefits under a group health plan. A QMCSO must meet certain requirements and cannot require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 U.S.C. 1396g-1. Procedures for determining the qualified status of medical support orders are available, without charge, from the Fund Office.

ARTICLE 10 – FAMILY AND MEDICAL LEAVE ACT

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act (FMLA). Details concerning FMLA leave are available from the Participant's Employer and requests for FMLA leave must be directed to such Employer. The Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA required contributions from the Employer.

ARTICLE 11 – INTERPRETATION OF PLAN DOCUMENTS

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

ARTICLE 12 – ABSENCE DUE TO MILITARY DUTY

If coverage under the Plan is terminating due to Uniformed Service (as defined in the Uniformed Services Employment and Reemployment Rights Act, USERRA), a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Fund Office as soon as he/she volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However,

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if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount. Notwithstanding, the Participant may elect to continue coverage by way of his/her Bank until it is exhausted. Upon separation from Uniformed Service, a Participant shall be reinstated under the same status he/she had prior to his/her military leave (however, his/her Bank will not be at the same level if he/she elected to continue coverage, above, using his/her Bank). Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities, injuries, or illnesses that the Veterans Administration determines to be service related. For this reinstatement and for these benefits to apply, however, the period of service must be less than five years, the Participant must not have been discharged for undesirable conduct (as determined by the Trustees and as allowed by law), and an Participant must return to work under the Collective Bargaining Agreement within the following time frames:

- For uniformed service of less than 31 days, by the next workday after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of the Participant or as otherwise required by USERAA.
- For service of more than 30 days but less than 181 days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant or as otherwise required by USERAA.
- For service of more than 180 days, within 90 days after completion of the service or as otherwise required by USERAA.

ARTICLE 13 – CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder, for any or all classes of Participants or Dependents, at any time.

The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments.

ARTICLE 14 – GENDER NEUTRALITY

Any term in this Plan stated in the masculine gender is also intended to be in the feminine gender, where applicable, and vice versa.

ARTICLE 15 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- 15.1** Protected Health Information (PHI) as defined in HIPAA, will only be disclosed to the Plan Sponsor when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations. The Fund otherwise complies with the terms of HIPAA.
- 15.2** The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA. The Plan Sponsor shall, among other things, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

ARTICLE 16 --RIGHT TO RECOVER AMOUNTS PAID FOR BENEFITS DUE TO MISTAKE OR FRAUD AND OUTSTANDING AMOUNTS

16.1 Rescission

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind

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coverage. Failure to inform the Fund Office of a divorce or any other event which makes a Dependent ineligible for coverage is considered fraud or intentional misrepresentation of material fact. A 30-day notice of rescission will be provided.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

16.2 Outstanding Payments

All monies payable to a Participant that have not been cashed or otherwise redeemed by the Participant within 12 months of the date of issuance will become null and void. After the expiration of the 12-month period, the monies shall remain assets of the Fund free and clear of claims made by any person or entity seeking to assert an interest in such monies.

In the event any other payment issued by the Fund, for any reason, has not been redeemed by the payee for a period of 24 months, or such lesser time as set forth on the payment issued by the Fund, such payment is void and reverts to the Plan as a plan asset.

ARTICLE 17-- OTHER PROVISIONS

17.1. Right of Recovery

If the Plan pays more for Covered Services than the provisions of this Plan require, the Plan has the right to recover the excess from anyone to or for whom the payment was made. The Participant agrees to do whatever is necessary to secure the Plan's right to recover the excess payment.

17.2. Subrogation

The Sheet Metal, Air, Rail and Transportation Association Local Union No. 33 Youngstown District Health & Welfare Fund will take advantage of its right to subrogation if a Participant or their dependent is paid benefits by the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity, including motor vehicle accidents.

The term Covered Person as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

Subrogation. In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity. The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person or entity. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person or entity. The Plan's subrogation interest shall apply regardless of whether the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person or entity. The "make-whole" rule shall not apply.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, health fund, health plan, insurance policies, or any other funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any party, person, corporation entity, insurance company, health fund, health plan, insurance policies, or any other funds, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any party, person, corporation entity, insurance company, health fund, health plan, insurance policies, or any other funds, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

Reimbursement. Each Covered Person hereby agrees to reimburse the Plan, for any Medical Benefits paid by the Plan, out of any money recovered from any person, entity, or Other Coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. The Plan has the right to be reimbursed in an amount equal to the amount of Medical Benefits paid hereunder, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Sponsor may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Plan Sponsor, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

For purposes of this provision, the term "Covered Person" includes anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

The Participant is also advised that when they or their eligible Dependents submits a claim to this Plan for injury or illness, such person will be required to complete and execute a form requesting the following information:

1. How the injury or illness occurred.
2. The identity of any potentially responsible third parties, including their insurer, adjuster, and claim numbers.
3. Accident reports.

4. An assignment of their beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

The Participant may also be required to sign other documents and do whatever is reasonably necessary to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

A Participant or their eligible Dependent shall not do anything to impair or negate this Plan's Right of Subrogation. If a Participant or their eligible Dependent(s) perform any act or fail to act, and such should compromise the Plan's Right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either a Participant or their eligible Dependent(s) in the amount of any outstanding lien.

The Plan may recover mistaken payments in any other lawful manner, as well.

ARTICLE 18 – OBTAINING A CERTIFICATE OF CREDIBLE COVERAGE

A Covered Person will be provided a certificate of creditable coverage, free of charge, from the Fund Office upon losing coverage under the Plan, when he/she becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, a Covered Person may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) upon enrolling in other coverage. You may request a certificate of creditable coverage by contacting the Fund Office, 3660 Stutz Drive, Suite 101 Canfield, Ohio 44406; telephone (330) 270-0453, or toll free (800) 589-8041.

ARTICLE 19 – STATEMENT OF ERISA RIGHTS

As a participant in the Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites 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.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 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 U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE 20 – GENERAL PLAN INFORMATION

Plan Name

Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund.

Plan Sponsor:

The Board of Trustees of the Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund.

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Type of Administration / Plan Administrator / Plan Sponsor / Plan Counsel:

The Plan is administered by a Board of Trustees consisting of six Trustees, of which three are designated as Employer Trustees and three are designated as Union Trustees. The current Trustees are:

Union Trustees	Employer Trustees
Rob Bodnar Sheet Metal Workers Local No. 33 200 McClurg Road Boardman, Ohio 44512	Kevin Reilly Builders Association P.O. Box 488 Vienna, Ohio 44473
Jesse Wright Sheet Metal Workers Local No. 33 200 McClurg Road Boardman, Ohio 44512	Adam Froelich TEMA Roofing Services 1596 Motor Inn Drive Girard, OH, 44420
Matthew Yurchison Sheet Metal Workers Local No. 33 200 McClurg Road Boardman, Ohio 44512	Jeremy Smith York Mahoning Mechanical Contractors 724 Canfield Rd. P.O. Box 3077 Youngstown, Ohio 44511-3077

The day-to-day responsibilities for Plan administration are performed by BeneSys. The Fund Office is located at 3660 Stutz Drive, Suite 101 Canfield, Ohio 44406. The Fund Office phone number is (330) 270-0453.

Employer Tax I.D. No. (EIN): 34-6751847
Plan Number: 501
Type of Plan: Self-Funded Welfare Benefit Plan—Group Health Plan
Plan Year Ends: December 31
Effective Date of Plan: January 1, 1976

Legal Counsel for the Plan:

Jacqueline A. Kelly, Esq.
Michael J. Asher, Esq.
AsherKelly, PLLC
25800 Northwestern Highway, Suite 1100
Southfield, MI 48075
(248) 746-2700

Statutory Agent for Service of Legal Process

The Board of Trustees of the Sheet Metal Air Rail and Transportation Association Local Union No. 33 Youngstown District Health and Welfare Fund, 3660 Stutz Drive, Suite 101 Canfield, Ohio 44406. Service of process may also be made upon the Fund Administrator, the Fund’s Legal Counsel, or any individual Trustee.

Collective Bargaining Agreements

The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Fund Office or are available for examination by participants and beneficiaries at the Fund Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

Source of Plan Contributions

This document is a SUMMARY of the official Plan document. Additional limitations and exclusions may be found in the official Plan document, which is available without charge at the Fund Office.

The primary source of financing for the benefits provided under this Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement(s). Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of the Plan assets is invested, and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Fund Office and may be examined at the Fund Office.

Welfare Trust Assets and Reserve

The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

THIS SUMMARY PLAN DESCRIPTION IS NOT INTENDED TO COVER EVERY DETAIL OF THE PLAN OR EVERY SITUATION THAT MIGHT OCCUR. IT IS SIMPLY A SUMMARY. THE COMPLETE PLAN IS AVAILABLE FOR INSPECTION AT ANY TIME AT THE FUND OFFICE. IF THERE IS ANY CONFLICT BETWEEN THIS SUMMARY AND THE PLAN, THE PLAN CONTROLS. FOR A MORE DETAILED STATEMENT OF YOUR RIGHTS AND OBLIGATIONS, CONSULT THE PLAN DOCUMENT.

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