SUMMARY PLAN DESCRIPTION

GLAZING HEALTH AND WELFARE TRUST

RESTATED JANUARY 1, 2022

SUMMARY PLAN DESCRIPTION

FOR

GLAZING HEALTH AND WELFARE TRUST

January 1, 2022

TRUST ADMINISTRATIVE OFFICE

BeneSys Administrators
8311 W. Sunset Rd., Suite 250
Las Vegas Nevada 89113
(702) 415 – 2191
(702) 257-5361 (FAX)

Glazing Health and Welfare Trust

Board of Trustees

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BeneSys Administrators

LEGAL COUNSEL
Christensen James & Martin

CONSULTANT
Kaufmann and Goble

AMENDMENT AND TERMINATION

In order that the Trust may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible Benefits for all Glaziers and Fabricators in Southern Nevada, the Board of Trustees expressly reserves the right in its sole discretion at any time, and from time to time:

1. To terminate or amend the amount or Eligibility conditions of any Benefit even though such termination or amendment affects claims which have already accrued.

2. To terminate the Plan, even though such termination affects claims which have accrued.

3. To alter or postpone the method of payment of any Benefits.

4. To amend or rescind any other provisions of the Plan.

RELATIONSHIP BETWEEN THE TRUST AND HEALTH CARE PROVIDERS

No health care Provider is an agent or representative of the Trust. The Trust does not control or direct the provision of health care services and/or supplies to Employees, Participants and Beneficiaries by anyone. The Trust makes no representation of any kind concerning the skills or competency of any health care Provider. The Trust makes no representation or guarantee of any kind that any Provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care Providers and all entities (and their agents, employees, and representatives) which contract with the Trust to offer other health-related services or supplies to Employees, Participants and Beneficiaries, including, but not limited to, Anthem Blue Cross, Behavioral Healthcare (EAP), Anthem Blue Cross Medicare, Vision Service Plan, Delta Dental Plan, LIBERTY Dental Plan, MetLife, and Harmony Healthcare Plan.

MESSAGE FROM THE BOARD OF TRUSTEES

Dear Employees and Participants:

The Board of Trustees is pleased to present this updated Summary Plan Description. This includes the changes in your Welfare Fund since the last booklet printing.

If there is something that you do not understand about the Plan, or if you need information about your individual Eligibility for Benefits, please feel free to contact the Trust Administrative Office. The Trust Administrative Office and the Board of Trustees will make every effort to assist you with any matter related to your Benefit program.

It is our sincere desire and hope that the Benefits of the Glazing Health and Welfare Trust add to your security and that of your family. We are confident that we have one of the finest Health and Welfare Benefit Plans available.

The Trustees will continue in their efforts to provide you and your family the maximum Benefit protection possible, while maintaining adequate reserves to safeguard the continuation of the Fund.

Please read this booklet carefully so that you will be aware of the Benefits available to you and your Dependents. We recommend that after you read this booklet, you keep it in a safe place for future reference. Please contact the Trust Administrative Office if you have any comments or questions.

Sincerely,

BOARD OF TRUSTEES

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ELIGIBILITY

Enrollment Card Information

PLEASE READ CAREFULLY

In order for you to receive Benefits under the Health and Welfare Trust, you must complete an enrollment card. Enrollment cards are available at the Trust Administrative Office and at your Union Local. After you complete the card, return it to the Trust Administrative Office at your earliest convenience. You will receive no Benefits unless a signed enrollment card is on file at the Trust Administrative Office. Please be advised that signing the enrollment card signifies the following:

> You certify and warrant to the Trust Fund that all information on the enrollment card is true, correct, and current as of the date signed. You agree to immediately notify the Trust Fund, in writing, of any changes in this information, including any change in Eligibility status for any Dependent listed on the enrollment card.
>
> You acknowledge the right of the Trust Fund to require, and promptly receive from you proof of Eligibility status, such as marriage licenses, birth certificates and marriage certificate or any other proof of Eligibility as the Trust Fund, in its sole discretion, may demand. You agree to promptly furnish such proof to the Trust Fund and further agree that furnishing such proof satisfactory to the Trust Fund is a precondition to the payment of any Benefits for you or on your behalf or on behalf of your Dependents. You understand that health care Benefits are not vested rights and that the Trust Fund has full authority to modify, limit, or terminate health care Benefits at any time as the Trust Fund deems appropriate.
>
> If the Trust Fund pays Benefits for you or on your behalf or on behalf of any person listed as a Dependent on your enrollment card, when you or such person is not in fact eligible or entitled to the Benefits, or if the Trust Fund otherwise mistakenly pays Benefits, you agree to promptly reimburse the Trust Fund in full for any monies so paid. You also agree that the Trust Fund, in its sole discretion, may deduct or offset any such monies from your future Benefits. If the Trust Fund files any legal action against you to recover any such monies, you agree to pay all attorneys' fees and costs of the Trust Fund, whether or not such an action proceeds to judgment.

Active Employee Eligibility

Initial Eligibility

You will become eligible and entitled to Coverage under this Plan on the first day of the month following the month your Employer reports that you have accumulated a minimum of 300 hours of work in covered employment. (Example: If you work 300 hours in September, your Employer will report your hours to the Administrative Office in October, and you will be eligible for Coverage on the first day of November.) A Non-Bargaining Unit Employee working an average of 20 or more hours per work week during a calendar month is considered a full-time Employee for that month.

When to Make Your Medical Plan Selection

You are given the opportunity to make your medical plan selection when you first become eligible for benefits under the Plan.

If you fail to submit an enrollment form, you will automatically be enrolled in the Anthem Blue Cross Health Maintenance Organization (HMO) Plan. The next opportunity to switch medical plans will be during the next open Open Enrollment period.

Open Enrollment

After your initial enrollment, you may change benefit options during each open enrollment period, which generally occurs during the month of November with changes effective January 1. The Administrator will send out open enrollment material with Plan information around the beginning of November.

Continuing Eligibility

All hours worked in excess of the number of hours required for monthly Eligibility (130 hours per month) are banked in your reserve account. Effective October 1, 2000, your reserve account may never contain more than 560 hours after deduction for the current month of Eligibility. Hours worked in excess of 130 will not be banked until your reserve account falls below 560 hours.

If you began participation before October 1, 2000, and have a full bank of 720 hours and work at least 130 hours per month, your bank will continue to be 720. However, if you work less than 130 hours in any month, your bank will be reduced by the number of hours you worked less than 130. For example, if you worked 110 hours in a month, your bank would be reduced by 20, and your maximum bank would never be more than 700. Your maximum bank will continue to be reduced each month you work less than 130 hours until your maximum hour bank is 560. After that, your maximum hour bank will continue to be 560.

You will continue to be eligible in each subsequent month provided you work or have sufficient hours (130 hours) in your reserve account for Eligibility.

Eligibility is determined by contributions actually made by your Employer. If no contributions are made by your Employer, you will have the option of self-paying or using your reserve account. If contributions are later received from your Employer, your reserve account will be reinstated or you will be reimbursed for the monthly self-payment amounts you have paid.

If, at any time as an Active Employee, you work for a non-signatory Employer, you will lose your Eligibility and any hours accrued in your reserve account. To reestablish your Eligibility you will be required to cease working for a non-signatory Employer and complete the Initial Eligibility requirements described above.

Re-Instatement of Eligibility

If you have qualified as an eligible Employee and subsequently lose Eligibility because of insufficient hours, you need not satisfy the rules for Initial Eligibility, if:

- within 12 months of the date of loss of Eligibility earned on the basis of hours worked, you have hours contributed on your behalf by one or more Contributing Employers; and

- the hours contributed, plus any residual hours in your reserve account, total at least 130 hours (the number required for Coverage).

If you fail to re-qualify under this rule within the 12-month period, any residual hours (less than 130 hours) can be used to offset the first monthly self-payment under the active self-payment option, Retiree self-payment, or COBRA, as follows:

(Number of residual hours less than 130) / (130 hours) = percentage offset applied to first monthly self-payment.

Coverage During Total Disability

If you become Totally Disabled, your reserve account will be frozen as of the first day of the month following 30 consecutive days of Disability. The Trust will keep Coverage in force for you and your eligible Dependents, at no cost to you, for a maximum of 12 consecutive months or until you are no longer Totally Disabled, whichever occurs first.

If at the end of 12 months you are still disabled, the hours remaining in your reserve account may be used to continue Coverage for a maximum of six months. If you are still disabled after six months, or after your reserve account runs out, whichever occurs first, you will be eligible to continue your Benefits for an additional 18 months under COBRA, or 29 months, provided the Active Employee or Dependent is Totally Disabled at the time Coverage would have otherwise terminated.

Please note: The 12 month waiver is only available once every 5 years and is based on a new Disability, if a previous 12 month waiver has been provided.

You must self-pay for COBRA continuation Coverage. The COBRA rates are determined periodically by the Board of Trustees. More information regarding COBRA continuation Coverage is contained within the section on COBRA in this Summary Plan Description. If you become eligible for Medicare before your COBRA effective date, you will not be entitled to COBRA continuation Coverage. However, if your Dependents lose Eligibility when you become covered under Medicare, they will be entitled to purchase COBRA Coverage for themselves for an additional period of time.

For the purpose of Eligibility for Coverage during Disability, a Disability is defined as (1) being under the care of a Physician, and (2) unable to work in the Glazing and Fabricating Industry.

Military Leave of Absence

If you are on a military leave of absence from your employment, and the period of military leave is less than 31 days, you will continue to be eligible for Coverage under this Plan during the 31-day leave with no self-payment required, provided you are in an eligible status under this Plan at the time your military leave begins. However, the Plan will not provide Benefits for treatment you receive from the Federal Government for injuries or illness related to your Military Service.

If you are on a military leave of absence from your employment, and the period of military leave is longer than 31 days, you may continue to be eligible for Coverage under this Plan for up to 18 months under the COBRA continuation Coverage provisions, provided you pay the applicable COBRA premium.

Upon release from active service, your Eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Act of 1994 (USERRA) described later in this Summary Plan Description.

Dependent Eligibility

Your eligible Dependents include your legal spouse, your Dependent children, including stepchildren, adopted children and children under 26 years of age.

Any unmarried Dependent child who is 26 years of age or older, but is incapable of self-support because of physical handicap or mental incapacity that commenced: (1) prior to the child's 26th birthday and (2) while the child was covered under this group Plan, is an eligible Dependent. A Physician's certificate of such incapacity must be submitted to the Trust Administrative Office within 31 days following the child's 26th birthday. Dependents in Military Service are not eligible.

Effective Date of Dependent Coverage

Coverage for you will begin on the date you satisfy the rules for Eligibility. Eligibility for your Dependents will begin on the date you become eligible or the date a person becomes your Dependent, if that is later.

Reciprocity

In order to enable Employees to maintain Eligibility when they work outside the jurisdiction of this Plan, the Trustees have entered into reciprocal agreements with certain other glazing industry health and welfare funds. Under these agreements, if you are

temporarily working in the jurisdiction of another Glaziers/Glassworkers local Union whose health and welfare fund is signatory to a reciprocal agreement with this Plan, contributions made on your behalf to the reciprocal fund can be transferred to this Plan to allow you to maintain your Eligibility under this Plan. In this instance, this Plan would be designated as your Home Fund.

If you are a Glazier from another local union temporarily working in the jurisdiction of Local 2001 and this Plan, and your home fund is signatory to a reciprocal agreement with this Plan, you may have your health and welfare contributions sent to your home fund in order to maintain Eligibility there.

Reciprocity is not automatic. You must authorize the transfer of health and welfare contributions in writing on a form approved by the Board of Trustees. These forms are available at the Trust Administrative Office and the local Union. To find out which other funds are signatory to a reciprocal agreement with this Plan, contact the Trust Administrative Office.

If you wish to participate in the reciprocity program, you must meet the following Eligibility criteria:

1. You must have been eligible for Benefits in your home fund for a continuous period of not less than one (1) year prior to the request to participate in the reciprocity program;

2. First you must exhaust all Eligibility and Benefits accrued in the reciprocal fund through the home fund; and

3. You must satisfy the reciprocal fund's current Eligibility requirements.

If you wish to participate in the reciprocity program, you must designate as your home fund a participating fund that fits one of the following definitions. If you are unable to satisfy the conditions stipulated in either definition, you will not be eligible to participate in the program.

1. Your home fund will be the participating fund that covers the local Union to which you belong, provided that you have been eligible for Benefits in that fund for a continuous period of not less than one (1) year prior to your participation in the reciprocity program; or

2. Your home fund will be the participating fund under which you are currently eligible for Benefits, provided you indicate your intention to return to work under the jurisdiction of the local Union to which you normally belong, as soon as work is available.

If you have already established Eligibility in this Plan, you cannot designate another fund as your home fund.

If you have any questions regarding reciprocity, contact the Trust Administrative Office.

Termination of Eligibility

You will cease to be eligible for Coverage on the first of the following dates:

- the date your reserve account contains less than 130 hours;
- the date a self-payment, if required, is not made;
- the date you enter into full-time active duty with the armed forces of any country, unless prohibited by law;
- the date you no longer qualify for continued Coverage under the Disability extension or COBRA extension; or
- the date you begin covered work for a non-signatory Employer.

Coverage for your Dependent(s) will cease on the first of the following dates:

- the date of your loss of Eligibility;
- the date they no longer qualify as Dependents, as defined in this Summary Plan Description;
- the date any self-payment, if required, is not made; or
- the date of entrance into full-time military duty with the armed forces of any country.

An Employee may elect to drop his or her eligible Dependent(s) from this Plan by submitting a letter to the Trust Administrative Office and providing proof that the Dependent(s) to be dropped has other Coverage. The effective date of terminated Coverage will be the first of the month following receipt and approval of the letter.

Once other Coverage has ended, eligible Dependents can be reinstated to the Plan provided that a written request is sent to the Trust Administrative Office within 30 days following termination of the other Coverage. The effective date of reinstated Coverage will be the first of the month following receipt and approval of the written request.

If termination of Coverage occurs for an Employee or Dependent, Coverage may be continued under the terms of COBRA, if a Qualifying Event has occurred (see the COBRA section for details).

Special Eligibility Problems

Because of the manner in which your hours are reported to the Trust Administrative Office, you may encounter special Eligibility problems in some instances, such as:

1. You are a new Employee;

2. You have returned to work after layoff or other break in service; or

3. You do not have sufficient hours in your reserve account.

If you encounter an Eligibility problem, please contact the Trust Administrative Office for assistance.

Retiree Eligibility (Self-Payment Option)

In order to be eligible to receive Retiree health and welfare Coverage at the subsidized Retiree self-payment contribution rate, a Retiree must have worked at least 15,000 hours for which contributions were made to the Fund on his behalf as an Active Employee by a Contributing Employer in the 120 months immediately prior to the Employee's date of retirement. For purposes of satisfying this rule, Eligibility maintained by self-paying the approved Active Employee self-payment rate will count towards the 15,000-hour requirement. Self-payment Eligibility as an Active Employee will be credited at 130 hours for each month of self-payments.

The Retiree self-payment contribution rate for a Retiree who (1) satisfies the Eligibility rules to receive the subsidized Retiree self-payment *and* (2) who resides outside of the geographical service area of the medical insurance provider of the Trust is one half of the actual cost of Coverage. This subsidized self-payment rate will be reviewed annually by the Trust. All other Retiree Eligibility rules will remain in effect.

If your Dependents lose Eligibility due to the death of the Retiree, they may choose to continue their health and welfare Benefits by self-paying a monthly rate subsidized by the Trust. Please note that the Dependent Life Coverage ceases upon the death of the Retiree. Your spouse may continue to self-pay until remarriage. Your Dependent child may continue to self-pay until age 26.

Retirees, who are unable to satisfy the rule outlined above, will be eligible to receive Retiree health and welfare Coverage by paying the approved monthly self-payment rate established for Active Employees who become eligible under the rules for COBRA continuation Coverage.

For the purposes of this section, retirement is defined as receiving a pension from any International Union of the Painting and Allied Trades (IUPAT) District Council or Union Local retirement plan, including those who receive a lump sum distribution from a defined contribution plan by virtue of meeting that plan's rules for retirement. Retirement also means not working in the construction industry in the geographic area covered by this Plan.

The Retiree self-payment option is not automatic. You or your eligible Dependent must apply and enroll in the program. Once a Retiree becomes Medicare eligible, the Retiree must obtain both Medicare Part A and Medicare Part B. Both Medicare Part A and Medicare Part B are required to enroll in the Retiree Medicare Advantage Plan. If a Retiree is eligible for Medicare, the Retiree is no longer eligible for the Active Medical Plan. Please contact the Trust Administrative Office for the required application materials.

The Plan has the right to repayment of monthly premiums for those who receive Coverage without meeting the Eligibility requirements for the self-payment option.

Self-Payment Option (Active Employees and Dependents)

If you or your Dependent cease to be eligible for health and welfare Benefits for any reason defined in the Termination of Eligibility section above, you may choose to continue your health and welfare Benefits by self-paying a monthly rate determined by the Trustees, provided that you are actively seeking work covered by a Collective Bargaining Agreement between a Contributing Employer and the Union and are on the "Out of Work" list maintained by the Union, as verified by the Trust Administrative Office. If you are no longer on the "Out of Work" list, but still ineligible for health and welfare Benefits, you may choose to continue Coverage through COBRA (see "Special Continuation Coverage (COBRA)" section below).

If your Dependents lose Eligibility due to the death of the Employee, they may choose to continue their health and welfare Benefits by self-paying a monthly rate subsidized by the Trust. Please note that Dependent Life Coverage ceases upon the death of the Active Employee. Your spouse may continue to self-pay until remarriage. Your Dependent child may continue to self-pay until age 26 years of age or up to 12 months, whichever occurs first. If the surviving Dependent is no longer eligible for the self-pay option, he or she may choose to continue through COBRA.

For the purpose of Eligibility for the self-payment option, a Disability is defined as: 1) being under the care of a Physician, and 2) unable to work in the Glazing and Fabricating Industry.

In order to participate in the self-payment option, an Employee or Dependent must reside in the geographical service area covered by the medical insurance provider to the Fund.

The Active Employee self-payment option is not automatic. You or your eligible Dependent must apply and enroll in the program. Please contact the Trust Administrative Office for the required application materials.

The Plan has the right to repayment of monthly premiums for those who receive Coverage without meeting the Eligibility requirements for the self-payment option.

Special Continuation Coverage (COBRA)

Under a Federal law known as "COBRA," a special extension of health Coverage is available on a self-pay basis if you or your eligible Dependents lose Eligibility for Benefits due to one of the following Qualifying Events:

1. The death of the Active Employee;

2. A Dependent's divorce or legal separation from an Active Employee;

3. Your Dependent child no longer qualifies as a Dependent (i.e. due to age or marriage); or

4. The reduction or termination (other than for gross misconduct) of your work hours.

Under this COBRA provision, you or your Dependent may continue your medical and prescription drug Benefits only, or your medical and prescription drug, dental and vision Benefits, if you had such Coverage. Life and accidental death and dismemberment Benefits may not be continued. If you elect to continue your medical and prescription drug Benefits only, you may not add dental and vision Benefits at a later date. You and your Dependents may each make a separate election.

You or your Dependents may continue Coverage only under the Plan or Plans in which you were enrolled as of the date Coverage would have otherwise ended.

COBRA continuation Coverage is only available to Employees and/or Dependents who were covered under the health Plans on the day before the Qualifying Event, except that a child born to or placed for adoption with the covered Employee during the period of COBRA continuation Coverage will also be eligible, provided that the covered Employee elects COBRA continuation Coverage for himself during the election period and elects Coverage for the child within 30 days of the child's birth or placement for adoption.

If you have been covered under a region-specific plan and you relocate to an area not covered by that plan, alternative coverage may not be available. If the Trust offers Coverage to Employees that is available in your new location, you may elect to receive that Coverage (some restrictions apply). However, COBRA continuation Coverage will not be provided to you if the Coverage offered to Employees is not available in the area to which you relocate.

Duration of Coverage

If you become entitled to COBRA continuation Coverage due to a reduction in your work hours or termination of your employment, you and your Dependents may continue Benefits for up to 18 months.

An Active Employee or Dependent who is Totally Disabled at the time Coverage would have otherwise terminated will be entitled to a total of 29 months of COBRA continuation Coverage, provided the Trust Administrative Office is notified in writing within the first 18 months of COBRA continuation Coverage and within 60 days after the Social Security Administration has determined that a Total Disability exists.

If a Dependent becomes entitled to COBRA continuation Coverage due to the death of an Active Employee, a divorce, legal separation or the loss of Dependent child status, the Dependent may continue Benefits for up to 36 months from the date Coverage would have otherwise terminated.

If a Dependent has COBRA continuation Coverage because of the Employee's termination or reduction in hours, the Dependent may extend Coverage from 18 months (29 if disabled) to up to a maximum of 36 months if a second Qualifying Event occurs during the first 18 month Coverage period (or 29 if disabled).

However, if you lose Coverage because of a reduction in your work hours or termination of your employment after you become entitled to Medicare, your Dependents will be allowed to continue their Coverage until the later of:

1. 18 months from the date Coverage was lost; or

2. 36 months from the date you became eligible for Medicare.

Notification Requirements

The Trust Administrative Office is responsible for notifying you or your Dependents of your right to this COBRA continuation Coverage in the event of the reduction in hours worked or termination of your employment, or in the event of the death of an Active Employee. However, it is suggested that a family member advise the Trust Administrative Office of the death of an Active Employee.

In the event of a divorce or a Dependent child's loss of Dependent status, you or your Dependent must notify the Trust Administrative Office in writing within 60 days of the later of:

1. The date of the Qualifying Event; or

2. The date Coverage would cease as a result of the Qualifying Event.

If the Qualifying Event is a divorce or legal separation, a copy of the legal document must be supplied within 60 days of the date of the decree.

If you do not provide a timely notice, you or your Dependent will not be entitled to the COBRA continuation Coverage and the Plan will have the right to repayment of premiums from you and those who receive Coverage without meeting the Eligibility requirements.

Cost of COBRA Continuation Coverage

The cost of the COBRA continuation Coverage is determined by the Board of Trustees. The cost is calculated to be equivalent to the expected cost of Coverage for similarly situated Active Employees, plus a 2% administrative fee. For Participants who, due to a Disability, are eligible for extended Coverage beyond the 18th month, the cost of Coverage is calculated to be 150% of the cost of covering similarly situated Active Employees. You will be sent information regarding the payments schedule and premium amounts at the time of loss of Eligibility.

The initial premium, which must include premiums due from the date your Eligibility would have terminated, must be paid to the Trust Administrative Office within 45 days following submission of the COBRA election form.

You or your Dependents are also responsible for sending payments, in full and on the premium due date, for all required monthly premiums, as established by the Trust Administrative Office. If premiums are not received within 30 days of the due date, Eligibility for COBRA continuation coverage will terminate.

Termination of COBRA Continuation Coverage

Eligibility for COBRA continuation coverage will terminate on the first day of the month following the occurrence of any one of the events listed below:

1. Failure to remit the required premium payment in full and on time (not later than 30 days following the due date established by the Trust Administrative Office, or no later than 45 days following submission of the initial COBRA election form);

2. You or your eligible Dependents receive Coverage, as an Employee or as a Dependent, under any other group health plan, provided, however, that if the successor group health plan excludes Coverage for a pre-existing condition, you may continue COBRA Coverage as long as the successor plan's pre-existing condition applies to you (but not beyond the end of the maximum COBRA Coverage period, as described above);

3. You or your Dependents become entitled to and are receiving Medicare Benefits;

4. The date the Fund ceases to provide group health Coverage to any Employees;

5. You or your Dependents have continued Coverage for additional months due to a Disability, and there has been a final determination by the Social Security Administration that you or your Dependents are no longer disabled. (In this case, Coverage ends on the first of the month that begins more than 30 days after the Social Security Administration makes a final determination that you or your Dependent are no longer disabled or at the end of the applicable 18 or 36 month maximum Coverage period described above, whichever occurs last); or

6. You reach the end of your maximum COBRA continuation Coverage period, as described above.

If you relocate to an area outside of the Anthem Blue Cross and LIBERTY Dental Coverage areas, COBRA continuation Coverage will not be available.

IMPORTANT NOTE: Should Federal legislation alter the provisions of COBRA in existence at the time this Summary Plan Description is printed, you will be advised of any such modification, as required.

Your Rights Under USERRA

This section provides information about your rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

Congress enacted USERRA to provide protection to individuals who are members of the "Uniformed Services." "Uniformed Services" is defined as the Armed Forces, the Army, Navy, Air Force, Marines, 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 Services, and any other category of persons designated by the President in time of war or national emergency. One of the protections provided by USERRA is that Employees covered under a group health plan must be given an opportunity to elect to continue Coverage for themselves and/or their Dependents, if they take leave to serve in the Uniformed Services (hereinafter "Military Leave").

The maximum period of continuation Coverage for health care under USERRA is the lesser of:

1. Twenty-four months (beginning from the date you leave work due to your Military Leave); or

2. The day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Trust.

If you elect continuation Coverage, the COBRA and USERRA continuation periods will run concurrently.

Generally, your right to continuation Coverage is governed by COBRA, as described above. However, in the event that you choose continuation Coverage, you have the same additional rights under USERRA. The first additional right is set forth above on page 12, which applies if your Military Leave from employment is less than 31 days, for which your last Employer will be responsible for the contributions required for Coverage. Second, if you become covered by another group health plan or entitled to Medicare during the USERRA maximum Coverage period described above, the continuation Coverage elected by you and your Dependents will not be terminated.

Qualified Medical Child Support Order (QMCSO)

Under the Omnibus Budget Reconciliation Act of 1993, the Trust must recognize a Qualified Medical Child Support Order, and enroll as directed by the Order any child of a Trust Participant specified by the Order. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court which:

- provides the child of a Trust Participant with child support or health Benefits under the Trust; or

- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Employee parent does not enroll the child, the non-Employee parent or state agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order;

- a reasonable description of the type of Coverage to be provided by the Plan to each such child, or the manner in which such type of Coverage is to be determined; and

- the period to which such Order applies.

In addition, a properly completed National Medical Support Notice will be deemed to be a Qualified Medical Child Support Order.

Further, a Medical Child Support Order will not qualify if it would require the Trust to provide any type or form of Benefit or any option not otherwise provided under the Trust, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Upon receipt of a Medical Child Support Order, the Trust Administrative Office will notify the Participant and each child of the receipt of the Order and the Trust's procedures for determining whether the Medical Child Support Order is qualified. Each child will also be notified of his or her right to designate a representative to receive copies of all notices sent to the child with respect to a Medical Child Support Order.

Upon receipt of a Medical Child Support Order, the Trust Administrative Office will review the Order to verify that it meets the standards set forth above. The Trust Administrative Office will make such a determination within a reasonable period, and notify the Participant and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan, provided the child lives within the Anthem Blue Cross Coverage area.

Any payment for Benefits by the Trust under the Medical Child Support Order to reimburse expenses advanced by an alternate recipient, or his/her custodial parent or legal guardian, shall be made to the alternative recipient, or his/her custodial parent or legal guardian.

NOTE: A Dependent will be eligible for Coverage only if his or her full name, date of birth, and relationship to the Employee have been registered with the Trust Administrative Office by filing a Trust Fund change form.

Family and Medical Leave Act (FMLA)

Under the **FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**, you may be entitled to family or medical leave. If you are eligible and elect to take **FMLA** leave, your Coverage under the Trust will continue with no interruption of active employment until the earlier of the end of such leave, or the date you notify your Employer you do not intend to return to work at the end of the **FMLA** leave. Under the law, Employers must grant unpaid leave to an eligible Employee for one or more of the following reasons:

1. To care for the Employee's child after birth, or placement for adoption or foster care;

2. To care for the Employee's spouse, son or daughter, or parent, who has a serious health condition; or

3. For a serious health condition that makes the Employee unable to perform the Employee's job.

Continued active participation in the Trust while on **FMLA** leave will be at your option. Premiums will continue to be paid on your behalf while you are on **FMLA** leave, so long as your Employer pays the required contributions on your behalf. If you elect not to continue your Benefits during the **FMLA** leave, your Coverage will be reinstated without regard to any pre-existing condition limitation on your return to active working status on or before the end of the **FMLA** leave.

You must contact your Employer to determine your Eligibility for FMLA leave. It is not the role of the Trustees or Trust Administrative Office to make this determination.

PRE-PAID MEDICAL PLAN

Eligible Employees and Dependents are provided with hospital, medical, surgical and prescription drug Coverage through pre-paid medical plans. At the time that this Summary Plan Description was issued, the Coverage is provided through Anthem Blue Cross. The Medical Plans are called a "Health Maintenance Organization" (HMO) Plan and a "Preferred Provider Organization" (PPO) Plan.

The Anthem Blue Cross HMO Plan is available to Eligible Actives and Early Retirees residing in the Anthem Blue Cross HMO service area. Eligible Actives and Early Retirees residing outside of the Anthem Blue Cross HMO Plan service area will be enrolled into the Anthem Blue Cross PPO Plan.

Health Maintenance Organization (HMO) Plan

HMO – Benefits apply when you obtain Coverage or arrange for Covered Services through an Anthem Blue Cross contracted Primary Care Physician.

You are responsible for all amounts exceeding the applicable Benefit maximums, Eligible Medical Expenses, payments to Out-of-Network Providers.

The following Benefit Summary is intended only as a general description of the medical Benefits available to Participants. For a complete description of medical Benefits and exclusions and limitations, please refer to the Evidence of Coverage booklet for your Plan provided by Anthem Blue Cross.

Also, please note that the Benefit Schedules which follow represent the Benefits in effect at the time that this Summary Plan Description is being printed. Should your Benefit Schedule change, you will be notified.

Please read your Anthem Blue Cross Evidence of Coverage and other applicable Endorsements, Riders and Attachments, if any, to determine the governing contractual provisions for this Plan and to understand how Eligible Medical Expenses (EME) are determined.

Benefit Summary

Lifetime Maximum: Unlimited

Calendar Year Deductible (CYD): There is no CYD when using In-Network HMO Providers.

Co-Payments: This Plan includes some fixed dollar co-payment amounts (which are not subject to the CYD) for certain Covered Services.

Calendar Year Out of Pocket Maximum: Calendar Year Out of Pocket expenses are limited to $4,500 of EME per Member and $9,000 of EME per family when using In-Network HMO Providers.

Note: You are responsible for all amounts exceeding the applicable Benefit maximums, EME payments to Out-of-Network Providers and penalties for not complying with the Anthem Blue Cross HMO Plan. Further, such amounts do not accumulate to your Calendar Year Out of Pocket Maximum.

Please read your Anthem Blue Cross Evidence of Coverage and all other applicable Endorsements, Riders and Attachments, if any, to determine the governing contractual provisions for this Plan and to understand how EME payments to Providers are determined.

In the table that follows, PAR means "Prior Authorization Required".

Benefit Summary			
Covered Services and Limitations	**PAR**	**HMO – In-Network**	**HMO- Out-of-Network**
Calendar Year Deductible		None	Not Covered
Calendar Year Out of Pocket Maximum		$4,500 Individual / $9,000 Family	Not Covered
Physician Services • Primary Care Visit • Specialist Visit • Retail Health Clinic • Preferred On-Line Visit	 No Yes No No	 $20 per visit $40 per visit $20 per visit No charge for the first 6 visits and then $20 per visit	Not Covered
Preventive Health Services	No	No charge	Not Covered
Prenatal and Post-Natal Care	No	No charge	Not Covered
Spinal Manipulation and Acupuncture *Coverage for spinal manipulation and acupuncture combined is limited to 20 visits per calendar year.*	Yes	$20 per visit	Not Covered
Inpatient Hospital Services, including emergency post-stabilization care and Substance Abuse Detoxification	Yes	$750 per admission	Not Covered

Benefit Summary			
Covered Services and Limitations	**PAR**	**HMO – In-Network**	**HMO- Out-of-Network**
Outpatient Surgery Facility - Hospital - Ambulatory Facility	Yes	 $300 per surgery $150 per surgery	Not Covered
Physician Surgical Services • Inpatient Hospital • Outpatient - Hospital - Ambulatory Facility	Yes	 $200 per visit $200 per visit $150 per visit	Not Covered
Emergency Services • Emergency Room • Hospital Admission	No	 $300 per visit Waived if admitted $750 per admission	Covered as In-Network
Urgent Care	No	$40 per visit	Not Covered
Ambulance Services	No	$250 per trip	Covered as In-Network
Hospice Care Services • Inpatient • Outpatient	Yes	 $750 per admission $20 per visit	Not Covered
Skilled Nursing Facility Services *Coverage for inpatient rehabilitation and skilled nursing services is limited to 100 days combined per calendar year.*	Yes	$500 per admission.	Not Covered
Rehabilitation Services • Office *Coverage for Physical, Speech, and Occupational therapy combined is limited to 60 visits per calendar year.* • Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	Yes	 $20 per visit $20 per visit	Not Covered
Cardiac Rehabilitation • Office *Coverage is limited to 36 visits per calendar year.* • Outpatient Hospital *Coverage is limited to 36 visits per calendar year.*	Yes	 $20 per visit $20 per visit	Not Covered
Laboratory Services	Yes	$20 per visit	Not Covered

Benefit Summary			
Covered Services and Limitations	**PAR**	**HMO – In-Network**	**HMO- Out-of-Network**
Routine Radiological and Advanced Diagnostic Imaging Services	Yes	$25 per visit	Not Covered
Home Health Care Services *Coverage is limited to 100 visits per calendar year. Limits are combined for all home health services.*	Yes	$35 per visit	Not Covered
Prosthetic Devices	Yes	$750 per device	Not Covered
Durable Medical Equipment	Yes	No Charge	Not Covered
Mental/Behavioral Health and Substance Abuse • Inpatient Facility Visit - Doctor Services • Outpatient Office Visit	Yes	 $750 per admission No Charge $20 per visit	Not Covered
Prescription Drugs • Tier I (Low Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery) • Tier II (Mid Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery) • Tier III (High Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery)	No	 $7 per prescription $17.50 per prescription $30 per prescription $75 per prescription $50 per prescription $125 per prescription	Not Covered
In order to be covered, drugs must be obtained with a prescription, approved by the FDA, dispensed by a licensed pharmacist, prescribed by a Plan Provider and not excluded by the Plan.			

Preferred Provider Organization (PPO) Plan

Your other medical plan option is the Anthem Blue Cross PPO Plan.

Lifetime Maximum: Unlimited

Calendar Year Deductible (CYD): There is $1,500 individual and $3,000 family calendar year deductible when using In-Network PPO Providers.

Co-Payments: This Plan includes some fixed dollar co-payment amounts that can be found in the table below.

Calendar Year Out of Pocket Maximum: Calendar Year Out of Pocket expenses are limited to $6,250 of EME per Member and $12,500 of EME per family when using In-Network PPO Providers.

PPO – Benefits apply when you obtain Coverage or arrange for Covered Services through an Anthem Blue Cross contracted Physician.

You are responsible for all amounts exceeding the applicable Benefit maximums, Eligible Medical Expenses, payments to Out-of-Network Providers.

The following Benefit Summary is intended only as a general description of the medical Benefits available to Participants. For a complete description of medical Benefits and exclusions and limitations, please refer to the Evidence of Coverage booklet for your Plan provided by Anthem Blue Cross.

Also, please note that the Benefit Schedules which follow represent the Benefits in effect at the time that this Summary Plan Description is being printed. Should your Benefit Schedule change, you will be notified.

In the table that follows, PAR means "Prior Authorization Required".

Benefit Summary			
Covered Services and Limitations	**PAR**	**PPO – In-Network**	**PPO- Out-of-Network**
Calendar Year Deductible		$1,500 individual / $3,000 family	$3,000 individual / $6,000 family
Calendar Year Out of Pocket Maximum		$6,250 individual / $12,500 family	$12,500 individual / $25,000 family
Physician Services • Primary Care Visit • Specialist Visit • Retail Health Clinic • Preferred On-Line Visit	 No Yes No No	 $35 per visit; deductible does not apply $55 per visit; deductible does not apply $35 per visit; deductible does not apply $35 per visit; deductible does not apply	 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met Not Covered
Preventive Health Services	No	No charge	50% coinsurance; deductible does not apply
Prenatal and Post-Natal Care	No	20% coinsurance; deductible does not apply	50% coinsurance after deductible is met

Benefit Summary			
Covered Services and Limitations	**PAR**	**PPO – In-Network**	**PPO- Out-of-Network**
Spinal Manipulation and Acupuncture *Coverage is limited to 20 visits for spinal manipulation and 20 visits for acupuncture per calendar year.*	Yes	$35 per visit; deductible does not apply	50% coinsurance after deductible is met
Inpatient Hospital Services, including emergency post-stabilization care and Substance Abuse Detoxification	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery Facility (Hospital and Ambulatory Facility)	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Benefit Summary			
Covered Services and Limitations	**PAR**	**PPO – In-Network**	**PPO- Out-of-Network**
Physician Surgical Services (Inpatient and Outpatient)	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Services • Emergency Room • Emergency Room Doctor and Other Services	No	$300 per visit; deductible does not apply; waived if admitted 20% coinsurance after deductible is met	Covered as In-Network
Urgent Care	No	$40 per visit; deductible does not apply	Not Covered
Ambulance Services	No	$250 per trip; deductible does not apply	Covered as In-Network
Hospice Care Services • Inpatient • Outpatient	Yes	 $750 per admission $35 per visit	Not Covered
Skilled Nursing Facility Services *Coverage for inpatient rehabilitation and skilled nursing services is limited to 150 days combined per calendar year.*	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation Services (Office and Outpatient Hospital) *Coverage for Physical and Occupational therapy combined is limited to 40 visits per calendar year. Coverage for Speech therapy combined*	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Benefit Summary			
Covered Services and Limitations	**PAR**	**PPO – In-Network**	**PPO- Out-of-Network**
is limited to 20 visits per calendar year.			
Cardiac Rehabilitation *Coverage for Office visits is limited to 36 visits per calendar year. Coverage for Outpatient Hospital visits is limited to 36 visits per calendar year.*	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Laboratory Services	Yes	$35 per visit; deductible does not apply	50% coinsurance after deductible is met
Routine Radiological and Advanced Diagnostic Imaging Services	Yes	$40 per visit; deductible does not apply	50% coinsurance after deductible is met
Home Health Care Services *Coverage is limited to 100 visits per calendar year. Limits are combined for all home health services.*	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	Yes	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Mental/Behavioral Health and Substance Abuse • Inpatient Facility Visit - Doctor Services Outpatient Office Visit	Yes	 20% coinsurance after deductible is met $35 per visit; deductible does not apply $35 per visit; deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs • Tier I (Low Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery) • Tier II (Mid Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery) • Tier III (High Cost Option) - 30 day supply (retail pharmacy) - 90 day supply (home delivery)	No	 $7 per prescription $17.50 per prescription $30 per prescription $75 per prescription $50 per prescription $125 per prescription	Covered as In-Network
In order to be covered, drugs must be obtained with a prescription, approved by the FDA, dispensed by a licensed pharmacist, prescribed by a Plan Provider and not excluded by the Plan.			

Locating Plan Providers

Plan Doctors

You can find a list of Providers by going to the web site:

www.anthem.com/find-care

Note that Providers may change, and you should always confirm whether or not your Provider is still an In-Network Provider before receiving treatment.

Plan Pharmacies

Members have access to local outlets of nationally recognized pharmacy chains. Plan Pharmacies are listed in the Anthem Blue Cross Provider Directory. Prescriptions must be filled at Plan Pharmacies in order for Benefits to be payable, unless dispensed in connection with an emergency or urgent condition.

How to File a Claim for Medical Benefits

In-Network Providers will file the claim for you. Out-of-Network Providers may require immediate payment from you for their services and supplies. When seeking reimbursement from Anthem Blue Cross for expenses incurred in connection with services received from Out-of-Network Providers, the Member must complete a Claim Form and submit it to the Anthem Blue Cross Claims Department with a copy of an itemized bill from the provider for the covered service. Claim Forms can be obtained by going to www.anthem.com/claims or by calling the number on your member ID card.

All claims must be submitted to Anthem Blue Cross within 90 days for In-Network Providers and a year for Out-of-Network Providers from the date that expenses were incurred, unless it is shown that it was not reasonably possible to do so, but that the claim was filed as soon as was reasonably possible.

The address for submission of claims is:

Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

If the Member authorizes payment directly to a Provider, a check will be mailed to that Provider. A check will be mailed to the Member directly if payment directly to the Provider is not authorized. The Member will receive an explanation of Benefits (EOB) to show how the payment was determined.

No payments will be made for any claims received by Anthem Blue Cross after 12 months from the date of service.

Anthem Blue Cross shall approve or deny a claim within 30 days after receipt of the claim. If the claim is approved, the claim shall be paid within 30 days after it has been approved. If the approved claim is not paid within that 30-day period, Anthem Blue Cross shall pay interest on that claim.

Denial of a Claim

Anthem Blue Cross may request additional information to determine whether to approve or deny the claim. Anthem Blue Cross shall notify the Member of its request for additional information after receipt of the claim. Anthem Blue Cross will notify the Provider of health care services of all the specific reasons for the delay in approving or denying the claim. Anthem Blue Cross shall approve or deny the claim after receiving the additional information. If the claim is approved, Anthem Blue Cross shall pay the claim after it receives the additional information. If the approved claim is not paid within that time period, Anthem Blue Cross shall pay interest on the claim.

If Anthem Blue Cross denies the claim, a notice to the Member will include the reasons for the rejection and the Member's right to file an appeal of the denied claim.

Appeal Procedures

For clinical issues, there are two (2) types of review: standard and expedited. Anthem offers an expedited appeal for decisions meeting the expedited criteria. Please note: Requests to handle a review as "expedited" are always handled as a member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision.

When a physician or other provider expresses dissatisfaction about an adverse utilization program decision involving a clinical issue, the issue can be handled as an appeal if the physician/provider formally requests an appeal or reconsideration instead of submitting a complaint. Utilization review decisions are communicated in writing to the provider and member. These letters provide details on appeal rights and the address to use when sending additional information. Reconsideration is when Anthem, upon request by a treating physician, re-evaluates the initial determination. Reconsiderations are handled outside of the appeals process and in accordance with Anthem UM policies.

A standard appeal is available following the reconsideration, or initially, if it is formally requested. Please note: Requests for appeal of pre-service requests will always be handled as a member appeal. An expedited appeal is available for cases meeting the expedited criteria.

An appeal may be appropriate if you are: Requesting a change in an Anthem decision(s) based on whether services or supplies are medically necessary or experimental/investigative, or appealing a clinical certification decision or a claims or predetermination decision.

Arbitration

If the Member is dissatisfied with the finding of an independent medical evaluation, the Member shall have the right to have the dispute submitted to binding arbitration before an arbiter under the Commercial Arbitration Rules applied by the American Arbitration Association. The arbiter will be selected by mutual agreement of Anthem Blue Cross and the Member. The cost and expense for filing arbitration shall split evenly among the parties. The arbiter may award arbitration fees, expenses, and compensation in an equitable fashion, in favor of any party. The decision of the arbiter is binding upon the Member and Anthem Blue Cross and shall be enforceable under Nevada law.

See Anthem Blue Cross' HMO or PPO Evidence of Coverage (EOC) for complete details.

Members are required to follow the above grievance procedures prior to filing any claim in court.

This Summary Plan Description contains only a brief summary of the Benefits, limitations, exclusions, procedures and policies described in the Anthem Blue Cross Evidence of Coverage and applicable Endorsements, Riders and Attachments. Those documents always take precedence in the case of a difference between information contained in the Summary Plan Description and information contained in those Anthem Blue Cross contractual agreements.

ANTHEM BLUE CROSS MEDICARE PLAN (PPO)

Benefit Summary

Lifetime Maximum: Unlimited

Calendar Year Deductible (CYD): There is no CYD.

Co-Payments: This Plan includes some fixed dollar co-payment amounts for certain Covered Services.

Coinsurance: Your Coinsurance for some Covered Services is 20% of Eligible Medical Expenses (EME).

Calendar Year Out of Pocket Maximum: Calendar Year Out of Pocket expenses are limited to $2,500 of EME per Member.

Note: You are responsible for all amounts exceeding the applicable Benefit maximums, EME payments to Out-of-Network Providers and penalties for not complying with Anthem Blue Cross' Medicare Plan (PPO). Further, such amounts do not accumulate to your Calendar Year Out of Pocket Maximum.

PLEASE READ YOUR ANTHEM Blue Cross Medicare Plan (PPO)
Evidence of Coverage and all other applicable Endorsements, Riders and Attachments, if any, to determine the governing contractual provisions for this Plan.

You are eligible to enroll in the Blue Cross Medicare Plan (PPO)
as long as:

· You meet the Eligibility requirements of the Plan;
· You have both Medicare Part A and Medicare Part B; and
· You live in the Anthem Blue Cross geographic service area; and
· -- You are a United States Citizen or are lawfully present in the United States; and
· -- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a Member of a Plan that we offer, or you were a member of a different plan that was terminated, or in some cases if you are enrolling in a former Employer, union group, or trust administrator sponsored plan.

Below is a summary of the Benefits available:

Anthem Blue Cross Medicare Plan (PPO) – Summary of Benefits	
Benefit	**Copayment**
Deductible	$1,
Out-of-Pocket Maximum	$2,500
Primary Care Physician	$0
Specialist	$0
Virtual Visits	$0
Inpatient Services	
Inpatient Hospital	$0 Per Admit
Inpatient Mental Health & Substance Abuse	$0 Per Admit
Skilled Nursing Facility	$0 Days 1-20; $25 for Days 21-100
Outpatient Services	
Outpatient Surgery	$0
Outpatient Mental Health & Substance Abuse	$15
Partial Hospitalization (Mental Health Treatment Per Visit)	$15
Occupational Therapy	$15
Physical/Speech/Language Therapy	$15
Cardiac/Pulmonary Rehabilitation	$15
Kidney Dialysis	$10
Part B Drugs	20%
Ambulance	$0
Emergency Room	$25, waived if admitted
Urgent Care	$15, contracted and non-contracted facilities
Home Health Care	$0
Hospice	$0
Outpatient X-Ray Services	$0
Clinical Laboratory Services	$0
Diagnostic Procedure/Test	$0
Diagnostic Radiology Services	$0
Therapeutic Radiology Services	$25
Durable Medical Equipment	$0
Prosthetics	$0
Orthotics & Diabetes Shoes/Inserts	$0
Diabetic Monitoring Supplies	$0
Insulin Pumps & Supply	$0
Chiropractic Visits (Medicare Covered)	$0
Podiatry Visit (Medicare Covered)	$0
Eye Exam (Medicare Covered)	$0
Hearing Exam (Medicare Covered)	$0
Preventive Services	
Bone Mass Measurements	$0
Part B Immunizations	$0
Colorectal Screening Exams	$0
Breast Cancer Screening (mammograms)	$0
Prostate Cancer Screening Exams	$0
Annual Wellness Visit	$0

This Summary Plan Description contains only a brief summary of the Benefits, limitations, exclusions, procedures and policies described in the Anthem Blue Cross Medicare PPO Plan Evidence of Coverage and applicable Endorsements, Riders and Attachments. Those documents always take precedence in the case of a difference between information contained in the Summary Plan Description and information contained in those Anthem Blue Cross contractual agreements.

SHOULD YOU HAVE ANY QUESTION PERTAINING TO YOUR BENEFITS, PLEASE CONTACT ANTHEM BLUE CROSS AT (800) 331-1476. YOU CAN ALSO CONTACT BENESYS AT (702) 415-2191.

DENTAL BENEFITS

There are two options for dental Benefits, the Delta Preferred Option Plan provided by Delta Dental and the LIBERTY Dental Plan.

The following Benefit Summaries for the Glaziers and the Fabricators are intended only as a general description of the dental Benefits available to Participants. For a complete description of dental Benefits and exclusions and limitations, please refer to the Delta Dental or LIBERTY Dental Plan Evidence of Coverage booklets for your Plan.

Also, please note that the Benefit Schedules that follow represent the Benefits in effect at the time that this Summary Plan Description is being printed. Should your Benefit Schedule change, you will be notified.

Delta Dental

NOTE: You will incur the lowest costs by using a "Preferred Option Dentist."

PPO Dentists are Participating Dentists who have agreed with Delta to participate in the Preferred Option Program. Under the Preferred Option Program, the Dentist agrees to a specific fee schedule set by Delta Dental for the area. These fees tend to be lower than the fees charged by the majority of Dentists in the same area. Thus, your coinsurance payments will tend to be lower when you choose a PPO Dentist.

Participating Dentists have executed an agreement with Delta Dental which specifies the fee they will charge for each service. A Participating Dentist cannot charge more than the "Usual, Customary and Reasonable" (UCR) amount for a given procedure.

If you use a Participating Dentist, your Dentist will file the claim and you will only need to pay your portion of the coinsurance. Your Dentist will be paid the remaining amount of the payment directly by Delta Dental.

Non-Participating Dentists have not entered into any agreement with Delta Dental regarding fees or claims procedures. Because Non-Participating Dentists have not entered into such an agreement with Delta Dental, they may charge more than the UCR amount. You may thus incur more out-of-pocket costs by using a Non-Participating Dentist. If you use a Non-Participating Dentist, you may need to pay the full amount of charges, submit your claim to Delta Dental, and have Delta Dental reimburse you directly for the amount that it covers.

A directory of PPO Dentists and a list of Preferred Option Dentists are available from the Trust Administrative Office. You are responsible for verifying whether the Dentist you select is a PPO Dentist or a Participating Dentist.

In this Plan, you pay the same coinsurance percentage of the Allowed Cost, regardless of whether you go to a PPO Dentist or not. But since the billed charge may be higher for Dentists who are not in the Preferred Option Program, you may pay more.

Dental Benefits

Calendar Year Deductible: $50 per enrollee, up to $150 per family.

The deductible does not apply to Diagnostic or Preventive Benefits. It also does not apply to Orthodontia Benefits.

Annual Maximum: $1,000 per enrollee

Lifetime Orthodontia Maximum: $1,000 per Dependent child

Waiting Periods: Coverage for the following services will not be provided, until you have been eligible for the amount of time specified:

Crowns and Cast Restorations:	12 months
Prosthodontic Benefits:	12 months
Orthodontic Benefits:	12 months

If you lose Eligibility and regain Eligibility within a 12-month period, you will receive credit from your original effective date toward the 12-month waiting period for Crowns, Jackets and Cast Restoration Benefits, Prosthodontic Benefits and Orthodontic Benefits. If you become eligible again for Coverage more than 12 months after Coverage is lost, you must meet a new full 12-month waiting period.

Delta will pay the Benefits for the following covered services, up to the specified percentage of the Contract Allowance:

Delta Dental - Dental Benefits	
Covered Service	**Percentage of Contract Allowance that Delta will pay**
Diagnostic and Preventive Benefits *Diagnostic: procedures to aid the Dentist in choosing required dental treatment.* *Preventive: prophylaxis (cleaning; periodontal cleaning in the presence of gingival inflammation is considered to be periodontal for payment purposes); topical application of fluoride solutions; space maintainers.*	**100%**
Basic Benefits Oral Surgery: *Extractions and other surgical procedures (includes pre-and post-operative care).* General Anesthesia: *General anesthesia given by a Dentist for a covered oral surgery procedure.* Endodontia: *Treatment of the tooth pulp.* Periodontia: *Treatment of the gums and bones supporting teeth.* Sealant Benefits: *Topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in molars for the purpose of preventing decay.*	**90%**
Restorative Benefits *Amalgam, synthetic porcelain, plastic fillings and prefabricated stainless-steel restorations for treatment of carious lesions (visible destruction of hard tooth structure).*	**90%**
Denture Repairs *Repair to partial or complete dentures including rebase procedures and relining.*	**90%**
Crowns, Jackets, and Cast Restorations *For treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations, or prefabricated stainless steel restorations.*	**60%**
Prosthodontic Benefits *Procedures to construct or repair fixed bridges and construction of partial or complete dentures.*	**60%**
Orthodontic Benefits **(For Dependent children under age 26 only)** *Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.*	**50%**

If you lose Eligibility and regain Eligibility within a 12-month period, you will receive credit from your original effective date toward the 12-month waiting period for Crowns, Jackets, and Cast Restoration Benefits, Prosthodontic Benefits and Orthodontic Benefits. If you become eligible again for Coverage more than 12 months after Coverage is lost, you must meet a new full 12-month waiting period.

Limitations and Exclusions

Limitations

Limitations on Diagnostic and Preventive Benefits:

a) Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than twice in any 12 month period while the patient is an enrollee under any Delta Dental care program.

b) Full-mouth x-rays or panographic x-rays will be provided when required by the Dentist, but no more than once each five (5) years will be paid by Delta Dental.

c) Bitewing x-rays are limited to twice in any 12-month period when provided to enrollees under age 18 and once each 12 months for enrollees age 18 and over.

d) Delta Dental will not pay for topical application of fluoride for anyone nineteen (19) years or older.

Limitations on Sealant Benefits:

a) Sealant Benefits are available only to enrollees through the age of 15.

b) Sealants are limited to application to permanent molar teeth with no caries (decay), without restorations and with the occlusal surface intact.

c) Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

Limitations on Crowns, Jackets, and Cast Restorations:

a) Delta Dental will not pay to replace any crown, jacket, or cast restoration which the patient received in the previous five (5) years.

b) Crowns, jackets, and cast restorations are limited to enrollees who have been enrolled in this Plan for 12 consecutive months. This provision will be waived for Employees and their Dependents enrolling on the effective date.

Limitations on Prosthodontic Benefits:

a) Delta Dental will not pay to replace any bridge or denture that the patient received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

b) Delta Dental limits Benefits for dentures to a standard partial or complete denture. A "standard" denture means a removable appliance to replace missing natural permanent teeth that is made from acceptable materials by conventional means.

c) Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Delta Dental will credit the cost of a standard complete or partial denture that would have been allowed under this Plan toward the cost of an implant and related services (copayments apply).

d) The initial installation of a fixed bridge or partial denture is not a Benefit, unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under a Delta Dental care program.

e) Prosthodontic Benefits are limited to enrollees who have been enrolled in this Plan for 12 consecutive months. This provision will be waived for Employees and their Dependents enrolling on the effective date.

Limitations on Orthodontic Benefits:

a) All payments will be on a monthly basis. The obligation of Delta Dental to make periodic payments for an Orthodontic treatment plan begun prior to the date the patient becomes covered will commence with the first payment due following the date the patient's Coverage is effective.

b) The obligation of Delta Dental to make periodic payments for orthodontic treatment will terminate on the payment due date next following the date the Dependent enrollee or the Primary enrollee loses Coverage, or upon termination of the contract, whichever occurs first.

c) Delta Dental will not make any payment for repair or replacement of an orthodontic appliance furnished, in whole or in part, under this program.

d) Orthodontic Benefits are limited to Dependent enrollee children (under age 26).

e) Orthodontic Benefits are limited to Dependent children who have been enrolled in this Plan for 12 consecutive months. This provision will be waived for Employees and their Dependents enrolling on the effective date.

f) X-rays or extractions are not subject to the orthodontic maximum.

g) Surgical procedures are not subject to the orthodontic maximum.

Limitations on all Benefits – Optional Services

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling would restore the tooth, a precision denture where a standard denture could be used, or an inlay instead of a restoration or a composite restoration instead of an amalgam restoration on posterior teeth. If you receive Optional Services, your Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard practice.

Exclusions

Delta Dental does not pay Benefits for:

a) Services for injuries or conditions which are compensable under workers' compensation or employees' liability laws; services which are provided to the enrollee by any Federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political subdivision, except as such exclusion may be prohibited by law.

b) Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration) of the teeth, and anodontia (congenitally missing teeth), except those services provided to newborn children for congenital defect or birth abnormalities or services that may be provided under orthodontic Benefits.

c) Services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration, periodontal splinting, and occlusal adjustment.

d) Any Single Procedure started prior to the date the person became covered for such services under this program.

e) Prescribed drugs, medication, or analgesia.

f) Experimental procedures.

g) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

i) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

j) Services with respect to any disturbance of the temporomandibular joint (jaw joint).

k) Services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist.

Claims Filing and Appeals Procedures

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement, which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 521-2651

Predeterminations

A Dentist may file an Attending Dentist Statement before treatment, showing the services to be provided to an enrollee. Delta Dental will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination, but not longer than the contract's term nor beyond the date the patient's Coverage ends. If an enrollee obtains a Predetermination from a participating Dentist who becomes a Non-Participating Dentist prior to completion of the procedure, the Benefit will be the amount which would have been paid prior to the termination of the contract.

Claim Appeals

Delta Dental will notify the primary enrollee if Benefits are denied for services submitted on an Attending Dentist's Statement, in whole or in part, stating the reason(s) for denial. The enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reasons why the denial was wrong. The enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 60 days after Delta Dental receives the request for appeal (30 days for Predeterminations). Delta Dental may ask for more documents if needed. In no event will the decision take longer than 60 days (30 days for Predeterminations). The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment, or clinical judgment in applying the terms of this contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the enrollee believes he/she needs further review of his/her claim, he/she may contact his/her state insurance regulatory agency, if applicable, or bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), if the contract is subject to ERISA.

Written Notice of Claim/Proof of Loss

Before approving a claim, Delta Dental will be entitled to receive to such extent as may be lawful, from any attending or examining Dentist or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an enrollee as may be required to administer the claim, or that an enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Delta Dental will give any Dentist or enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the enrollee (or the parent or guardian, if the patient is a minor) and submitted to Delta. If the form is not furnished by Delta Dental within fifteen (15) days after requested by a Dentist or enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Delta Dental must be given written proof of loss within 90 days after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within 90 days of the termination of the contract.

Time of Payment

Claims payable under the contract for any loss other than loss for which the contract provides any periodic payment will be paid within 30 days after receipt of reasonable written proof of such loss. Delta Dental will notify the Primary Enrollee and his/her Dentist of any additional information needed to process the claim within this 30-day period. Delta Dental will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this contract provides periodic payment will be paid monthly.

LIBERTY DENTAL PLAN

Benefit Plans:

Glaziers: NV-400 with NVORTHO-1350 Rider

Fabricators: NV-400 with NVORTHO-1350 Rider

Using This Plan

This Plan offers you a choice of where you receive your dental care. However, to receive Benefits under this Plan, you must receive care from a Plan Provider. When you choose to receive your care from any Dentist that is a Plan Provider, your costs will be limited by the costs identified in the Co-Pay column on the Schedule of Benefits. You will not need to submit any claim forms when you receive your care from a Plan Provider.

To receive Benefits for care provided by a Specialist, your Plan Provider must initiate the referral process with LIBERTY. LIBERTY will then refer you to a Specialist who is a Plan Specialty Provider for approved Specialty services. Specialty services not pre-authorized by LIBERTY are not covered under this Plan.

You and your enrolled Dependents can choose a Plan Provider from a network of private practice dental offices. A list of Plan Providers is available through the Plan or on the internet: www.Libertydentalplan.com. Plan Provider pre-assignment is not necessary. To utilize the Plan, simply contact a Plan Provider, identify yourself as a LIBERTY Member, and the Plan Provider will verify your Eligibility with LIBERTY.

If you choose to receive care from a Dentist that is not a Plan Provider, you will not have a Benefit under this Plan.

Emergency Services

In the event of an emergency outside the service area of the Plan, the Member should contact LIBERTY at (888) 401-1128. The Plan will direct you to an available Plan Provider if possible. Should no Plan Provider be available in a fifty (50) mile radius you can seek treatment from any licensed Dentist. In such an event, the Plan will reimburse you for the cost of qualified emergency services received from an out-of-network Provider up to a maximum of seventy-five dollars ($75), less any applicable Member co-payments based on the Plan Benefits. Any non-qualified emergency services will not be considered as reimbursable emergency services.
The Plan provides Coverage for emergency dental services only if the services are required to alleviate severe pain or bleeding or if an enrollee reasonably believes that the condition, if not diagnosed or treated, may lead to Disability, dysfunction or death.

Qualified emergency dental service and care include a dental screening, examination, evaluation by a Dentist or dental specialist to determine if an emergency dental condition

exists, and to provide care that would be acknowledged as within professionally recognized standards of care in order to alleviate any emergency symptoms in a dental office.

LIBERTY Dental Plan Benefits

Calendar Year Deductible
Per Member None
Annual Maximum
Per Member None
Waiting Period **None**

Covered Services	NV-400 Member Co-Pays *
Diagnostic & Preventive Benefits	
Oral evaluations	$0
Full mouth x-rays	$0
Bitewing x-rays	$0
Prophylaxis (routine cleaning)	$0
Fluoride	$0
Sealant	$0
Space maintenance	$0 - $15
Restorative Benefits	
Fillings – amalgam (silver)	$0
Fillings – resin-based composite	$0
Single crowns	$70 **
Endodontic Benefits	
Pulp cap	$0
Root canal – anterior tooth	$34
Root canal – bicuspid tooth	$80
Root canal – molar tooth	$105
Periodontal Benefits	
Gingivectomy/gingivoplasty	$10 - $40
Osseous surgery	$175
Root scaling & planning, per quadrant/tooth	$15
Periodontal maintenance	$10
Removable Prosthodontic Benefits	
Complete denture	$85
Partial denture	$90 - $300
Reline complete denture	$16 - $28
Reline partial denture	$16 - $28
Implant Benefits	
Surgical placement, implant body	$2,000
Abutment/implant supported crown	$670 - $1,110
Abutment/implant supported fixed bridge (per unit)	$670 - $1,110
Fixed Prosthodontic Benefits	
Fixed bridge pontic	$70 **
Fixed bridge abutment crown	$70 **
Oral Surgery Benefits	
Simple extraction	$0
Surgical extraction	$0 - $48

***** Member co-pay amounts and Plan amounts are determined by the actual procedure performed. Variables shown allow for all procedures within the general service description.

****** Base metal is the Benefit. Single crowns, abutment crowns and pontics with noble metal, high noble metal and titanium will be charged to the Member at the additional lab cost of the metal. Resin, porcelain, resin-to-metal, and porcelain-to-metal on single crowns, abutment crowns and pontics on molar teeth will be charged to the Member at the additional cost to add the resin or porcelain. The maximum amount chargeable to the Member for metal upgrades and/or adding resin or porcelain on molar teeth is $250.

This table is a partial Schedule of Benefits and is intended only as a brief summary. Please refer to the complete Schedule of Benefits for a complete listing of covered procedures.

LIMITATIONS:

1. Prophylaxis procedures are covered once every 6 consecutive months;
2. Complete series of x-rays (full mouth x-rays) or panoramic films are covered once every 36 consecutive months;
3. Fluoride treatments are covered once every 6 consecutive months;
4. Sealants are covered only on the first and second permanent molars with no caries (decay) for Dependent children up to the 14th birth date. Limited to once per tooth per thirty-six (36) month period;
5. Scaling and root planing per quadrant/site is covered once every 24 consecutive months;
6. Replacement of crowns, labial veneers or fixed partial dentures (bridgework), per unit, are limited to once every five (5) year period;
7. Replacement of an existing full and partial denture is covered once per arch every five (5) years if the appliance cannot be made functional through reline or repair;
8. Denture Relines are covered twice every 12 consecutive months;
9. Fabricated crowns, onlays and inlays may be covered when a tooth with a good prognosis requires restoration but has insufficient remaining structure to reliably retain a filling. Coverage for these procedures limited to Members age 16 and over;
10. The replacement of an amalgam or resin restoration in less than twelve months by the same contracted Dentist or office is not chargeable to the Plan or the Member;
11. Procedure(s) that appear to have a poor prognosis as determined by a licensed LIBERTY Dentist consultant are not covered;
12. Localized delivery of antimicrobial agents may be covered 4-6 weeks after the completion of scaling and root planing as an adjunctive procedure for two non-responsive sites in a quadrant with 5 mm pockets or deeper plus inflammation;
13. For treatment plans involving seven (7) or more units of crowns and/or fixed partial dentures (bridges), contracted Providers may charge an additional $200 co-payment per unit. In such cases, the first six (6) units as described in limitation #6 above are covered at the specified Member co-payment amount only, as documented on the Plan's Schedule of Benefits;

14. Fixed Partial Dentures (bridges) are covered when: replacing a "like-for-like" existing fixed partial denture with identical pontics and abutment teeth with a good prognosis; abutment teeth qualify for crowns on their own merit, as described in limitation #6 above; there is only one missing permanent tooth in a full arch and the bridge would have opposing teeth in the opposite arch;
15. Surgical periodontal services are limited to once every thirty-six (36) month period;
16. Full mouth debridement is limited to once in a twenty-four (24) month period;
17. Pediatric referrals, if authorized by LIBERTY Dental Plan, are covered only for Dependent children through the age of six (6), unless the child qualifies under the American with Disabilities Act (ADA).

EXCLUSIONS:
1. Any procedure not specifically listed as a covered Benefit;
2. Replacement of lost or stolen prosthetics or appliances, including partial dentures, full dentures, and orthodontic appliances;
3. General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist other than those situations described in the Schedule of Benefits (**);
4. Treatment started prior to Coverage or after termination of Coverage;
5. Procedures, appliances, or restorations to treat temporomandibular joint dysfunctions (e.g. adjustments/corrections to the facial bones), congenital or developmental situations (including supernumerary teeth) or medically induced dental disorders, including but not limited to: myofunctional treatment (e.g. speech therapy), or myoskeletal dysfunctions, unless otherwise covered as an orthodontic Benefit;
6. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations; congenitally missing teeth and teeth that are discolored or lacking enamel;
7. Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice;
8. Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion;
9. Any services performed outside of a contracted LIBERTY dental office, unless expressly authorized by LIBERTY, or unless as outlined and covered in "Emergency Dental Care" section of the Evidence of Coverage;
10. The removal of asymptomatic, unerupted third molars (or other teeth) that appear to have an unimpeded pathway to eruption and no active pathology;
11. Procedures or appliances that are provided by a Dentist who specializes in prosthodontics services;
12. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding occlusion or maintaining chewing surfaces of teeth that are out of alignment or for stabilizing teeth. Examples of such treatment are equilibration and periodontal splinting;
13. Any routine dental services performed by a Dentist or dental specialist in an inpatient/outpatient hospital setting;
14. Consultations for non-covered services.

Orthodontic Benefits

Glaziers and Fabricators: NVORTHO-1350 Orthodontic Rider

Orthodontic Benefits are covered for both adults and children. Orthodontic treatment must be provided by a Plan Provider. There are no orthodontic Benefits if an Out-of-Network Provider performs the treatment. To receive Benefits for orthodontic treatment, your Plan Provider should initiate the referral process with LIBERTY Dental Plan. LIBERTY Dental Plan will then refer you to an orthodontic specialist who is a Plan Specialty Provider. If you do not have a Plan Provider, contact the Plan at (888) 401-1128 for assistance.

Member Co-Pays

Diagnostic records (start-up fee):	$ 250
Limited orthodontic treatment:	$1,300
Interceptive orthodontic treatment:	$ 500
Comprehensive orthodontic treatment:	$ 850
Minor treatment/harmful habits:	$ 350
Orthodontic retention (retainers):	$ 250

ORTHODONTIC EXCLUSIONS:

1. Replacement of lost or stolen orthodontic appliances;
2. Lost, stolen or broken appliances;
3. Orthodontic treatment started prior to Member's effective date of Coverage unless covered through an orthodontic takeover provision;
4. Extractions for orthodontic purposes (will not be applied if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition);
5. Treatment in progress at the time of Eligibility, unless included as an orthodontic rider to the groups Benefits;
6. Temporomandibular joint syndrome (TMJ) surgical orthodontics;
7. Myofunctional therapy;
8. Treatment of cleft palate;
9. Treatment of micrognathia;
10. Treatment of macroglossia;
11. Changes in orthodontic treatment necessitated by accident of any kind;
12. Orthodontic Coverage is limited to 24 months of treatment, followed by 24 months of retention office visits;
13. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient;
14. In the event of termination the patient is responsible for the usual fee of the treating Dentist pro-rated over the remainder of treatment and/or retention.

Claim Payments

Plan Providers are paid an amount agreed upon between the Plan and the Plan Provider plus any copayment from the Member required by the Benefit Schedule.

All claims shall be approved or denied within thirty (30) days after receipt by the Plan, unless additional information is requested. If the claim is approved, the claim will be paid within thirty (30) days after it is approved. If the Plan requires additional information, the Member shall be notified within twenty (20) days after the Plan actually receives the claim. The claim will be paid or denied within thirty (30) days of the Plan's receipt of all of the additional information it requested.

All claims must be submitted to LIBERTY Dental Plan within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. No payments shall be made with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by LIBERTY Dental Plan within twelve (12) months after the date Covered Services were provided.

Please contact LIBERTY Dental Plan at (888) 401-1128 for claim filing information.

Appeals and Grievances

The LIBERTY Dental Plan Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration, you wish to appeal an Adverse Benefit Determination or there is another concern you wish to bring to LIBERTY Dental Plan's attention. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Member with the appropriate information.

Please contact LIBERTY Dental Plan at (888) 401-1128 for information and assistance regarding Appeals and Grievances.

VISION BENEFITS

Vision Benefits are provided through Vision Service Plan (VSP).

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician whether a VSP Member Doctor or Non-Member Provider.

When Plan Benefits are received from Member Doctors, Benefits appearing in the first column below are applicable to any Copayment as stated below. When Plan Benefits are received from Non-Member Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the second column below, less the $20 Copayment.

Glaziers Vision Benefits			
Plan Benefits	**Member Doctor Benefit**	**Non-Member Provider Benefit**	**Frequency Allowed**
Copayments: Benefits marked with an * are subject to a $20 Copayment payable by the Covered Person to the Member Doctor at the time services are rendered. The $20 Copayment is the total Copayment paid for exam, lenses and frames.			
Exam			
Vision Examination *Complete initial vision analysis, which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.*	Covered in Full*	Up to $46.00*	Once every 12 months
Prescription Eyewear – You may choose between glasses or contacts. Before selecting your eyewear, ask your Doctor what is covered by your VSP Plan.			
Lenses Single Vision Bifocal Trifocal Lenticular	 Covered in Full* Covered in Full* Covered in Full* Covered in Full*	 Up to $47.00* Up to $66.00* Up to $85.00* Up to $125.00*	Once every 12 months
Frames	Covered up to Plan Allowance*	Up to $45.00*	Once every 24 months

Glaziers Vision Benefits			
Plan Benefits	**Member Doctor Benefit**	**Non-Member Provider Benefit**	**Frequency Allowed**
Contact Lenses			
Visually Necessary			
Professional Fees and Materials	Covered in Full*	Up to $210.00*	Once every 12 months
Elective			
Professional Fees and Materials	Up to $120*	Up to $105.00*	
	The allowance is applied toward both the contact lens exam and the contact lenses. The Plan includes a 15% discount off the contact lens exam (fitting and evaluation), when obtained from a VSP Doctor. This exam is performed in addition to your routine eye exam. It is essential to check for eye health risks associated with improper wearing or fitting of contacts that, if left untreated, can affect the overall health of your eyes.		

Finding a VSP Provider

There are two ways to locate a VSP Doctor within your locality or to verify whether or not your Doctor is a VSP Doctor:

- Through VSP's web site:

1. Go to **http://www.vsp.com**

2. On the home page of the web site, login by entering the covered Member's ID to begin the search. You can search for a Doctor by name or by location.

By calling VSP's Member Services Department at (800) 877-7195. VSP's automated service allows you to search for a Doctor by zip code or name.

Exclusions and Limitations

Limitations

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options:

1. Blended lenses.

2. Contact lenses (except as noted elsewhere herein).

3. Oversize lenses.

4. Photochromatic lenses; tinted lenses, except Pink #1 and Pink #2.

5. Progressive multifocal lenses.

6. The coating of the lens or lenses.

7. The laminating of the lens or lenses.

8. A frame that costs more than the Plan allowance.

9. Certain limitations on low vision care.

10. Cosmetic lenses.

11. Optional cosmetic processes.

12. UV (ultraviolet) protected lenses.

Exclusions
There is no Benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals;

2. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

3. Medical or surgical treatment of the eyes;

4. Any eye examination or any corrective eyewear required by an Employer as a condition of employment.

5. Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

NOTE: VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

How to File a Vision Claim

If you utilize the services of a VSP Provider, the VSP Provider will file the claim for you. If you see an out-of-network Provider, you must pay the entire bill when you receive services, then send your itemized receipt to VSP within six months from the date of service. Included with your receipt should be the covered Member's name, phone number, address, Member ID, the name of the Trust, the patient's name, date of birth,

phone number and address, and the patient's relationship to the covered Member (such as spouse, child, etc.).

Keep a copy of the information for your records and mail original claim forms to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

VSP Appeal Procedures

If an Enrollee has a complaint/grievance (hereafter "grievance") regarding VSP service or claim payment, the Enrollee may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll-free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 6:00 p.m., Pacific Standard Time. Grievances may be filed in writing with VSP at 3333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the Enrollee acknowledging receipt and/or disposition of the grievance within five (5) business days. If a resolution cannot be reached within thirty (30) days, a 15-day interim notification will be sent to the Enrollee informing of the resolution's status. (VSP will keep all grievances and the responses thereto on file for seven (7) years.)

Employee Assistance Program Services

Behavioral Healthcare EAP - The Life Connection

We recognize the challenges of balancing work and the demands of everyday life. That's why you and your family have access to support through The Life Connection Employee Assistance, Work-Life Resource and Referral program. When you call the toll-free number, you will be assisted by a qualified EAP/Work- Life consultant, who will respond to your request thoroughly and promptly. And when you log on to the Work-Life website, you'll find an abundance of useful resources, articles, links and interactive tools.

The Life Connection program is free of charge to all Trust Members and all in their households.

TLC includes:

- Three face-to-face or telephonic counseling sessions
- Your entire household is eligible to use the program
- Single point of contact for all life management needs
- 24-hour crisis support
- Always confidential and free of charge

You can talk to your EAP counselor confidentially about:

- Anxiety and depression
- Emotional/personal conflicts
- Grief and loss
- Managing stress and change
- Marital conflicts
- Parenting
- Questions about alcohol/drug use/gambling addictions

Work-Life Consultations are available to Employees and their household members to access professionals in the following areas:

- Legal consultation
- Financial consultation
- Child care and elder care consultation service
- Daily living service

Online Work-Life Resources are available by visiting:

- www.bhoptions.com
- Select "I am: A member", then select "Work-Life Resources"
- Enter company code: glaziers

Employees can call BHO at 1-800-280-3782 24 hours a day to receive assistance.

WEEKLY DISABILITY BENEFITS GLAZIERS AND FABRICATORS

You must have had at least five hundred (500) hours contributed on your behalf to the Trust during the previous twelve (12) month period to be eligible for the Weekly Disability Benefit. If you do not have at least five hundred (500) hours contributed to the Trust during the previous twelve (12) month period and you become Totally Disabled, you may maintain Coverage for you and your eligible Dependents at no cost to you for a maximum of twelve (12) months or until you are no longer Totally Disabled, whichever comes first.

If you lose Eligibility under the Trust, but subsequently re-establish your Eligibility, you must have at least five hundred (500) hours contributed on your behalf to the Trust during the previous twelve (12) month period after re-establishing Eligibility to become eligible for the Weekly Disability Benefit.

If you become Totally Disabled as a result of Injury or Sickness while you are covered under the Plan, and if your Total Disability continues without interruption for a period longer than the Waiting Period, you will be paid the Benefits described and limited in the following paragraphs.

The Trustees, in their sole discretion, may require a Certificate of Disability, which must be administered by a Plan Physician. Recertification by a Plan appointed Physician may be required at the discretion of the Trustees.

Total Disability, the Weekly Disability Benefit, Waiting Period and Maximum Payment Period are defined in the following paragraphs:

a) You must be continuously and completely prevented by Injury or Sickness to engage in any occupation or business for an income or profit. In addition, you will be considered Totally Disabled for the purpose of Weekly Disability Benefits only if during your entire period of Disability, you are under the direct care of a Physician other than yourself or a family member.

b) The Weekly Disability Benefit for different Employee classifications are listed below:

1. Journeyman $750.00 per week
2. Fabricators and Architectural Glaziers $500.00 per week
3. 35% Apprentice $262.50 per week
4. 40% Apprentice $300.00 per week
5. 45% Apprentice $337.50 per week
6. 50% Apprentice $375.00 per week
7. 60% Apprentice $450.00 per week
8. 70% Apprentice $525.00 per week
9. 80% Apprentice $600.00 per week
10. 90% Apprentice $675.00 per week

c) The Waiting Period for Weekly Disability Benefits is seven (7) days for disabilities as a result of Sickness and immediate Benefit payments as a result of Injury.

d) If you become Totally Disabled as a result of Injury or Sickness and if your Total Disability, as defined above, continues without interruption for longer than the Waiting Period, you will be paid weekly Benefits.

e) The Maximum Payment Period is 26 weeks in a 60-month period.

f) If, within a 60-month period after recovery from any period of Disability for which Weekly Disability Benefits have become payable and while you are still covered under this Plan Benefit, you again become Totally Disabled from the same or any related cause or causes for more than ten (10) consecutive days, such Disability will be considered a continuation of the previous period of Disability; otherwise any subsequent period of Disability will be considered a new period of Disability.

Exclusions of Weekly Disability Benefits are as follows:

a) Any Injury or Sickness entitling you to Benefits under any worker's compensation act or similar law;

b) War or any act of war, including armed aggression resisted by the armed forces of any country, combination of countries or international organization, whether or not war is declared;

c) Service (other than active duty service of two months or less for training purposes only) in the armed forces of any county or international organization;

d) Intentionally self-inflicted injuries, unless the Plan is notified of a related cause that is the source of the Injury and is a protected source of Injury under applicable Federal law (for example, the Health Insurance Portability and Accountability Act);

e) Any Sickness or Injury resulting from criminal activity;

f) Any like-kind Benefit paid by a third party for any part of any period of Disability during which you are not in the United States, unless the Plan agrees in writing to continue Benefits prior to your leaving the United States; or

g) Anything excluded under the General Exclusions and Limitations of the Plan.

If you apply for Weekly Disability Benefits because you are unable to work or to earn wages and you believe that another person is or may be liable to you or financially responsible for your inability to work or earn wages, the Trust may choose to pay Weekly

Disability Benefits to you on condition that you agree to repay the Trust upon receipt of any related recovery that you or any representative receive from any other person, including any workers' compensation insurer or other similar entity. Whether to pay Weekly Disability Benefits in such circumstances is a decision over which the Trustees exercise sole and full discretion. You will not be eligible to receive Weekly Disability Benefits in such circumstances and your application will not be considered by the Trust, unless you, and any attorney you engage to pursue any claim you may possess for money related to your inability to work or earn wages, both execute the Trust's Reimbursement Agreement. The following rules govern the receipt of Weekly Disability Benefits in such circumstances, and the Trust's right to be reimbursed.

a) By signing the Trust's Reimbursement Agreement, which the Trustees may revise from time to time, you will assign to the Trust the gross amount of any recovery received, no matter how such recovery may be described, up to the amount of the Weekly Disability Benefits paid by the Trust. Your recovery may be the result of a lawsuit, a settlement or some other act. The Trust is entitled to be paid out of any recovery related to your inability to work or earn wages, up to the amount of Weekly Disability Benefits the Trust pays, regardless of attorney's fees, costs or other charges.

b) You will take no action that would prejudice the Trust's assignment, reimbursement, or subrogation rights. You will comply with all requirements stated in the Reimbursement Agreement and will direct all your representatives to do so. You will cooperate in doing what is reasonably necessary to assist the Trust in enforcing its reimbursement rights or subrogation rights.

c) You will not enter into any agreement with a third party that would undermine the assignment, subrogation or reimbursement rights of the Trust. All such agreements will be deemed unenforceable and will be ignored for purposes of determining and enforcing the rights of the Trust. The Trust's rights will not be reduced because your recovery does not fully compensate you.

d) The Trust may enforce its assignment, reimbursement and subrogation rights by filing a lien with any third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party. The Trust also may claim a lien upon funds held by any person, including your attorney or other party who has or who had (before disbursement) the custody of such funds.

e) The Trust shall be entitled to a court order barring you and any representative from spending or transferring any portion of any recovery you obtain, until any dispute between the Trust and you (or a representative) is finally resolved, or until a court issues a final decision regarding the Trust's rights.

f) The amount of the Trust's reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Trust expressly agrees otherwise in writing. The Trust may elect to charge (offset) any assignment, reimbursement, or subrogation sums due under this provision against any further Benefit payments for you or your Dependents under the terms of the Trust's Plan Document.

g) Both you and your attorney must acknowledge in the Reimbursement Agreement that the Trust's rights to assignment, reimbursement, and subrogation, are not subject to equitable defenses, including the "make whole" and "common fund" doctrines.

h) The Trust will not pay your attorney's fees or costs associated with efforts to recover payment from any person, nor will the Trust reduce its reimbursement pro rata for payment of any attorney's fees or collection costs. Any attorney's fees you owe will be payable out of the recovery only after the Trust has received full reimbursement.

i) You and any representative (including any attorney) who receives any recovery, whether by judgment, settlement, compromise or otherwise, has an absolute obligation to immediately tender the recovery or recoveries to the Trust. If any recovery or funds received are not immediately tendered to the Trust, you, your attorney or any other person possessing the recovery will hold the recovery in trust for the Trust.

j) The Trust's right to collect from you under this provision shall be governed by Federal law. The Trust's right to collect monies under this provision from your attorney may be based on Federal and/or state laws. The Trust's right to collect from your attorney is separate from and in addition to its right to collect from you.

LIFE INSURANCE AND AD&D BENEFITS

(Actives and Retirees)

Underwritten by MetLife

Life Insurance

Life Insurance Amount

In the event of your death, $10,000* will be paid to your Beneficiary.
* Reduced to $5,000 at age 70.

Dependent Life Insurance Amount (Coverage ceases upon death of Employee or Retiree)

Spouse	$5,000
Child 15 days to six months old:	$ 100
Child more than six months old:	$2,500
Child limiting age: 26 years of age	

Conversion Privilege

If your life insurance Benefit is terminated or reduced, you are entitled to convert all or a portion of the insurance to an individual life insurance policy. You will not be required to submit proof of good health in order to convert. If you wish to apply for individual life insurance, contact the Trust Administrative Office for further information.

- If you lose Eligibility under this Plan, you can convert up to the amount of insurance which was terminated, less any amount for which you become eligible under this Plan or another group policy within 31 days from the date you lost Eligibility.

- If your life insurance is reduced because you reach age 70, you may convert up to the amount of the reduction.

- If this life insurance policy is terminated by the Plan, or is amended so that Coverage for your class is eliminated, you may convert up to $2,000 of life insurance, provided you have been continuously insured under the Plan for at least five (5) years. You must do so within 31 days of loss of Coverage.

The premium charged for your individual life policy will be based on the rates in effect at that time for a person in your risk category.

If you should die during the 31 days following your loss of Eligibility, your life insurance amount will be paid to your Beneficiary, whether or not you have applied for an individual policy.

Waiver of Premium

If you become Totally Disabled while you are covered under the Plan and prior to attaining age sixty (60), you may apply to continue your life insurance without payment of premium as long as you remain Totally Disabled.

Total Disability or Totally Disabled means your complete inability, due to Injury or Sickness, to engage in any business, occupation or employment for which you are qualified or become qualified by reason of education, training, or experience for pay, profit, or compensation.

The initial period of Coverage will be for 12 months from the date premium payments on your behalf cease, but in no event longer than 24 months from the date Total Disability began. To continue Coverage beyond that, you must submit satisfactory written proof (the "Initial Proof") of Total Disability within 12 months from the date premium payments on your behalf cease; but in no event more than 24 months from the date of Total Disability began. Initial Proof must show that the Total Disability began while you were covered under the policy, that you were less than sixty (60) years of age at the onset of the Disability, and that the Disability has continued for at least nine months.

The waiver of premium may be continued in 12-month increments if proof of Disability is submitted each year. MetLife has the right to have you examined at its own expense by a Doctor of its choice during the course of your Disability.

Accidental Death and Dismemberment Benefit (AD&D)

This Benefit will be payable if, while insured, you sustain any of the losses listed below as a direct result of an accidental Injury. For Benefits to be payable, the loss must be independent of all other causes and take place within 90 days from the date of the accident.

Benefits

FOR LOSS OF:	THE BENEFIT IS:
Life	$10,000
Two Feet	$10,000
Two Hands	$10,000
Sight of Two Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and Sight of One Eye	$10,000
One Foot and Sight of One Eye	$10,000
One Hand or One Foot	$5,000
Sight of One Eye	$5,000

If you suffer more than one loss in any one accident, payment will be made only for that loss for which the largest amount is payable.

Who Will Receive Benefits

For loss of life, Benefits will be paid to the Beneficiary you name. For any other loss, the Benefits will be paid to you.

If no Beneficiary has been designated, or if a designated Beneficiary dies before the benefit is paid, the benefit shall be paid to one (1) or more of the following surviving relatives: lawful spouse, child or children, including legally adopted children, mother, father, brothers and sisters or the Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereurider to the extent of such payment.

Definitions

1. The loss of hand or foot means that the limb is completely severed at or above the wrist or ankle joint, respectively.

2. Loss of sight means the total and irrecoverable loss of sight.

Losses that are not Covered

No Benefit is payable under this section if your death or any loss is caused directly or indirectly, wholly or partly, by:

1. bodily or mental illness, or disease of any kind;

2. ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

3. suicide or attempted suicide while sane or insane;

4. intentional self-inflicted Injury

5. participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a terrorist act, or a civil commotion;

6. war or an act of war, whether declared or undeclared, or any act related to war or insurrection;

7. service in any military, naval or air force of any country while such country is engaged in war; or

8. police duty as a member of any military, naval, or air organization.

Beneficiary

You may name anyone you wish as your Beneficiary. You may change your Beneficiary at any time by completing the proper form. The change will be effective when the form is received by the Trust Administrative Office.

How to File a Claim

Proof of Claim will include a copy of the covered individual's death certificate and any other data that the Claims Administrator may require to establish the validity of the claim. You should submit the claim to the Trust Administrative Office.

Claim forms for AD&D Benefits can be obtained from the Trust Administrative Office. The claim form along with the proof of loss, including documentation regarding the nature of the loss and date of the loss, should be submitted to the Trust Administrative Office. The Trust Administrative Office will notify the claimant if any additional information is needed in order to process the claim.

The Trust Administrative Office will submit the complete claim to MetLife.

Appeal Process

A claimant, or the claimant's authorized representative, cannot start any legal action with respect to a claim until 60 days after the proof of claim has been presented, but not more than three (3) years from the time that the proof of claim is required.

Issues related to rival claimants for proceeds are referred to the Legal Department of MetLife for handling. Otherwise, a claim determination, Benefit denial or other matters related to the administration of the policy may be appealed, if disputed by an insured or Beneficiary or representatives of such persons. MetLife Claims Examiner immediately shall forward the claim file and an explanation of the dispute to the Manager of Life Claims Department. If the Manager is unable to resolve the matter, the claim will then be reviewed by the Vice President for Group Operations, the Vice President for Underwriting, the Legal Department, and, if necessary, the Medical Director to determine appropriate action. The consensus recommendation of those individuals shall be provided to the Manager for implementation after their receipt of the claim information.

A first denial by the Company can be further appealed by the Insured or Beneficiary in accordance with the ERISA claims appeals procedure available through the Trust.

The address for all correspondence regarding claims and appeals is:

MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

The above explanations of life insurance and AD&D insurance Benefits, policies, and procedures is only a brief summary of the provisions of the contract. Please see your Evidence of Coverage provided by MetLife for complete details.

DRUG ABUSE DETECTION AND PREVENTION POLICY

Testing and Rehabilitation Administered through Harmony Healthcare.

Background

The Drug Abuse Detection and Prevention Program is intended to enhance workplace safety, promote a drug-free environment, and to provide a management procedure for addressing job-site drug abuse issues. All Glazier and Fabricator apprentices, journeymen and job applicants covered by Collective Bargaining Agreements may be required to undergo drug screening.

Drug Abuse Detection and Prevention Policy and Procedures

1. Prohibited Conduct. Use, possession, transfer or sale of illegal drugs, narcotics, or other unlawful substances are absolutely prohibited while an Employee is on the Employer's job premises or while working on any site in connection with the Employer's work performed under applicable Collective Bargaining Agreements ("Participating Employer").

2. Participating Employer Drug Screens. A Participating Employer may require its Employees to submit to a drug screen in accordance with its lawful policy. The drug screen is paid for by the Participating Employer and is administered through a competent testing administrator selected by the Participating Employer, subject to the following procedures:

    a. Testing Notice. Copies of any Participating Employer testing notice will be sent to the Union and applicable Employer Association.

    b. Clean Card Request. Upon written request with proper documentation, the Trust Administrator will issue a "Clean Card" for any Employee who has successfully completed the drug screen required by a Participating Employer.

    c. Rehabilitation and Reinstatement. A current Employee who tests positive may enroll in a rehabilitation program within the Trust's Plan with no loss of employment, provided the Employee is unimpaired, attending and compliant with the requirements of the rehabilitation program. Upon successful completion, a Participating Employer will not discriminate in any way against the rehabilitated Employee. If work exists for which the rehabilitated Employee is qualified, the Employee will be reinstated by the Participating Employer.

d. Healthcare (Rehabilitation Program). To enroll in a Plan rehabilitation program, please call the Trust Administrator at (702) 415-2191.

e. Program Completion. Upon satisfactory completion of an approved Plan rehabilitation program, the Employee may qualify for issuance of a "Clean Card" by the Trust.

f. Termination. Any Employee who refuses to take a drug screen, lawfully required by a Participating Employer, may be terminated.

g. Reasonable Cause Testing. A Participating Employer may require that any Employee who was involved in or contributed to an accident which resulted in a material loss of work time, material damage to property, an Injury requiring medical attention or a Reportable Accident under the Nevada Industrial Insurance Statutes, submit to a drug screen, if the Participating Employer has reasonable cause to believe that the accident resulted from unlawful drug use, or when required by the Participating Employer's insurance carrier or if required by the Nevada Industrial Insurance Statutes or other applicable law.

h. No Random Testing. There will be no random testing by Participating Employers.

i. Prescription Medication. The unsafe use of prescribed medication, or where the use of prescribed medication impairs the Employee's ability to perform work, is a basis for removal of an Employee from the Participating Employer's job site.

LEGISLATION AFFECTING HEALTH CARE BENEFITS

Newborn and Mother's Health Protection Act of 1996

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 you or your 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 your or your newborn's attending Provider, after consulting you, from discharging you or your newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay that is less than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical Benefits for a mastectomy, and if you were to need a mastectomy, you would also be covered for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery/reconstruction on the other breast to produce a symmetrical appearance; and
- prostheses and/or physical complications that may arise, including lymphedemas.

Health Insurance and Portability and Accountability Act (HIPAA)

Changes in Federal law may affect your health Coverage if you are enrolled or become eligible to enroll in health Coverage that excludes Coverage for preexisting medical conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which Coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition may not be excluded from Coverage for more than 12 months (or 18 months if you don't enroll at your first opportunity). The 12-month (or 18-month) exclusion period is reduced by your prior health Coverage and you are entitled to a certificate that shows evidence of your prior health Coverage. If you have 12 months of continuous Coverage under the Trust, your new health care plan cannot exclude your preexisting conditions from Coverage, except under the following situations:

- if you do not enroll at your first opportunity, in which case the new health care plan can exclude your preexisting conditions up to 18 months; and

- if you have a lapse in Coverage lasting 63 days or longer. A 63-day lapse in Coverage has the effect of erasing all Creditable Coverage.

When your Coverage under the Trust ends, you are entitled to a Certificate of Creditable Coverage that shows you were covered under a medical Benefit program, and the length of time you were covered. You should automatically receive a Certificate of Creditable Coverage. If you do not receive this Certificate, contact the Trust Administrative Office.

Certificate of Former Coverage

If you or your Dependent loses Coverage under the Trust, you will be furnished with a Certificate of Former Coverage. You may need the Certificate if your new plan excludes Coverage for pre-existing conditions. If you are entitled to COBRA Coverage, the Certificate will be mailed when a notice for a Qualifying Event under COBRA is required, and after COBRA Coverage ends. You also may request a Certificate at any time within 24 months after your Coverage ends.

Patient Protection and Affordable Care Act

The information under this heading is required by the Federal Patient Protection and Affordable Care Act.

Under the Patient Protection and Affordable Care Act (PPACA), informally known as the Healthcare Reform Law, the Anthem Blue Cross medical Plan offered through the Trust is no longer considered to be a "grandfathered plan".

Since the Anthem Blue Cross Plan is no longer considered grandfathered, Anthem Blue Cross must comply with additional requirements under PPACA, including:

- Preventive care must be provided with no cost sharing;

- Expanded internal claims and appeals procedures and an external review process must be implemented;

- Emergency services must be covered without pre-authorization and without increased cost-sharing for out-of-network services; and

- Members must be allowed to select any primary care Physician, including pediatricians for children; women must be allowed access to OB/GYN services without a referral.

For specific information about any of these requirements, please contact Anthem Blue Cross directly at (800) 331-1476.

The Trust will cover children for all Benefits up to age 26, without regard to financial dependency, marital status, residency, student status, or employment. In addition, Coverage is now available to children under Anthem Blue Cross up to age 26, regardless

of whether they have health Coverage available to them under another employer-sponsored health plan. If you miss the special enrollment period to re-enroll your Dependent children, you will have an opportunity to do so during the regular open enrollment period of every year.

The Trust will not generally be able to retroactively rescind Coverage once you are enrolled, unless due to your fraud or intentional misrepresentation of material fact.

Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan and what might cause a plan to change from a non-grandfathered health plan status can be directed to the Trust Administrative Office (Agent), whose address and telephone number are on the second page of the booklet. 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 a non-grandfathered health plan.

CLAIMS APPEAL AND REVIEW PROCEDURES

No Employee, Dependent or other Beneficiary shall have any right or claim to Benefits under the Trust, except as specified in this Summary Plan Description or the Trust Agreement. Any dispute as to Eligibility, type, amount or duration of Benefits under the Trust, or any amendment or modification thereof, shall be resolved by the Board of Trustees and/or the designated insurance carrier under and pursuant to the Trust and the Trust Agreement. The Board's decision shall be final and binding upon parties to the dispute. No action for Benefits may be brought unless and until the Employee, Dependent or other Beneficiary in accordance with the claims appeal and review procedures (1) has submitted a written claim for Benefits, (2) has been notified that the application is denied, (3) has filed a written request for a review of the application through all levels of appeals with the Trust Administrative Office or the appropriate insurance carrier, as applicable, and (4) has been notified in writing that the insurance company or Trust has confirmed the denial of the claim.

If you have a claim for a Benefit that does not involve Trust Fund Eligibility, you must follow the claims, appeal, and review procedures set forth in the Evidence of Coverage booklet provided by Anthem Blue Cross, Delta Dental, LIBERTY Dental, Vision Service Plan and MetLife, as applicable. For more details about each organization's claims, appeal, and review procedures, please refer to that organization's Evidence of Coverage booklet or contact the organization directly. You may obtain an Evidence of Coverage booklet free of charge from the Trust Administrative Office.

If you have a general question as to your Eligibility under the Trust, please call the Trust Administrative Office.

The Trustees have complete and sole discretion to interpret the Trust documents and to determine Eligibility. Such determinations shall be conclusive and binding on all persons. Except under extraordinary circumstances, an Appeal will **not** be considered, unless submitted in writing at least thirty (30) days before consideration by the Trustees and including all support information and documents relevant to the Appeal.

NEVADA NOTICE

The Nevada Division of Insurance has established a toll-free telephone number to receive inquiries and complaints from consumers of health care in Nevada concerning health care plans.

a) The name of the division is the Department of Business and Industry, Division of Insurance.

b) The hours of operation of the Division are:
Monday through Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST)

c) For consumers having local access to the Carson City office of the Division of Insurance, the telephone number is 775-687-0700.

For consumers having local access to the Las Vegas office of the Division of Insurance, the telephone number is 702-486-4009.

For all other consumers the toll-free number is 888-872-3234. This toll-free number is for consumers only.

DEFINITIONS

Attending Dentist Statement
A form used to report dental procedures to a third-party payer.

Beneficiary
Means the person you name according to the procedures of the Plan to receive death or other Plan Benefits when you die. You may name anyone as your Beneficiary and you may change your Beneficiary at any time.

Benefits or Covered Benefit
A health service or item that is included in your Coverage under this Trust.

Board of Trustees
Means the Plan sponsor representatives and fiduciaries of this Trust who have exclusive authority and discretion to manage the assets of the Trust.

Certificate of Creditable Coverage/Certificate
Means a written certificate that states the period of time one is covered by a health plan.

Collective Bargaining Agreement
Means the Collective Bargaining Agreements between the Employers and Union which provide for contributions to the Trust (also referred to as a Participation Agreement for those Employees not covered by a Collective Bargaining Agreement).

Contributing Employer
Means an Employer who is required under a collective bargaining or Participation Agreement to make contributions to the Glazing Health and Welfare Trust.

Coverage
Means Benefits available to an eligible individual covered under this Trust.

Dentist
Means a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD).

Dependent(s)
Means those eligible Dependents of the Employee as specified on page 12 of the Eligibility section of this booklet.

Disability
As used in connection with the self-payment option for health and welfare Benefits, means that due to Injury or Sickness an Employee is: 1) under a Physician's care; and 2) completely and continuously unable to work in the Glazing and Fabricating Industry. (Also see Total Disability definition in this section.)

Eligibility
Means having satisfied the rules to be eligible for Coverage under this Trust.

Employee or Active Employee (or Participant)
Means any Employee who meets the requirements for continuing Eligibility as defined on page 9 of this booklet.

Employer
Employer means a participating Employer in the Glazing Health and Welfare Trust.

Employer Association
Means the Glazing Contractors Association of Southern Nevada.

Evidence of Coverage
Means the booklet provided by your HMO, dental, vision or life insurance Provider describing the terms and Benefits of your medical, vision, or dental Plan.

Fund/Trust/Trust Fund/Plan
Means the Glazing Health and Welfare Trust (also referred to as Plan).

Injury
Means an Injury to the body that is sustained accidentally.

Inpatient
Means an Insured Person who is confined in a hospital or a convalescent or skilled nursing facility and is charged for room and board.

Insurance Companies or Insurers
Means the MetLife for Life and AD&D Benefits; Delta Dental and LIBERTY Dental Plan for Dental Benefits; Anthem Blue Cross for medical and prescription drug Benefits, Vision Service Plan for vision Benefits.

Open Enrollment
A period during which one may freely enroll in or change one's selection of a health insurance plan or other benefit program that is ordinarily subject to restrictions.

Medicare
Medicare means Parts A & B of Title XVIII of the Social Security Act, U.S. Public Law 89-97, and any amendments thereto.

Member (or Participant)
Means a person who is eligible for Plan Benefits under this Trust.

Physician
Mean a licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered by the laws of the jurisdiction where the treatment is given.

Plan Testing Administrator
Means Harmony Healthcare, the current drug screening and rehabilitation Provider for the Trust, or its successor.

Provider
Means the Insurer, Insurance companies, or Providers of service to the Trust as listed on page 76 of this booklet, and as described above under the definition of Insurance Company.

Qualified Medical Child Support Order or QMCSO
Qualified Medical Child Support Order or QMCSO means a legal document issued by a court or other agency that orders an Employee covered under the Plan to enroll a child as a Dependent.

Qualifying Event
Means an event which qualifies an Employee or Dependent for continuation of Benefits Coverage under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, Public Law 99272, and any amendments thereto.

Retiree
Any Active Employee who retires from an Employer who becomes covered by the Retiree Plan, effective on the date of termination of Coverage under this Plan, and who meets the Retiree Plan's Eligibility requirements.

Sickness
Means an illness or disease.

Summary Plan Description
Means the written statement or booklet of the Trust that contains information regarding participation, Coverage and Employee rights under any ERISA-covered Benefit Plan.

Testing Administrator
Means Harmony Healthcare, the drug abuse screening and rehabilitation Provider for the Trust.

Total Disability or Totally Disabled
As used in connection with all life insurance Benefits means that due to Injury or Sickness an Employee is: 1) under a Physician's care; and 2) completely and continuously unable to engage in any occupation or business for an income or profit. (Also see Disability definition in this section.)

Trust Administrative Office
Means the BeneSys Administrative Office in Las Vegas, Nevada.

Trust Agreement
Is the agreement that spells out the guidelines for receipt, investment and disbursement of funds under the Trust.

Union
Means International Union of the Painting and Allied Trades (IUPAT) District Council 16, Glaziers Local No. 2001.

INSURERS AND PROVIDERS OF SERVICE TO THE TRUST

The Insurers and Providers of service to the Trust are as follows:

For Hospital, Medical, Surgical, and Prescription Drug Benefits

Anthem Blue Cross Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

For Dental Benefits

Delta Care Dental Plan, Inc.
3012 West Charleston Boulevard, Suite 120
Las Vegas, NV 89102

LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799-6110

For Vision Benefits

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

For Life and AD&D Benefits

MetLife
4150 N. Mulberry Drive, Suite 300
Kansas City, MO 64116

For Drug Abuse Testing and Rehabilitation

Harmony Healthcare
1701 West Charleston, Suite 300
Las Vegas, NV 89102

STATEMENT OF ERISA RIGHTS

As a Participant covered under this Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Trust Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Trust Administrative Office and at the Union Local No. 2001 office all Trust documents, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Trust with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain upon written request to the Trust Administrative Office, copies of documents governing the operation of the Trust, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Trust Administrative Office may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Trust Administrative Office is required by law to furnish each Participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health 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 COBRA continuation Coverage rights.

You can reduce or eliminate 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 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.

Prudent Actions by Fiduciaries

In addition to creating rights for Trust Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Trust's Benefits. 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 a way to prevent you from obtaining a welfare Benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Trust documents or the latest annual report from the Trust 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 Trust Administrative Office to provide the materials and the Trust to 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 Trust Administrative Office. 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 Trust'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 Trust fiduciaries misuse the Trust'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 the Trust or your Benefits, you should contact the Trust Administrative Office. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Trust Sponsor

Board of Trustees
Glazing Health and Welfare Trust

Name and Address of Trust Administrator

BeneSys Administrators
8311 W. Sunset Rd, Suite 250
Las Vegas, NV 89113

Type of Administration

The Trust is administered by the Board of Trustees with the help of the Trust Administrator and staff, consultants, attorneys, accountants, etc.

The Benefits are provided through group insurance policies and pre-paid service plans, or organizations, which have agreements with the Trust. The Benefits provided through these policies and agreements are governed by the terms of those agreements. Copies of these documents are available for inspection at the Trust Administrative Office. Payments by the Trust are subject to the terms of the Collective Bargaining Agreements and the availability of funds to the Trust.

Name and Address of Agent for Service of Legal Process on the Trust

The name and address of the Agent designated for Service of Legal Process is:

BeneSys Administrators
8311 W. Sunset Rd, Suite 250
Las Vegas, NV 89113

Internal Revenue Service Plan Identification Number

88-6023293

Plan Number

502

Plan Fiscal Year End

June 30

Collective Bargaining Agreements

The Plan is maintained and funded from Employer contributions. Employers make contributions for bargaining unit Employees as required by the various Collective Bargaining Agreements between the IUPAT District Council 16, Glaziers Union Local No. 2001 and the Glazing Contractors Association of Southern Nevada. Some Employers also make monthly contributions for non-bargaining unit Employees in amounts comparable to what is paid for the covered Employees in the bargaining unit under the Collective Bargaining Agreements.

All contributions are paid to the Glazing Health and Welfare Trust.

Copies of the applicable Collective Bargaining Agreements under which the Participant or Beneficiary is covered will be furnished by the Trust Administrative Office, upon written request addressed to the Trust Administrative Office. The Trustees may impose a reasonable charge for these copies. Also, copies are available for examination at the Trust Administrative Office and at the Union Local office.

Source of Financing of the Plan and Identity of any Organization through which Benefits are Provided

All contributions to the Trust are made by individual Employers in compliance with Collective Bargaining Agreements in force with their affiliated local Union or a recognized Participation Agreement.

The Benefits provided by this Trust, while intended to remain in effect indefinitely, can be maintained only as long as the parties to the Collective Bargaining Agreements continue to require contributions to the Trust sufficient to fund the cost of the Benefits. Should contributions cease and the reserves be expended, the Trust would no longer be obligated to furnish Coverage. These are not guaranteed lifetime Benefits.

Trust Termination

The Board of Trustees may terminate the Trust pursuant to its authority under the Trust Agreement. In no event will the termination of the Trust result in a reversion of any assets to a participating Employer.

Names and Addresses of Trustees

See page 81.

Insurers and Providers of Service to the Trust

See page 76.

TRUSTEES AND PROFESSIONALS

Union Trustees

Robert Williams (Co-Chairman)
IUPAT District Council 16
2705 Constitution Drive
Livermore, CA 94551
(925) 245-1080

Daniel Lincoln
IUPAT District Council 16
1701 Whitney Mesa Drive, Suite 105
Henderson, NV 89014
(702) 494-9599

Keith Markland
IUPAT District Council 16
1701 Whitney Mesa Drive, Suite 105
Henderson, NV 89014
(702) 688-0653

Administrator

BeneSys Administrators
8311 W. Sunset Rd., Suite 250
Las Vegas, NV 89113
(702) 415-2180
(702) 257-5361 (Fax)

Attorney

Christensen James & Martin, Chtd.
7440 West Sahara Avenue
Las Vegas, NV 89117
(702) 255-1718
(702) 255-0871 (Fax)

Employer Trustees

Terry Mayfield (Co-Chairman)
Executive Director
Glazing Contractors Association of Southern Nevada
2303 East Sahara Avenue, Suite 101
Las Vegas, NV 89104
(702) 457-0556
(702) 457-1965 (Fax)

Gene Shaffer
Academy Glass
5070 S. Arville Street, Suite 10
Las Vegas, NV 89119
(702) 871-6999
(702) 871-6996 (Fax)

Charles Sproul
Avanti Glass
5380 Procyon Street
Las Vegas, NV 89118
(702) 740-2260

Mike Davis, Alternate Trustee
Davis Glass & Mirror
5135 S. Valley Blvd.
Las Vegas, NV 89118
(702) 334-0550

Consultant

Kaufmann and Goble
160 W. Santa Clara St., Suite 1550
San Jose, CA. 95113
(408) 298-1170
(408) 298 -1180 (FAX)

CPA/Auditors

RubinBrown
10801 W. Charleston Blvd., Suite 300
Las Vegas, NV 89135
(702) 415-2112